

NEW YORK STATE
CONSOLIDATED QUARTERLY REPORT
For the Period: 07/01/11 - 06/30/12

SCHEDULE CQR-i
AGENCY IDENTIFICATION
AND CERTIFICATION STATEMENT

QUARTERLY

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.

Person to Contact with Regard to Questions Concerning this Report:

FEDERAL EMPLOYER ID NUMBER: _____

Name Telephone Number ()

CHECK THE STATE AGENCY(IES): OASAS _____
OMH _____
OPWDD _____

Title

SUBMISSION TYPE: **QUARTERLY**

E-mail Address FAX Number ()

QUARTER REPORTED (Please Check):
____ 1st ____ 2nd ____ 3rd ____ Mid-Year ____ Final Revision # ____

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

Date Prepared

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

E-mail Address

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 NUMBER OF PAGES SUBMITTED: _____