

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 ____/____/____ to ____/____/____
- 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)

(Type name)

BY: _____
(Signature)

Renee C. Burawski, LCSW
(Type name)

Title _____

Title _____ Assistant Commissioner

Provider
Agency: _____

Departmental Department of Human Services
Component: Division of Mental Health & Addiction Services

Date: _____

Date: _____

DATE EFFECTIVE: _____