**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: