Authorization of Secure Ambulance Transportation to/from Behavioral Health Services

Washington State Health Care Authority

Purpose

The Authorization of Secure Ambulance Transportation to/from Inpatient Behavioral Health Services form supplies demographic information necessary for the creation of eligibility for an individual without active Medicaid coverage.

Client Name (Last, First, Middle Initial) _____ **Date of transport** _____ **ProviderOne Client ID *(If Applicable)*** _____

Address _____ **City** _____ **State** _____ **ZIP Code** _____

County of Residence

_____ ☐ Homeless ☐ Transient ☐ Other:_____

Birthdate (MM/DD/YYYY) _____ **SSN** _____ **Gender** ☐ Male ☐ Female

Service Status *(check the appropriate box)* ☐ **Voluntary** ☐ **Involuntary**

Voluntary Services Attestation

By signing below, I certify that the above-named individual has been assessed by an Emergency Room Doctor/ Attending Physician and found to meet criteria for voluntary behavioral health services and is **not** detained or committed pursuant to RCW 71.05 or 71.34.

Signature of Medical Professional _____ **Date** _____

Involuntary services

The section below is for involuntary services and must be completed by a Designated Crisis Responder (DCR).

Reason for detention (check all that apply):

- ☐ Danger to self
- ☐ Danger to others
- ☐ Gravely disabled
- ☐ LRA revocation
- ☐ Danger to property

ITA status at time of transport:

- ☐ Detained
- ☐ Committed
- ☐ LRA/CR revoked

LRA = Less restrictive alternative
CR = Conditional release

Date of detention _____ **Destination facility name** _____ **Destination county** _____

DCR Attestations

By signing below, I certify that the following statements are true:

- 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.

Name of DCR (print) _____ **Signature of DCR** _____ **Date** _____

Behavioral Health Administrative Service Organization (BH-ASO)
or Behavioral Health Organization (BHO) — including county: _____

PROVIDER: Attach a completed copy of this form, to your claim submission; keep the original in the client's file.