Enclosure A
COUNTY CERTIFICATION
PEI STATEWIDE PROGRAM FUNDING REQUEST

County Name: _____

County Mental Health Director	**Program Lead**
Name: Telephone Number: E-mail:	Name: Telephone Number: E-mail:
Mailing Address:	

I hereby certify that I am the official responsible for the administration of public community mental health services in and for said County and that the County has complied with all pertinent regulations, laws and statutes for this update to the Three-Year Program and Expenditure Plan. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code Section 5891 and California Code of Regulations (CCR), Title 9, Section 3410, Non-Supplant.

This Plan or update has been developed with the participation of stakeholders, in accordance with CCR, Title 9, Sections 3300, 3310(d) and 3315. The draft Program and Expenditure Plan or update was circulated for 30 days to stakeholders for review and comment. If this is the county's first submission of a PEI component, the local mental health board or commission has held a public hearing on the Plan. All input has been considered with adjustments made, as appropriate.

All documents in the attached Program and Expenditure Plan or Update are true and correct.

_____ _____ _____

Signature Date Title
Local MH Director/Designee