COMPLETE ONLY
IF THIS REPORT
CONTAINS STATE AID
FUNDED PROGRAMS

NEW YORK STATE
CONSOLIDATED FISCAL REPORT
For the Period: July 1, 2020 to June 30, 2021

SCHEDULE CFR-iii
COUNTY/NYC
CERTIFICATION
STATEMENT

AGENCY NAME: _____ **AGENCY CODE:** _____

COUNTY/NYC - OPERATED OR VOLUNTARY LOCAL SERVICE PROVIDER CERTIFICATION

I certify that the attached statement fully and accurately represents all reportable income and expenditures made for services performed in accordance with the provision of the Mental Hygiene Law and approved budgets.

There are records and worksheets to support this statement in the custody of the above named agency. Such records and worksheets include the necessary summaries of payrolls and time records, abstracts from ledgers, registers or other expense records. All income from fees, all payments by other State or Federal agencies and any other income have been recorded, included and summarized in support of the amounts reported herein.

Records and worksheets, including records which show that the agency has applied for and received, or received formal notification of refusal of, all forms of third party reimbursement and federal aid, which may be appropriate for such services, are on file at the above location and available for audit by the Office of the State Comptroller and/or representatives of the New York State Commissioner of the Office of Addiction Services and Supports, Commissioner of the Office For People With Developmental Disabilities, or the Commissioner of the Office of Mental Health.

I understand that the State Aid paid on the basis of this certification for local assistance providers may be adjusted, modified and reduced if the records referred to above do not support this financial statement, and that such a reduction may require a repayment to the State of any overpayments which are disclosed by audit.

Signed: _____
(For Voluntary Local Service Provider)

Name: _____
(First and Last Name of Service Provider's Chief Executive Officer)

Title: _____
(Service Provider's Chief Executive Officer)

Date: _____

Signed: _____
(For County/City Operated Local Service Provider)

Name: _____
(First and Last Name of LGU's Chief Fiscal Officer)

Title: _____
(LGU's Chief Fiscal Officer)

Date: _____

LOCAL GOVERNMENTAL UNIT CERTIFICATION

I have verified that the costs and revenue reported in the Total column of Schedule DMH-3 are consistent with the contract expenditures and income amounts as approved by this local governmental unit. I also affirm that the expenditures were necessary to provide the services covered by the approved budget and that further review will establish if all income has been fully reported.

I understand that the State Aid paid to this local governmental unit on the basis of this certification may be adjusted, modified and reduced if records are not available, or do not support this financial statement. I hereby recommend that final reimbursement be approved.

Signed: _____
Director of Community Mental Health Services

Name: _____
(First and Last Name of Director of Community Mental Health Services)

Local Governmental Unit: _____
(Specify)

Date: _____