

NEW YORK STATE
CONSOLIDATED BUDGET REPORT
For the Period: 01/01/09 - 12/31/09

SCHEDULE CBR-i
AGENCY IDENTIFICATION
AND CERTIFICATION
STATEMENT

B U D G E T

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 (OMRDD ONLY): _____

Name Telephone Number ()

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

Title

E-mail Address FAX Number ()

SUBMISSION TYPE: **B U D G E T**

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

Date Prepared

PLEASE NUMBER ALL PAGES CONSECUTIVELY. LIST THE NUMBER OF PAGES SUBMITTED: _____