Bobby Jindal
GOVERNOR

Kathy H. Kliebert
SECRETARY

State of Louisiana

Department of Health and Hospitals
Health Standards Section

****Notice of Revised Attestation Form****

Date: August 3, 2015

TO: Adult Residential Care Providers

From: Christopher Vincent, RN, MCPM1
Health Standards Section

RE: Revised Licensing Regulations for Adult Residential Care Providers

On June 23, 2015, existing ARC providers were notified to submit to Health Standards Section signed attestation forms which certifies that the ARC is, and/or shall be in compliance with the new licensing standards by August 15, 2015. Additionally, existing ARC providers were notified that if they elect to provide medication administration after August 15, 2015, then the attestation form for medication administration shall be completed and submitted to Health Standards Section.

This letter is notification that the previously issued attestation forms have been revised. The following information was removed from the attestation forms: "I further attest that if the above referenced ARCP fails to meet any of the applicable requirements of the specified ARCP Licensing Standards, I, or my designee, shall immediately notify the Health Standards Section of the Department of Health and Hospitals (DHH) of this failure."

Please immediately discontinue using the previous attestation forms and begin using the attached revised attestation forms. Providers who have completed and submitted the previous attestation forms are **NOT REQUIRED** to re-submit the revised attestation forms.

Questions regarding the content of this notice may be directed to Health Standards at 225-342-3204.

This notice and attestation forms are available on the HSS Adult Residential Care Provider Internet address at: http://dhh.louisiana.gov/index.cfm/directory/detail/702

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DEPARTMENT OF HEALTH AND HOSPITALS

Health Standards Section

Attestation Form
Adult Residential Care Providers

ARCP Attestation Date:	ARCP Attestation Effective Date:
ARCP Director/Designee:	Designated Contact Person/telephone number:
ARCP Name:	
ARCP Address:	
ARCP Telephone:	ARCP Fax:
Name of ARCP Location Being Attested To:	
Address of ARCP Location Being Attested To:	

This attestation form shall be signed by the Director/Designee of the Adult Residential Care Provider (ARCP).

Attention: Please review the following before signing:

I have reviewed the **Adult Residential Care Provider Licensing Standards** (LAC 48:I. Chapter 68), effective August 15, 2015, and based upon my personal knowledge and belief, I attest that ____(ARCP name & location being attested to), effective ______________________ (date), meets and shall continue to meet the applicable requirements of the **Adult Residential Care Provider Licensing Standards** (LAC 48:I.Chapter 68), effective August 15, 2015.

I understand that the Health Standards Section of DHH, or its representative, has the authority to conduct an on-site survey at any time to determine whether the information provided is accurate and/or whether the ARCP is in compliance with applicable requirements. In accordance with §6801.H(4), failure of an existing ARC provider to submit the required attestation(s) shall be grounds for either denial of license or revocation of licensure.

(Director/Designee only) Signature:______________________________ Date:_______________

DEPARTMENT OF HEALTH AND HOSPITALS

Health Standards Section

Attestation Form
Adult Residential Care Providers
Staff Administration of Medications

ARCP Attestation Date:	ARCP Attestation Effective Date:
ARCP Director/Designee:	Designated Contact Person/telephone number:
ARCP Name:	
ARCP Address:	
ARCP Telephone:	ARCP Fax:
Name of ARCP Location Being Attested To:	
Address of ARCP Location Being Attested To:	

This attestation form shall be signed by the Director/Designee of the Adult Residential Care Provider (ARCP).

Attention: Please review the following before signing.

I have reviewed the **Adult Residential Care Provider Licensing Standards** (LAC 48:I. Chapter 68), effective August 15, 2015, and based upon my personal knowledge and belief, I attest that ______________________________ (ARCP name & location being attested to), effective ______________ (date), meets and will continue to meet the applicable requirements for Staff Administration of Medication (Part §6843.C.3).

I understand that the Health Standards Section of DHH, or its representative, has the authority to conduct an on-site survey at any time to determine whether the information provided is accurate and/or whether the ARCP is in compliance with applicable requirements. In accordance with §6801.H(4), failure of an existing ARC provider to submit the required attestation(s) shall be grounds for either denial of license or revocation of licensure.

(Director/Designee only) Signature:______________________ Date______________