INITIAL Authorization
for
Restorative Services of Community Residences
in
Adult Apartment and Congregate Residences

Transitional Living Services of Northern New York
482 Black River Parkway
Watertown, NY 13601

Initial Authorization for the receipt of Restorative Services not to exceed:

☐ 6 months for Congregate Residences **(Check One Only)**
☐ 12 months for Apartment Residences **(Check One Only)**

CLIENT'S NAME: _____

CLIENT'S MEDICAID #: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me, and having conducted a face-to-face assessment with said client as required pursuant to Part 593 of Title 14 NYCRR, have determined that

_____ **would benefit from the provision of**
(Client's Name)
mental health restorative services as known to me and defined pursuant to Part 593 of Title 14 NYCRR.

_____ _____
Month/Day/Year **Physician's Signature**

_____ _____
License Number & State **Type or Print Physician's Name**

_____ **Provider enrollment in Medicaid verified by OPRA search [ ] Yes [ ] No**
reviewed by (init/date)