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## *Approved Entities*

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**Waiver Number**                    **323**

**Primary Entity Name**            **Center for Hearing and Communication**

**Primary Address**                *50 Broadway*

**Primary Phone Number**        *(917) 305-7700*

*New York*

*New York*

*10004-*

**Current Waiver Issued Beginning Period**

*7/1/2013*

**Current Waiver Ending Period**

*6/30/2016*

**County**                            *New York*

<input type="checkbox"/> LMSW	<input type="checkbox"/> CAT	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Nursing (RN or Nurse Practitioner)
<input checked="" type="checkbox"/> LCSW	<input type="checkbox"/> Psychology	<input type="checkbox"/> Occupational Therapy	<input checked="" type="checkbox"/> Medicine (Physician, Physician Asst., Specialist Asst.)
<input checked="" type="checkbox"/> Mental Health Counseling	<input type="checkbox"/> Optometry	<input checked="" type="checkbox"/> Audiology/Speech Lang.	<input type="checkbox"/> Other: <input type="text"/>

***Additional Sites if any - with Certificate Number***

**Certificate Number**

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