

**Instructions:** Complete and submit to address below.

| Agency   |   |                      |
|--|---|----------------------|
| AGENCY NAME  | FEIN(s) (include all related FEINS)                   | FISCAL YEAR END DATE |
| CONTACT NAME   | TITLE   |                      |
| SIGNATURE  | DATE  |                      |
| TELEPHONE  | FAX   | E-MAIL               |
| TOTAL FEDERAL FUNDING (including program income)<br>\$ | TOTAL NYSDOH FUNDING (including program income)<br>\$ |                      |

### Certification

For the indicated fiscal year, the above-named contractor (including any parent, sibling or subsidiary corporations) is exempt from (check one or both):

- The requirements of the Federal Single Audit Act - OMB Circular A-133  
(Less than \$500,000 total Federal funding [*including program income*] in the fiscal year)
  
- The requirements of the Department - Appendix A-1 section 3  
(Less than \$300,000 in Department [*combined Federal and State*] funding [*including program income*] in the fiscal year)

### Auditor

|               |                               |        |
|---------------|-------------------------------|--------|
| FIRM NAME     |                               |        |
| CPA NAME      | NEW YORK STATE LICENSE NUMBER |        |
| CPA SIGNATURE | DATE                          |        |
| TELEPHONE     | FAX                           | E-MAIL |

**Attach financial statements and submit to:** NEW YORK STATE DEPARTMENT OF HEALTH  
AUDIT UNIT  
1243 Corning Tower  
Albany, NY 12237-0041  
Tel: (518) 474-1458  
Fax: (518) 473-4610  
Email: fmgau@health.state.ny.us

DOH USE ONLY:  FORM  F/S  AGENCY  CPA  FUNDING  PGM. APPROVE/DENY. BY/ DATE \_\_\_\_\_