NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: July 1, 2001 to June 30, 2002

SCHEDULE CFR-i
AGENCY IDENTIFICATION AND CERTIFICATION STATEMENT

AGENCY NAME: _____

AGENCY ADDRESS: _____

_____

☐ Please check the box if the agency address changed from the prior reporting period.

AGENCY CODE: _____

COUNTY NAME: _____

COUNTY CODE: _____

TYPE OF OWNERSHIP:

NOT-FOR-PROFIT: _____

PROPRIETARY: _____

GOVERNMENTAL: _____

FEDERAL EMPLOYER ID NUMBER (OMRDD Only): _____

Person to Contact with Regard to Questions Concerning this Report:

_____ ( ) _____

Name Telephone Number

_____

Title

_____ ( ) _____

E-mail Address FAX Number

☐ Please check the box if the person to contact changed from the prior reporting period.

CHECK THE STATE AGENCY(IES):

OMH _____
OMRDD _____
OASAS _____
SED _____

CHECK THE SUBMISSION TYPE:

FULL REPORT _____
ABBREVIATED REPORT _____
MINI-ABBREVIATED REPORT _____
ESTIMATED CLAIM _____

MISREPRESENTATION OF ANY INFORMATION CONTAINED IN THIS REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER NEW YORK STATE LAW.

CERTIFICATION STATEMENT

I HEREBY CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE STATEMENT, THAT THE INFORMATION FURNISHED IN THIS REPORT HAS BEEN COMPLETED IN ITS ENTIRETY, AND IS IN ACCORDANCE WITH THE INSTRUCTIONS AND IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I FURTHER ATTEST TO THE FACT THAT THERE ARE RECORDS AND ALLOCATION WORKSHEETS TO SUPPORT ALL THE INFORMATION CONTAINED HEREIN, IN THE CUSTODY OF THE ABOVE NAMED SPONSORING AGENCY. I ACKNOWLEDGE THAT THE DEPARTMENT OF MENTAL HYGIENE, OR ANY OF ITS OFFICES OR DIVISIONS, OR THE STATE EDUCATION DEPARTMENT, OR ANY OF ITS OFFICES OR DIVISIONS, MAY REJECT THIS REPORT IF IT HAS NOT BEEN FULLY, OR ACCURATELY COMPLETED.

_____ _____

Date Name and Title

( ) _____ _____

Telephone Number Signature of Chief Executive Officer

☐ Please check the box if the Chief Executive Officer changed from the prior reporting period.

PLEASE NUMBER ALL PAGES CONSECUTIVELY. LIST THE TOTAL NUMBER OF PAGES SUBMITTED. _____