

Residential Treatment Facility Model Attestation Letter

(The facility director must sign this attestation)

(RTF LETTERHEAD)
NAME OF THE RTF
ADDRESS
CITY, STATE, ZIP CODE
PHONE NUMBER

Medicaid Provider Number	
Number of Beds in Facility	
Number of individuals currently served in the PRTF who are receiving Alabama Medicaid covered <i>Psych Under 21</i> (PRTF) benefits	
Number of individuals, if any, whose PRTF services are being paid for by a state Medicaid agency other than Alabama Medicaid	

Dear (ALABAMA MEDICAID COMMISSIONER):

A reasonable investigation subject to my control having been conducted in the subject facility, I make the following certification. I hereby attest that I have read all of the requirements set out in the regulations as codified at 42 CFR 483.350-483.376. Based upon my personal knowledge and belief, I attest that the (NAME OF FACILITY) hereby complies with all of the requirements set forth in the interim final rule governing the use of restraint and seclusion in psychiatric residential treatment facilities providing inpatient psychiatric services to individuals under age 21 published on January 22, 2001, and amended with the publication of May 22, 2001 (*Psych Under 21 rule*).

I understand that the Centers for Medicare and Medicaid Services (CMS, formerly HCFA), the Alabama Medicaid Agency, or their representatives may rely on this attestation in determining whether the facility is entitled to payment for its services and, pursuant to Medicaid regulations at 42 CFR, Section 431.610, have the right to validate that (NAME OF FACILITY) is in compliance with the requirements set forth in the *Psych Under 21* rule, and to investigate serious occurrences as defined under this rule.

(NAME OF FACILITY) will submit a new attestation of compliance by July 21st of each year (-or by the next business day if July 21st falls on a weekend or holiday).

In addition, I will notify the Alabama Medicaid Agency immediately if I vacate this position so that an attestation can be submitted by my successor. I will also notify the Alabama Medicaid Agency if it is my belief that (NAME OF FACILITY) is out of compliance with the requirements set forth in the *Psych Under 21* rule.

Signature _____ Title _____

Printed Name _____ Date _____

This attestation must be signed by an individual who has the legal authority to obligate the facility.

Revised 09/29/2014

This form can be downloaded from the Alabama Medicaid Agency website: www.medicaid.alabama.gov