

FORM A

**New York State Consultant Services  
Contractor's Planned Employment**  
From Contract Start Date Through the End of the Contract Term

State Agency Name: *OCFS*  
 State Agency Department ID: \_\_\_\_\_  
 Contractor Name: *Shehal R. Shehal MD*  
 Contract Start Date: *3/10/2020*  
 Agency Business Unit: \_\_\_\_\_  
 Contract Number: *5010227*  
 Contract End Date: *2/12/2021*

Employment Category	Number of Employees	Number of Hours to be Worked	Amount Payable Under the Contract
	0.00	0.00	SD \$0.00
<i>29-1066.00</i>	0.00	<del>888</del> SD 0.00	<i>257,520</i> \$0.00
<i>Psychiatric Services</i>	<i>one</i> 0.00	<i>520 hrs</i> 0.00	<del><i>150,800</i></del> \$0.00
	0.00	0.00	\$0.00
	0.00	0.00	\$0.00
	0.00	0.00	\$0.00
	0.00	0.00	\$0.00
	0.00	0.00	\$0.00
	0.00	0.00	\$0.00
	0.00	0.00	\$0.00
	0.00	0.00	\$0.00
	0.00	0.00	\$0.00
	0.00	0.00	\$0.00
	0.00	0.00	\$0.00
	0.00	0.00	\$0.00
	0.00	0.00	\$0.00
	0.00	0.00	\$0.00
Total this Page	<i>one</i> 0.00	<i>520 hr</i> 0.00	<del><i>150,800</i></del> \$0.00
<b>Grand Total</b>	<i>one</i>	<i>520 hr</i> <del><i>888</i></del> SD	<del><i>150,800</i></del> <i>257,520</i> SD

Name of person who prepared this report: *Shehal R. Shehal MD*  
 Title: *MD* Phone #: *845-797-5252*  
 Preparer's Signature: \_\_\_\_\_  
 Date Prepared: *1/14/2020*