

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: <i>OCFS SD</i>	Agency Business Unit: <i>OCFS01 SD</i>
State Agency Department ID: <i>3400000 SD</i>	Contract Number: <i>5010205 SD</i>
Contractor Name: <i>Kathleen Baynes SD</i>	Contract End Date: <i>9/30/19 SD</i>
Contract Start Date: <i>10/1/18 SD</i>	

Employment Category	Number of Employees	Number of Hours to be Worked	Amount Payable Under the Contract
<i>29-1066.00</i>	<i>1</i> 0.00	<i>17.077</i> 0.00	<i>346,320</i> \$0.00
	0.00	<i>888 SD</i> 0.00	\$0.00
	0.00	0.00	\$0.00
	0.00	0.00	\$0.00
	0.00	0.00	\$0.00
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	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	0.00	0.00	\$ 0.00
Grand Total			<i>346,320.00</i>

Name of person who prepared this report: *Kathleen Baynes MD SD*
 Title: *Psychiatrist II* Phone #: *917-273-0293 SD*
 Preparer's Signature: *[Signature]*
 Date Prepared: *10/28/18*