

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: January 1, 2020 to December 31, 2020

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	N/A															
2	Collateral	N/A															
3	Group Collateral	N/A															
4	Crisis	N/A															
	Intensive Psychiatric Rehab. (2320)																
5	Regular	N/A															
	Clinic Treatment (2100)																
6	Service Days	1.00															
	Continuing Day Treatment (1310)																
7	Half Day	0.50															
8	Full Day	1.00															
	PROS (6340) (7340)																
9	PROS Units	1.00															
	Day Treatment (0200)																
	On Site Rehabilitation (0320)																
10	Brief Day	0.33															
11	Half Day & Pre-Admission Half Day Visits	0.50															
12	Full Day & Pre-Admission Full Day Visits	1.00															
13	Collateral, Home & Crisis Visits	0.33															
	Other/Residential/Total																
14	All Other	1.00															
15	Residential (Patient Days)	1.00															
16	Total																

**NEW YORK STATE
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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																
1a	Regular - Medicaid Fee for Service	N/A															
1b	Regular - Medicaid Managed Care	N/A															
2	Collateral																
5a	Regular - Medicaid Fee for Service	N/A															
5b	Regular - Medicaid Managed Care	N/A															
	CLINIC TREATMENT (2100)																
6	Service Days																
6a	Service Days - Medicaid Fee for Service	1.00															
6b	Service Days - Medicaid Managed Care	1.00															
	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															

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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	
	PROS (6340) (7340)																	
9	PROS Units																	
9a	PROS Units - Medicaid Fee for Service	1.00																
9b	PROS Units - Medicaid Managed Care	1.00																
	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 Ser	0.50																
11b	Half Day & Pre-Admission Half Day Visits - Medicaid Managed C	0.50																
12	Full Day & Pre-Admission Full Day Visits																	
12a	Full Day & Pre-Admission Full Day Visits - Medicaid Fee for Ser	1.00																
12b	Full Day & Pre-Admission Full Day Visits - Medicaid Managed C	1.00																
13	Collateral, Home Visit & Crisis Visits																	
13a	Collateral, Home Visit & Crisis Visits - Medicaid Fee for Service	0.33																
13b	Collateral, Home Visit & Crisis Visits - Medicaid Managed Care	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																	

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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				

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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
Payors:			
1	Medicare Only		
2	Medicaid Fee-for-Service Only		
3	Medicaid Managed Care		
4	Medicaid Fee-for-Service and Medicare		
5	Medicaid Managed Care and Medicare		
6	Medicaid Fee-for-Service 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		
Safety Net:			
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 1-9, 11, 12, 13 and 14)		
16	Visits Eligible for Safety Net Reimbursement (Sum Lines 11-14)		
17	Safety Net Visits (Line 16) as Percent of Total Visits (Line 15)		