**Attestation Letter of Compliance with 42 CFR 483.350-483.376**
**Condition of Participation for the use of Restraint or Seclusion in**
**Psychiatric Residential Treatment Facilities (PRTF)**

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|---|---|
| **Name of PRTF:** | |
| **Address:** | **City, State, Zip Code:** |
| **Telephone Number:** | **Fax Number:** |
| **State License Number:** | **Federal Provider Number:** |
| **Administrator:** | |
| **E-Mail Address:** | |
| **Total Number of Beds:** | **Total Number of Medicaid Residents in Facility:** |
| **Number of residents for whom the Psych under 21 is paid for by another state:** | |
| **List of all states from whom the facility has ever received Medicaid payment for the provision of the Psych under 21 benefit :** | |
| **Attestation Submitted Annually- Last Date submitted:** | |

Based upon my best knowledge, information, belief, reasonable interpretation and understanding 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, on behalf of _____(Name of the Facility), I hereby attest that this facility meets the Conditions of Participation found in 42CFR Part 483 Subpart G that all residents meet the certification of need requirements for PRTF Treatment Facilities Providing Inpatient Psychiatric Services for Individuals under Age 21.

I understand that the Centers for Medicare & Medicaid Services (CMS), the State Medicaid Agency or their representatives may survey this facility to determine compliance with the requirements set forth in the Condition of Participation as established by the interim final rule in accordance with and to the extent authorized by 42 CFR § 431.610.

In addition, I will notify The Department of Health and Hospitals-Health Standards Section and the State Management Organization immediately if I vacate this position so that an attestation can be submitted by my successor. I will also notify The Department of Health and Hospital-Health Standards Section and the State Management Organization if it is my belief this facility is out of compliance with the requirements set forth in the Psych under 21 rule.

Facility Director (Type or Print)_____

Facility Director Signature    _____    Date

*HSS-PT-04 (revised 01/18/12; 02/24/2020)*