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

| **Amendment Request Form** | | | |
|---|---|---|---|
| **Please submit via email to: SAPCMonitoring@ph.lacounty.gov & CC: *Your CPA*** | | | |
| **Network Provider Name:** | | **Contract #:** | |
| **Contract Type:** | ☐ DMC ☐ CENS ☐ RBH ☐ Prevention ☐ Youth Residential | | |
| **Levels of Care:** | ☐ 0.5 ☐ 1.0 ☐ 2.1 ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ OTP ☐ 1-WM ☐ 2-WM ☐ 3.2-WM ☐ 3.7-WM ☐ 4-WM ☐ PEP ☐ CCP ☐ FNL ☐ Special Projects | | |
| **Service Planning Area(s):** | | **Supervisorial District(s):** | |
| **Type of Request:** | ☐ Funding Augmentation ☐ New Site ☐ Relocation ☐ Bed Change ☐ Change in Hours ☐ Level of Care | | |

## REQUEST INFORMATION

### FUNDING AUGMENTATION

**Necessary Documentation:** ☐ Budget Summary (Form Link) ☐ Budget Narrative (Form Link)

**Fiscal Year:** FY _____

**Contract Amount:** $ _____

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

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

**New Amended Total:** $ _____

### CONTRACT CHANGE

**Necessary Documentation:**

New Site, Relocations, Additional Beds and Level of Care Request:

☐ DMC Certification ☐ DMC & CalOMS Provider Number ☐ AOD Certification (Residential & WM)

Please Include If Youth Residential Request:

☐ CDSS / CCL License ☐ Resumes or Narrative Demonstrating 2 years of Youth Experience

☐ Budget Summary (Form Link) ☐ Budget Narrative (Form Link)

**New Site(s) Address:** _____ **Service Start Date** _____

**Previous Address:** _____ **Last Date of Service** _____

**New Bed Count:** _____ **Previous Bed Count:** _____

**New Hours:** _____

**Additional Level of Care:** ☐ 0.5 ☐ 1.0 ☐ 2.1 ☐ 3.1 ☐ 3.3 ☐ 3.5 ☐ OTP ☐ 1-WM ☐ 2-WM ☐ 3.2-WM ☐ 3.7-WM ☐ 4-WM ☐ PEP ☐ CCP ☐ FNL ☐ Special Projects

**Additional Service Description:** _____

## JUSTIFICATION (You may attach additional sheets if necessary)

| Provide a needs assessment highlighting substance use or related health and environmental factors that support justification on this request. |
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| 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 (if applicable). |
| |
| Other important information relevant to this requested change (if applicable). |
| |

Agency Address: _____

Authorized Agency Representative Name: _____ Authorized Agency Representative Title: _____

Authorized Agency Representative Signature: _____ Date: _____