Family Services

What We Do

Sunrise Family Services is a growing network of servant-minded, compassionate mental health professionals who are licensed by the Commonwealth of Kentucky in a variety of disciplines and specialties. Our team has accepted the call to serve and do so daily in a variety of settings and ways.

Our team can provide individual and family therapy services to address:

- Emotional, social and situational problems
- Anxiety, depression, grief/loss, relationship issues, stress, trauma
- Substance related and addictive disorders
- ADD, ODD, OCD, PTSD, bipolar, dissociative, impulse-control, disruptive, and personality disorders
- Short-term, long-term and crisis problems

We also offer targeted case management services for adults and children, which is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet the client's health and human services needs.

Services Available

- Individual therapy
- Family therapy
- Assessments
- Telehealth
- Educational opportunities and professional training
- Targeted case management, adult and child

Methods of Payment

- Kentucky Medicaid
- Self pay
- Select commercial insurances

Locations

1925 Frederica Street
Suite 200
Owensboro, KY 42301
270.926.2484

400 Cunningham Way
Danville, KY 40422
859.936.3492

1079 Thornberry Drive
Suite 203
Madisonville, KY 42431
270.874.2560

123 Weddington Branch Rd
Pikeville, KY 41501
606.437.9500

300 Hope Street
Mt. Washington, KY 40047
502.538.1000

To schedule an appointment or learn more:

Contact the office near you.

SUNRISE
Children's Services

Danielle Mertz
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sunrise.org

SUNRISE
Children's Services

FS-010 Provider Referral Form

☐ **Danville**	☐ **Madisonville**	☐ **Owensboro**	☐ **Pikeville**	☐ **Mt. Washington**
Phone: 859.936.3492	Phone: 270.874.2560	Phone: 270.926.2484	Phone: 606.437.9500	Phone: 502.538.1000
Fax: 502.538.1148	Fax: 270.825.8081	Fax: 270.685.6015	Fax: 606.432.0047	Fax: 502.538.1100

☐ **Case Management** ☐ **Therapy**

Client's Name: _____ Referral Date: _____

Gender: ☐ Male ☐ Female Date of Birth: _____ SSN: _____

Medicaid/Insurance Info: _____

Mental Health Dx: _____

Custody of: ☐ Parent ☐ DCBS ☐ DJJ ☐ Other: _____

Name: _____ Phone: _____

Address: _____ County: _____

City, State, Zip: _____

School: _____ Grade: _____

Email: _____ Cell: _____

Issues / Problems / Reason for Referral

Referred by (Agency/Contact Person): _____

Phone: _____ Email: _____