State of Wyoming, Department of Health, Medicaid

PSYCHIATRIC RESIDENTIAL TREATMENT FACILITY (PRTF) FORM

ATTESTATION OF FACILITY COMPLIANCE

***** To be completed and signed by Facility Director *****

1. Facility Name					
2. Facility Address					
3. City		4. State		5. Zip	
6. Telephone #		7. Fax #			
8. Email		9. Medicaid Provider # *(existing providers only)*			

10. Accrediting Agency *(check only one)*	☐ Joint Commission on Accreditation of Healthcare Organizations (JCAHO) ☐ Commission on Accreditation of Rehabilitation Facilities (CARF) ☐ Council on Accreditation of Services for Families and Children (CASFC)	11. Type of Control *(check only one)*	☐ Private Non-Profit ☐ Proprietary ☐ Religious Affiliation ☐ Vol Non-Profit Relig Affl ☐ For Profit ☐ Not For Profit ☐ Corporation ☐ State ☐ Local Government

12. Total number of **facility** beds Total number of **PRTF** beds	
13. Number of Wyoming Medicaid residents in the facility at the present time	
14. Number of residents for whom the Psych under 21 is paid for by another state	
15. List of all states from whom the facility has ever received Medicaid payment for the provision of the Psych under 21 benefit	
16. Do you certify that the facility currently meets and will continue to meet all of the requirements in C.F.R. Part 483, Subpart G, governing the use of restraint and seclusion?	☐ YES ☐ NO
17. Do you certify that the facility currently meets all of the requirements of C.F.R. Part 441, Subpart D, which includes state accreditation, certification of need for the services, the team certifying the need for services, active treatment, components of an individual plan of care, and the team involved in developing the individual plan of care?	☐ YES ☐ NO
18. Do you acknowledge the right of the State Survey Agency (or its agents) and if necessary, CMS to conduct an on-site survey at any time to validate the facility's compliance with the requirements of the rule, to investigate complaints lodged against the facility, or to investigate serious occurrences?	☐ YES ☐ NO
19. Do you acknowledge that the facility will submit a new attestation of compliance annually by July 21st, and in the event that the facility director is no longer in such position?	☐ YES ☐ NO

20. A PRTF is a facility other than a hospital. "Facility" means a **distinct, stand alone entity,** providing a range of needed services to a distinct population. Clients receiving inpatient psychiatric services **cannot** be co-mingled with clients who are **not** receiving inpatient psychiatric services at any time, including during meals, therapies, schooling, etc. Do you acknowledge that the inpatient psychiatric (PRTF) population is separate from other client populations at all times?	☐ YES ☐ NO
21. Do you acknowledge that all inpatient psychiatric services are being provided before the individual reaches 21, or if the individual was receiving services prior to turning 21, that the services will no longer be paid by Medicaid at the time the individual no longer requires services, or the date on which the individual reaches 22?	☐ YES ☐ NO
22. Do you acknowledge that: (1) ambulatory care resources available in the community do not meet the treatment needs of the residents and that according to §441.152 (2) proper treatment of the residents' psychiatric conditions require services on an inpatient basis under the direction of a physician; and (3) the services can reasonably be expected to improve the residents' conditions or prevent further regression so that the services will no longer be needed.	☐ YES ☐ NO
23. Does the facility have contracts in place with local providers such as general hospitals, dentists, optometrists, pharmacies, physical therapists, occupational therapists, speech therapists, etc., to ensure the medical care of a Wyoming Medicaid client? Please provide information regarding these contracts and how the facility's processes work, i.e.; names of those contracted with, types of services provided, etc.	☐ YES ☐ NO
24. Does the facility have contracts or agreements in place with Wyoming agencies such as the Wyoming Department of Family Services, Wyoming Department of Health (other than Medicaid), Wyoming Department of Education, or other agencies? If yes, please provide information regarding these contracts and how the facility's processes work, i.e.; names of those contracted with, types of services provided, etc.	☐ YES ☐ NO

Certification. In signing this document you are attesting that you have read, understand and agree to all conditions for participation as a Psychiatric Residential Treatment Facility as required by the Code of Federal Regulations, Wyoming Statute and Wyoming Medicaid Rules and that all statements contained herein are true to the best of your knowledge.

25. Director's Name Printed			
26. Director's Signature		27. Date Signed	
FOR STATE MEDICAID AGENCY USE			
Date Attestation Received by OHC		Date Attestation Sent to OHLS	
Action Taken			