

Agency Name: Your Agency Name Here

Contact Person: Contact Person Name Here **Title:** Title Of Contact Person

Address: Address Here

Phone #: 414-999-9999

Fax # 414-999-9999

Email: youremail@here

AUDIT WAIVER REQUEST

Dennis Buesing,
Contract Administrator
Milwaukee County Department of Health & Human Services (DHHS)
1220 West Vliet St. Suite B26 #4
Milwaukee, WI 53205

Re: 2013 Purchase of Services Waiver of Audit Request

- 1. **Date of Request:** _____ 1a. **Type of Entity:** Individual
- 2. **Program:** Program(s) Names Here
- 3. **DHHS Division:** DCSD
- 4. **Total Amount of Contract with DHHS:** \$0.00
- 5. **Total Amount Earned/payment received from Milwaukee County DHHS:** \$0.00
- 6. **Total amount earned/received from other Government Sources (e.g. State, city):** \$0.00
- 7. **Reason Audit Waiver is being requested:**

a. Experience:

Number of years in Business: 0

Number of year's experience providing these services: 0

Number of year's experience providing these services to DHHS: 0

Payment Method: Unit Rate

Other program reports submitted to DHHS: Other Program Reports e.g. Daily Time Sheets, Monthly Evaluation Reports, etc.

b. Audit Fee exceeds 5% of payments under DHHS contract:

Audit Cost:\$0.00

Source of estimate: CPA Firms name, Contact & Phone number

c. Audit not cost effective or undue burden. Please explain: Any other reasons for audit being undue burden or unnecessary. e.g. Not Cost Effective, Single Member LLC, Sole Proprietorship, etc.

8. Alternate Form of Financial Statement/Reports being provided in lieu of certified audit reports (Check all that you can provide)

- CPA Compiled /Reviewed Internally Generated Financial Statement,
- Statement of Revenue and Expenditure by Program, Copy of Tax return

Signature _____

Date _____

OFFICE USE:

___ Recommended

___ Denied

Vendor Type: Low Risk/High Risk

Comments/ alternate form of Financial and/or Program compliance monitoring being implemented:

Signature

Date