

**NEW YORK STATE**  
**CONSOLIDATED FISCAL REPORT**  
 For the Period: January 1, 2006 to December 31, 2006

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

Page \_\_\_\_\_

AGENCY NAME: _____ AGENCY CODE: _____	SITE ADDRESS: _____ 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	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
<b>Pharmacy Services</b>						<b>Home Care Services</b>					
1	a. Prescription Drugs					23	a. Home Health Care				
2	b. Non-Prescription Drugs					24	b. Personal Care				
3	c. Medical Supplies *					25	c. Private Duty Nursing				
4	d. Enteral Formulae					<b>Medical Services</b>					
5	e. Diapers					26	a. General Medical - Direct Service				
<b>Equipment</b>						27	b. General Medical - Consultation				
6	a. Durable Medical					28	c. Nursing				
7	b. Prosthetic & Orthotic					29	d. All Dental Services				
<b>Service Coordination</b>						30	e. Clinical Laboratory				
8	a. Service Coordination					31	f. X-Ray Diagnostic				
<b>Transportation Services</b>						32	g. Specialized (Specify)				
9	a. To Medical Office/Clinic					33	h. Specialized (Specify)				
<b>Therapy Services (See definition)</b>						34	i. Specialized (Specify)				
10	a. Physical Therapy - Direct Service					<b>Complete this section only if this site is funded for Day Services within the ICF/DD Rate</b>					
11	b. Physical Therapy - Consultation					35	a. Day Programming **				
12	c. Occupational Therapy - Direct Service					36	b. Day Training				
13	d. Occupational Therapy - Consultation					37	c. Sheltered Workshop				
14	e. Speech Therapy - Direct Service					38	d. Education				
15	f. Speech Therapy - Consultation					<b>Definitions:</b>  <b>Consultation</b> - Practitioner provides training, oversight and direction to direct care staff.  <b>Direct Service</b> - Practitioner directly treats the consumers.					
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)										

\* 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.