NEW YORK STATE CONSOLIDATED FISCAL REPORT

SCHEDULE OMH-2

For the Period: July 1, 2016 to June 30, 2017

MEDICAID UNITS OF SERVICE

BY PROGRAM/SITE

Page ____

AGENCY NAME: ____

AGENCY CODE:_

	COLUMN NUMBER																
Line	PROGRAM CODE (PROGRAM CODE INDEX)			()		()		()		()		()
No.	PROGRAM TYPE																
	PROG/SITE ID. #																
		WEIGHT									SERVICE					WEIGHTED	
	(PROGRAM CODE)	FACTOR	VISITS	VISITS	HOURS	VISITS	VISITS	HOURS	VISITS	VISITS	HOURS	VISITS	VISITS	HOURS	VISITS	VISITS	HOURS
	PARTIAL HOSPITALIZATION (2200)																
1	Regular																
1a	Regular - Medicaid Fee for Service	N/A															
1b	Regular - Medicaid Managed Care	N/A															
2	Collateral															1	
2a	Collateral - Medicaid Fee for Service	N/A															
2b	Collateral - Medicaid Managed Care	N/A															
3	Group Collateral																
3a	Group Collateral - Medicaid Fee for Service	N/A															
3b	Group Collateral - Medicaid Managed Care	N/A															
4	Crisis																
4a	Crisis - Medicaid Fee for Service	N/A															
4b	Crisis - Medicaid Managed Care	N/A															
	INTENSIVE PSYCHIATRIC REHAB. (2320)																
5	Regular															1	
5a	Regular - Medicaid Fee for Service	N/A															
5b	Regular - Medicaid Managed Care	N/A															
	CLINIC TREATMENT (2100)															1	
6	Service Days															1	
6a	Service Days - Medicaid Fee for Service	1.00															
6b	Service Days - Medicaid Managed Care	1.00														1	
	CONTINUING DAY TREATMENT (1310)																
7	Half Day																
7a	Half Day - Medicaid Fee for Service	0.50															
7b	Half Day - Medicaid Managed Care	0.50															
8	Full Day																
8a	Full Day - Medicaid Fee for Service	1.00															
8b	Full Day - Medicaid Managed Care	1.00															

NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: January 1, 2017 to December 31, 2017

SCHEDULE OMH-2

OMH-2.1 Rev. Feb. 2018

MEDICAID

UNITS OF SERVICE

BY PROGRAM/SITE

Page AGENCY NAME: AGENCY CODE: COLUMN NUMBER PROGRAM CODE (PROGRAM CODE INDEX) Line PROGRAM TYPE No. PROG/SITE ID. # TOTAL WEIGHTED SERVICE TOTAL WEIGHTED SERVICE TOTAL WEIGHTED SERVICE TOTAL WEIGHTED TYPE OF SERVICE WEIGHT SERVICE TOTAL WEIGHTED SERVICE FACTOR VISITS HOURS VISITS VISITS HOURS VISITS VISITS HOURS VISITS VISITS HOURS VISITS VISITS (PROGRAM CODE) VISITS HOURS PROS (6340) (7340) (8340) 9 PROS Units - Medicaid Fee for Service 9a PROS Units - Medicaid Fee for Service 1.00 PROS Units - Medicaid Managed Care 1.00 9b DAY TREATMENT (0200) 10 Brief Day 10a Brief Day - Medicaid Fee for Service 0.33 10b Brief Day - Medicaid Managed Care 0.33 11 Half Day & Pre-Admission Half Day Visits 11a Half Day & Pre-Admission Half Day Visits - Medicaid Fee for Service 0.50 11b Half Day & Pre-Admission Half Day Visits - Medicaid Managed Care 0.50 12 Full Day & Pre-Admission Full Day Visits 12a Full Day & Pre-Admission Full Day Visits - Medicaid Fee for Service 1.00 12b Full Day & Pre-Admission Full Day Visits - Medicaid Managed Care 1.00 13 Collateral, Home Visit & Crisis Visits 13a Collateral, Home Visit & Crisis Visits - Medicaid Fee for Service 0.33 Collateral, Home Visit & Crisis Visits - Medicaid Managed Care 13b 0.33 14 All Other 14a All Other - Medicaid Fee for Service 1.00 14b All Other - Medicaid Managed Care 1.00 15 **Residential (Patient Days)** 15a Residential (Patient Days) - Medicaid Fee for Service 1.00 15b Residential (Patient Days) - Medicaid Managed Care 1.00 16 TOTAL - Medicaid Units of Service 16a TOTAL - Medicaid Fee for Service 16b TOTAL - Medicaid Managed Care

Rev. Feb. 2018

OMH-2.2