

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2009 to December 31, 2009

SCHEDULE OMH-1
UNITS OF SERVICE
BY PROGRAM/SITE

AGENCY NAME: _____
 AGENCY CODE: _____

Line No.	COLUMN NUMBER																	
	PROGRAM CODE (PROGRAM CODE INDEX)	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()
	PROGRAM TYPE																	
	PROG/SITE ID. #																	
	TYPE OF SERVICE (PROGRAM CODE)	WEIGHT FACTOR	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	
	Partial Hospitalization (2200)																	
1	Regular																	
2	Collateral																	
3	Group Collateral																	
4	Crisis																	
	Intensive Psychiatric Rehab. (2320)																	
5	Regular																	
	Clinic Treatment (2100)																	
6	Brief	0.50																
7	Regular	1.00																
8	Group	0.35																
9	Collateral	1.00																
10	Group Collateral	0.35																
11	Crisis	1.00																
	Day Treatment (0200)																	
	Sheltered Workshop (0340)																	
	On Site Rehabilitation (0320)																	
	Continuing Day Treatment (1310)																	
12	Brief Day	0.33																
13	Half Day	0.50																
14	Full Day	1.00																
15	Collateral	0.33																
16	All Other	1.00																
17	Residential (Patient Days)	1.00																
18	Total																	

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2009 to December 31, 2009

SCHEDULE OMH-2
MEDICAID
UNITS OF SERVICE
BY PROGRAM/SITE

Page _____

AGENCY NAME: _____
 AGENCY CODE: _____

Line No.	COLUMN NUMBER																
	PROGRAM CODE (PROGRAM CODE INDEX)	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()	()
	PROGRAM TYPE																
	PROG/SITE ID. #																
	TYPE OF SERVICE (PROGRAM CODE)	WEIGHT FACTOR	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS	TOTAL VISITS	WEIGHTED VISITS	SERVICE HOURS
	Partial Hospitalization (2200)																
1	Regular																
2	Collateral																
3	Group Collateral																
4	Crisis																
	Intensive Psychiatric Rehab. (2320)																
5	Regular																
	Clinic Treatment (2100)																
6	Brief	0.50															
7	Regular	1.00															
8	Group	0.35															
9	Collateral	1.00															
10	Group Collateral	0.35															
11	Crisis	1.00															
	Day Treatment (0200)																
	Continuing Day Treatment (1310)																
12	Brief Day	0.33															
13	Half Day	0.50															
14	Full Day	1.00															
15	Collateral	0.33															
16	All Other	1.00															
17	Residential (Patient Days)	1.00															
18	Total																

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
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SCHEDULE OMH-3
CLIENT
INFORMATION

Page _____

AGENCY NAME:	_____
AGENCY CODE:	_____

Line No.	COLUMN NUMBER				
	PROGRAM CODE (PROGRAM CODE INDEX)	()	()	()	()
	PROGRAM TYPE				
	PROG/SITE ID. #				
	PERSONS SERVED DURING THE YEAR				
1	Persons on Rolls, Beginning of Year				
2	New Persons added to Rolls				
3	Persons Removed from Rolls				
4	Persons on Rolls, End of Year				

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
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SCHEDULE OMH-4
UNITS OF SERVICE
BY PAYOR
BY PROGRAM/SITE

Page _____

AGENCY NAME: _____
AGENCY CODE: _____

Line No.	PROGRAM CODE (PROGRAM CODE INDEX) PROGRAM TYPE PROG/SITE ID. #	()	TOTAL VISITS	Revenue Earned By Payor
1	Totals From OMH-1			
Payors:				
2	Medicaid			
3	Medicaid Managed Care			
4	Child and Family Health Plus			
5	Medicare			
6	Other Private Insurance			
7	Participant Fees- Copays and Deductibles			
Uncompensated Care:				
8	Participant Fees- Not Including Copays			
9	Third Party - Non-Covered Services			
10	Third Party - Non-Eligible Licensed Staff			
11	Third Party- Non-Eligible Out of Network			
12	Total Visits (Sum of Lines 2-11)*			
13	Visits Eligible for Uncompensated Care Reimbursement (Sum Lines 8-11)			
14	Uncompensated Care Visits (Line 13) as Percent of Total Visits (Line 12)			

* Line 12 Visits should equal Line 1 Visits.