

DEPARTMENT OF STATE HEALTH SERVICES



Amendment
To

The Department of State Health Services (DSHS) and HIDALGO COUNTY (Contractor) agree to amend the Program Attachment # 001 (Program Attachment) to Contract # 2010-035483 (Contract) in accordance with this Amendment No. 001A : Office of Border Health, effective 01/25/2011.

The purpose of this Amendment is to: Revising contract end date to align with the end of the federal project period per federal guidance.

Therefore, DSHS and Contractor agree as follows:

1 change at paragraph (2)

PROGRAM ATTACHMENT NO. ~~001~~ 001A

1 change at paragraph (8)

TERM:08/01/2010 THRU: ~~07/31/2012~~ 07/31/2011

1 change at paragraph (53)

Contractor shall request payment ~~using by submitting~~ the State of Texas Purchase Voucher (Form ~~B-13A~~) B-13 on a monthly basis and acceptable supporting documentation for reimbursement of the required services/deliverables. ~~The B-13A can be found at~~ Additionally, Contractor shall submit ~~the following link~~ <<http://www.dshs.state.tx.us/grants/forms/b13form.doc>>. ~~Vouchers Match/Reimbursement Certification (Form B-13a) and the Financial Status Report (FSR-269A) on a quarterly basis. Voucher~~ and supporting documentation ~~should~~ shall be mailed or submitted by fax or electronic mail to the addresses/number below.

1 change at paragraph (61)

The fax number for submitting State of Texas Purchase Voucher (Form ~~B-13~~) B-13, Match/Reimbursement Certification Form (B13-a), and Financial Status Report (FSR-269A) to the Claims Processing Unit is (512) 458-7442. The email address is invoices@dshs.state.tx.us <<mailto:invoices@dshs.state.tx.us>>.

1 change at paragraph (75)

Contractor shall request payment using the State of Texas Purchase Voucher (Form ~~B-13A~~) B-13 and acceptable supporting documentation as indicated in the attached Exhibit A.

All other terms and conditions not hereby amended are to remain in full force and effect. In the event of a conflict between the terms of this contract and the terms of this Amendment, this Amendment shall control.

Department of State Health Services

Signature of Authorized Official

Date: _____

Bob Burnette, C.P.M., CTPM

Director, Client Services Contracting Unit

1100 WEST 49TH STREET
AUSTIN, TEXAS 78756

(512) 458-7470

Bob.Burnette@dshs.state.tx.us

Contractor

Signature of Authorized Official

Date: _____

Name: _____

Title: _____

Address: _____

Phone: _____

Phone: _____

Email: _____