YELLOW LEAF
SUPPORT CENTER

Welcome to Yellow Leaf Support Center, an ABHI program providing compassionate, person-centered residential crisis stabilization services in a safe, supportive, and recovery-focused environment.

Yellow Leaf Support Center provides short-term residential crisis stabilization services designed to address immediate needs and support a return to pre-crisis functioning. Crisis stabilization services are available for a maximum of ten (10) days. During this time, services focus on identifying current stressors, including those that precipitated the crisis, and reducing the intensity of thoughts, emotions, and behaviors related to the crisis. Our goal is to foster emotional self-regulation, build coping skills, and support the individual's return to baseline functioning with dignity, respect, and hope.

Who We Serve

To be eligible for Residential Crisis Stabilization Services, an individual must meet the following criteria:

- Be 18 years of age or older
- Be a Minnesota resident
- Be assessed as experiencing a mental health crisis or emergency by a mental health crisis team, emergency department, or mental health professional, at a level that does not require a higher level of care such as hospitalization or a detoxification facility
- Be assessed as needing the structure and support of residential crisis stabilization to restore the individual to their pre-crisis level of functioning

Most payers are accepted, though prior authorization may be required. Assistance is available for individuals who are uninsured or underinsured.

What to Expect

Yellow Leaf Support Center provides structure and support to adults in a welcoming, community-based living environment grounded in trauma-informed and recovery-oriented care. A crisis stabilization treatment plan is developed to address the needs for services and supports identified during the individual's crisis assessment. Our multidisciplinary team works collaboratively with each individual to develop a strengths-based discharge plan, including referrals to ongoing mental health services, recovery supports, and meaningful connections to community resources that promote long-term stability and wellness.

Required Intake Documentation

This packet includes the following required forms:

- Crisis Assessment Form, used to gather information about the individual and determine program eligibility
- Medical Standing Orders Form

Please note: A physician's order is required for admission regarding all medications, including both prescribed and over-the-counter medications. A physician's order is also required to change, discontinue, or continue medications after discharge. Medications will be returned to the individual upon discharge only if there are current physician orders. Any medications without current physician orders will be disposed of.

Next Steps

All submitted information will be reviewed by our clinical team to ensure eligibility requirements are met and that admission can be completed safely and thoughtfully. Once eligibility is confirmed and admission is approved, a member of our team will contact you to coordinate next steps and schedule an arrival time.

If you have any questions or concerns, please contact us. Our team is committed to collaboration and continuity of care and is happy to assist you throughout the referral and admission process.

Yellow Leaf Support Center

A Brightwater Health Program

YELLOW LEAF
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Yellow Leaf Support Center – *an ABHI Program*

Client Information

Name:

Date:

Sex: ☐ Male ☐ Female ☐ Other

Preferred Pronouns:

Date of Birth:

SSN:

Street Address:

City, State, Zip:

Primary Phone #:

County of Financial Responsibility:

Guardian (if applicable):

Tribal Affiliation: ☐ Yes ☐ No **Tribe:**

Emergency Information

Name of Emergency Contact:

Emergency Contact Phone #:

Advanced Care Directive: ☐ Yes ☐ No

Race

☐ Black or African American
☐ Asian
☐ White
☐ Native Hawaiian/Pacific Islander
☐ American Indian/Alaska Native

Ethnicity

☐ Hispanic/Latino
☐ Not Hispanic/Latino

Medical Insurance Information

☐ Medical Assistance ☐ Commercial ☐ No Insurance

Insurance ID #:

Referral Information

Referral Source:

Is the client currently on commitment? ☐ Yes ☐ No

If yes, type:

Current Life Situation & Reason for Referral

Current Life Situation & Reason for Referral:

Safety & Risk Assessment

Suicidal Ideation: ☐ Current ☐ Past ☐ None

Describe:

Suicidal Plan: ☐ Current ☐ Past ☐ None

Describe:

Suicidal Means / Lethality / Availability: ☐ High ☐ Medium ☐ Low ☐ None

Harm to Others: ☐ Current ☐ Past ☐ None

Describe:

Intent to Harm Others: ☐ High ☐ Medium ☐ Low ☐ None

Describe:

Previous Suicide Attempt: ☐ Yes ☐ No

Describe (method, date of last attempt, circumstances):

Non-Suicidal Self-Injury: ☐ Yes ☐ No

Describe (method, date of last episode, frequency):

Hallucinations: ☐ Yes ☐ No

Please describe (e.g., auditory, visual, tactile, command, frequency):

Mental Health & Current Supports

Mental Health Diagnoses, Current Symptoms, Safety Concerns, and Risk Behaviors:

Current Life Situation / Mental Health Issues Contributing to Crisis:

Current Service Providers *(agency, provider name, and service provided):*

Substance Use & Withdrawal Risk

Currently Under the Influence of Substances? ☐ Yes ☐ No ☐ Don't Know

Drug / Alcohol Use:

History of Seizures Due to Withdrawal? ☐ Yes ☐ No

If yes, please describe:

Is Detox Required? ☐ Yes ☐ No

Is the client diagnosed with a seizure disorder? ☐ Yes- If yes, please describe ☐ No

Current Functioning

Appearance: ☐ Good ☐ Adequate ☐ Poor ☐ Other: _____

Speech: ☐ Slow ☐ Pressured ☐ Normal ☐ Other: _____

Orientation: ☐ Person ☐ Place ☐ Time

Mood: ☐ Appropriate ☐ Anxious ☐ Blunted ☐ Depressed ☐ Angry ☐ Guarded

☐ Other: _____

Sleep: - Last time slept: - Average hours of sleep per night:

Appetite: - Last time ate: - Last food consumed:

Does the client have diabetes? ☐ Yes ☐ No

Dietary Issues:

Housing: ☐ Group Home ☐ Shelter ☐ Boarding Lodge ☐ Apartment

☐ Other: _____

Strengths and Vulnerabilities

Strengths and Vulnerabilities: *(effective coping skills, caring, sensitive, organized, cooperative, intent to remain sober, stable housing/finances, prideful, strong faith, independent, mature, intellectual, assertive, open minded, honest, determined, resilient, self-confident, patient)*

Cultural / Spiritual Influences or Considerations:

Family and Children / Responsibilities:

Legal:

Employment / School

Employment / School:

Highest Level of Education Completed:

Client Willing to Accept Services Voluntarily? ☐ Yes ☐ No

Medication Information

Medication List (or attach on separate page):

Drug Type	Drug Name	Frequency / Route of Administration

Allergies:

Medication Comments:

Is the client taking medications as prescribed? ☐ Yes ☐ No
If no, how long?

List all medical needs and/or health issues below:

Additional Information and Special Considerations

Additional Information and Special Considerations:

Attestation

By signing this document, I attest that the individual named above is experiencing a mental health crisis or emergency. This individual is in need of residential stabilization services in order to restore them to their pre-crisis level of functioning.

Signature:

Name (Print):

Date:

Title / Credentials:

If you are completing this document and you are not a member of a mobile crisis team, a mental health professional, or an emergency department, name and signature of the Mental Health Professional/Clinical Supervisor must be included:

Signature:

Name (Print):

Date:

Title / Credentials:

Brightwater Health Employee Section

Admit: ☐ Yes ☐ No

Waitlist: ☐ Yes ☐ No

Details:

Signature:

Name (Print):

Date:

Title / Credential: