

## Approved Entities

**Waiver Number**                    **58**  
**Primary Entity Name**            **Center for Autism & Related Disorders, Inc.**  
**Primary Address**                *6 North Main Street*                    **Primary Phone**            *(585) 377-6590*  
    *Suite 110*                                    **Number**  
    *Fairport*  
    *NY*    **Current Waiver Issued Beginning Period**  
    *14450-*                                        *6/1/2014*  
       **Current Waiver Ending Period**  
**County**                                *Monroe*                                        *5/31/2017*

<input type="checkbox"/> LMSW	<input type="checkbox"/> CAT	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Nursing (RN or Nurse Practitioner)
<input type="checkbox"/> LCSW	<input checked="" type="checkbox"/> Psychology	<input checked="" type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Medicine (Physician, Physician Asst., Specialist Asst.)
<input 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**

<b>Certificate Number</b>	<b>JT - 58 - 39</b>	<b>Center for Autism &amp; Related Disorders Inc.</b>
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