

NEW YORK STATE
SA-111 SUPPLEMENTAL SCHEDULES
For the Period: July 1, 2010 to June 30, 2011

SCHEDULE 8-i
AGENCY IDENTIFICATION
AND CERTIFICATION
STATEMENT

Page _____

AGENCY NAME: _____
AGENCY ADDRESS: _____

AGENCY CODE: _____
COUNTY NAME: _____
COUNTY CODE: _____

TYPE OF OWNERSHIP:
NOT-FOR-PROFIT:
PROPRIETARY:
GOVERNMENTAL:

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

SCHOOL CODE (SED ONLY): _____

FEDERAL EMPLOYER ID NUMBER: _____

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
 OPWDD
 OASAS
 SED

CHECK THE SUBMISSION TYPE:
 FULL CFR
 ABBREVIATED CFR
 ARTICLE 28 ABBREVIATED CFR
 MINI-ABBREVIATED CFR
 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. _____

CFR-i
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