



Ohio Department of Health
 Bureau for Children with Medical Handicaps and Early Intervention Services
 Addendum to Provider Agreement



Please use this form to communicate with the department any changes, as outlined in the provider agreement.

Requested Change	Required Supporting Documents
Affiliation with evidence-based home visiting model	Letter of affiliation from model or Attachment #2 from application
Home Visitor	Leaving agency: Last date of employment Joining agency: Date of hire, FTE, credential, ET data use agreement
Supervisor	Leaving agency: Last date of employment Joining agency: Date of hire, FTE, credential, ET data use agreement
Contract Manager	Leaving agency: Last date of employment Joining agency: Date of hire, contact information
Subcontractor	Letter of affiliation from model or Attachment #2 from application, Attachment # 4 from application
Agency Capacity	Justification for change
Counties Served	2 letters of support from the county proposing to serve Outreach and referral information for county proposing to serve, Attachment #7

Program Name		Date Requested	
Contract Manager		Date Required	
Requestor		Title	

Change Request Details

- 1.
- 2.
- 3.
- 4.

Justification For Addendum

Describe foreseen impact of the suggested changes.

This agreement shall be binding upon the parties, their sub-contractors, or designees. This agreement shall be enforced in accordance with Ohio Administrative Code 3701-8-02 (with authorization from Ohio Revised Code 3701.61)

Signature of Authorized Representative

Date

Printed Name

On Behalf of (print Agency Name)

Decision	
<input type="checkbox"/> Approved	<input type="checkbox"/> Rejected Provider Number _____
<input type="checkbox"/> Approved with modifications	<input type="checkbox"/> Deferred
Consultant Name:	Signature:
Date:	
Supervisor Name:	Signature:
Date:	
Justifications (if necessary)	