State of Nevada
Division of Health Care Financing and Policy
Residential Treatment Center (RTC) Medicaid Policy Compliance Form

The Division of Health Care Financing and Policy (DHCFP) requests verification of compliance with the following requirements for providing behavioral health treatment at _____, a RTC located at _____

RESIDENTIAL TREATMENT CENTER INFORMATION	
Facility Name:	
Address:	
Telephone number:	
Fax number:	
E-Mail:	
Contact Person:	
Please initial in box to indicate compliance with requirement, and/or provide dates and authorized signature where requested.	
Requirements	**Initials**
Currently Accredited by: ☐ Joint Commission ☐ Commission on Accreditation of Rehabilitation Facilities (CARF) ☐ Council on Accreditation of Services for Families and Children (COA)	
Licensed as a Residential Treatment Facility within the State the facility operates. Name_____ Lic. No. _____	
Facility is operated in accordance with current Medicaid Services Manual (MSM) Chapter 400 Section 403.8 (revised as of _____/_____/_____).	
Letter of Attestation on file with the State of Nevada confirming the facility is in compliance with Centers for Medicare and Medicaid Services (CMS) standards governing the use of restraint and seclusion (42CFR, Part 483, Subpart G). Date of Letter: _____/_____/_____ Signing Authority: (Print Name)_____	
Quality Assurance (QA)/Quality Improvement program in place.	
Facility has a process to submit an annual QA report to the DHCFP upon request.	
Facility is compliant with Quarterly Family Visits policy outlined in MSM 403.8B.6.	
Notification of Critical Events (Incident Reports or Sentinel Events) is consistent with timeframes specified in MSM 403.8B.2.	
Facility has understanding of services and medications included in per diem rate MSM 403.8A(1).	

Further provider information regarding Nevada Medicaid RTC policy can be found in the MSM Chapter 400, Section 403.8 available at: https://dhcfp.nv.gov/index/htm.

By signing this form, authorized person (i.e., facility director, CEO, or administrator) is confirming that _____ is in compliance with MSM policies relevant to enrollment in Nevada Medicaid for providing RTC services for the State of Nevada.

_____ _____
Signature Title

_____
Date