**STATE OF NEW JERSEY**

 **DEPARTMENT OF HUMAN SERVICES P1.10**

 **CONTRACT MODIFICATION FORM ATTCH A**

|  |  |  |  |
| --- | --- | --- | --- |
| 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) to be modified:

1. [ ]  Changes 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 Contract 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 Services.

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 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: |  | BY: |  |
|  | (Signature) |  | (Signature) |
|  |  |  | Jonathan S. Seifried |
|  | (type name) |  | (type name) |
|  Title |  |  Title | Acting Assistant Commissioner |
|  |  |  |  |
| Provider |  | Departmental |  |
| Agency: |  | Component:  |  DHS/DDD   |
| Date: |  | Date: |  |
|  |  |
| DATE EFFECTIVE |  |

OCP&M rev. 2/05 (To be completed by the Department)