Psychiatric Residential Treatment Facility

Attestation Form

Provider Name:

Provider ID: NPI:

Address:

Phone: FAX:

Email Address:

I, a representative of the facility , attest that:

1. The Provider hereby complies and meets all requirements set forth in Subpart G of Part 483 of Title 42 of the Code of Federal Regulations (42 C.F.R. §§ 483.350 through 483.376) (hereinafter, “Subpart G”), governing the use of restraint or seclusion in psychiatric residential treatment facilities (PRTFs) providing inpatient psychiatric services to individuals under age 21.
2. The Centers for Medicare and Medicaid Services (CMS), the Oklahoma Health Care Authority (OHCA), and the Oklahoma State Department of Health (OSDH), and any representatives thereof, shall rely on this attestation in determining whether the facility is entitled to payment for its services.
3. Pursuant to Medicaid regulations, including, but not limited to, 42 C.F.R. § 431.610, OHCA, CMS, OSDH, and/or any other entity authorized by law has the right to validate that Provider is in compliance with the requirements set forth in Subpart G, to investigate complaints lodged against the facility, and to investigate serious occurrences as defined in Subpart G. Surveyors must make a determination regarding the compliance or non-compliance of the overall Condition of Participation under Subpart G at the end of each facility survey. A determination of non-compliance may be based upon either patterns of performance or isolated instances with real or potential harm for residents.
4. OHCA, CMS, OSDH, and/or any other entity authorized by law, as well as any agents or representatives thereof, has the right to conduct an on-site survey at any time as deemed necessary, in accordance with the law.
5. I shall notify OHCA immediately if I vacate this position so that an attestation can be submitted by my successor.
6. I shall notify OHCA, OSDH, and any other entity as required by law for regulatory compliance, if it is my belief that the Provider is out of compliance with requirements set forth in Subpart G.

Number of PRTF Beds: \_\_\_\_\_\_

Number of Medicaid children currently in PRTF treatment from the State of Oklahoma: \_\_\_\_\_\_\_

Number of Medicaid children currently in PRTF treatment from other states: \_\_\_\_\_\_

Specify states: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all states from which the PRTF has ever received Medicaid payment for the provision of inpatient psychiatric services to individuals under age 21: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*For out-of-state providers only*

Does your state offer Medicaid reimbursement for services provided in a PRTF?  Y  N

If yes, are you a contracted Medicaid PRTF Provider?  Y  N

If yes, number of Medicaid children currently in PRTF treatment that are residents of your state: \_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Facility Director

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Printed Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title Date