Single Bed Certification Form WAC 388-865-0526

Fax requests to:
Eastern State Hospital FAX# 509-565-4616

Requesting BHO: GC BHO NC BHO SC BHO Facility	Initial request	Extension request

Name and title of requester: *(Facility name in the case of a child under 18 years of age)*

Requester Fax #:	Requester Phone #:
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 consumer for whom the single bed certification is sought. The single bed certification will apply only to that facility.

Facility:	Accepted by:	Acceptor's Phone #:

Patient name (first, last, M.I.):

DOB:	SSN: (if avail.)	CID: (ProviderOne or CIS)
Gender: M F Other	Legal status at time of request: 72 hour hold 14 Day Commitment LRA Revocation 90 Day Commitment 180 Day Commitment	

Criteria for Request – check one box:

The consumer 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 consumer's individual treatment needs.

The consumer 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 Y N (Requests for RTFs that are not an E&T must be accompanied with an attachment detailing how the placement will meet the consumer's evaluation and treatment needs.)

The consumer can receive appropriate mental health treatment in one of the following:

A hospital with a psychiatric unit
A hospital that can provide timely and appropriate mental health treatment
A psychiatric hospital

The consumer requires MEDICAL services that are not generally available at a facility certified under WAC 388-865-0526. Describe the medical condition and medical services that are needed.

_____
_____
_____

If consumer is under 18 years of age, is this request for certification on an adult unit: Y N

This portion of form to be completed by state hospital staff

Certification approved by:	Title:
Date approved:	Time approved:

THIS CERTIFICATION EXPIRES 30 DAYS FROM DATE OF APPROVAL

ESH Switchboard: 509-565-4644

BHA form issued: 04/01/2016