NEW YORK STATE DEPARTMENT OF HEALTH
Audit Unit

Audit Report Exemption Form

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)	TOTAL NYSDOH FUNDING (including program income)
$	$

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
2266 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_____