

LOS ANGELES COUNTY – DEPARTMENT OF MENTAL HEALTH
 CONTRACT PROVIDER TECHNOLOGICAL NEEDS PROJECTS

FORM OF CHANGE NOTICE

REQUEST DATE: _____	DMH CONTROL NO. (DMH Use Only)
REQUESTOR INFORMATION: Contractor Name: _____ Address: _____ City, State, ZIP: _____ Phone: _____ Email: _____ Contractor's Project Director: _____	PROJECT NAME: Project ID No. _____ Contract No. _____ Legal Entity No. _____

1. **Shift of project funds up to 15% of original project budget:**

Between budget categories within a project Between two or more approved projects:

From Project No(s). _____ To Project No(s). _____

Description: _____

2. **Change project budget within 15% of original project budget. Total Compensation Amount (TCA) remains the same and funds are not shifting to/from other approved project(s):**

Increase project budget, using remaining TCA funds or portion thereof

Decrease project budget, returning funds to TCA

Description: _____

	Original Budget	Revised Budget	Percent of Change
Project Budget Change: _____	_____	_____	_____

3. **Add or Modify Technological Needs Project Proposal (Exhibit A):**

Add a new Project Modify Project Schedule

Modify Project Scope Modify Project Approach Other

Description: _____

Contractor's Project Director **Signature:** _____ **Date:** _____

DMH USE ONLY	
County's Project Manager Signature: _____	Date: _____
County's Project Director Signature: _____	Date: _____
APPROVED <input type="checkbox"/> DENIED <input type="checkbox"/> If denied, state reason: _____	