NEW YORK STATE

CONSOLIDATED FISCAL REPORT

For the Period: July 1, 2016 to June 30, 2017

SCHEDULE CFR-i
AGENCY IDENTIFICATION
AND CERTIFICATION
STATEMENT

TYPE OF OWNERSHIP:

Page_

Rev.

July 2017

NOT-FOR-PROFIT: □ **AGENCY CODE:** AGENCY NAME: **AGENCY ADDRESS: COUNTY NAME:** PROPRIETARY: GOVERNMENTAL: □ COUNTY CODE: ☐ Please check the box if the agency address changed from the prior reporting period. SCHOOL CODE (SED ONLY): Person to Contact with Regard to Questions Concerning this Report: FEDERAL EMPLOYER ID NUMBER: CERTIFIED FINANCIAL STATEMENT REPORTING PERIOD: Telephone Number Name CHECK THE STATE AGENCY(IES): OMH **OPWDD** Title OASAS SED E-mail Address CHECK THE CFR SUBMISSION TYPE: ☐ FULL CFR □ ABBREVIATED CFR ☐ Please check the box if the person to contact changed from the prior reporting period. ☐ ARTICLE 28 ABBREVIATED CFR Contact Information for President/Chair, Board of Directors: ☐ MINI-ABBREVIATED CFR Name Title E-mail Address 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. Name and Title Date Telephone Number E-mail Address Signature of Chief Executive Officer CFR-i

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