

Authorization of Ambulance/Secure Transportation Services under the Involuntary Treatment Act (ITA)

Use this form for mental health transports and for substance use disorder transports.

Client name		Date of transport	County of residence
Address		City	State
			ZIP Code
<input type="checkbox"/> Homeless <input type="checkbox"/> Transient <input type="checkbox"/> Other:			Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
Birthdate (MM/DD/YYYY)	SSN	ProviderOne ID	

The section below must be completed by a Designated Crisis Responder (DCR).

Reason for detention (check all that apply): <input type="checkbox"/> Danger to self <input type="checkbox"/> Danger to others <input type="checkbox"/> Gravely disabled <input type="checkbox"/> LRA revocation <input type="checkbox"/> Danger to property		
ITA status at time of transport: <input type="checkbox"/> Detained <input type="checkbox"/> Committed <input type="checkbox"/> LRA/CR revoked <i>LRA = Less restrictive alternative/CR = Conditional release</i>		
Date of detention	Destination facility name	Destination county

DCR Attestations By signing below, I certify that the following statements are true: <ul style="list-style-type: none"> • The above-named individual has been assessed by a DCR and found to meet criteria for detention/revocation/commitment, per RCW 71.05, or RCW 71.34. • I am authorized to take said individual or cause said individual to be taken into custody and placed into a treatment facility or crisis center, per RCW 71.05.150(4), or RCW 71.05.153(1). • The individual named above has been detained, committed, or is being returned to the hospital by a petition for detention/revocation or an order of commitment pursuant to RCW 71.05, or RCW 71.34. 	
Signature of DCR	Date
Name of DCR (print)	BHO (including county)

PROVIDER: Attach a completed copy to your claim; keep the original in the client's file.