NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2009 to June 30, 2010

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: July 1, 2009 to June 30, 2010

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
For the Period: July 1, 2009 to June 30, 2010

SCHEDULE OMH-3
CLIENT
INFORMATION

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
For the Period July 1, 2009 to June 30, 2010

SCHEDULE OMH-4
UNITS OF SERVICE
BY PAYOR
BY PROGRAM/SITE

AGENCY NAME: _____
AGENCY CODE: _____

Line No.			
	PROGRAM CODE (PROGRAM CODE INDEX)	**( )**	
	PROGRAM TYPE		
	PROG/SITE ID. #		
		TOTAL VISITS	**REVENUE EARNED BY PAYOR**
	Payors:		
1	**Medicare Only**		
2	**Medicaid Fee-for-Service Only**		
3	**Medicaid Managed Care**		
4	**Medicaid and Medicare**		
5	**Medicaid Managed Care and Medicare**		
6	**Medicaid and Other Private Insurance**		
7	**Medicaid Managed Care and Other Private Insurance**		
8	**Child Health Plus or Family Health Plus**		
9	**Other Private Insurance**		
10	**Participant Fees- Co-pays and Deductibles**		
	Uncompensated Care:		
11	**Participant Fees- Not Including Co-pays**		
12	**Third Party - Not Paid - Non-Covered Services**		
13	**Third Party - Not Paid - Non-Eligible Licensed Staff**		
14	**Third Party - Not Paid - Non-Eligible Out of Network**		
15	**Total Visits (Sum of Lines 1-14)**		
16	**Visits Eligible for Uncompensated Care Reimbursement (Sum Lines 11-14)**		
17	**Uncompensated Care Visits (Line 16) as Percent of Total Visits (Line 15)**		