# HOSPITAL
# SPECIALIZED UNIT
# ATTESTATION FORM
# (Louisiana Medicaid Program)

# Burn Care Criteria

**(Form is subject to change without notice)**

# BURN CARE CRITERIA

## LOUISIANA MEDICAID ATTESTATION REQUIREMENTS

Louisiana Medicaid Provider Number | | | | | | | |

National Provider Identifier (NPI) | | | | | | | | | | |

Louisiana Medicaid Provider Name: _____

Contact Name: _____

Contact Phone Number: (  )  -

The above-named Facility attests its compliance with the following:

- Meets all Federal, State and local laws provided for licensing establishments of this nature, and is licensed pursuant to such law.
- Has in place the organizational and administrative structure, including adequate policy and procedures, to function as a Burn Care Unit. Written patient selection criteria are established. A collaborative quality assurance process is active and on-going.
- Has a Medical Director who meets the qualifications and who functions within the established administrative structure. Surgical specialists are on call and promptly available for consultation. Non-surgical specialists are available.
- Has a qualified Registered Nurse (BSN) administratively responsible for the burn unit. Physical and occupational therapists are on staff or available through arrangement. Burn rehabilitative therapists are on staff and on duty. A BCSW is assigned to the unit. A Registered Dietitian and a Registered Pharmacist are available on a daily basis for consultation. Respiratory therapists, Clinical Psychologists and clergy are available for consultation.
- Meets all external and internal physical requirements. An adequate rehabilitation program (recreational and educational services) is provided. Discharge planning and follow-up are addressed.
- Meets all medical equipment provisions and space requirements indicated in the burn unit criteria.
- Has reviewed all Louisiana Medicaid requirements and is in compliance with these requirements as of the date of this attestation.

**ATTENTION: Read the following carefully before signing.**

By this document, I hereby consent to allow State Survey Agency personnel to conduct an on-site survey to ensure that the State Medicaid requirements are met. I also agree to provide any additional information or material related to my request for Medicaid Approval that the State Survey Agency may require.

Whoever knowingly and willfully falsifies, conceals or covers up by any means, a material fact, or makes any false or fraudulent statement or misrepresentations, or makes or uses any false writing or document knowing the same to contain any false, fictitious fraudulent statement or entry, shall be fined or imprisoned or both according to State law and shall be barred from participation in Medicaid reimbursement from the date of attestation to the date of discovery.

I, therefore, attest and do sign below, in my own hand, that I an authorized agent of this Facility and all information is true, accurate, and complete.

**I understand that if this Facility is found to not meet the level attested to, it may be subject to recoupment of Medicaid funds.**

Print Name of the Authorized Representative _____ Title/Position _____

Signature of the Authorized Representative _____ Date of Signature MM/DD/YYYY _____