Schedule 2 – Personal Qualifying Information

Contents:

Instructions for Completing Schedules 2A, 2B and 2C.

Schedule 2A Personal Qualifying Information. Signature and Notary Required.
Schedule 2B Personal Financial Statement for Individuals Contributing Capital in Support of the Project. Signature and Notary Required.
Schedule 2C Not-for-Profit Directors Statement. Signature and Notary Required.
Schedule 2D Instructions and Forms for Requesting Compliance Statements for Out-of-State Health Care Facilities.

Note: Individual copies of this schedule must be filled out by each person required to file personal qualifying information. Therefore, multiple copies should be made, completed, signed and submitted as appropriate. Signed originals should be scanned and saved in PDF format for the electronic copy that applicants should provide as a supplement to the required paper copies.

Instructions

Schedule 2 is required for directors, proprietors, and certain members and shareholders of the operator and management company, if any, when an establishment application is filed, including certain transfers of ownership or interest. Ensure that responses are entered to ALL questions and that, where required, the forms are signed and notarized. Refer to the specific type of transactions below for further instructions. Those submitting Schedule 2 due to their affiliation with the operator must also submit three letters of personal reference.

Sole Proprietors

Sole Proprietors must submit Schedules 2A and 2B.

Limited Liability Companies

Only members who own ten percent or more of an ACF's membership interest must submit Schedules 2A and 2B. This information is also required for any member, stockholder, officer or director of any member or parent corporations of the limited liability company.

Not-for-Profit Corporations

Each member, officer and director who contributes capital in support of the project must submit Schedules 2A and 2B. Directors who do not contribute capital in support of a project must submit Schedules 2A and 2C.

Business Corporations

Stockholders, officers and directors of the applicant who own ten percent or more of the ACFs issued stock must submit Schedules 2A and 2B. Schedules 2A and 2B are also required for each stockholder, officer and director of any parent corporations.

General or Registered Limited Liability Partnerships

All partners must submit Schedules 2A and 2B.

Management Company

All directors, proprietors, members and shareholders of a proposed management company must submit Schedule 2A.

Transfer of Ownership Interest

Incoming owners, stockholders, members or partners who will own ten percent or more of a partnership, business corporation or limited liability company must submit Schedules 2A and 2B. Transfers of less than ten percent to a new partner or stockholder require only prior notice.

The worksheet on the following page is intended to assist you in identifying the persons for whom Schedules 2A, 2B or 2C are required.

Table 2A-1 Personal Information Tracking

Instructions: Refer to the Schedule 2 instructions to determine who should submit Schedule 2 and then enter the names accordingly on the following worksheet. Attach additional sheets if necessary. Attachment # .

Legal Operator: List Stockholder(s), Officer(s), Director(s), LLC Member(s) or Manager(s) or Partners(s) Under Each Entity Named	**Title or Position That Requires This Individual to Submit Schedule 2**	**Mark "X " if Required to Submit this Schedule**			
		2A	2B	2C	Three Letters of Reference
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
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		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐
		☐	☐	☐	☐

1. Personal Identifying Information

LAST NAME | FIRST NAME | MI

HOME STREET ADDRESS

CITY | STATE | ZIP

E-MAIL ADDRESS | TELEPHONE

DATE OF BIRTH (MONTH/DAY/YEAR) | PLACE OF BIRTH (COUNTY/STATE) | POSITION WITH APPLICANT

BUSINESS NAME AND STREET ADDRESS

CITY | STATE | ZIP | TELEPHONE

2. Formal Education

Institution	Address	Attended FROM	Attended TO	Degree	Date Received

3. Licenses Held: List any and all licenses issued by a governmental or other regulatory entity.

Type of Professional License (Include Specialty)	License Number	Institution Granting License (Mailing Address, Phone, Email)	Effective Date	Expiration Date

4. Employment History for the Past 10 Years

☐ Currently Employed ☐ Retired If retired, please specify date of retirement: ________

Start with MOST RECENT employment and include employment during the last 10 years. Please attach additional sheets, if necessary.

NAME OF EMPLOYER TYPE OF BUSINESS

STREET ADDRESS OF EMPLOYER

CITY STATE ZIP

STARTING DATE OF EMPLOYMENT ENDING DATE OF EMPLOYMENT

NAME OF SUPERVISOR FOR REFERENCE TELEPHONE

POSITION/RESPONSIBILITIES

REASON FOR DEPARTURE

NAME OF EMPLOYER TYPE OF BUSINESS

STREET ADDRESS OF EMPLOYER

CITY STATE ZIP

STARTING DATE OF EMPLOYMENT ENDING DATE OF EMPLOYMENT

NAME OF SUPERVISOR FOR REFERENCE TELEPHONE

POSITION/RESPONSIBILITIES

REASON FOR DEPARTURE

NAME OF EMPLOYER TYPE OF BUSINESS

STREET ADDRESS OF EMPLOYER

CITY STATE ZIP

STARTING DATE OF EMPLOYMENT ENDING DATE OF EMPLOYMENT

NAME OF SUPERVISOR FOR REFERENCE TELEPHONE

POSITION/RESPONSIBILITIES

REASON FOR DEPARTURE

5. Offices Held or Ownership in Health Care Facilities or Programs

The purpose of this section is to obtain a listing of any affiliations as referenced below with which the owners, officers, directors, controlling persons or partners of the proposed organization have been associated in the past 10 years. Affiliation, for the purposes of this section, includes serving as either a voting officer, director or principal stockholder of any health care, adult care, behavioral or mental health facility, program or agency requiring licensure or certification in New York State. Officerships and directorships in similar facilities or programs outside of New York State must also be disclosed. Include facilities for which applications were previously disapproved or withdrawn.

Provide documentation from the appropriate regulatory agency in the states (other than New York State) where you note affiliations, reflecting that the affiliated facilities, programs and agencies operated in substantial compliance with applicable codes, rules and regulations for the past ten years (or for the period of your affiliation, whichever is shorter). Instructions for the out-of-state review, a sample letter of inquiry and a recommended form are provided in Schedule 2D to assist you in securing this information.

a. Applicant's Offices/Ownership Interests

Have you ever owned or operated any adult care facilities or other health care programs or institutions or had any affiliations with health care or health related operations in New York, in the USA, or in other countries?

☐ Yes ☐ No If **Yes**, complete the following.

FROM TO NAME AND ADDRESS

TYPE CERTIFICATE NUMBER (IF ANY) OFFICE HELD/NATURE OF INTEREST ☐ Open ☐ Closed ☐ Proposed

NAME AND ADDRESS OF LICENSING AGENCY

FROM TO NAME AND ADDRESS

TYPE CERTIFICATE NUMBER (IF ANY) OFFICE HELD/NATURE OF INTEREST ☐ Open ☐ Closed ☐ Proposed

NAME AND ADDRESS OF LICENSING AGENCY

FROM TO NAME AND ADDRESS

TYPE CERTIFICATE NUMBER (IF ANY) OFFICE HELD/NATURE OF INTEREST ☐ Open ☐ Closed ☐ Proposed

NAME AND ADDRESS OF LICENSING AGENCY

FROM TO NAME AND ADDRESS

TYPE CERTIFICATE NUMBER (IF ANY) OFFICE HELD/NATURE OF INTEREST ☐ Open ☐ Closed ☐ Proposed

NAME AND ADDRESS OF LICENSING AGENCY

FROM TO NAME AND ADDRESS

TYPE CERTIFICATE NUMBER (IF ANY) OFFICE HELD/NATURE OF INTEREST ☐ Open ☐ Closed ☐ Proposed

NAME AND ADDRESS OF LICENSING AGENCY

b. Relative's Ownership Interests

Has a relative ever owned or operated any adult care facilities or other health care program or institutions or had any affiliations with health care or health related operations in New York, in the USA, or in other countries?

☐ Yes ☐ No If **Yes**, complete the following.

NAME OF RELATIVE RELATIONSHIP TO APPLICANT

FROM TO NAME AND ADDRESS

TYPE CERTIFICATE NUMBER (IF ANY) OFFICE HELD/NATURE OF INTEREST ☐ Open ☐ Closed ☐ Proposed

NAME AND ADDRESS OF LICENSING AGENCY

NAME OF RELATIVE RELATIONSHIP TO APPLICANT

FROM TO NAME AND ADDRESS

TYPE CERTIFICATE NUMBER (IF ANY) OFFICE HELD/NATURE OF INTEREST ☐ Open ☐ Closed ☐ Proposed

NAME AND ADDRESS OF LICENSING AGENCY

NAME OF RELATIVE RELATIONSHIP TO APPLICANT

FROM TO NAME AND ADDRESS

TYPE CERTIFICATE NUMBER (IF ANY) OFFICE HELD/NATURE OF INTEREST ☐ Open ☐ Closed ☐ Proposed

NAME AND ADDRESS OF LICENSING AGENCY

NAME OF RELATIVE RELATIONSHIP TO APPLICANT

FROM TO NAME AND ADDRESS

TYPE CERTIFICATE NUMBER (IF ANY) OFFICE HELD/NATURE OF INTEREST ☐ Open ☐ Closed ☐ Proposed

NAME AND ADDRESS OF LICENSING AGENCY

NAME OF RELATIVE RELATIONSHIP TO APPLICANT

FROM TO NAME AND ADDRESS

TYPE CERTIFICATE NUMBER (IF ANY) OFFICE HELD/NATURE OF INTEREST ☐ Open ☐ Closed ☐ Proposed

NAME AND ADDRESS OF LICENSING AGENCY

c. Enforcement Actions

If you answered "yes" to sections **a** or **b** above, please answer the following:

During the period of your (or your relative's) affiliation, were any of the facilities or other health care programs subject to an enforcement or administrative action taken by the State regulatory agency due to the facility's violation of applicable laws and regulations?

☐ Yes ☐ No If **Yes**, please provide the following information:

NATURE OF VIOLATION

AGENCY OR BODY ENFORCING VIOLATION (NAME & ADDRESS)

Has the enforcement or administrative action been resolved? ☐ Yes ☐ No If **No**, please provide an explanation:

d. Affirmative Statement of Qualifications

For individuals who have not previously served as a director/officer nor have had managerial experience with a health care facility or other health care program, please provide in the space below an affirmative statement explaining why you are qualified to operate the proposed facility. This statement should include, but not be limited to, any relevant community/volunteer background and experience.

6. Record of Legal Actions

	Yes	No
1) Except for minor traffic violations, have you ever been convicted of, or had a sentence imposed for, a crime?	☐	☐
2) Are there any criminal actions pending against you?	☐	☐
3) Have you ever pleaded nolo contendre (no contest) to a felony charge?	☐	☐
4) Have you ever been named as a defendant in any civil action, including but not limited to malpractice, fraud or breach of fiduciary responsibility, including but not limited to Medicare and Medicaid issues?	☐	☐
5) Have you ever been held liable or enjoined by final judgment as a result of a criminal or civil action involving fraud, embezzlement, fraudulent conversion, or misappropriation of property?	☐	☐
6) Are you/have you ever been subject to an injunctive restrictive/restraining order, or federal or state restrictive/restraining order, relating to business or health care related activity as a result of an action brought by a public agency or department?	☐	☐
7) Have you ever had a discharge in bankruptcy, or have you been found insolvent in any court action?	☐	☐
8) Are there now or have there ever been any civil or administrative actions pending against you or any professional/business entity with which you are affiliated?	☐	☐
9) Are there now or have there ever been any insurance arbitration awards against you or any professional/business entity with which you are affiliated?	☐	☐
10) Have you ever been a defendant in a hearing before an official body in relation to the operation of a home or institution caring for people?	☐	☐
11) Have you ever been dismissed or discharged from any employment at any healthcare provider for reasons other than lack of work or funds?	☐	☐
12) Have you ever received a discharge from the Armed Forces of the United States which was other than "honorable" or which was issued under other than honorable circumstances?	☐	☐
13) Have you ever forfeited bail or bond posted to guarantee your appearance in court to answer to any criminal charge?	☐	☐
14) Have you ever been denied approval to care for unrelated dependent children or adults, or had any such approval withdrawn?	☐	☐

If the answer to any of the previous questions were "yes," complete the section below:

DATE OF ACTION (MONTH/DAY/YEAR) | TYPE OF ACTION | LOCATION OF ACTION

PERSONS AND/OR FACILITIES INVOLVED

DATE OF CONVICTION/JUDGEMENT | ISSUER OF ORDER | PENALTY IMPOSED/DAMAGES ASSESSED

PROVIDE ANY FURTHER DETAILS

	Yes	No
15) Have you ever changed your name or used an alias, including changing your maiden name to a married name? If "yes," provide details below:	☐	☐
16) During the last 10 years, have you been refused a professional, occupational or vocational license by any public or governmental licensing agency or regulatory authority, or has such a license held by you during such period been suspended, revoked or otherwise subjected to administrative action?	☐	☐
17) Have you ever been involved in an action or proceeding brought by any public or governmental licensing agency or regulatory authority for violation of any securities, insurance or health law or regulation?	☐	☐
18) Have you ever been an officer, director, trustee, member, manager, partner, management employee or stockholder of a company, including the applicant company, where you occupied any such position or served in any such capacity wherein the company:	☐	☐
a) became insolvent, declared or was forced to declare bankruptcy or was placed in receivership or conservatorship?	☐	☐
b) was enjoined from or ordered to cease and desist from violating any securities, insurance or health law or regulation?	☐	☐
c) was the subject of an investigation by either federal or state law enforcement agencies on issues related to Medicare or Medicaid fraud?	☐	☐
d) was required to enter into a Corporate Integrity Agreement as part of a settlement with the Office of Inspector General of the U.S. Department of Health and Human Services or the New York State Office of the Medicaid Inspector General?	☐	☐
e) suffered the suspension or revocation of its certificate of authority or license to do business in any state?	☐	☐
f) was denied a certificate of authority or license to do business in any state?	☐	☐
g) If you have a been the subject of an Agency Action by New York State Office of the Medicaid Inspector General please disclose the details in full.	☐	☐

If the answer is "yes" to questions 16, 17, or 18, provide details below or attach an explanation, including, where applicable, the date, type, and location of the action, and all relevant details.

19) Have you ever been in a position that required a fidelity bond? If "no," skip to next section.	☐	☐
a) Were any claims made against that bond? If "yes," provide details below.	☐	☐
b) Have you ever been denied a fidelity bond or had such fidelity canceled or revoked? If "yes," provide details below.	☐	☐

The undersigned hereby certifies, under penalty of perjury, that the information contained herein or attached hereto is accurate, true, and complete in all material respects.

SIGNATURE | DATE

TYPE OR PRINT NAME | TITLE

NOTARY (NOTARY MUST AFFIX STAMP OR SEAL | DATE

Please refer to the Schedule 2 instructions prior to completing.

LAST NAME | FIRST NAME | MI

HOME STREET ADDRESS

CITY | STATE | ZIP

E-MAIL ADDRESS | TELEPHONE

BUSINESS OR PROFESSION

NAME OF EMPLOYER

OTHER BUSINESS VENTURES IN WHICH YOU ARE A PARTNER OR AN OFFICER (ATTACH ADDITIONAL PAGES, IF NECESSARY)

Anticipated Personal Income

Salaries & Wages	
Fees Or Commission	
Interest & Dividends	
Investments	
Other Partnerships/proprietorships	
Other Business Interests	
Other (Specify) _____	

Describe any contingent liabilities:

Describe your business ventures:

1. Balance Sheet **Summarizes from following sections**

ASSETS

Cash (Section 2) _____

Stocks and Bonds (Section 3) _____

Accounts Receivable (Section 4) _____

Notes Receivable (Section 4)

A. Due from Relatives and Friends _____

B. Due from others - Good _____

C. Due from others - Doubtful _____

Real Estate Owned (Section 5 and 6) _____

Cash Surrender Value of Life Insurance (Section 7) _____

Health Facility Realty Interests _____

Health Facility Operational Interests _____

Business Interests (Itemize) (Section 9):

1 _____ _____

2 _____ _____

3 _____ _____

4 _____ _____

5 _____ _____

Investments _____

other (specify) _____

TOTAL _____

Amount of Assets Pledged _____

NET WORTH _____

LIABILITIES

Notes Payable (Section 8)

A. Banks _____

B. Relatives _____

C. Health Care Facility _____

D. Other (Specify) _____

Accounts Payable

A. Health Care Facilities _____

B. Other (Specify) _____

Mortgages Payable

A. Health Care Facilities _____

B. Other (Specify) _____

Federal and State Income Taxes Payable _____

Other Accrued Taxes & Interests Payable _____

Installment Contracts Payable _____

Other Liabilities (Itemize)

1 _____ _____

2 _____ _____

3 _____ _____

4 _____ _____

TOTAL _____

Amount of Liabilities Secured _____

2. Cash on Hand

Name of Bank	Account Balance	Amount Pledged (if any)

Cash on Hand _____

Total as Per Statement _____

3. Stocks and Bonds

Stock ="S" Bond = "B"	Name of Security (example "US Gov't. Series --")	In Name of	If Pledged, State to Whom	Present Market Value

4. Accounts and Notes Receivable

Name and Address of Debtor	Amount	Are Assets Pledged as Collateral?	Amount Pledged (if any)

5. Real Estate Owned

Location, Type of Property	Date Acquired	Title in Name of	Cost	Approximate Current Value	Method of Payment	Mortgage Amount Original	Mortgage Amount Current

6. Real Estate Mortgages Owned

Type of Lien (1st, 2nd, 3rd, etc.), Location, Type of Property	Mortgages of Record	Original Amount	Method of Payment	Present Amount

Are there any principal payments, interest or taxes in arrears? ☐ Yes ☐ No

Are there any unrecorded assignments? ☐ Yes ☐ No

If "yes" to either question, please explain below:

7. Life Insurance

Face Amount	Name of Company	Beneficiary	Loans Against Policy	Type of Policy	Cash Value	Method of Payment

Are any of the above policies assigned except for loans as above? ☐ Yes ☐ No

If "yes," please explain below:

8. Notes Payable/Liabilities (other than mortgages listed above)

Name of Creditor	Indicate Method of Borrowing and how Note is Endorsed, Guaranteed or Secured	Interest Rate	Current Balance/ Due Date	Amounts and Assets Offered as Security

9. Business Interests

Are any of the assets business interests? If yes, they must be supported by the latest available certified financial statements and/or federal income tax returns for the appropriate entity. ☐ Yes ☐ No

Attachment Titles:

The undersigned hereby certifies, under penalty of perjury, that the information contained herein or attached hereto is accurate, true, and complete in all material respects.

SIGNATURE _____ DATE _____

TYPE OR PRINT NAME _____ TITLE _____

NOTARY (NOTARY MUST AFFIX STAMP OR SEAL) _____ DATE _____

Please refer to the Schedule 2 instructions prior to completing.

NAME OF INDIVIDUAL

This statement must be completed by directors of not-for-profit corporations who are not contributing capital in support of the project. The form is completed in lieu of Schedule 2B. This schedule is required for all not-for-profit adult care facility establishment applications.

Statement of Business Associations with Health Care Facilities

☐ I do NOT receive any income directly or indirectly from any other health care facility.

☐ I DO receive income directly or indirectly from the following health care facilities.
For each, please briefly describe the nature of the relationship and method of payment.

The undersigned hereby certifies, under penalty of perjury, that the information contained herein or attached hereto is accurate, true, and complete in all material respects.

SIGNATURE | DATE

TYPE OR PRINT NAME | TITLE

NOTARY (NOTARY MUST AFFIX STAMP OR SEAL) | DATE

The review of out-of-state operations should not be initiated until the application is assigned a project number and the Department of Health (Department) project manager instructs you to send the required information to the state regulatory agencies. Ensure that the project name and number are entered on the New York State Department of Health Compliance Report Form.

Note that the term "health care entity" includes hospitals; nursing homes; home care agencies; hospices; diagnostic and treatment centers; ambulatory surgery facilities; adult day health care programs; laboratories; health maintenance organizations; pharmacies; alcohol and substance abuse programs; facilities for the mentally ill; facilities for the developmentally disabled; adult care facilities; enriched housing programs; assisted living programs; and rehab facilities. Please include only those agencies, facilities and programs that are actually licensed or certified in their respective states.

Instructions

1. For **each affiliated health care entity** located in a state other than New York State, complete the applicant's portion of the two-page New York State Department of Health Compliance Report Form. Enter the project number at the top of the form. In the first paragraph, enter the applicant's name* and the date on which the completed form must be returned to the Department. Allow thirty days for a response. On the following pages, provide all identifying information for the entity being reviewed, including its name, address, license or certificate number and the time period for which the review should be conducted. New York State requires a ten-year compliance history. If the entity has been operational or affiliated for less than ten years, enter the entire time period with which it was affiliated with the applicant or board member.

2. Using the sample letter provided, forward to the appropriate regulatory agency in each state copies of the Compliance Report Forms. Enter the applicant's name in the first paragraph. In the second paragraph, enter the name of the project manager to whom the completed form should be returned and the due date (as entered on the Compliance Report Form). In the last paragraph, reference the project manager as the contact person and provide the reviewer's phone number. Contact information regarding project managers is provided at the end of Schedule 2D. Enclose a stamped, addressed envelope to facilitate the state's reply.

Please Note: Some states charge a fee for this information. The applicant is responsible for the payment of such fees.

3. Forward to the appropriate project manager a copy of all correspondence (including copies of the Compliance Report Form) prepared for the out-of-state review. Reference the project name and number. If the review is being conducted for board member affiliations, please clarify which board members are affiliated with which health care entities.

4. If you have completed an out-of-state review in the last three years, please contact your project manager to discuss what additional information is required.

*If the out-of-state review is being conducted for a board member's affiliations, ensure the Compliance Report Form reflects the name of the applicant and not the name of the board member.

New York State Department of Health Project Name and Number: _____

The applicant has submitted an application for establishment/change of ownership to the New York State Department of Health. In conjunction with the application, the Department requests compliance information regarding the health care facility or program named below, which has been operated or affiliated with the applicant for the specified time period. Please respond to the questions and provide details of any enforcement or administrative actions taken against the operator of this facility or program. Please also consider the operator's complaint history.

It is requested that this form be returned within 60 days of receipt to: Bureau of Licensure and Certification, Division of Assisted Living, New York State Department of Health, 875 Central Avenue, Albany, New York 12206.

To be Completed by APPLICANT:

NAME OF FACILITY OR PROGRAM TO BE REVIEWED

ADDRESS OF FACILITY OR PROGRAM

LICENSE OR CERTIFICATE NUMBER

TIME PERIOD TO BE REVIEWED

To be Completed by STATE REGULATORY AGENCY:

1. Time period reviewed, if different from requested time period: _____

2. Is the facility or program currently operational? ☐ Yes ☐ No

   a. If yes, is the facility or program currently in compliance with all applicable codes, rules and regulations? ☐ Yes ☐ No

   b. If the facility or program is not currently in compliance, describe below the nature of the non-compliance.

3. Were any enforcement or administrative actions taken against the facility or program during the specified time period? ☐ Yes ☐ No

   If yes, specify the number of actions. _____

4. Provide further details regarding each enforcement or administrative action taken.

   a. Cite the violations specific to each enforcement or administrative action. Include dates of surveys relative to each.

   b. Were any of these actions for repetitive violations? ☐ Yes ☐ No

   If yes, please explain. _____

   c. Has the enforcement or administrative action(s) been resolved? ☐ Yes ☐ No

   d. If yes, indicate the date the action(s) was resolved and specify any civil fine paid or corrective measures taken to resolve the action.

   e. If no, indicate the current status of the enforcement or administrative action and if possible, indicate when it is expected to be resolved.

5. Are there any other issues regarding this facility or program which you feel the New York State Department of Health should be aware of in determining the character and competence of the applicant? ☐ Yes ☐ No

   If yes, please explain. _____

NAME OF CONTACT PERSON

TITLE

STATE

PHONE (INCLUDE AREA CODE)

EMAIL

DATE

Dear (State Regulatory Agency):

The New York State Department of Health is currently reviewing an application for establishment/change of ownership submitted by (Applicant). As part of the regulatory requirements for establishing the character and competence of (Applicant), the Department must receive documentation that affiliated health care facilities/agencies/programs located in your state have been in substantial compliance with all applicable codes, rules and regulations.

The health care entities for which this information is requested are shown on the enclosed forms. Please complete the remainder of the form by responding to the questions and providing any additional information, as applicable. If this documentation is not available for the entire time period requested, please indicate the dates for which you conducted your review. The form should be returned to (project manager) in the New York State Department of Health by (Due Date). A stamped, addressed envelope is enclosed for your convenience.

Your assistance with this matter is appreciated. Should you have any questions, please contact (project manager) in the New York State Department of Health at (project manager phone).

Sincerely,

Enclosure