| **Demographic Information****Health Care Authority Treat and Refer Program Participation Attestation**  |
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| EMS Service / Agency Name:       | Provider One ID Number:       |
| National Provider Identification (NPI) Number:       |
| Agency Email:       | Phone number:      |
| Agency Mailing Address:       |
| City:       | State:       | ZIP Code:       | County:       |
| Treat and Refer Coordinator Name:      | Treat and Refer Coordinator Email:      |
| MPD Name:      | MPD Email:      |
| **Treat and Refer Attestation**  |
| * By signing this form, I acknowledge that I have read, understand, and agree to abide by the Health Care Authority’s (agency) rules under Washington Administrative Code (WAC) 182-531-1740 for participation in the agency’s Treat and Refer program.
* I certify that my organization understands that as a condition of payment under the Treat and Refer program that my organization must be an enrolled eligible Medicaid provider as defined under chapter 182-502 WAC and meet the requirements to develop a community assistance referral and education services (CARES) program under RCW 35.21.930.
* If at any time the organization no longer meets the requirements for this program, the organization will immediately notify the agency by contacting provider enrollment at providerenrollment@hca.wa.gov.
	+ By signing below, I certify that I have read and understand the Health Care Authority Treat and Refer Program Participation Agreement. I have also read, understand, and agree to abide by the agency’s rules for participation in the Treat and Refer program, including all applicable federal and state statutes, rules, and policies, and I have discussed any questions concerning participation in the program with the agency:

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print or Type Name     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signed at (City)      , (State)       on (Date)      |
| **Treat and Refer Self Attestation Form Submission Instructions** |
| Email the completed attestation with required signature to the address below: providerenrollment@hca.wa.gov |