# Health & Human Services Committee

**Tuesday, June 6, 2023 3PM**

40 McMaster Street, Ballston Spa, NY

Chair: Phil Barrett

Members:
- John Lant
- Scott Ostrander
- Tom Richardson
- Jonathan Schopf - vc
- Tom Wood
- Mo Wright

I. Welcome and Attendance

II. Approval of the minutes of the April 4, 2023 meeting.

III. Daniel Khules, Department of Health

a. Authorizing a transfer of a portion of opioid settlement funds to the Saratoga County Department of Health to support prevention programs

b. Authorizing Acceptance of Year 10 Local Health Department Performance Incentive Award and amending the 2023 County Budget in relation thereto

c. Authorizing the transfer of a portion of opioid settlement funds to the Saratoga County Department of Health and an agreement with Herren Project/Herren Talks

d. Authorizing an agreement with Nixon Peabody, LLP to provide specialized legal services for the enforcement of the New York State Sanitary Code for the Saratoga County Department of Health

e. Authorizing the adoption of a Fee Schedule for Saratoga County Department of Health Environmental Health Programs

IV. Other Business

V. Adjournment

*To view the webcast live or once recorded, go to [https://www.saratogacountyny.gov/meetings/2023-meetings/](https://www.saratogacountyny.gov/meetings/2023-meetings/)*

# SARATOGA COUNTY

## AGENDA ITEM REQUEST FORM

**TO:** Steve Bulger, County Administrator
Ridge Harris, Deputy County Administrator
Michelle Granger, County Attorney
Therese Connolly, Clerk of the Board
Stephanie Hodgson, Director of Budget

**CC:** John Warmt, Director of Purchasing
Jason Kemper, Director of Planning and Economic Development
Bridget Rider, Deputy Clerk of the Board
Matt Rose, Management Analyst
Tracy Goodson, County Attorney's Office
Audra Hedden, County Administrator's Office

**DEPARTMENT:** Department of Health

**DATE:** 05/05/2023

**COMMITTEE:** Health & Human Services

1. Is a Resolution Required:

   Yes, Other

2. Proposed Resolution Title:

   Transfer a Portion of Opioid Settlement Funds to SCDOH to Support Prevention Programs, Prevent Misuse of Opioids, and Prevent Overdose Deaths and Other Harms

3. Specific Details on what the resolution will authorize:

   In accordance with the Exhibit E of the Opioid Settlement Agreement, Schedule A (item G4) and Schedule B (items G4, H1, H2, H3, H6, H7, H8 and H9), the transfer of $72,000 to SCDOH's budget for the purchase of naloxboxes, fentanyl and xylazine test strips, drug disposal systems and ancillary supplies.

This column must be completed prior to submission of the request.

County Attorney's Office Consulted Yes

4. Is a Budget Amendment needed: ☑ YES or ☐ NO
If yes, budget lines and impact must be provided.
Any budget amendments must have equal and offsetting entries.

County Administrator's Office Consulted Yes

☐ Please see attachments for impacted budget lines.
(Use ONLY when more than four lines are impacted.)

Revenue

| Account Number | Account Name | Amount |
|---|---|---|
| A.40-2727 | Opioid Revenue | $72,000 |

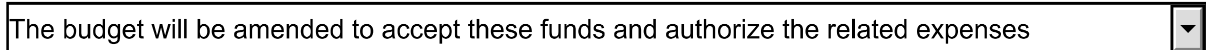
Expense

| Account Number | Account Name | Amount |
|---|---|---|
| A.40.408-8519 | Personal Safety Supplies | $69,000 |
| A.40.408-8200 | Department Supplies | $3,000 |

Fund Balance (if applicable): (Increase = additional revenue, Decrease = additional expenses)

Amount:

5. Identify Budget Impact (**Required**):


The budget will be amended to accept these funds and authorize the related expenses

a. G/L line impacted 408

b. Budget year impacted 2023

c. Details

6. Are there Amendments to the Compensation Schedule?

☐ YES **or** ☑ NO (If yes, provide details)

Human Resources Consulted

a. Is a new position being created? ☐ Y ☐ N

Effective date

Salary and grade

b. Is a new employee being hired? ☐ Y ☐ N

Effective date of employment

Salary and grade

Appointed position:

Term

c. Is this a reclassification? ☐ Y ☐ N

Is this position currently vacant? ☐ Y ☐ N

Is this position in the current year compensation plan? ☐ Y ☐ N

7. Does this item require the awarding of a contract: ☐ Y ☑ N

Purchasing Office Consulted

a. Type of Solicitation

b. Specification # (BID/RFP/RFQ/OTHER CONTRACT #)

c. If a sole source, appropriate documentation, including an updated letter, has been submitted and approved by Purchasing Department? ☐ Y ☐ N ☐ N/A

d. Vendor information (including contact name):

e. Is the vendor/contractor an LLC, PLLC, or partnership:

f. State of vendor/contractor organization:

g. Commencement date of contract term:

h. Termination of contract date:

i. Contract renewal date and term:

k. Is this a renewal agreement: ☐ Y ☐ N

l. Vendor/Contractor comment/remarks:

County Administrator's Office Consulted

**8.** Is a grant being accepted: ☐ YES or ☑ NO

a. Source of grant funding:

b. Agency granting funds:

c. Amount of grant:

d. Purpose grant will be used for:

e. Equipment and/or services being purchased with the grant:

f. Time period grant covers:

g. Amount of county matching funds:

h. Administrative fee to County:

9. Supporting Documentation:

- ☐ Marked-up previous resolution
- ☐ No Markup, per consultation with County Attorney
- ☐ Information summary memo
- ☐ Copy of proposal or estimate
- ☐ Copy of grant award notification and information
- ☐ Other ________________________________________________

10. Remarks:

-Saratoga County libraries have requested naloxboxes.
-Fentanyl and xylazine test strips, drug disposal systems and ancillary supplies will be included in the County's Overdose Rescue Kits which are distributed at community events.

# SARATOGA COUNTY

## AGENDA ITEM REQUEST FORM

**TO:** Steve Bulger, County Administrator
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**CC:** John Warmt, Director of Purchasing
Jason Kemper, Director of Planning and Economic Development
Bridget Rider, Deputy Clerk of the Board
Matt Rose, Management Analyst
Tracy Goodson, County Attorney's Office
Audra Hedden, County Administrator's Office

**DEPARTMENT:** Department of Health

**DATE:** 5/22/23

**COMMITTEE:** Health & Human Services

1. Is a Resolution Required:

   Yes, Other

2. Proposed Resolution Title:

   Acceptance of Year 10 Local Health Department Performance Incentive Award

3. Specific Details on what the resolution will authorize:

   the acceptance of Performance Incentive Award in the amount of $22,208.00 which must be used to support costs associated with Article 6 eligible services.

This column must be completed prior to submission of the request.

County Attorney's Office Consulted Yes

County Administrator's Office Consulted Yes

4. Is a Budget Amendment needed: ☑ YES or ☐ NO
If yes, budget lines and impact must be provided.
Any budget amendments must have equal and offsetting entries.

☐ Please see attachments for impacted budget lines.
(Use ONLY when more than four lines are impacted.)

Revenue

| Account Number | Account Name | Amount |
|---|---|---|
| A.40.3401 | State Aid | 22,208.00 |

Expense

| Account Number | Account Name | Amount |
|---|---|---|
| A.40.409-7033 | Personal Computers | 7,400.00 |
| A.40.409-8190 | Other Professional Services | 1,625.00 |
| A.40.409-8200 | Department Supplies | 4,183.00 |

Fund Balance (if applicable): (Increase = additional revenue, Decrease = additional expenses)

Increase A-0599.B Appropriated Fund Balance-Budgetary

Amount: 9,000.00

5. Identify Budget Impact (**Required**):

The budget will be amended to accept these funds and authorize the related expenses

a. G/L line impacted 409

b. Budget year impacted 2023

c. Details

6. Are there Amendments to the Compensation Schedule?

☐ YES **or** ☑ NO (If yes, provide details)

a. Is a new position being created? ☐ Y ☐ N

Effective date

Salary and grade

b. Is a new employee being hired? ☐ Y ☐ N

Effective date of employment

Salary and grade

Appointed position:

Term

c. Is this a reclassification? ☐ Y ☐ N

Is this position currently vacant? ☐ Y ☐ N

Is this position in the current year compensation plan? ☐ Y ☐ N

| Human Resources Consulted |
|---|
| |

7. Does this item require the awarding of a contract: ☐ Y ☑ N

a. Type of Solicitation

b. Specification # (BID/RFP/RFQ/OTHER CONTRACT #)

| Purchasing Office Consulted |
|---|
| |

c. If a sole source, appropriate documentation, including an updated letter, has been submitted and approved by Purchasing Department? ☐ Y ☐ N ☐ N/A

d. Vendor information (including contact name):

e. Is the vendor/contractor an LLC, PLLC, or partnership:

f. State of vendor/contractor organization:

g. Commencement date of contract term:

h. Termination of contract date:

i. Contract renewal date and term:

k. Is this a renewal agreement: ☐ Y ☐ N

l. Vendor/Contractor comment/remarks:

County Administrator's Office Consulted

**8.** Is a grant being accepted: ☐ YES or ☑ NO

a. Source of grant funding:

b. Agency granting funds:

c. Amount of grant:

d. Purpose grant will be used for:

e. Equipment and/or services being purchased with the grant:

f. Time period grant covers:

g. Amount of county matching funds:

h. Administrative fee to County:

9. Supporting Documentation:

- ☑ Marked-up previous resolution
- ☐ No Markup, per consultation with County Attorney
- ☐ Information summary memo
- ☐ Copy of proposal or estimate
- ☑ Copy of grant award notification and information
- ☐ Other ______________________________________________

10. Remarks:

**Department of Health**

KATHY HOCHUL
Governor

MARY T. BASSETT, M.D., M.P.H.
Commissioner

KRISTIN M. PROUD
Acting Executive Deputy Commissioner

Dear Commissioner Dr. Kuhles,

Thank you for your participation in the New York State Department of Health's ongoing Local Health Department (LHD) Performance Incentive Program. In year ten (2022) of the program, which began in March 2022 and concluded in September 2022, the Department focused on collecting the experiences of LHDs with the COVID-19 pandemic response.

The Department is pleased to announce that once again county participation in the program was strong. This year, 57 LHDs receive an award.

Saratoga County participated and has been awarded a total of $22,208.00. Congratulations.

As with prior Performance Incentive program years, awards must be used to support costs associated with Article 6 eligible services. While costs associated with any eligible activity are acceptable, LHDs are encouraged to consider utilizing the award funds to support ongoing disease prevention efforts, and promotion of COVID-19 vaccination.

The Article 6 Team is requesting that each LHD submit a separate voucher for the Performance Incentive award specified in this letter. However, LHDs are not required to voucher the full award amount in a single voucher and may claim award funds throughout the 2023 program (calendar) year, allowing each LHD to determine the timing of the Performance Incentive award payment(s). The Performance Incentive award amount must be reflected on the Performance Incentive line in the 2023 Quarterly Expenditure Report (QER) and may be submitted with any 2023 QER(s) no later than March 31, 2024. Please submit the Performance Incentive award voucher electronically to a6fis@health.ny.gov.

Thank you again for your participation. We look forward to continuing to work with you and your staff to improve the delivery of public health services. Please send any questions regarding the award program to a6PI@health.ny.gov.

Sincerely,

Bryan Tarr
GPHW Manager

Christopher F. Davis
Performance Incentive Coordinator

6/21/22

# SARATOGA COUNTY BOARD OF SUPERVISORS

**RESOLUTION ~~198 - 2022~~**

**Introduced by Health and Human Services: ~~Supervisors Barrett, Butler, Connolly~~, ~~Edwards, Lant, Schopf and Wood~~**

**AUTHORIZING ACCEPTANCE OF YEAR ~~9~~ 10 LOCAL HEALTH DEPARTMENT PERFORMANCE INCENTIVE AWARD FROM THE NEW YORK STATE DEPARTMENT OF HEALTH, AND AMENDING THE ~~2022~~ 2023 BUDGET IN RELATION THERETO**

**WHEREAS**, the New York State Department of Health (DOH) has awarded ~~$34,000~~ $22,208 to Saratoga County ~~Public Health Services~~ Department of Health for its participation in Year ~~9~~ 10 of the Local Health Department (LHD) Performance Incentive Program; and

**WHEREAS**, the acceptance of this LHD Performance Incentive Award requires this Board's approval and an amendment to the ~~2022~~ 2023 County Budget; now, therefore, be it

**RESOLVED**, that the Chair of the Board is authorized to execute all documents necessary to accept a Year ~~9~~ 10 Local Health Department Performance Incentive Award in the amount of ~~$34,000~~ $22,208 from the New York State Department of Health; and it is further

**RESOLVED**, that the form and content of such documents shall be subject to the approval of the County Attorney; and, be it further

**RESOLVED**, that the ~~2022~~ 2023 Saratoga County Budget is hereby amended as follows:

Department of Health
~~PUBLIC HEALTH SERVICES~~

Increase Appropriations:

| Account | Amount |
|---|---|
| ~~Acct.: #A.40.409-7010 Furniture and Furnishings~~ | ~~$ 2,800~~ |
| Acct.: #A.40.409-7033 Personal Computers | ~~$10,500~~ 7400. |
| Acct.: #A.40.409-8200 Departmental Supplies | ~~$16,700~~ 4183. |
| ~~Acct.: #A.40.409-8511 Association Dues~~ | $ ~~500~~ |
| Acct~~.: #A.40.409-8514 Publications~~ | $ ~~500~~ |
| ~~Acct.: #A.40.409-8520 Software~~ | ~~$ 3,000~~ |
| A.40.409-8190 Other Professional Services | ~~$34,000~~ 1,625 |
| A-0599B Fund Balance-Budgeting | 9,000 |

Increase Revenues:

| Account | Amount |
|---|---|
| Acct.: # A.40-3401 Nursing Service/State Aid | ~~$34,000~~ 22,208. |

and, be it further

**RESOLVED**, that this Resolution shall take effect immediately.

BUDGET IMPACT STATEMENT: The budget will be amended to accept these funds and authorize the related expenses.

June 21, 2022 Regular Meeting
Motion to Adopt by Supervisor Hammond, Seconded by Supervisor Lant

AYES (230267): Eric Connolly (11831), Joseph Grasso (4328), Philip C. Barrett (19014.5), Jonathon Schopf (19014.5), Eric Butler (6500), Diana Edwards (819) Jean Raymond (1333), Michael Smith (3525), Kevin Veitch (8004), Arthur M. Wright (1976), Kevin Tollisen (25662), Mark Hammond (17130), Scott Ostrander (18800), Thomas Richardson (5163), Theodore Kusnierz (16202), Sandra Winney (2075), Thomas N. Wood, III (5808), Tara N. Gaston (14245.5), Matthew E. Veitch (14245.5), Edward D. Kinowski (9022), John Lawler (8208), John Lant (17361)

NOES (0):

ABSENT (5242): Willard H. Peck (5242)

# SARATOGA COUNTY

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Matt Rose, Management Analyst
Tracy Goodson, County Attorney's Office
Audra Hedden, County Administrator's Office

This column must be completed prior to submission of the request.

**DEPARTMENT:** Department of Health

**DATE:** 05/22/2023

**COMMITTEE:** Health & Human Services

County Attorney's Office Consulted Yes

1. Is a Resolution Required:

   Yes, Other

2. Proposed Resolution Title:

   Transfer a Portion of Opioid Settlement Funds to SCDOH to Support Drug Prevention Education Programming

3. Specific Details on what the resolution will authorize:

   In accordance with the Exhibit E of the Opioid Settlement Agreement, Schedule B (items G2, G8, G10), the transfer of $30,000 to SCDOH's budget to support a professional services contract with the Herren Project/Herren Talks to result in four assembly presentations for students in the South Glens Falls, Burnt Hills-Ballston Lake and Shenendehowa School Districts on October 18 and 19, 2023.

4. Is a Budget Amendment needed: ☑ YES or ☐ NO
If yes, budget lines and impact must be provided.
Any budget amendments must have equal and offsetting entries.

County Administrator's Office Consulted Yes

☐ Please see attachments for impacted budget lines.
(Use ONLY when more than four lines are impacted.)

Revenue

| Account Number | Account Name | Amount |
|---|---|---|
| A.40-2727 | Opioid Revenue | $30,000 |

Expense

| Account Number | Account Name | Amount |
|---|---|---|
| A.40.408-8190 | Professional Services | $30,000 |

Fund Balance (if applicable): (Increase = additional revenue, Decrease = additional expenses)

Amount:

5. Identify Budget Impact (**Required**):

The budget will be amended to accept these funds and authorize the related expenses

a. G/L line impacted 408

b. Budget year impacted 2023

c. Details

6. Are there Amendments to the Compensation Schedule?

☐ YES **or** ☑ NO (If yes, provide details)

a. Is a new position being created? ☐ Y ☐ N

Effective date

Salary and grade

b. Is a new employee being hired? ☐ Y ☐ N

Effective date of employment

Salary and grade

Appointed position:

Term

c. Is this a reclassification? ☐ Y ☐ N

Is this position currently vacant? ☐ Y ☐ N

Is this position in the current year compensation plan? ☐ Y ☐ N

| Human Resources Consulted |
|---|

7. Does this item require the awarding of a contract: ☐ Y ☑ N

a. Type of Solicitation

b. Specification # (BID/RFP/RFQ/OTHER CONTRACT #)

| Purchasing Office Consulted |
|---|

c. If a sole source, appropriate documentation, including an updated letter, has been submitted and approved by Purchasing Department? ☐ Y ☐ N ☐ N/A

d. Vendor information (including contact name):

e. Is the vendor/contractor an LLC, PLLC, or partnership:

f. State of vendor/contractor organization:

g. Commencement date of contract term:

h. Termination of contract date:

i. Contract renewal date and term:

k. Is this a renewal agreement: ☐ Y ☐ N

l. Vendor/Contractor comment/remarks:

County Administrator's Office Consulted

**8.** Is a grant being accepted: ☐ YES or ☑ NO

a. Source of grant funding:

b. Agency granting funds:

c. Amount of grant:

d. Purpose grant will be used for:

e. Equipment and/or services being purchased with the grant:

f. Time period grant covers:

g. Amount of county matching funds:

h. Administrative fee to County:

9. Supporting Documentation:

☐ Marked-up previous resolution

☐ No Markup, per consultation with County Attorney

☐ Information summary memo

☐ Copy of proposal or estimate

☐ Copy of grant award notification and information

☑ Other Communication with County Administration.

10. Remarks:

Chris Herren is a former professional basketball player and a person in long-term recovery. Since 2009, Chris Herren has spoken to over 1 million students and community members, sparking honest discussions on the topics of substance use disorder and wellness. During the assembly presentations, Mr. Herren will share his story with a focus on prevention education and challenging the audience to rethink how it looks at the disease of addiction.

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Bridget Rider, Deputy Clerk of the Board
Matt Rose, Management Analyst
Tracy Goodson, County Attorney's Office
Audra Hedden, County Administrator's Office

**DEPARTMENT:** Department of Health

**DATE:** 5/24/2023

**COMMITTEE:** Health & Human Services

1. Is a Resolution Required:

   Yes, Contract Approval

2. Proposed Resolution Title:

   Contract with Nixon Peabody, LLP to provide specialized legal services for the enforcement of the New York State Sanitary Code for the Saratoga County Department of Health.

3. Specific Details on what the resolution will authorize:

   Transition from a minor to major contract with Nixon Peabody, LLP to provide specialized legal services for the enforcement of the New York State Sanitary Code for the Saratoga County Department of Health.

This column must be completed prior to submission of the request.

County Attorney's Office Consulted Yes

County Administrator's Office Consulted Yes

4. Is a Budget Amendment needed: ☐ YES or ☑ NO
If yes, budget lines and impact must be provided.
Any budget amendments must have equal and offsetting entries.

☐ Please see attachments for impacted budget lines.
(Use ONLY when more than four lines are impacted.)

Revenue

| Account Number | Account Name | Amount |
|---|---|---|
| | | |

Expense

| Account Number | Account Name | Amount |
|---|---|---|
| | | |

Fund Balance (if applicable): (Increase = additional revenue, Decrease = additional expenses)

Amount:

5. Identify Budget Impact (**Required**):

No Budget Impact. Funds are included in the Department Budget

a. G/L line impacted A.40.415-8110

b. Budget year impacted 2023

c. Details

6. Are there Amendments to the Compensation Schedule?

☐ YES **or** ☑ NO (If yes, provide details)

a. Is a new position being created? ☐ Y ☐ N

Effective date

Salary and grade

b. Is a new employee being hired? ☐ Y ☐ N

Effective date of employment

Salary and grade

Appointed position:

Term

c. Is this a reclassification? ☐ Y ☐ N

Is this position currently vacant? ☐ Y ☐ N

Is this position in the current year compensation plan? ☐ Y ☐ N

Human Resources Consulted

7. Does this item require the awarding of a contract: ☐ Y ☑ N

a. Type of Solicitation

b. Specification # (BID/RFP/RFQ/OTHER CONTRACT #)

Purchasing Office Consulted

No

c. If a sole source, appropriate documentation, including an updated letter, has been submitted and approved by Purchasing Department? ☐ Y ☐ N ☐ N/A

d. Vendor information (including contact name):

e. Is the vendor/contractor an LLC, PLLC, or partnership:

f. State of vendor/contractor organization:

g. Commencement date of contract term:

h. Termination of contract date:

i. Contract renewal date and term:

k. Is this a renewal agreement: ☐ Y ☑ N

l. Vendor/Contractor comment/remarks:

County Administrator's Office Consulted

**8.** Is a grant being accepted: ☐ YES or ☑ NO

a. Source of grant funding:

b. Agency granting funds:

c. Amount of grant:

d. Purpose grant will be used for:

e. Equipment and/or services being purchased with the grant:

f. Time period grant covers:

g. Amount of county matching funds:

h. Administrative fee to County:

9. Supporting Documentation:

- ☐ Marked-up previous resolution
- ☐ No Markup, per consultation with County Attorney
- ☐ Information summary memo
- ☑ Copy of proposal or estimate
- ☐ Copy of grant award notification and information
- ☐ Other ______________________________

10. Remarks:

Nixon Peabody, LLP will provide assistance with the operation and enforcement of Saratoga County Department of Health's Environmental Health programs at the following rates:

Justin Pfeiffer , Counsel: $500/hour
New Associates and Senior Partners: $300-$650/hour
Legal Assistants: $200-$275/hour

Nixon Peabody LLP
677 Broadway, 10th Floor
Albany, NY 12207-2996

Attorneys at Law
nixonpeabody.com
@NixonPeabodyLLP

**Justin Pfeiffer**
Counsel

T / 518.427.2742
F / (907) 531-9800
jpfeiffer@nixonpeabody.com

May 25, 2023

Via Email: dkuhles@saratogacountyny.gov

Daniel Kuhles, M.D., M.P.H., Commissioner

Saratoga County Department of Health
6012 County Farm Road
Ballston Spa, NY 12020

**RE: Agreement for Legal Services**

Dear Mr. Kuhles:

We are pleased that you have asked Nixon Peabody LLP (the "Firm") to provide legal services to the Saratoga County Department of Health.

This letter and the accompanying Terms and Conditions of Engagement, which are incorporated herein by reference, describe the basis on which the Firm will provide those services. In addition, this letter and enclosure include specific details that are required to be set forth in writing by the ethics rules pursuant to which we practice. It is preferable to put all of these details in writing so that our role and responsibilities are completely understood and agreed to at the commencement of our engagement.

Our sole client in this matter will be the Saratoga County Department of Health (hereinafter "you"). We will provide you with assistance with regard to the operation and enforcement of the county's environmental health programs with respect to program operations. This letter supplements our previous engagement letter, dated March 4, 2023, which indicated that our services would terminate July 31, 2024, so that our services may extend beyond that date to a date you specify.

We believe in utilizing lawyers, legal assistants and other professional staff with levels of experience and expertise appropriate to each aspect of the engagement. I will be the principal attorney involved in this engagement. I will be the "Client Attorney" with overall responsibility for managing the relationship, and should be viewed as your contact in the event of questions or concerns, particularly as they relate to service and billing matters.

The fees for our work will be based on the hourly billing rate for each attorney, paralegal, legal assistant and other professional staff member devoting time to this matter. My current billing rate is $500 per hour. Our billing rates for attorneys currently range from $300 per hour for new associates to $650 per hour for senior partners. Time devoted by legal assistants is charged at

billing rates ranging from $200 to $275 per hour. We try to staff projects in a cost-efficient manner, and we will be happy to discuss the staffing of your engagement with you. As discussed, once the fee for our services reaches $15,000, you will need to seek the approval of your Board of Supervisors. At that time, we may need to renegotiate the terms of our engagement letter.

This firm represents and in the future will represent many other clients. Some may be your direct competitors or otherwise may have business interests that are contrary to your interests. It is even possible that, during the time we are working for you, an existing or future client may seek to engage us in connection with an actual or potential transaction or pending or potential litigation or other dispute resolution proceeding in which such client's interests are or potentially may become adverse to your interests.

The Firm cannot enter into this engagement if it could interfere with our ability to represent existing or future clients who develop relationships or interests adverse to you. We therefore ask you to confirm that the Firm may continue to represent or may undertake in the future to represent any existing or future client in any matter (including but not limited to transactions, litigation or other dispute resolutions), even if the interests of that client in that other matter are directly adverse to the Firm's representation of you, as long as that other matter is not substantially related to this or our other engagements on your behalf. In the event of our representation of another client in a matter directly adverse to you, however, the Firm's lawyers or other service providers who have worked with you will not work for such other client, and appropriate measures will be taken to assure that proprietary or other confidential information of a non-public nature concerning you acquired by the Firm as a result of our representation of you will not be transmitted to our lawyers or others in the Firm involved in such matter.

In other words, we request that you confirm that (1) no engagement that we have undertaken or may undertake on your behalf will be asserted by you either as a conflict of interest with respect to, or as a basis to preclude, challenge or otherwise disqualify the Firm from, any current or future representation of any client in any matter, including without limitation any representations in negotiations, transactions, counseling or litigation adverse to you, as long as that other matter is not substantially related to any of our engagements on your behalf, (2) you hereby waive any conflict of interest that exists or might be asserted to exist and any other basis that might be asserted to preclude, challenge or otherwise disqualify the Firm in any representation of any other client with respect to any such matter, (3) you have been advised by the Firm, and have had the opportunity to consult with other counsel, with respect to the terms and conditions of these provisions and its prospective waiver, (4) your consent to these provisions is both voluntary and fully informed, and (5) you intend for your consent to be effective and fully enforceable, and to be relied upon by the Firm.

You have the right to repudiate this waiver should you later decide that it is no longer in your interest. However, if we have acted in reliance on the waiver, we may have the right – and possibly a duty, under the applicable rules of professional conduct – to withdraw from representing you.

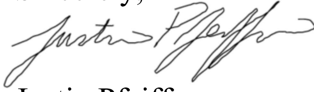
NIXON PEABODY LLP
ATTORNEYS AT LAW

NIXONPEABODY.COM
@NIXONPEABODYLLP

In the event that a dispute arises between you and the Firm relating to our fees, under New York law you may have the right to arbitration of the dispute pursuant to Part 137 of the Rules of the Chief Administrator of the Courts, a copy of which will be provided to you upon request.

Please sign and return to me, by fax or e-mail, a copy of this letter in order to confirm that it accurately reflects the scope, terms and conditions with respect to this engagement. However, please note that your instructing us or continuing to instruct us on this matter will constitute your full acceptance of the terms set out above and attached. If you would like to discuss any of these matters, please give me a call. We appreciate your decision to retain us and look forward to working with you.

Sincerely,



Justin Pfeiffer

The undersigned has read and understands the above letter and enclosure, and accepts and agrees to all of their terms and conditions.

Date: May __, 2023

SARARTOGA DEPARTMENT OF HEALTH

By: ____________________________
Steve Bulger

Title: Saratoga County Administrator

# SARATOGA COUNTY

## AGENDA ITEM REQUEST FORM

**TO:** Steve Bulger, County Administrator
Ridge Harris, Deputy County Administrator
Michelle Granger, County Attorney
Therese Connolly, Clerk of the Board
Stephanie Hodgson, Director of Budget

**CC:** John Warmt, Director of Purchasing
Jason Kemper, Director of Planning and Economic Development
Bridget Rider, Deputy Clerk of the Board
Matt Rose, Management Analyst
Tracy Goodson, County Attorney's Office
Audra Hedden, County Administrator's Office

**DEPARTMENT:** Department of Health

**DATE:** 5/24/2023

**COMMITTEE:** Health & Human Services

1. Is a Resolution Required:

   Yes, Other

2. Proposed Resolution Title:

   Fee Schedule for Saratoga County Department of Health Environmental Health Programs

3. Specific Details on what the resolution will authorize:

   Adoption of the New York State Department of Health's (NYSDOH) Fee Schedule for Environmental Health Programs and linkage of Saratoga County Department of Health's Fee Schedule for Environmental Health Programs to the NYSDOH Fee and Fine Schedule for future changes.

This column must be completed prior to submission of the request.

County Attorney's Office Consulted Yes

4. Is a Budget Amendment needed: ☐ YES or ☑ NO
If yes, budget lines and impact must be provided.
Any budget amendments must have equal and offsetting entries.

County Administrator's Office Consulted Yes

☐ Please see attachments for impacted budget lines.
(Use ONLY when more than four lines are impacted.)

Revenue

| Account Number | Account Name | Amount |
|---|---|---|

Expense

| Account Number | Account Name | Amount |
|---|---|---|

Fund Balance (if applicable): (Increase = additional revenue, Decrease = additional expenses)

Amount:

5. Identify Budget Impact (**Required**):

Other

a. G/L line impacted

b. Budget year impacted 2023

c. Details

No current budget impact. Permitted entities will not be charged until their renewal of their permit by SCDOH is required. SCDOH will issue a no-cost permit for each entity for the time period that they have already paid NYSDOH.

Human Resources Consulted

6. Are there Amendments to the Compensation Schedule?

☐ YES **or** ☑ NO (If yes, provide details)

a. Is a new position being created? ☐ Y ☐ N

Effective date

Salary and grade

b. Is a new employee being hired? ☐ Y ☐ N

Effective date of employment

Salary and grade

Appointed position:

Term

c. Is this a reclassification? ☐ Y ☐ N

Is this position currently vacant? ☐ Y ☐ N

Is this position in the current year compensation plan? ☐ Y ☐ N

7. Does this item require the awarding of a contract: ☐ Y ☑ N

Purchasing Office Consulted

No

a. Type of Solicitation

b. Specification # (BID/RFP/RFQ/OTHER CONTRACT #)

c. If a sole source, appropriate documentation, including an updated letter, has been submitted and approved by Purchasing Department? ☐ Y ☐ N ☐ N/A

d. Vendor information (including contact name):

e. Is the vendor/contractor an LLC, PLLC, or partnership:

f. State of vendor/contractor organization:

g. Commencement date of contract term:

h. Termination of contract date:

i. Contract renewal date and term:

k. Is this a renewal agreement: ☐ Y ☑ N

l. Vendor/Contractor comment/remarks:

County Administrator's Office Consulted

**8.** Is a grant being accepted: ☐ YES or ☑ NO

a. Source of grant funding:

b. Agency granting funds:

c. Amount of grant:

d. Purpose grant will be used for:

e. Equipment and/or services being purchased with the grant:

f. Time period grant covers:

g. Amount of county matching funds:

h. Administrative fee to County:

9. Supporting Documentation:

- ☐ Marked-up previous resolution
- ☐ No Markup, per consultation with County Attorney
- ☐ Information summary memo
- ☐ Copy of proposal or estimate
- ☐ Copy of grant award notification and information
- ☑ Other NYSDOH Fee Schedules, Forms and Summary

10. Remarks:

New York Codes, Rules and Regulations, Title 10: Section 40-4.1 establishes that fees shall be charged for departmental services Saratoga County must charge a fee for the granting of a permit, inspections, or other services prerequisite to the issuance of a permit, or for other environmental health services. Such fee shall be nonrefundable. Cumulative fees for a single operator at a single location shall not exceed $1,000 per year.

# Summary of New York State Department of Health

# Fees For Environmental Health Programs and Services

**New York Codes, Rules and Regulations, Title 10: Section 40-4.1 establishes that fees shall be charged for departmental services**

New York State must charge a fee for the granting of a permit, inspections, or other services prerequisite to the issuance of a permit, or for other environmental health services. Such fee shall be nonrefundable. Cumulative fees for a single operator at a single location shall not exceed $1,000 per year.

"Seasonal facility," for the purpose of determining the annual fee levels for such facility, is defined as a facility permittable under the provisions of the State Sanitary Code which operates 26 weeks or less in a calendar year. Such seasonal facility must be designated as such on any permit issued to it, which shall also state the starting and ending dates of the seasonal operating period. Such seasonal facility shall be entitled to a 10% reduction from the normal annual fee.

Fees for Environmental Health programs and services, are established as follows:

| | |
|---|---|
| **Food service establishments, taverns, bars** | |
| Seating Capacity 100 or less, including takeout or stand-up service | $75.00 |
| Seating Capacity 101 or more | $150.00 |
| Caterers and Commissaries | $200.00 |
| **Temporary Food Service and Mobile Vendors** | $30.00 |
| **Hotels, Motels, Cabins, Cottage Colonies** | |
| Number of rental units 1-20 units | $50.00 |
| Number of rental units 21-50 | $100.00 |
| Number of rental units 51-100 | $150.00 |
| Number of rental units 101-200 | $200.00 |
| Number of rental units 201+ | $400.00 |

Additional Food service dining areas (such as a cocktail lounge, night club, etc.)

Capacity 1 - 100 add $50.00 for each separate area/facility

Capacity 101 or more add $100.00 for each separate area/facility

Additional Pool add $30.00 for each separate pool

Additional Beach add $20.00 for each separate beach

**Campgrounds, Travel Trailer, and RV Parks**

| | |
|---|---|
| Number of Sites 50 or less | $50.00 |
| Number of Sites 51 - 200 | $75.00 |
| Number of Sites 201 - 500 | $100.00 |
| Number of Sites 501 - 750 | $150.00 |
| Number of Sites 751 or more | $250.00 |

Additional food service dining areas (such as a cocktail lounge, night club, etc.)

Capacity 1 - 100 add $50.00 for each separate area/facility

Capacity 101 or more add $100.00 for each separate area/facility

Additional Pool add $30.00 for each separate pool

Additional Beach add $20.00 for each beach

**Mobile Home Parks**

| | |
|---|---|
| Number of sites less than 50 | $50.00 |
| Number of sites 50-100 | $100.00 |
| Number of sites 101 or more | $200.00 |

Additional pool add $30.00 for each separate pool

Additional Beach add $20.00 for each separate beach

**Migrant Farmworker Housing**

| | |
|---|---|
| Occupancy of 5 - 50 | $50.00 |
| Occupancy of 51 or more | $100.00 |

**Swimming Pools and Common Use Spa Pools**

Maximum permitted number of bathers (25 sq. ft./bather)

| | |
|---|---|
| Number of permitted bathers 1 - 100 | $50.00 |
| Number of permitted bathers 101 or more plus wave pools and slides | $100.00 |

**Bathing Beaches**

| | |
|---|---|
| Less than 5000 sq. ft. | $30.00 |
| 5000 sq. ft. or more | $70.00 |

**Indoor Tanning Facilities**

| | |
|---|---|
| Bed Fee for 2 years - Multiply $50 x number of beds and/or booths | $50 x #beds/booths |
| Inspection fee for 2 year permit | $30/2 years |
| **Multipurpose Recreational Facilities** | |
| Base fee for primary service (food, pool, beach, etc. as as designated by operator) | $500.00 |
| Additional services (other than primary) | |
| Food service add $50.00 for each separate area/facility | |
| Pool add $30.00 for each separate area/facility | |
| Beach add $20.00 for each separate area/facility | |
| **Community Water Supplies** | |
| Population Served: Less than 1000 | $100.00 |
| Population served 1000 - 9999 | $500.00 |
| Population served 10,000 or more | $1000.00 |
| **Unpermitted Noncommunity Water Supplies** | $100.00 |
| **Mass Gatherings, Including Plan Review** | $500.00 |
| **Public Functions of Over 5000 People Not Constituting Mass Gatherings** | |
| Number of emergency health care units Less than 3 | $100.00 |
| Number of emergency health care units 3 or more | $200.00 |
| **Children's Camps** | $200.00 |
| **Frozen Desserts** (soft ice cream) | $25.00 |
| **Engineering / Architectural Plan review fee (per project)** | |
| Food Service Establishments, Caterers, Commissaries, etc. | $75.00 |
| Hotels, Motels, Cabins, Cottage Colonies. | |
| Number of stories or structures 1 or 2 | $50.00 |
| Number of stories or structures 3 or more | $200.00 |
| Campgrounds and Travel Trailer Parks | $100.00 |
| Mobile Home Parks | $100.00 |
| Migrant Farmworker Housing | $50.00 |
| Swimming Pools and Bathing Beaches | |
| 100 - 5000 sq. ft. | $100.00 |

| | |
|---|---|
| 5001 sq. ft. or more | $150.00 |
| Wave pools, slides, spa pools | $150.00 |
| Realty Subdivisions (as prescribed by Public Health Law, section 1119) | $25.00/lot |
| Community and Noncommunity Water Supply | |
| Cost of Project Less than $10,000 | $50.00 |
| Cost of Project $10,000 - $100,000 | $100.00 |
| Cost of Project more than $100,000 $200.00 | |
| Individual Sewage System. (alternative design) | $50.00 |

S:\Environmental Health\01-Administration\Operating Procedures\Fee Schedules\Fees For Departmental Services.docx

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Environmental Health Protection

# Mobile Home Park Fee Determination Schedule

**As required by Article 6, PHL, effective 1/1/88**

Fee Exemption Requested? ☐ Yes If Yes, complete sections A, C and D below and return. ☐ No

**FOR OFFICE USE ONLY**
Cashline #
Amount $
Received by

INSTRUCTIONS
Print or type the requested information. Determine the correct fee. Note the maximum fee charged is $1,000.00. Make your check payable to the New York State Department of Health. Mail the completed form and your check to the appropriate Department of Health Regional or District Office within 30 days of receipt of this form.

## SECTION A

1a. Name of Establishment

b. Address (No. & Street, City, State, Zip)

2. Type of Operation ☐ Year Round ☐ Seasonal (specify dates of operation): from ____________ to ____________

## SECTION B

BASIC FEE 1. Check the appropriate number of sites to determine the site fee

☐ Less than 50 sites = $50.00 ☐ 51 to 100 sites = $100.00 ☐ 101 or more sites = $200.00 TOTAL FEE FOR ALL SITES $__________

ADDITIONAL SERVICES
2. Check the boxes to indicate additional services provided at each site. If the facility offers more than one of the service, enter the appropriate number in the space provided. E.g., If there are two cafeterias seating more than 101 persons in each, write "2" in the space provided. Then multiply the number of services by the fee to arrive at the correct fee for additional services.

| | Number | Fee for Each Service | Total for Type of Service |
|---|---|---|---|
| ☐ Food Service(s), Seating Capacity 1 - 100 plus stand up or take out service | | $50 | $__________ |
| ☐ Food Service(s), Seating Capacity 101 or more | | $100 | $__________ |
| ☐ Pool(s) | | $30 | $__________ |
| ☐ Beach(es) | | $20 | $__________ |

3. Add the Total Site Fee and the Total Additional Service Fee to determine the TOTAL FEE DUE: $__________

SEASONAL FACILITY
4. If you operate a total of 26 weeks or less per year and as noted on your operating permit, you qualify as a seasonal facility, deduct 10% from your total fee due. $__________

TOTAL FEE MUST BE NO MORE THAN $1,000.00 TOTAL DUE $__________

## SECTION C - Exemption Request

1. Is this facility used for religious, educational or philanthropic purposes? ☐ Yes ☐ No
2. Is this facility operated by a municipality (city, town, village)? ☐ Yes ☐ No
3. If the answer to questions 1 or 2 is "yes" you may request exemption from payment of the annual registration fee. Please indicate documentation that will be made available upon inspection request.

☐ Incorporation Papers ☐ Other (specify)______________________________

## SECTION D - Certification

False Statements on this application are punishable under article 170 of the Penal Law

I hereby certify that the statements made on this form are accurate to the best of my knowledge.

Signature of Operator Date

DOH-2225(a) (03/07)

# Migrant Labor Camps and Children's Camps Fee Determination Schedule

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Environmental Health Protection

**As required by Article 6, PHL, effective 1/1/88**

Fee Exemption Requested? ☐ Yes If Yes, complete sections A, C and D below and return. ☐ No

**FOR OFFICE USE ONLY**

Cashline #

Amount $

Received by

INSTRUCTIONS
Print or type the requested information. Determine the correct fee. Make your check payable to the New York State Department of Health. Mail the completed form and your check to the appropriate Department of Health Regional or District Office within 30 days of receipt of this form.

**SECTION A**

1a. Name of Establishment

b. Address (No. & Street, City, State, Zip)

2. Name of Operator Title

**SECTION B**

Check the appropriate category.

☐ MIGRANT LABOR CAMP

Occupancy - check the correct number to determine fee.

☐ 5 - 50 = $50.00

☐ 51 or more = $100.00

☐ CHILDREN'S CAMPS = $200.00

TOTAL FEE DUE: $____________

**SECTION C - Exemption Request**

1. Is this facility used for religious, educational or philanthropic purposes? ☐ Yes ☐ No
2. Is this facility operated by a municipality (city, town, village)? ☐ Yes ☐ No
3. If the answer to questions 1 or 2 is "yes" you may request exemption from payment of the annual registration fee. Please indicate documentation that will be made available upon inspection request.

☐ Incorporation Papers ☐ Other (specify)__________________________________

**SECTION D - Certification** False Statements on this application are punishable under article 170 of the Penal Law.

I hereby certify that the statements made on this form are accurate to the best of my knowledge.

Signature of Operator Date

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Environmental Health Protection

# Plan Review Fee Determination Schedule

| Name and Address of Establishment | Date | Public Water Supply ID | FOR OFFICE USE ONLY |
|---|---|---|---|
| | mm dd yyyy | N Y | Cashline #<br>Amount $<br>Received by |

**Improperly completed forms or improperly calculated fees will be returned and may delay processing of your plans.**

**Instructions to operator for completion of this form:** To determine what fee applies to your operation:

**A. Exempt - no fee**

**A. Exemption Request**

1. Is this facility operated by a religious, educational or philanthropic organization? ☐ Yes ☐ No
2. Is this facility operated by a municipality (city, town, village)? ☐ Yes ☐ No
3. If the answer to questions 1 or 2 is "yes," you may request exemption from payment of the annual registration fee.

   Please indicate documentation that will be made available upon inspection request.

   ☐ Incorporation Papers

   ☐ Other (specify) ____________________

**B. All others**

**B. Locate category type of your establishment on the list below (e.g., food service, temporary residence).**

1. Locate the specific capacity which best reflects your operation.
2. Enter the amount indicated under "Fee Calculation" on the right side of the form.
3. Enter total at bottom of form.
4. Sign and date the fee determination schedule.
5. Submit this completed form with fee in the amount indicated under "Total Fee" to the appropriate NYS Department of Health Regional/District Office.

| Type of Establishment | Fee | State Sanitary Code | Fee Calculation |
|---|---|---|---|
| Food service establishments, taverns, bars, caterers, commissaries, etc. | $75 | Subpart 14-1 Food Service Establishments | |
| Hotels, motels,bungalow colonies, cottage colonies, cabins<br>Number of stories or structures:<br>1 or 2<br>3 or more | <br><br>$50<br>$200 | Subpart 7-1 Temporary Residences | |
| Campgrounds and travel trailer parks | $100 | Subpart 7-3 Campgrounds | |
| Mobile home parks | $100 | Part 17 Mobile Home Parks | |
| Migrant labor camps | $50 | Part 15 Migrant Farmworker Housing | |
| Swimming pools and bathing beaches<br>100-5000 sq. ft.<br>5001 sq. ft. or more,<br>wavepools, slides, spa pools | <br>$100<br>$150<br>$150 | Subpart 6-1 Swimming Pools<br>Subpart 6-2 Bathing Beaches | |
| Realty subdivisions (per lot) | $25 x number of lots | Sec. 1119, PHL (amended, 1989) | |
| Community and non-community water supplies<br>Cost of project:<br>Less than $10,000<br>$10,000-$100,000<br>More than $100,000 | <br><br>$50<br>$100<br>$200 | Subpart 5-1<br>Public Water Systems | |
| Individual sewage system (alternative design) | $50 | Part 75<br>Individual Residential Wastewater Treatment Systems | |
| | | **TOTAL** | |

Certification Statement: I hereby certify that the statements made above are accurate to the best of my knowledge.

Signature of Operator ____________ Title ____________ Date ____________

**Note: False statements on this form are punishable as crimes under Article 170 of the Penal Law**
**Make checks payable to: New York State Department of Health.**

DOH-2249 03/07

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Environmental Health Protection

# Campgrounds and Travel Trailer Park Fee Determination Schedule

**As required by Article 6, PHL, effective 1/1/88**

Fee Exemption Requested? ☐ Yes If Yes, complete sections A, C and D below and return. ☐ No

**FOR OFFICE USE ONLY**
Cashline #
Amount $
Received by

INSTRUCTIONS
Print or type the requested information. Determine the correct fee. Note the maximum fee charged is $1,000.00. Make your check payable to the New York State Department of Health Mail the completed form and your check to the appropriate Department of Health Regional or District Office within 30 days of receipt of this form.

**SECTION A**

1a. Name of Establishment

b. Address (No. & Street, City, State, Zip)

2. Type of Operation ☐ Year Round ☐ Seasonal (specify dates of operation): from ____________ to ____________

3. Name of Operator Title

**SECTION B**

BASIC FEE 1. Check the appropriate number of sites to determine the site fee

☐ 50 or less = $50.00 ☐ 201 - 500 = $100.00
☐ 51 - 200 = $75.00 ☐ 501 - 750 = $150.00 ☐ 750 or more = $250.00

TOTAL FEE FOR ALL SITES $__________

ADDITIONAL SERVICES
2. Check the boxes to indicate additional services provided at each site. If the facility offers more than one of the service, enter the appropriate number in the space provided. E.g., If there are two cafeterias seating more than 101 persons in each, write "2" in the space provided. Then multiply the number of services by the fee to arrive at the correct fee for additional services.

| | Number | Fee for Each Service | Total for Type of Service |
|---|---|---|---|
| ☐ Food Service(s), Seating Capacity 1 - 100 plus stand up or take out service | | $50 | $__________ |
| ☐ Food Service(s), Seating Capacity 101 or more | | $100 | $__________ |
| ☐ Pool(s) | | $30 | $__________ |
| ☐ Beach(es) | | $20 | $__________ |

3. Add the Total Site Fee and the Total Additional Service Fee to determine the TOTAL FEE DUE: $__________

SEASONAL FACILITY
4. If you operate a total of 26 weeks or less per year and as noted on your operating permit, you qualify as a seasonal facility, deduct 10% from your total fee due. $__________

TOTAL FEE MUST BE NO MORE THAN $1,000.00 TOTAL DUE $__________

**SECTION C - Exemption Request**

1. Is this facility used for religious, educational or philanthropic purposes? ☐ Yes ☐ No
2. Is this facility operated by a municipality (city, town, village)? ☐ Yes ☐ No
3. If the answer to questions 1 or 2 is "yes" you may request exemption from payment of the annual registration fee. Please indicate documentation that will be made available upon inspection request.

☐ Incorporation Papers ☐ Other (specify)______________________________

**SECTION D - Certification** False Statements on this application are punishable under article 170 of the Penal Law

I hereby certify that the statements made on this form are accurate to the best of my knowledge.

Signature of Operator Date

DOH-2225(I) (03/07)

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Environmental Health Protection

# Mass Gathering and Public Functions Fee Determination Schedule

**As required by Article 6, PHL, effective 1/1/88**

Fee Exemption Requested? ☐ Yes If Yes, complete sections A, C and D below and return. ☐ No

**FOR OFFICE USE ONLY**
Cashline #
Amount $
Received by

INSTRUCTIONS
Print or type the requested information. Determine the correct fee. Make your check payable to the New York State Department of Health. Mail the completed form and your check to the appropriate Department of Health Regional or District Office within 30 days of receipt of this form.

## SECTION A

1a. Name of Establishment ______ b. Federal ID Number ______

c. Address (No. & Street, City, State, Zip) ______

2. Name of Operator ______ Title ______

## SECTION B

1. Check the appropriate category.

| | | | |
|---|---|---|---|
| ☐ Mass Gatherings, including Plan Review | = | $500.00 | $__________ |
| ☐ Public Functions of over 5,000 people not constituting mass gatherings | | | |
| ☐ Less than 3 emergency health care units | = | $100.00 | $__________ |
| ☐ 3 or more emergency health care units | = | $200.00 | $__________ |

TOTAL FEE DUE: $___________

## SECTION C - Exemption Request

1. Is this facility used for religious, educational or philanthropic purposes? ☐ Yes ☐ No
2. Is this facility operated by a municipality (city, town, village)? ☐ Yes ☐ No
3. If the answer to questions 1 or 2 is "yes" you may request exemption from payment of the annual registration fee. Please indicate documentation that will be made available upon inspection request.

☐ Incorporation Papers ☐ Other (specify)________________________________

## SECTION D - Certification

False Statements on this application are punishable under article 170 of the Penal Law.

I hereby certify that the statements made on this form are accurate to the best of my knowledge.

Signature of Operator ______ Date ______

# Caterers, Commissaries, Temporary Food Mobile Vendors & Frozen Desserts (free-standing) Fee Determination Schedule

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Environmental Health Protection

**As required by Article 6, PHL, effective 1/1/88**

Fee Exemption Requested? ☐ Yes If Yes, complete sections A, C and D below and return. ☐ No

**FOR OFFICE USE ONLY**
Cashline #
Amount $
Received by

INSTRUCTIONS
Print or type the requested information. Determine the correct fee. Make your check payable to the New York State Department of Health. Mail the completed form and your check to the appropriate Department of Health Regional or District Office within 30 days of receipt of this form.

**SECTION A**

1a. Name of Establishment

b. Address (No. & Street, City, State, Zip)

2. Type of Operation: ☐ Caterer or Commissary ☐ Mobile Vendor ☐ Temporary Food ☐ Frozen Dessert

3. Name of Operator Title

**SECTION B**

1. Check the appropriate category to determine the total fee due.

| | | | |
|---|---|---|---|
| ☐ | Caterer or Commissary | = | $200.00 |
| ☐ | Temporary Food or Mobile Vendor | = | $30.00 |
| ☐ | Frozen Dessert (free standing) | = | $25.00 |

TOTAL FEE DUE: $___________

**SECTION C - Exemption Request**

1. Is this facility used for religious, educational or philanthropic purposes? ☐ Yes ☐ No
2. Is this facility operated by a municipality (city, town, village)? ☐ Yes ☐ No
3. If the answer to questions 1 or 2 is "yes" you may request exemption from payment of the annual registration fee. Please indicate documentation that will be made available upon inspection request.

☐ Incorporation Papers ☐ Other (specify)________________________________

**SECTION D - Certification** False Statements on this application are punishable under article 170 of the Penal Law

I hereby certify that the statements made on this form are accurate to the best of my knowledge.

Signature of Operator Date

DOH-2225(j) (03/07)

# Community Water Supply and Unpermitted Noncommunity Water Supply Fee Determination Schedule

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Environmental Health Protection

**As required by Article 6, PHL, effective 1/1/88**

Fee Exemption Requested? ☐ Yes If Yes, complete sections A, C and D below and return. ☐ No

**FOR OFFICE USE ONLY**
Cashline #
Amount $
Received by

INSTRUCTIONS
Print or type the requested information. Determine the correct fee. Make your check payable to the New York State Department of Health. Mail the completed form and your check to the appropriate Department of Health Regional or District Office within 30 days of receipt of this form.

**SECTION A**

1a. Name of Establishment b. Federal ID Number

c. Address (No. & Street, City, State, Zip)

2. Type of Operation: ☐ Year-round ☐ Seasonal (specify dates of operation) from____________to______________

3. Name of Operator Title

**SECTION B**

1. Check the appropriate category.

| | | | |
|---|---|---|---|
| ☐ Unpermitted Noncommunity Water Supplies | = | \$100.00 | \$__________ |
| ☐ Community Water Supplies<br>Check the population served | | | |
| ☐ Less than 1,000 | = | \$100.00 | \$__________ |
| ☐ 1,000 - 9,999 | = | \$500.00 | \$__________ |
| ☐ 10,000 or more | = | \$1,000.00 | \$__________ |

TOTAL FEE DUE: \$___________

**SECTION C - Exemption Request**

1. Is this facility used for religious, educational or philanthropic purposes? ☐ Yes ☐ No
2. Is this facility operated by a municipality (city, town, village)? ☐ Yes ☐ No
3. If the answer to questions 1 or 2 is "yes" you may request exemption from payment of the annual registration fee. Please indicate documentation that will be made available upon inspection request.

☐ Incorporation Papers ☐ Other (specify)________________________________

**SECTION D - Certification** False Statements on this application are punishable under article 170 of the Penal Law.

I hereby certify that the statements made on this form are accurate to the best of my knowledge.

Signature of Operator Date

DOH-2225(h) (05/08)

# Food Service Establishment, Tavern, Bar Fee Determination Schedule

## (Includes $25 Frozen Dessert Fee)

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Environmental Health Protection

**As required by Article 6, PHL, effective 1/1/88**

Fee Exemption Requested? ☐ Yes If Yes, complete sections A, C and D below and return. ☐ No

**FOR OFFICE USE ONLY**
Cashline #
Amount $
Received by

INSTRUCTIONS
Print or type the requested information. Determine the correct fee. Make your check payable to the New York State Department of Health. Mail the completed form and your check to the appropriate Department of Health Regional or District Office within 30 days of receipt of this form.

**SECTION A**

1a. Name of Establishment

b. Federal ID Number

c. Address (No. & Street, City, State, Zip)

2.Type of Operation: ☐ Year-round ☐ Seasonal (specify dates of operation) from________ to________

3. Name of Operator

Title

**SECTION B**

Basic Fee
Check the appropriate seating capacity to determine fee.

| | | | |
|---|---|---|---|
| ☐ Less than 100, take out or stand-up service | = | $75.00 | $________ |
| ☐ 101 or more | = | $150.00 | $________ |

TOTAL FEE DUE: $________

Seasonal Facility
If you operate a total of 26 weeks or less per year and as noted on your operating permit, you qualify as a seasonal facility, deduct 10% from your total fee due.

LESS 10%: $________

FEE DUE: $________

**SECTION C - Exemption Request**

1. Is this facility used for religious, educational or philanthropic purposes? ☐ Yes ☐ No
2. Is this facility operated by a municipality (city, town, village)? ☐ Yes ☐ No
3. If the answer to questions 1 or 2 is "yes" you may request exemption from payment of the annual registration fee. Please indicate documentation that will be made available upon inspection request.

☐ Incorporation Papers ☐ Other (specify)________________

**SECTION D - Certification** False Statements on this application are punishable under article 170 of the Penal Law

I hereby certify that the statements made on this form are accurate to the best of my knowledge.

Signature of Operator

Date

DOH-2225(g) (08/08)

# Migrant Labor Camps and Children's Camps Fee Determination Schedule

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Environmental Health Protection

**As required by Article 6, PHL, effective 1/1/88**

Fee Exemption Requested? ☐ Yes If Yes, complete sections A, C and D below and return. ☐ No

**FOR OFFICE USE ONLY**

Cashline #

Amount $

Received by

INSTRUCTIONS
Print or type the requested information. Determine the correct fee. Make your check payable to the New York State Department of Health. Mail the completed form and your check to the appropriate Department of Health Regional or District Office within 30 days of receipt of this form.

**SECTION A**

1a. Name of Establishment

b. Address (No. & Street, City, State, Zip)

2. Name of Operator Title

**SECTION B**

Check the appropriate category.

☐ MIGRANT LABOR CAMP

Occupancy - check the correct number to determine fee.

☐ 5 - 50 = $50.00

☐ 51 or more = $100.00

☐ CHILDREN'S CAMPS = $100.00

TOTAL FEE DUE: $____________

**SECTION C - Exemption Request**

1. Is this facility used for religious, educational or philanthropic purposes? ☐ Yes ☐ No
2. Is this facility operated by a municipality (city, town, village)? ☐ Yes ☐ No
3. If the answer to questions 1 or 2 is "yes" you may request exemption from payment of the annual registration fee. Please indicate documentation that will be made available upon inspection request.

☐ Incorporation Papers ☐ Other (specify)_________________________________

**SECTION D - Certification** False Statements on this application are punishable under article 170 of the Penal Law.

I hereby certify that the statements made on this form are accurate to the best of my knowledge.

Signature of Operator Date

NEW YORK STATE DEPARTMENT OF HEALTH
Division of Environmental Health Protection

# Multipurpose Recreational Facility Fee Determination Schedule

**As required by Article 6, PHL, effective 1/1/88**

Fee Exemption Requested? ☐ Yes If Yes, complete sections A, C and D below and return. ☐ No

**FOR OFFICE USE ONLY**
Cashline #
Amount $
Received by

INSTRUCTIONS
Print or type the requested information. Determine the correct fee. Note the maximum fee charged is $1,000.00. Make your check payable to the New York State Department of Health. Mail the completed form and your check to the appropriate Department of Health Regional or District Office within 30 days of receipt of this form.

## SECTION A

1a. Name of Establishment b. Federal ID Number

c. Address (No. & Street, City, State, Zip)

2. Type of Operation ☐ Year Round ☐ Seasonal (specify dates of operation): from ____________ to ____________

## SECTION B

BASIC FEE 1. Check the appropriate primary service. Base Fee- $500

☐ Food ☐ Pool ☐ Beach TOTAL $__________

ADDITIONAL SERVICES
2. Check the boxes to indicate additional services provided at each site. If the facility offers more than than one of the service, enter the appropriate number in the space provided. EX: If there are two cafeterias seating more than 101 persons in each, write "2" in the space provided. Then multiply the number of services by the fee to arrive at the correct fee for additional services.

| | Number | Fee for Each Service | Total for Type of Service |
|---|---|---|---|
| ☐ Food Service(s), Seating Capacity 1 - 100 plus stand up or take out service | | $50 | $__________ |
| ☐ Food Service(s), Seating Capacity 101 or more | | $100 | $__________ |
| ☐ Pool(s) | | $30 | $__________ |
| ☐ Beach(es) | | $20 | $__________ |

3. Add the Total Site Fee and the Total Additional Service Fee to determine the TOTAL FEE DUE: $__________

SEASONAL FACILITY
4. If you operate a total of 26 weeks or less per year and as noted on your operating permit, you qualify as a seasonal facility. Deduct 10% from your total fee due. $__________

TOTAL FEE MUST BE NO MORE THAN $1,000.00

TOTAL DUE $__________

## SECTION C - Exemption Request

1. Is this facility used for religious, educational or philanthropic purposes? ☐ Yes ☐ No
2. Is this facility operated by a municipality (city, town, village)? ☐ Yes ☐ No
3. If the answer to questions 1 or 2 is "yes" you may request exemption from payment of the annual registration fee. Please indicate documentation that will be made available upon inspection request.

☐ Incorporation Papers ☐ Other (specify)______________________________

## SECTION D - Certification

False Statements on this application are punishable under article 170 of the Penal Law.

I hereby certify that the statements made on this form are accurate to the best of my knowledge.

Signature of Operator Date

DOH-2225(b) (05/08)

NEW YORK STATE DEPARTMENT OF HEALTH
Bureau of Community Environmental Health and Food Protection

# Tanning Facilities Program Fee Determination Schedule

**INSTRUCTIONS**

Print the requested information. Determine the correct fee. Make your check payable to the New York State Department of Health. Mail this completed form and your check along with a completed Application for a Permit to Operate (DOH-3915) to the appropriate Department of Health Office within 30 days of receipt of this form. A $20 fee will be charged for a returned check.

**FOR OFFICE USE ONLY**

Cashline Number ____________________

Amount **$** ____________________

Received By ____________________

## SECTION A – FACILITY

1. a. Facility Name ____________________

   b. Facility Address ____________________
   Number and Street

   ____________________
   City State ZIP

   c. County ____________________

2. Name of Operator ____________________

3. Type of Facility: ☐ Tanning Only ☐ Salon/Spa ☐ Fitness ☐ Other

## SECTION B – BASIC FEE (Two-year Registration Period)

Indicate the number of tanning devices in the facility, then multiply the number of devices by $200.

Number of tanning devices ________ X $200 $ ____________________

Add a $120 registration fee $ ____________________

**TOTAL FEE DUE** $ ____________________

## SECTION C – CERTIFICATION

I hereby certify that the statements made on this form are accurate to the best of my knowledge.

Signature of Operator ____________________ Date ____________