

**NYS OTDA CONSULTATIVE EXAMINATION**  
**\_\_\_\_\_ COUNTY STATEMENT OF WORK –**

**Target Population:** Please check target populations and provide an estimate of numbers to be served for each population targeted:

Category	Target Population?	Initial referrals ( ? ) months	Ongoing referrals
TANF	<input type="checkbox"/> Yes <input type="checkbox"/> No	___ per month	___ per month
SNA Families	<input type="checkbox"/> Yes <input type="checkbox"/> No	___ per month	___ per month
SNA singles or childless couples	<input type="checkbox"/> Yes <input type="checkbox"/> No	___ per month	___ per month
MA Aid to Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No	___ per month	___ per month
NPA-SNAP only	<input type="checkbox"/> Yes <input type="checkbox"/> No	___ per month	___ per month

**Referral Process:**

**The DSS (referring unit[s]) will identify the client based on the listed criteria checked below:**

- Client claims to be unable to work or participate in work activities due to a medical or mental health condition.
- Client's medical states numerous medical conditions.
- Client's medical from their provider does not identify diagnosis and/or length of time client is unable to work or is contradicted by other evidence.
- Client has demonstrated an inability to successfully participate in work activities or employment and is suspected of having a disability/work limitation that is not being claimed.
- Client does not have a current treating source or the current treating source is either unable or unwilling to provide documentation needed to determine employability
- Medical documentation is needed to support application for federal disability benefits.
- Medical documentation is needed to support application for Medicaid Aid to Disabled.
- Medical documentation is needed to grant waiver for ILP compliance.

Client will be referred to (Contractor) by one of the following designated staff:  
(list titles and any supervisory oversight)

(Identify Title of District Staff Responsible) will schedule appointments and track all appointments through a log indicating names, date, referral, CIN #, Case #, type of exam requested and date of appointment. Reports from (Contractor) will be forwarded to the (Identify Name/Title of District staff responsible) regarding clients that reported/failed to report for appointment.

\_\_\_\_\_ County DSS staff will meet with each client that is to be referred to (Contractor). DSS staff will identify pertinent treatment and case records, obtain the appropriate releases and submit the information to (Contractor). \_\_\_\_\_ County DSS will securely fax or mail all background medical information so (Contractor) receives it at least two days prior to the appointment date and will encourage the client to bring any additional records to their appointment. DSS staff will ensure that the client has a viable mode

of transportation, if needed. Payment for the transportation will be provided by DSS. DSS staff will also ensure that temporary assistance applicants and recipients have child care, if needed to complete the evaluation. Payment for such childcare will be provided by DSS.

**Scheduling:** \_\_\_\_\_ County will schedule examinations by phone (or other secure method). (Contractor) (will/will not) automatically reschedule the client after the first no-show. On a daily basis, (Contractor) will securely contact the referring district worker or \_\_\_\_\_ listing the names for the examinations completed, show/no shows for the day and an estimate of the date the reports will be provided to the district.

**Type of Examinations:** Physical, Psychological and Intelligence examinations. Ancillary testing or additional examinations will (be added as needed based on the doctor's discretion and with the prior approval of) or (will require approval of) \_\_\_\_\_ County DSS. The district will identify the reason for the examination (either employment/eligibility related [including SSI/SSDI recommendations or ability to comply with ILP] or Medicaid Aid to Disabled) to insure the proper report form is used by the contractor.

**Fee:** The fee for each examination will be in accordance with the contractually agreed upon fee rate between OTDA and the contractor (see attachment D), which is subject to periodic revision. \_\_\_\_\_ County DSS will submit a revenue intercept letter to Michael Cody, OTDA authorizing OTDA to intercept dollars from the district's RF-2 or RF-2A federal settlement to cover the cost of the examinations. \_\_\_\_\_ County DSS will claim the appropriate shares based upon client category and in accordance with guidelines established in 17-LCM-XX.

**Medical Reports:** (Contractor) will review and consider all records or information provided by the individual, his or her treating health care practitioner, or \_\_\_\_\_ County DSS that are pertinent to the claimed medical/psychological condition and provided at or within 4 business days of the examination or obtained through ancillary testing approved by \_\_\_\_\_ County DSS. (Contractor) will provide - \_\_\_\_\_ County with a signed, typed report. The completed report will be (method of delivery) to (District title[s]). The forms designated by OTDA will be used. The district will receive the report no more than 20 days after the examination is requested, unless the district requests the contracted provider schedule a third appointment due to a missed exam. Also, the report must be provided no later than 10 business days after the examination is performed;

**Billing/Vouchering:** Each month (Contractor) will generate an Excel spreadsheet, as well as a hard copy, of the name, CIN #, case #, exam type, exam reason and testing for each client seen during the month. (Contractor) will send them to OTDA together with a completed "standard voucher" with the total amount due for the month (one voucher per month). OTDA receives a monthly voucher and summary of examinations and verifies services billed with district staff. \_\_\_\_\_ County receives medical reports, as produced on a daily basis, but no invoice. Districts will be required to verify in a timely manner to OTDA the examinations/testing and receipt of the reports from the contractor.

**Outcomes:** Outcomes generated by (Contractor) will be recorded on log, indicating if the client showed for appointment and results of the doctor's evaluation. At the end of each month, the log will be reconciled with the spread sheet from (Contractor) and results will be distributed to the counselor for appropriate action and a monthly report will be generated. Authorization for payments to (Contractor) issued by OTDA will be based on medical reports being reconciled with (Contractor) records.

**Reporting:** \_\_\_\_\_ County will submit quarterly outcome reports to OTDA.

**Other:** Both \_\_\_\_\_ County and (Contractor) agree to any performance reviews by OTDA.  
\_\_\_\_\_ County and (Contractor) will notify all involved parties of any significant changes in scope (i.e. target population, notification process, etc.) to this Statement of Work.

**Date:** \_\_\_\_\_

**Submitted by:** \_\_\_\_\_

**County Contact(s)\*:** Primary and Secondary

**Phone :** \_\_\_\_\_ **and** \_\_\_\_\_

**E-Mail :** \_\_\_\_\_ **and** \_\_\_\_\_

**\*To verify services billed (includes primary and back-up contact person)**