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| Guidelines & Protocol Title: Contract Change Request (CCR) |
| Category: Contracts |
| Effective Date: June 2013 | Last Revision Date: July 20, 2018 |
| DPH Unit of Origin: Business Office; Contract Development & Technical Assistance (CDTA) |
| Policy editor: Valerie Wiggins | Phone: 255-3514 | Email: valerie.wiggins@sfdph.org |
| Distribution DPH-wide: [ ]  Yes [x]  No | Attachments: CCR Instructions, Form & Flowchart  |

Purpose

To establish protocol and guidelines for Service Providers and System of Care Program Managers (SOC PM) who wish to make programmatic and/or budget changes to an existing certified contract or request a contract negotiation.

Guidelines

Service Providers or SOC PMs may request program or budget changes to an existing DPH contract during the current fiscal year. Requests for changes shall be communicated to the Contract Development & Technical Assistance (CDTA) Program Manager (PM) using the procedure outlined below:

* Requests are limited to no more than two (2) contract change requests per funding year.
* **All requests for contract changes must be received and approved before the last quarter of the current funding year.** Any requests made subsequent to the third quarter will be considered for the next funding year, and will be reviewed for inclusion in the following year’s contract.
* A separate Contract Change Request (CCR) Form must be completed for each program where change(s) are requested within the contract.

Protocol

1. The initiator must make their requests via the CCR Form (attached). The Service Provider may discuss proposed changes before submission of the form with their CDTA PM and/or SOC PM.
2. The CCR Form must be completed, signed, and attached to all relevant documents and justifications that support the request. The CDTA PM can offer technical assistance in developing these materials.
3. The form and materials must be sent via email to the CDTA PM.
4. The form and materials will be received by CDTA for review and forwarded to SOC PM for approval. The System of Care Director will either approve or deny requested change(s) within 5 business days.
5. Pending approval, the Service Provider or SOC PM will be informed by the CDTA PM thin 10 business days of the SOC Director’s decision.
6. If the request is approved, CDTA will work with the Service Provider or SOC PM to process the contract amendment. If denied, the CDTA PM will inform the person who initiated the request.

Instructions

1. Please fully complete all sections 1 through 7 on the CCR Form.
2. If you marked any part of sections 5, 6, or 7, please attach a clear explanation or budget narrative in support of the change request. For Service Providers, supporting justifications should be written on agency’s letterhead.
3. Clearly indicate or highlight the placement of any changes (deletions, insertions, or edits) to Appendix A or B content from the current contract.
4. The Executive Director (or authorized designee) must sign and date the Contract Change Request Form, scan as PDF format, and submit all documents electronically to the designated CDTA PM.

What Happens Next

1. If the CCR Form is Service Provider initiated, the CDTA PM will review the request and supporting materials, and will either:
	* Sign and forward all materials to the System of Care Director for approval; Or,
	* Return the form and supporting documentation requesting further clarification or justification.
2. If SOC initiated, the SOC PM obtains the approval and signature of the appropriate SOC Director, and then submits the authorized CCR to the assigned CDTA PM.
3. Once approved, the CDTA PM will advise of the next steps necessary to implement the authorized changes to the contract.
4. In addition, the CDTA PM will send an electronic copy of the approved CCR form to the Service Provider, SOC Director, BOCC Director (if applicable), Contract Analyst, Budget Analyst, and SOC PM.
5. If the SOC Director does not approve the Contract Change Request, the CDTA PM will return the signed form to the initiator informing them of the determination of their request.
6. **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**

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| --- | --- |
| **Ambulatory Care—Behavioral Health Services**[ ]  **Adult and Older Adult (AOA)**[ ]  **Children, Youth & Families (CYF)**[ ]  **Mental Health Services Act (MHSA)**[ ]  **Substance Use Disorder (SUD)**[ ]  **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)** |

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 in excess of 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **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**

COVID Impact Mitigation Request

1. **Purpose of Request**

[ ] Reduce Units of Services (UOS) greater than the standard 25%

[ ] Switch from Fee for Service (FFS) Invoice to Cost Reimbursement (CR) Invoice

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

1. **Explain the reason for the request and the impact to your program/agency if approval/denied:**

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

 **Signature Date**

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

**Effective Date:** Click here to enter text. \_\_\_\_ **End Date:** \_\_ Click here to enter text. \_\_\_\_

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

**Signature of SOC Director, DPH Business Office Director, DPH Deputy CFO or Authorized Designee Date**