State of California
Health and Human Services Agency

Department of Health Care Services

ANNUAL MHSA REVENUE AND EXPENDITURE REPORT and ADJUSTMENT WORKSHEET COUNTY CERTIFICATION

County/City: _____

Local Mental Health Director

Name: _____

Telephone: _____

Email: _____

Document for Certification:

_____ **FY:** _____

I hereby certify[1] under penalty of perjury under the laws of the State of California that the attached Annual MHSA Revenue and Expenditure Report or Adjustments to Revenue or Expenditure Summary Worksheet is complete and accurate to the best of my knowledge.

Local Mental Health Director (PRINT)	Signature	Date

[1] Welfare and Institutions Code section 5899(a)