**NOTIFICATION OF LICENSED PUBLIC ACCOUNTANT\***

|  |  |
| --- | --- |
| Provider Agency Name: |  |
| Address: |  |
| Contact Individual and Title: |  |
|  |  |  |
| Telephone No.  |  | Agency Fiscal Year to be Audited: |  |
| Federal ID No.  |  | Charities Registration No.: |  |

List All State and Federal Financial Funding During the Fiscal Year Under Audit

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Department |  | Division |  | Contract No. |  | Contract Period |  | Contract Amount |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |

Use back of form to list additional State and Federal Funding

Licensed Public Accountant (attach photocopy of firm’s license to practice, **and most recent external quality control review)**

|  |  |
| --- | --- |
| Firm Name: |  |
| Address: |  |
| Telephone No.: |  |  | Firm License No.: |  |
| E-Mail Address: |  |
| Currently Licensed to practice in the State(s) of:  |  | Expiration Date:  |  |
| Contact Individual and Title: |  |

Certification:

I certify that we are aware of the requirements in DHS.P7.06 and that the audit will comply with this policy.

|  |  |  |  |
| --- | --- | --- | --- |
| **LPA** Signature |  | Title |  |

Audit Report Deficiencies- Does your firm have any outstanding audit reports with deficiencies for any provider agency contracting with any NJ State Department? [ ]  YES [ ]  NO

I certify that the above information is accurate. Any inaccurate information may result in termination of your contract with the provider listed above.

|  |  |  |  |
| --- | --- | --- | --- |
| **Provider** Signature |  | Title |  |

\*This Notification (NLPA) is to be sent to the Department of Human Services’ Office of Auditing with the completed audit report. Although the NLPA form and the audit report shall be submitted together, all of the information in the NLPA form should relate to the subsequent year of the completed audit report. The anticipated completion date should not be more than 120 days after the end of the fiscal year. The Provider Agency and the licensed public accountant should fill out this form to this point in its entirety.

|  |  |  |  |
| --- | --- | --- | --- |
| Date Received: |  | Audit Control No.: |  |
| Date Verified: |  | By:  |  |  | Licensed: |  |
| Division: |  |  | Approved:  | [ ]  | Not Approved:  | [ ]  |

(Revised 3/08)