ANNUAL ATTESTATION OF COMPLIANCE WITH SUBPART G OF PART 483 OF TITLE 42 OF THE CODE OF FEDERAL REGULATIONS

Each licensed psychiatric residential treatment facility (PRTF) shall annually complete and submit this form to the Department of Health Care Services attesting, in writing, that the facility is in compliance with the Centers for Medicare and Medicaid Services' standards governing the use of restraint and seclusion. (See 42 C.F.R. § 483.374(a); PRTF Interim Regulations, § 3(c).)

INSTRUCTIONS FOR COMPLETION OF THIS FORM

Please read and follow these instructions carefully and, complete each item requested. Submit your attestation only after it has been properly completed and signed.

DO NOT LEAVE any questions, boxes, lines, or fields blank.

DO NOT USE staples on this form or on any attachments.

DO NOT SUBMIT doubled-sided or bound documents.

DO NOT USE plastic sheets or page protectors, correction tape, white out, or highlighter pen or ink of a similar type on this form. If you must make corrections, please line through, date, and initial in ink.

You may attach additional documents if your response to a section in this form does not fit in the provided space. Label each additional document with a unique attachment name (for example, "Attachment A"), and identify that attachment in the appropriate section of the form. You must provide a response in all sections that request information. If a section does not apply, enter "N/A."

SECTION A – FACILITY INFORMATION

Facility Name, Telephone, and Email Address – Enter the name, telephone number, and email address (if applicable) of the facility.

Facility Street Address – Enter the physical location of the facility.

Facility Mailing Address – Enter the facility's mailing address, if different from the street address.

Total number of licensed beds – Enter the number of beds that the facility is licensed to provide services for.

SECTION B – ATTESTATION

Read the attestation carefully before signing the form. The attestation shall be signed by the facility administrator.

SECTION A – FACILITY INFORMATION

Facility Name:	Telephone:
	Email Address (If applicable):

Facility Street Address:	City:	Zip Code:	County:
Facility Mailing Address: (if different from above)	City:	Zip Code:	County:

Total number of licensed beds:
Date annual attestation was last submitted:

SECTION B – ATTESTATION

I declare, under penalty of perjury under the laws of the State of California and certify that the PRTF identified in this form is in compliance with Subpart G of Part 483 of Title 42 of the Code of Federal Regulations.

I declare that I am authorized to sign this form on behalf of the PRTF.

Facility Administrator, Print Name:	
Facility Administrator, Signature:	Date:

Please submit your attestation to:
Department of Health Care Services
Licensing and Certification Division
ATTN: Mental Health Licensing and Certification Branch
P.O. Box 997413, (MS 2800)
Sacramento, CA 95899-7413
Main Line: (916) 323-1864
Fax: (916) 324-0993
Email: PRTF@dhcs.ca.gov

PRIVACY NOTICE ON COLLECTION

The purpose of this form is to collect information for licensure of PRTFs. The information collected in this form is required by the Department of Health Care Services (Department), Licensing and Certification Division, Mental Health Licensing and Certification Branch by the authority of Health and Safety Code sections 1250.10 and 1254, Welfare and Institutions Code sections 4081 and 4082, and the PRTF Interim Regulations. The personal information collected in this form is confidential and protected by the Information Practices Act (California Civil Code section 1798 et seq.), Department policy, and state policy.

All information requested in this form is mandatory. The consequence of not supplying the mandatory information requested or supplying incomplete information is that review of the application shall be terminated. The Department may share provided information with other state agencies to perform its constitutional or statutory duties where the use is compatible with a purpose for which the information was collected. The Department may also share information with local, state, or federal government entities if required by state or federal law. Please do not provide any personal information other than the information that is specifically requested in this form.

In most cases, individuals have a right to access information about them that is in federal and state records. For more information or access to records containing your personal information maintained by the Department, contact the following:

Licensing and Certification Division
Section Officer of the Day
1501 Capitol Avenue, MS 2601
Sacramento, CA 95814
Tel: (916) 322-2911

The Department of Health Care Services' policies regarding personal information are available online in the Department's Notice of Privacy Practices (https://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx) and the Privacy Policy Statement (https://www.dhcs.ca.gov/pages/privacy.aspx).