State of California
Health and Human Services Agency

Department of Health Care Services

MENTAL HEALTH SERVICES ACT
PRUDENT RESERVE ASSESSMENT/REASSESSMENT

County/City: _____

Fiscal Year: _____

Local Mental Health Director

Name: _____

Telephone: _____

Email: _____

I hereby certify[1] under penalty of perjury, under the laws of the State of California, that the Prudent Reserve assessment/reassessment is accurate to the best of my knowledge and was completed in accordance with California Code of Regulations, Title 9, section 3420.20 (b).

Local Mental Health Director (PRINT NAME)	Signature	Date

[1] Welfare and Institutions Code section 5892 (b)(2)