



**Attestation Form for Part 820 Residential Services for
OASAS Certified Programs**

To:	From:
Re:	
Program Name:	
Program Address:	
Current Operating Certificate #:	PRU #:

ELEMENT:	<input type="checkbox"/> Stabilization	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Reintegration
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Instructions to Provider: Please complete the below form while closely reviewing the guidance document entitled, "Part 820 Policy and Procedure Guidance Document".

Criteria:	Protocols Meet Criteria (Y/N)	Requested Deviations from Criteria (briefly explain):
<u>Admission and Discharge, including Transfer and Referral Procedures</u>		
Admission Criteria	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Initial Determination	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Level of Care determination	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Admission Decision/Assessment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Admission Priorities	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Rules and Regulations; Confidentiality and Voluntary Participation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Transfer	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Referral	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Discharge Criteria	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Involuntary Discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Discharge Planning	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Discharge Summary	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Treatment/Recovery/Service Plans</u>		
Treatment/Recovery/Service Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Treatment/Recovery/Service Plan Review	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Care Coordination	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<u>Staffing</u>		
Addresses clinical supervision and on-going training needs of staff	<input type="checkbox"/> Yes <input type="checkbox"/> No	



Criteria:	Protocols Meet Criteria (Y/N)	Requested Deviations from Criteria (briefly explain):
Screening and Referral Procedures for Associated Physical or Psychiatric Conditions		
Medical Assessment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Psychiatric assessment	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Physical Exam	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Schedule for Fee for Services Rendered		
Addresses process for collection of fees	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Infection Control Procedures		
Policy developed in consultation with medical staff and include universal precautions	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cooperative Agreements		
Addresses services needed by other entities and described referral and follow up process	<input type="checkbox"/> Yes <input type="checkbox"/> No	
HIV/AIDS Education, Testing and Counseling and Medication Supported Recovery		
Policy with a focus for provision of HIV/AIDS services (including education, testing, pre- and posttest counseling), whether in house or by referral	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Policy contains a statement of the program's provision of this service and its philosophy regarding this practice	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Alcohol and Drug Screening Tests		
Policy meets the requirements of Part 815.8 and includes: <ul style="list-style-type: none"> • When a screen will be conducted • How results are documented • Chain of custody process • How staff are notified of step-by-step collection process 	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ordering, Procuring and Disposing of Medication, as well as Self-Administration		
Ordering	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Procuring	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Disposal	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Self-Administration	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Quality Improvement and Utilization Review		
Quality Improvement	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Key Performance Measures	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Utilization Review Process	<input type="checkbox"/> Yes <input type="checkbox"/> No	



Criteria:	Protocols Meet Criteria (Y/N)	Requested Deviations from Criteria (briefly explain):
Emergencies		
Policy in place outlines staff response to emergencies	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Incident Reporting and Review in accordance with Part 836		
Responsibility	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Corrective Action Plans	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Incident Review Committee	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Annual Review	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Periodic Training	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Retention of Records	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Recording and Reporting Procedures	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Minimum Standards for Investigation	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Overall Effectiveness	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Record Keeping		
Record Keeping	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Type of System	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Procurement, Storage, Preparation of Food and Nutritional Planning		
Addresses methods for obtaining, proper storage and meal planning	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Records Retention		
Policy established includes: How long resident case records are maintained; minimum standards are met	<input type="checkbox"/> Yes <input type="checkbox"/> No	



Attestation:

By signing below, I attest that policies and procedures for the above-named program meet the criteria as described in, “Part 820 Policy and Procedures Guidance Document” and are written from a Trauma Informed, Strength based, Person Centered perspective. I understand that OASAS retains the right to review my program’s policies and procedures at any time, and if the policies are found to be out of compliance with the above criteria and/or not to meet the standard of care for any reason, OASAS retains the right to request revisions , and initiate regulatory action as necessary and appropriate.

Signature of Program Representative

Date

OASAS REVIEW:

I have reviewed and accepted the attestation from Provider

OASAS Representative Signature

Date