Authorization for Transportation to an Evaluation and Treatment Facility

Washington State Health Care Authority

Transportation Service Provider

Phone number | Fax number

Address

Select One: ☐ Mental Health Transport ☐ Chemical Dependency Transport

Attestation: (All must apply per RCW 70.168)

- ☐ Client is safe to be transported via ambulance
- ☐ Client is Medicaid eligible and being transported to a Medicaid eligible facility
- ☐ Client has a clear history of mental health or chemical dependency problems
- ☐ Client consents to transport to an evaluation and treatment facility
- ☐ Client consents to voluntary evaluation and treatment
- ☐ Client is ambulatory, cooperative, and non-combative
- ☐ Normal level of consciousness, no medical issues suspected

Section 1 Client Information

Last name | First name

Client ID number | Client date of birth (mm/dd/yyyy) | ☐ M ☐ F Gender

Client address

Date of transport (mm/dd/yyyy) | Place of pickup

Name of facilty

Address of treatment facility

Section 2 Certification

I certify that the information contained above accurately represents that the client is eligible for non-emergency evaluation and treatment transportation in accordance with RCW 71.05 and/or 70.96A.

Client signature | Date (mm/dd/yyyy)

Emergency/medical personnel name (please print): | Title

Emergency/medical personnel signature | Date (mm/dd/yyyy)