**Authorization for Transportation to an Evaluation and Treatment Facility**

**Transportation Service Provider:**

**Phone #:**       **Fax #:**

**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 I - Client Information**

Last name:       First name:

M  F Client ID number:       DOB:

Client address:

Date of transport(mm/dd/yyyy):

Place of pickup:

Name and address of treatment facility:

**Section II – 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:

Emergency/medical personnel name (please print):

      Title:

Emergency/medical personnel signature:

      Date: