

**Managed Care Supplemental Payment Program
Managed Care Visit and Revenue (MCVR) Report
Report Period: January 2018 – December 2018**

CERTIFICATION

FQHC Name:

Report Submission Date:

mm/dd/yy

The undersigned hereby certifies that to the best of my informed knowledge and belief the statements made herein and the documents attached hereto are accurate, true and complete in all material aspects.

I understand that the New York State Department of Health is relying upon this certification as part of its review and approval process, and that should it be determined that this certification is materially false or incomplete or incorrect or includes incorrect, false or misleading information, appropriate enforcement action will be taken.

Signature: _____
Executive Director/CEO/CFO

Date: _____