**Purpose of this Request:** [x] Programmatic Changes [x] Budget Changes [x]  **Contract Negotiation**

**(Check all that apply)**

1. **Initiated by:** [ ] **Service Provider or** [ ] **System of Care**
2. **Service Provider Name:** Click here to enter text.**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Requestor’s Name: Click here to enter text. Phone/Email: Click here to enter text.

Program Name(s) & Appendix #: Click here to enter text.

Contract Fiscal Year: Click here to enter text. CMS/FSP#: Click here to enter text.

1. Applicable Funding Sources: Click here to enter text.

Current Total Contract Amount: **$** Click here to enter text.

Proposed Total Contract Amount: **$** Click here to enter text.

Current Program Amount: **$** Click here to enter text.

Proposed Program Amount: **$** Click here to enter text.

1. **Applicable DPH Section**

|  |  |
| --- | --- |
| **Ambulatory Care—Behavioral Health Services**[ ]  **Adult and Older Adult (AOA)**[ ]  **Children, Youth & Families (CYF)**[ ]  **Mental Health Services Act (MHSA)**[ ]  **Substance Use Disorder (SUD)**[ ]  **Forensic and Justice-Involved (FJI)**[ ]  **Transitional Aged Youth (TAY)** | **Population Health**[ ]  Community Health Equity & Promotion (CHE&P)[ ]  HIV Prevention Services (HPS)**Ambulatory Care**[ ]  **Community-based Primary Care (CBPC)**[ ]  **HIV Health Services (HHS)**[ ]  **Maternal, Child & Adolescent Health (MCAH)****Other (please print) Click here to enter text. \_\_\_\_** |

1. **Requested Programmatic Change(s)** (Check all that apply and attach justification for request)

[ ]  Change in the Scope of Work or Methodology (Changes to the scope of work that violate the conditions of the solicitation under which the services are funded will not be allowed)

[ ]  Change to Process & Outcome Objectives

[ ]  Other: Click here to enter text. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Requested Change(s) to Contract Deliverables** (Check all that apply and attach justification for request)

[ ]  Addition or deletion of a mode of service as listed in Appendix B

[ ]  Increase/decrease in contract deliverables (either UOS or UDC)

[ ]  Change to services provided by subcontractor

1. **Requested Budget Change(s)** (Check all that apply and attach justification for request)

[ ]  Additional funds

[ ]  A reallocation of existing funds

[ ]  A change in the time-period for which the funds are allocated

[ ]  Creation of a budget line item not included in the certified contract

[ ]  Movement of budgeted funds between Salaries/Benefits and Operating Expenses more than 10% of the currently certified budget. [See Invoice Manual for more Instructions if over 10% or $10k]

[ ]  Other: Click here to enter text. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_ Click here to enter text. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Click here to enter text.\_\_\_\_\_\_\_\_\_\_

**Signature of Executive Director, Authorized Designee or SOC PM Date**

[ ] Received by CDTA Program Manager Click here to enter text. \_\_\_\_\_\_\_

 **Signature Date**

**Determination of System of Care Director (Sign by 5 Business Days):** [ ] Approved [ ] Denied

Click here to enter text. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Click here to enter text. \_\_\_\_\_\_\_\_\_\_\_\_

 **Signature of SOC Director Date**