

**Managed Care Supplemental Payment Program  
Managed Care Visit and Revenue (MCVR) Report  
Report Period: January 2014 – December 2014**

**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: \_\_\_\_\_