**SAMPLE**

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| **Dear Dr**. \_\_Smart\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_: | |
| According to the Office of Mental Health and Medicaid regulations, individuals accepted into a Congregate Care Setting must have an initial Physician Authorization form completed and signed by a Physician prior to entry into a residential program. Per Medicaid Regulations 593.61, the Initial Authorization for Medicaid Restorative services must be based on clinical information and a face to face assessment. | |
| The regulations also require that a resident’s most recent quarterly review of the service plan be submitted to the physician for review, and re-authorization be obtained every six months for individuals living in community residence settings, and yearly for individuals living in treatment apartment programs. | |
| Below you will find a Physician Authorization Form for our resident and attached a copy of the most recent service plan review - if this is not an initial authorization request. We ask that you please review the enclosed service plan review\*(for the period \_\_\_NA\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_NA\_\_\_\_\_\_\_\_), and complete and sign the Physician Authorization Form. | |
| Please contact the Program Director at \_123\_\_-\_\_4567\_\_\_\_ to request any additional documentation necessary to determine the need for provision of mental health restorative services defined pursuant to Part 593 of 14 NYCRR. Your timely attention to this matter will allow us to comply with the current Office of Mental Health and Medicaid regulations. Thank you for your time.  Sincerely, | |
| **Program Director Name (Please Print):**  Theresa Jones | **Program Director’s Signature:**  Theresa Jones |
| **Program:**  Unity House Community Residence | **Date:**  1/18/16 |

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| AUTHORIZATION FOR  RESTORATIVE SERVICES OF COMMUNITY RESIDENCES | | |
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| **√** | INITIAL AUTHORIZATION (admission) | |
|  | SEMI-ANNUAL AUTHORIZATION (Community Residence) | |
|  | ANNUAL AUTHORIZATION (Transitional Apartment Services) | |
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| **Consumer Name:**  John Doe | | **Primary Diagnosis:**  [Major Depressive Disorder, Recurrent, Severe Without Psychotic Features](http://allpsych.com/disorders/mood/majordepression.html) |
| **Consumer Medicaid Number:**  AB12345C | | **DSM V Code/ICD 10 Code:**  F33.2 |
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| I, the undersigned physician, based on my review of the service plan review attached\*, have determined that  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_John Doe\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  would benefit from the provision of mental health restorative services defined pursuant to Part 593 of 14 NYCRR.  This determination is in effect for the period \_\_2\_\_/\_\_2\_\_/\_16\_\_ to \_\_8\_\_/\_\_2\_\_/\_16\_\_, at which time there will be an evaluation for continued stay. | | |
| **Physician’s Name (Please Print):**  Dr. Jane Smart | | **Physician’s Signature:**  Jane Smart |
| **Physician’s NY State Licensure #:**  123456 | | **Date:**  2/2/16 |
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Updated 9/15