

Annual MHSA Revenue and Expenditure Report for FY 10-11

COUNTY CERTIFICATION

County _____

County Mental Health Director	Fiscal Manager
Name _____	Name _____
Phone _____	Phone _____
E-mail _____	E-mail _____
Mailing Address	

I HEREBY CERTIFY to the best of my knowledge and belief the Annual Mental Health Services Act (MHSA) Revenue and Expenditure Report in all aspects is true, correct and in accordance with the law. I am the official responsible for the administration of county mental health services in and for _____ County. I certify that the County has complied with all pertinent regulations, laws and statutes for this Annual MHSA Revenue and Expenditure Report for FY 2010-11. The information/data provided in the Annual MHSA Revenue and Expenditure Report is in compliance with California Code of Regulations Title 9, section 3510.

Mental Health Director/Designee (PRINT)

Signature

Date