

# Single Bed Certification Form

WAC 182-538D-0526

Fax requests to: Eastern State Hospital at (509) 565-4616.

To speak with the nurse processing SBCs, please call (509) 565-4644

County:		<input type="checkbox"/> Initial Request	
		<input type="checkbox"/> Extension Request	
Name and title of requestor –OR– facility name for persons under 18 years of age:			
Requestor fax number:	Requestor phone number:	Date requested:	Time requested:

The facility that is the site of the proposed single bed certification confirms that it is willing and able to provide directly, or by direct arrangement with other public or private agencies, timely and appropriate mental health treatment to the person for whom the single bed certification is sought. The single bed certification will apply only to that facility only for a period of 30 days.

Facility:	City:
Name and title of acceptor:	Acceptor phone number:

<b>Patient information</b>	First name:	Last name:	Middle Initial:
Date of Birth:	If person is under 18 years of age, is this request for certification on an adult unit? <input type="checkbox"/> Yes <input type="checkbox"/> No		Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other
<b>Legal status</b>	<input type="checkbox"/> 72 Hour Detention	<input type="checkbox"/> 14-Day Commitment	<input type="checkbox"/> 90-Day LRA Revocation Order
	<input type="checkbox"/> LRA Revocation Detention	<input type="checkbox"/> 90-Day Commitment	<input type="checkbox"/> 180-Day LRA Revocation Order
		<input type="checkbox"/> 180-Day Commitment	<input type="checkbox"/> 365-Day LRA Revocation Order

<b>Criteria for Request</b>
<input type="checkbox"/> The person is expected to be ready for discharge from inpatient services within the next thirty days and being at a community facility would facilitate continuity of care, consistent with the person's individual treatment needs.
<input type="checkbox"/> The person can receive appropriate mental health treatment in a residential treatment facility, as defined in WAC 246-337-005. The RTF is a certified E&T: <input type="checkbox"/> Yes <input type="checkbox"/> No – If the RTF is not an E&T, the SBC requires an attachment documenting how the RTF will meet the person's evaluation and treatment needs per WAC & RCW
<input type="checkbox"/> The person can receive appropriate mental health treatment at a: <input type="checkbox"/> Hospital with a psychiatric unit <input type="checkbox"/> Hospital that can provide timely and appropriate mental health treatment <input type="checkbox"/> Psychiatric hospital
<input type="checkbox"/> The person requires MEDICAL services that are not generally available at a facility certified under WAC 388-865-0526.
<input type="checkbox"/> The person is awaiting transportation to an identified bed at a certified E&T and the Emergency Room is willing and able to provide mental health treatment in the interim.
Describe why person meets Criteria for Request. (Include medical services required.)

<b>FOR USE BY STATE HOSPITAL STAFF ONLY</b>		
Certification approved by:		Title:
Date approved:	Time approved:	<b>THIS CERTIFICATION EXPIRES 30 DAYS FROM DATE OF APPROVAL</b>