Unity House
Empowering Lives. Securing Futures.

Authorization for Restorative Services of Supportive Apartments

☐ Initial Authorization (**requires physician signature**)

☐ Annual Authorization (**can be signed by a physician or a physician assistant/nurse practitioner specializing in psychiatry in NY State**)

Client Name: _____ Date of birth: _____

Medicaid Number: _____

I, the undersigned licensed physician, based on my review of the assessments made available to me (and a face to face interview with the client for the initial authorization), have determined that

_____ would benefit from the provision of mental health
Client Name

restorative services known to me and defined pursuant to Part 593.4 (b) of 14 NYCRR.

_____ _____

Printed Name Month/Day/Year

_____ _____

Signature Licensure Number and Type