DMH Licensing Bulletin #20-05R
COVID-19 Infection Control and Other Requirements in Response to the COVID-19 Pandemic
Tier 1 Attestation Form
(Must be completed by all facilities)

I, _____ , hereby certify that I am the administrator or other duly authorized officer or representative of _____ , located at _____ , (hereinafter "inpatient psychiatric facility") and that inpatient psychiatric facility meets the Tier 1 criteria established by DMH Licensed Facility Bulletin 20-05R May 26, 2020: COVID-19 Infection Control and Other Requirements in Response to the COVID-19 Pandemic.

Additionally, I attest and warrant that:

1. The inpatient psychiatric facility will meet daily COVID-19 reporting requirements as outlined in DMH Licensed Facility Bulletin 20-05R May 26, 2020: COVID-19 Infection Control and Other Requirements in Response to the COVID-19 Pandemic.
2. The inpatient psychiatric facility will not close a pediatric or geriatric unit without prior approval from DMH (104 CMR 27.03(23)(d).
3. The inpatient psychiatric facility will comply with DMH Bulletin 20-04, dated May 20, 2020.
4. The inpatient psychiatric facility will agree to complete facility-wide COVID-19 testing of all staff and patients in the event DMH determines such testing to be necessary.

Further, I hereby acknowledge that the inpatient psychiatric facility will cooperate fully with required daily reporting, any site visits, inspections, or requests for information or documentation related to its compliance with the conditions set forth in DMH Licensed Facility Bulletin 20-05R May 26, 2020: COVID-19 Infection Control and Other Requirements in Response to the COVID-19 Pandemic. If the inpatient psychiatric facility becomes unable to comply with any condition set forth in DMH Licensed Facility Bulletin 20-05R May 26, 2020: COVID-19 Infection Control and Other Requirements in Response to the COVID-19 Pandemic, I will promptly notify DMH via email to Janet.Ross@massmail.state.ma.us

I hereby certify that the above information is true and correct.

Printed Name:

Title: _____

Signature: _____

Date: _____

Please submit a scanned copy of the executed attestation via email to Teresa.J.Reynolds@massmail.state.ma.us

DMH Licensing Bulletin #20-05R
COVID-19 Infection Control and Other Requirements in Response to the COVID-19 Pandemic
Tier 2 Attestation Form

I, _____ , hereby certify that I am the administrator or other duly authorized officer or representative of _____ , located at _____ , (hereinafter "inpatient psychiatric facility") and that inpatient psychiatric facility meets the Tier 2 criteria established by DMH Licensed Facility Bulletin 20-05R May 26, 2020: COVID-19 Infection Control and Other Requirements in Response to the COVID-19 Pandemic.

Additionally, I attest and warrant that, in addition to the Tier 1 attestation, submitted herewith:

1. The inpatient psychiatric facility will accept patients confirmed to be infected with COVID-19 from outside the facility's own medical system.
2. The inpatient psychiatric facility shall actively work with Tier 1 facilities to accept patients confirmed to be infected with COVID-19.
3. The inpatient psychiatric facility will partner with DMH to flex COVID-19 capacity as needed.

Further, I hereby acknowledge that the inpatient psychiatric facility will cooperate fully with required daily reporting, any site visits, inspections, or requests for information or documentation related to its compliance with the conditions set forth in DMH Licensed Facility Bulletin 20-05R May 26, 2020: COVID-19 Infection Control and Other Requirements in Response to the COVID-19 Pandemic. If the inpatient psychiatric facility becomes unable to comply with any condition set forth in DMH Licensed Facility Bulletin 20-05R May 26, 2020: COVID-19 Infection Control and Other Requirements in Response to the COVID-19 Pandemic, I will promptly notify DMH via email to Janet.Ross@massmail.state.ma.us

Required data points at time of attestation:

If designated Tier 2, maximum operational capacity to provide ongoing management for patients confirmed to be infected with COVID-19:	
At 12:01am at the date of attestation, number of patients confirmed to be infected with COVID-19:	

I hereby certify that the above information is true and correct.

Printed Name:

Title: _____

Signature: _____

Date: _____

Please submit a scanned copy of the executed attestation via email to Teresa.J.Reynolds@massmail.state.ma.us