

**FORM A**

**New York State Consultant Services  
Contractor's Planned Employment**  
From Contract Start Date Through the End of the Contract Term

State Agency Name: *Yonkers Residential Center*  
 State Agency Department ID: \_\_\_\_\_ Agency Business Unit: \_\_\_\_\_  
 Contractor Name: *Andrea Sandoy* Contract Number: \_\_\_\_\_  
 Contract Start Date: *10/11/2017* Contract End Date: *9/13/2021*

*CF801-5010197-3400000*

| Employment Category    | Number of Employees | Number of Hours to be Worked    | Amount Payable Under the Contract    |
|------------------------|---------------------|---------------------------------|--------------------------------------|
| <i>1666.00</i>         | 0.00                | <i>12<sup>0</sup>/week</i> 0.00 | <i>12<sup>0</sup>/w x 300</i> \$0.00 |
|                        | 0.00                | 0.00                            | \$0.00                               |
|                        | 0.00                | 0.00                            | \$0.00                               |
|                        | 0.00                | 0.00                            | \$0.00                               |
|                        | 0.00                | 0.00                            | \$0.00                               |
|                        | 0.00                | 0.00                            | \$0.00                               |
|                        | 0.00                | 0.00                            | \$0.00                               |
|                        | 0.00                | 0.00                            | \$0.00                               |
|                        | 0.00                | 0.00                            | \$0.00                               |
|                        | 0.00                | 0.00                            | \$0.00                               |
|                        | 0.00                | 0.00                            | \$0.00                               |
|                        | 0.00                | 0.00                            | \$0.00                               |
|                        | 0.00                | 0.00                            | \$0.00                               |
|                        | 0.00                | 0.00                            | \$0.00                               |
|                        | 0.00                | 0.00                            | \$0.00                               |
|                        | 0.00                | 0.00                            | \$0.00                               |
|                        | 0.00                | 0.00                            | \$0.00                               |
|                        | 0.00                | 0.00                            | \$0.00                               |
| <b>Total this Page</b> | 0.00                | 0.00                            | \$ 0.00                              |
| <b>Grand Total</b>     |                     |                                 |                                      |

Name of person who prepared this report: *Andrea Sandoy MD*  
 Title: *Child + Adolescent Psychia trist* Phone #: *585-533-2608*  
 Preparer's Signature: *[Signature] MD*  
 Date Prepared: *1/1*