COUNTY OF LOS ANGELES – DEPARTMENT OF PUBLIC HEALTH
SUBSTANCE ABUSE PREVENTION AND CONTROL

Amendment Request Form

Network Provider Name:				Contract #	
Contract Type:	☐ DMC	☐ CENS	☐ RBH	Prevention	☐ APS ☐ CPS ☐ EPS ☐ EOP
Service Planning Area(s):			**Supervisorial District(s):**		
Service City(ies)/Community(ies):					
Treatment Levels of Care:	☐ 1.0 ☐ 2.1 ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ OTP ☐ 1-WM ☐ 2-WM ☐ 3.2-WM ☐ 3.7-WM ☐ 4-WM				

REQUEST INFORMATION

Fiscal Year:

Contract Amount: $

Amount Expended: $ **Percent Expended:** %

Amount Requested: $ **Percent Increase:** %

Additional Site(s) Address:

Additional Service Description:

JUSTIFICATION

Provide a needs assessment highlighting substance use or related health and environmental factors that support justification of this request.

Provide supporting evidence that existing network capacity does not meet community needs. (Example: No services for a given population within an identified region, etc.)
Provide documentation and history of serving high risk and/or special populations, if this is a component of justification of this request.
Other important information relevant to this requested change.

Authorized Agency Representative Name:

Authorized Agency Representative Signature: **Date:**