



PROVIDER MILESTONE MODIFICATION REQUEST

Provider Milestone Modification Request **Must be requested prior to June 1.

Provider Name:

Contract Number:

Original Outcomes:

15 DAY	45 DAY	90 DAY
Original Contract Total:		

Proposed Modification:

15 DAY	45 DAY	90 DAY
Proposed Contract Total:		

Justification:

****A proposed contract total greater than the original contract total will result in an automatic rejection. That will require a submission of a formal amendment request to your designated Project Officer prior to April 15.**

 Printed Name and Signature of Authorized Agent

 Date

 Printed Name and Signature of DRS - Community Resources Manager

 Date