NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: July 1, 2005 to June 30, 2006

SCHEDULE OMRDD-1
SCHEDULE OF SERVICES -
ICF/DDs Only

AGENCY NAME: ______________________________

AGENCY CODE: ______________________________

SITE ADDRESS: ______________________________
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OPERATING CERTIFICATE NUMBER: ______________________________

Complete a separate schedule for each site. For each service type or supply, check Cols. 1, 2 or 3. If Col. 2 or 3 is checked, show the dollar amount associated with Col. 2 or 3 in Column 4.

Line No.	SERVICE TYPE	Col. 1 Exclusively Purchased w/ Medicaid Card	Col. 2 Exclusively Purchased by ICF	Col. 3 ICF Purchases Made Only Where MA Card Did Not Cover Items	Col. 4 ICF Purchase Amount Associated w/ Col. 2 or 3
	Pharmacy Services				
1	a. Prescription Drugs				
2	b. Non-Prescription Drugs				
3	c. Medical Supplies *				
4	d. Enteral Formulae				
5	e. Diapers				
	Equipment				
6	a. Durable Medical				
7	b. Prosthetic & Orthotic				
	Service Coordination				
8	a. Service Coordination				
	Transportation Services				
9	a. To Medical Office/Clinic				
	Therapy Services (See definition)				
10	a. Physical Therapy - Direct Service				
11	b. Physical Therapy - Consultation				
12	c. Occupational Therapy - Direct Service				
13	d. Occupational Therapy - Consultation				
14	e. Speech Therapy - Direct Service				
15	f. Speech Therapy - Consultation				
16	g. Psychological - Direct Service				
17	h. Psychological - Consultation				
18	i. Physician - Direct Service				
19	j. Physician - Consultation				
20	k. Psychiatrist - Direct Service				
21	l. Psychiatrist - Consultation				
22	m. Other (Specify)				

Line No.	SERVICE TYPE	Col. 1 Exclusively Purchased w/ Medicaid Card	Col. 2 Exclusively Purchased by ICF	Col. 3 ICF Purchases Made Only Where MA Card Did Not Cover Items	Col. 4 ICF Purchase Amount Associated w/ Col. 2 or 3
	Home Care Services				
23	a. Home Health Care				
24	b. Personal Care				
25	c. Private Duty Nursing				
	Medical Services				
26	a. General Medical - Direct Service				
27	b. General Medical - Consultation				
28	c. Nursing				
29	d. All Dental Services				
30	e. Clinical Laboratory				
31	f. X-Ray Diagnostic				
32	g. Specialized (Specify)				
33	h. Specialized (Specify)				
34	i. Specialized (Specify)				
	Complete this section only if this site is funded for Day Services within the ICF/DD Rate				
35	a. Day Programming * *				
36	b. Day Training				
37	c. Sheltered Workshop				
38	d. Education				

Definitions:

Consultation - Practitioner provides training, oversight and direction to direct care staff.

Direct Service - Practitioner directly treats the consumers.

* **Medical Supplies: If Column 2 or 3 is checked, complete Schedule OMRDD-2 for each site as well.**

** **If Line 35 (Day Programming) is completed, attach a list of consumers whose day service costs are included in the ICF/DD rate. Include each consumer's Medicaid Identification number. The list of consumers should only be sent to OMRDD.**