California Department of Education

**This form must be completed, signed, and returned by September 15, 2017 to:**

California Department of Education

Audits and Investigations Division

1430 N Street, Suite 5319

Sacramento, CA 95814

Attention: Robert Hoyer, Analyst

Email: [rhoyer@cde.ca.gov](mailto:rhoyer@cde.ca.gov)

Fax: 916-323-5279

**Annual Audit Status Certification**

**Fiscal Year 2016-2017**

**Please see instructions for assistance.**

|  |  |  |
| --- | --- | --- |
| **AGENCY NAME** | **VENDOR NUMBER** | **EMPLOYER IDENTIFICATION NUMBER** |
| **MAILING ADDRESS** | **COUNTY** | **E-MAIL ADDRESS** |
| **CITY STATE ZIP CODE** | | **FAX NUMBER** |
| **NAME AND TITLE OF AUTHORIZED REPRESENTATIVE (First, M.I., Last, Title)** | | **PHONE NUMBER** |
| **ORGANIZATION TYPE**  Nonprofit  For Profit  Hospital  Indian Tribal Council  Government  Higher Education | | **AGENCY’S 12-MONTH FISCAL YEAR**  July – June  October – September  January – December  Other: |
| **FUNDING FROM CALIFORNIA DEPARTMENT OF EDUCATION**  Child Care and Development  Nutrition    Food Commodities  Adult Education  Other: | | **TOTAL FEDERAL FINANCIAL ASSISTANCE EXPENDED**  Less than $25,000  $25,000 - $749,999  $750,000 or more |
| **AUDIT TYPE (See Instructions)**  Contract  Program  Single Audit |
| **CHECK ONE BOX BELOW:**  Agency will submit the required audit report.  Agency does not have an audit report requirement.    Reason: | | |
| **I hereby certify that I am an authorized representative of the above named agency and to the best of my knowledge, the information on this form is true and correct as applicable to the programs administered by the California Department of Education. I understand that any correction to the above information requires the submission of a revised Annual Audit Status Certification form.** | | |
| **SIGNATURE OF AUTHORIZED REPRESENTATIVE** | | **DATE** |

(REV. 06/2017)