

Single Bed Certification Form - WAC 388-865-0526

Fax requests to:

Eastern State Hospital FAX# 509-565-4616

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

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|-----------------|-----------------------------------|---------------------------------|---------------------------------|--|
| Requesting BHO: | <input type="checkbox"/> GC BHO | <input type="checkbox"/> NC BHO | <input type="checkbox"/> SC BHO | <input type="checkbox"/> Initial Request |
| | <input type="checkbox"/> Facility | | | <input type="checkbox"/> Extension Request |

Name and title of requester: (Facility name in case of a consumer under 18 years of age):
 DMHP;

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| 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.

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| Facility: | City: |
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| Accepted By: | Acceptors Phone #: |
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| Patient Name (first, last, M.I.): | DOB: |
|-----------------------------------|------|

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|---|--|--|---|
| Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other | Legal Status at the request: | <input type="checkbox"/> 72 Hour Hold | <input type="checkbox"/> LRA Revocation |
| | <input type="checkbox"/> 14 Day Commitment | <input type="checkbox"/> 90 Day Commitment | <input type="checkbox"/> 180 day Commitment |
| | <input type="checkbox"/> 90 day Rev | <input type="checkbox"/> 180 Day Rev | <input type="checkbox"/> 365 Day Rev |

Criteria for Request - check appropriate 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
- The consumer can receive appropriate mental health treatment at a:
 - Hospital with a psychiatric unit
 - Hospital that can provide timely and appropriate mental health treatment
 - Psychiatric hospital
- The consumer requires MEDICAL services that are not generally available at a facility certified under WAC 388-865-0526.
- The consumer 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.

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| Describe why consumer meets criteria for request. (Include medical services needed.) |
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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.)

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| Certification approved by: | Title: |
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| Date approved: | Time approved: |
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THIS CERTIFICATION EXPIRES 30 DAYS FROM DATE OF APPROVAL

BHA form issued: 6/12/2017