Medicaid Extended Health Services
Local Services Plan Program Modification

MODIFICATION COVER PAGE

Date Completed: _____

County: _____

Name of District/BOCES: _____

Program Contact Name: _____

Phone: _____

Email: _____

Local Services Plan Year: _____

Modification Number: _____

Please be sure to complete and submit all parts of the modification. Requests for Modifications will be returned to districts that do not provide all of the requested information. Please note that there is NO DEADLINE for modification submissions.

Reason for Contract Modification

Please provide a narrative that briefly explains the reason for this modification to your Local Services Plan below. Indicate what services were added or removed and explain why these changes occurred.

Medicaid School Health Program
Local Services Plan Modification

EXECUTIVE SUMMARY

School District or BOCES: _____

LSP Program Year: _____

1. Original LSP Expenditure Budget Summary
   If this is the first LSP modification for this program year, please list the expenditures entered in the original LSP in the table below. If this is not the first LSP modification for this program year, please use the expenditures listed in your most recent modification.

Original LSP Expenditures	Dollar Amount	Percentage
Administration	$	
Health Services	$	
Total Spending	$ 0.00	0.00

2. Modified LSP Expenditure Budget Summary
   In the table below, please indicate the modified expenditures

Modified LSP Expenditures	Percentage	
Administration		
Health Services		
Total Percentage	0.00	

Indicate the estimated expenditures for administration and health services for the program year that you are modifying. List the amount for each spending category (Administrative and Health Services). Determine the percentages for each category and indicate these numbers in the Percentage column.

Summarize the added/modified services in the table below (add rows if necessary):

Service	Type of Service	Goal # & Objective #	%	# of Students
		G: O:		
		G: O:		
		G: O:		
		G: O:		
		G: O:		

Types of services
DS = Direct Service, IS = Indirect, OS = Other Service, SS = Subcontracted Service

Subcontracted Services

If any services will be subcontracted please indicate the name of the subcontractor, the activities being subcontracted according to the chart above and how the subcontractor was chosen on a separate sheet.

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GOALS AND OBJECTIVES

School District or BOCES: _____

LSP Program Year: _____

Additional Program Goals

Goal #	Goal
_____	_____
_____	_____
_____	_____

Additional Program Objectives

Goal # _____ Obj # _____ % _____ # Students Served _____

Objective	
Monitoring Plan	

Goal # _____ Obj # _____ % _____ # Students Served _____

Objective	
Monitoring Plan	

Goal # _____ Obj # _____ %_____ # Students Served _____

Objective	
Monitoring Plan	

Part III – Total Number of Students: 0

Part III – Total % 0