Help Me Grow Home Visiting
Contract and Provider Agreement Addendum

Instructions: Complete this form to communicate any changes to the Ohio Department of Health as outlined in your contract or provider agreement. Indicate the change(s) below and send the completed form with any required attachments to your Early Childhood Home Visiting Program Consultant. If you are expanding to serve a new county or implementing a new model, and have not done so already, you must first complete and submit the HEA 0210 Expansion Implementation Plan.

Agency Information

Agency Name:	Contract Manager:	
Requestor:	Title:	Date:

Change Request (check all that apply)

Requested Change	Required Documentation	Justification/Additional Information
☐ Staffing: Home Visitor, Home Visiting Supervisor, Program Manager (new staff hired, staff leaving agency)	☐New Hire: OCHIDS User Agreement ☐ New Hire: Credential Certificate	Include the name(s) of all new staff and their date of hire and the name(s) of any staff leaving the agency and their last day of employment. **Note: The names of new staff should match the first and last name used in their profile in the Ohio Professional Registry.**
☐ Agency Capacity (includes either an increase or decrease in capacity)	N/A	Model/Funding Stream — Current Capacity — New Capacity Requested _____ _____ _____ _____ _____ _____ _____ _____ _____ Provide the reason you are requesting the change. If you are requesting an increase in capacity in any model and have not maintained 85% enrollment in the last six months with your current capacity, please share your plan to increase and maintain enrollment percentage.
☐ Counties Served	☐ Adding county: Letter of support from the Local Health District or community organization/partner	*If adding an additional county:* List the names of the additional county(s) you are seeking to serve and the model you planning to implement. Include your plan to work with the local Central Intake and Referral agency on outreach, support, and enrollment.

	serving families, of the county proposing to serve	*If dropping a county you are currently serving:* List the names of the county you will no longer be serving, your reason for no longer serving them and your transition plan for currently enrolled families.
☐ Subcontractor	N/A	Provide the name and contact information of new contractor(s) and name of contractor(s) with whom you will no longer be working. Please describe the reason for the change.
☐ Evidence-Based or Promising-Practice Model Implemented	☐ New Providers: Letter of Affiliation from Model if not submitted with application (does not apply to Moms & Babies First) ☐ Providers Expanding to new model: Letter of Affiliation from Model if not submitted with HEA 0201 Expansion Implementation Plan (does not apply to Moms & Babies First, HFA Child Welfare Protocols or NFP Expanded Eligibility)	*If you are adding a model: I*ndicate the model(s) you are adding: ☐ Nurse Family Partnership ☐ Parents as Teachers ☐ Healthy Families America ☐ Moms & Babies First ☐ Healthy Families America – Child Welfare Protocols ☐ Nurse Family Partnership – Expanded Eligibility If you are dropping a model: Indicate the model(s) you are dropping: ☐ Nurse Family Partnership ☐ Parents as Teachers ☐ Healthy Families America ☐ Moms & Babies First ☐ Healthy Families America – Child Welfare Protocols ☐ Nurse Family Partnership – Expanded Eligibility Will families currently receiving services need to transition to a new model as a result of this change? ☐ Yes ☐ No If yes, please describe your transition plan for these families:

This agreement shall be binding upon the parties, their subcontractors, or designees. This agreement shall be enforced in accordance with Ohio Revised Code 3701.61 and Ohio Administrative Code 3701-8.

_____	_____	_____
Contract Manager (please print)	Contract Manager Signature	Date

Decision (for Ohio Department of Health use only)		
Approved: ☐ Yes ☐ No Comments:		
Consultant Name:	Signature:	Date:
Supervisor Name:	Signature:	Date: