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|  | **Initial Assessment**  **ECLIPSE Certification and Signatures** |

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| CHILD’S NAME ECLIPSE FACILITY CHILD ATTENDING | |
| By signing below, I certify that the **child meets medical necessity** and have the expertise to make that determination based on the evidence presented. **WAC 284-43-5440** | |
| PROGRAM PHYSICIAN CONSULTANT SIGNATURE | DATE |
| ECLIPSE ADMINISTRATOR SIGNATURE | DATE |
|  | |
| By signing below, I certify that the **child does not meet medical necessity** and have the expertise to make that determination based on the evidence presented. **WAC 284-43-5440** | |
| PROGRAM PHYSICIAN CONSULTANT SIGNATURE DATE | |
| ECLIPSE ADMINISTRATOR SIGNATURE DATE | |