NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2019 to June 30, 2020

SCHEDULE OMH-1
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	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
CONSOLIDATED FISCAL REPORT

For the Period: July 1, 2019 to June 30, 2020

SCHEDULE OMH-2

MEDICAID
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																	
1a	Regular - Medicaid Fee for Service	N/A																
1b	Regular - Medicaid Managed Care	N/A																
2	Collateral																	
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																	
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

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																

NEW YORK STATE
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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
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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 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)**		