



Provider Agency Attestation Telehealth/Telemedicine for Psychiatric Emergency Screening Service Providers in Response to COVID-19

I, _____, authorized representative for _____, hereby affirm and attest that effective March 20, 2020 and during the COVID-19 New Jersey State of Emergency:

- a. The psychiatric emergency screening service (PESS or screening service) shall make a good faith effort to provide all emergency psychiatric services pursuant to N.J.A.C. 10:31-1.3 and N.J.A.C. 10:31-2.3 (f)2i and 2.3(i) for which PESS is designated under Fiscal Year 2020 contract(s) (and any subsequent renewal thereof into Fiscal Year 2021) with DMHAS; and
- b. The screening service shall be open for admission and provide vital services that are ***reasonably feasible under current staffing conditions, consumer demand and COVID-19 State of Emergency mandates and the DMHAS guidance through telehealth and telemedicine***; and
- c. The screening service shall comply with the New Telehealth/Telemedicine law P.L. 2017 c. 117 and P.L. 2020 c.3;
- d. The screening service shall comply with applicable federal and state confidentiality laws and regulations including, but not limited to, HIPAA according to current guidance provided by the Office of Civil Rights and 42 CFR Part 2 according to current SAMHSA waivers and interpretations to address COVID-19 behavioral health; and
- e. The screening service shall comply with the NJ Medicaid Newsletter dated March 21, 2020 entitled Temporary Telehealth Guidelines; and
- f. The PESS shall continue to bill Medicaid in accordance with Federal and State Medicaid guidance and mandates as appropriate; and
- g. The PESS shall ensure that the staff of the screening services are providing treatment services via telemedicine or telehealth are doing so within the applicable scope of practice and in accordance with any professional licensing law and regulations governing telehealth and telemedicine; and
- h. The screening service will maintain and provide documentation necessary to determine compliance with this Attestation and its good faith efforts.

I affirm and attest that the foregoing statements made by me are true. I understand that if Provider Agency fails to comply with any of the above, DMHAS reserves all rights of remedy and enforcement, including but not limited to recoupment of funds.

Dated: _____ , 2020 _____

Authorized Representative Signature