|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **DEPARTMENT OF HEALTH SERVICES** | | |  | **STATE OF WISCONSIN** | | | |
| Division of Enterprise Services | | |  |  | | |  |
| F-80479 (10/2024) | |  |  |  | | |  |
|  | |  |  |  | | |  |
| **AUDIT CONFIRMATION REQUEST**  At the request of CPA firms, the Department of Health Services will provide confirmation of amounts paid on grant contracts to provider agencies directly funded by the Department of Health Services and will identify differences wherever possible. | | | | | | | |
| **Mail completed request *and self-addressed envelope* directly to:** | Audit Confirmation Coordinator  Bureau of Fiscal Services, Room 750  1 W. Wilson Street, P.O. Box 7850  Madison, WI 53707-7850 | | | | | **Email DHS BFS General** [**DHSBFSGeneral@dhs.wisconsin.gov**](mailto:DHSBFSGeneral@dhs.wisconsin.gov) | |
| 1. Contact Person Name | | | | | 2. Phone Number | | |
| 3. Grant Contract Recipient Name | | | | | | | |
| 4. Program Name | | | | | | | |
| 5. Purchase Order Number or Other Identifying Information | | | | | | | |
| 6. Grant Contract Periods        to | 7. Grant Contract Amount | | | | 8. Amount Earned Per Grant Contract | | |
| 9. Grant contract balance as of: | | | | | **$** | | |
| 10. Does this grant include federal financial assistance dollars?  Yes  No | 11. Catalog of Federal Domestic Assistance (CFDA) Number | | | | 12. Percentage of Federal Funds | | |
|  | | |
| The above information agrees with our records, except as indicated (to be completed by Audit Confirmation Coordinator). | | | | | | | |
| **SIGNATURE** | Date Signed | | | | Phone Number | | |
|  | | | |  | | |