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