NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2005 to June 30, 2006

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: ☐

SCHOOL CODE (SED 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.

FEDERAL EMPLOYER ID NUMBER (OMRDD Only): _____

CHECK THE STATE AGENCY(IES):
☐ OMH
☐ OMRDD
☐ OASAS
☐ SED

CHECK THE CFR 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.