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:_____ BY:_____
(Signature) (Signature)

_____ Lynn A. Kovich
(Type name) (Type name)

Title_____ Title Assistant Commissioner

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

Date:_____ Date:_____

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