AUTHORIZATION FOR RESTORATIVE SERVICES

☐ Initial Authorization

☐ Semi-Annual Authorization

☐ Annual Authorization

CLIENT'S NAME: _____

CLIENT'S MEDICAID NUMBER: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me, have determined that _____.
(client's name)
would benefit from the provision of mental health restorative services as known to me and defined pursuant to Part 593 of 14 NYCRR.

_____ _____
Mo/Day/Yr **Signature & Licensure #**

_____
Print Name

DISABILITY VERIFICATION FOR HUD SHELTER PLUS CARE ELIGIBILITY

CLIENT'S NAME: _____

I, the undersigned licensed professional, based on my review of the assessments made available to me, have determined that _____
(client's name)
meets criteria for the primary diagnosis of _____

and that this disability is expected to be long-continuing and of indefinite duration, and substantially impedes his/her ability to live independently. This disability could be improved by the provision of more suitable housing conditions.

_____ _____
Mo/Day/Yr **Signature & Licensure #**

_____
Print Name