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

# PICU Services

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

## PICU SERVICES

## LOUISIANA MEDICAID ATTESTATION REQUIREMENTS

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

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

Louisiana Medicaid Provider Name: _____

Contact Name: _____

Contact Phone Number: (  )  -

**Please check the appropriate Level that you are applying for:** **LEVEL I** ☐ **LEVEL II** ☐

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 PICU. A collaborative quality assessment process is active.
- Has a Medical Director who meets the qualifications of education, training, and research involvement and who functions within the established administrative structure.
- Has qualified nursing and respiratory staff as well as additional team members to meet the needs of patients. Appropriate staff (biomedical technician, physical therapist, nutritionist, clergy, etc.) and support services (pharmacy, radiology, laboratory, operating room, etc.), are also in place. All personnel training is documented and meets all requirements.
- Meets all external and internal physical requirements. Adequate equipment is available and maintained.
- 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