STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
P1.10 CONTRACT MODIFICATION FORM

Provider Agency Name __________________________ Modification # ________________
Fiscal-Year-End __________________________ Contract Term __________________________ thru __________________________

Contract # __________________________ Cognizant Contract: Yes ______ No ______
Division(s) affected by the Modification __________________________

Date of most recently approved Contract Modification: __________________________
Requested effective date for this Contract Modification: __________________________

Check applicable area(s) for modification:

1) _____ Change to the Reimbursable Ceiling: from _____ to _____
2) _____ Increase in Total Cost: from _____ to _____
3) _____ Change in the Contract term: currently from __/__/__ to __/__/__ to the revised term __/__/__
4) _____ Change exceeding the Flexible Limits.
5) _____ Transfer of budgeted cost across DHS Contracts or Clusters.
6) _____ Transfer of federal and/or other revenue across DHS Contracts or Clusters.
7) _____ Change to the method of allocating G&A, the indirect cost rate and/or its application.
8) _____ Addition or deletion of an entire Budget category (A through M individually).
9) _____ Addition of Line Items within Budget Category (B) Consultants and Professional Fees.
10) _____ Equipment not in approved budget above $5,000 per item.
11) _____ Change in payment methodology.
12) _____ Change in the payment rate(s)
13) _____ Change in target population
14) _____ Change in contracted performance standards
15) _____ Change in contracted level of service
16) _____ Change in contracted staff/client ratios.
17) _____ Change of Subcontractors providing direct services or change to subcontracted direct services.

Please attach an explanation

This form, its attachments and/or revised section(s) of the programmatic Annex A and/or the revised itemized Annex B Budget or Rate Information Summary, constitute this entire Contract Modification. The persons whose signatures appear below agree to this Contract Modification.

BY: __________________________ (Signature) __________________________ (Signature)
     (Type name) __________________________ (Type name) Lynn A. Kovich
Title __________________________ Title Assistant Commissioner

Provider Agency: __________________________ Departmental Component: Division of Mental Health & Addiction Services
Date: __________________________ Date: __________________________

DATE EFFECTIVE: __________________________ (To be completed by the Department)

OCP&M rev 2/05