

Psychiatric Residential Treatment Facility  
Attestation Form

Provider Name:

Provider ID:

NPI:

Address:

Phone:

FAX:

Email Address:

With a reasonable investigation having been conducted in the subject facility, Provider makes the following certification:

1. Based upon my personal knowledge and belief, I attest Provider hereby complies with all of the 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. I understand that the Centers for Medicare and Medicaid Services (CMS) and the Oklahoma Health Care Authority (OHCA), or representatives thereof, may rely on this attestation in determining whether the facility is entitled to payment for its services. I also understand that, pursuant to Medicaid regulations, including, but not limited to, 42 C.F.R. § 431.610, OHCA, CMS, 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.
3. I understand that OHCA, CMS, 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.
4. I will notify OHCA immediately if I vacate this position so that an attestation can be submitted by my successor.
5. I will notify OHCA if it is my belief that Provider is out of compliance with the 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?:

If yes, are you a contracted Medicaid PRTF Provider?:

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

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Signature of Facility Director

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Printed Name

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Title

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Date

Psychiatric Residential Treatment Facility (PRTF)  
Children's Specialty  
Approval Form

Provider Name:

Provider ID:

NPI:

Address:

Phone:

FAX:

By signing this agreement, Provider agrees:

1. A physician will see each member at minimum, once a week.
2. To maintain medical records that document the degree and intensity of the psychiatric care delivered to children.
3. To maintain a staffing ratio of 1:3 at a minimum during routine waking hours and 1:6 during time residents are asleep, with 24-hour nursing care supervised by a RN for management of behaviors and medical complications.
4. To be a secure unit, due to the complexity of needs and safety considerations.
5. To meet admission guidelines found in all applicable State and Federal law, including, but not limited to, OAC 317:30-5-95.24 and Subpart D of Part 441 of Title 42 of the Code of Federal Regulations.

**All requirements are mandatory to be recognized as a PRTF Children's Specialty.**

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Name and Position of Person Completing this Form

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Contact Telephone Number

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Date

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Signature of Provider

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Name of OHCA Representative

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Date

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Signature of OHCA Representative