DEPARTMENT OF STATE HEALTH SERVICES

Amendment #1

The Department of State Health Services (DSHS) and Corpus Christi-Nueces County Public Health District (Contractor) agree to amend Contract ID#2015-047050 (Contract), DSHS Program: CHS-Breast and Cervical Cancer, Purchase Order 0000408200; which was effective on September 1, 2014. This Contract has not been amended prior to this Amendment.

I. The Parties agree to amend this Contract's Program Attachment #001 to #001A.

II. The Parties agree to amend Section II. PERFORMANCE MEASURES: (D)(6), second paragraph, of this Contract to read as follows:

Contractor must provide breast and cervical services to 300 (decrease of 450) unduplicated clients who live or receive services in the following county(ies)/area: Nueces

III. Section VII. BUDGET of this Contract is amended to decrease the total amount of Contract to $161,802.00 (decrease of $41,463)

Funding Source and Type of Service	**Funding Amount**
BCCS (CDC) Screening, Diagnostic and Case Management (September 2014 – June 2015)	$52,777.00 (decrease of $16,807)
BCCS (CDC) Screening, Diagnostic and Case Management (July 2015-August 2015)	$14,449.00
Title V Cervical Dysplasia Management and Treatment	$7,068.00 (increase of $974)
TANF Screening, Diagnostic, Case Management and MBCC Case Management	$61,878.00
General Revenue (GR) Screening, Diagnostic, Case Management and MBCC Case Management	$25,630.00 (decrease of $25,630)

Total payments for services provided under this Program Attachment shall not exceed $161,802.00 (decrease of $41,463)

IV. Except as provided in this Amendment, all other terms and conditions in the Contract and its Program Attachment will remain and be in full effect.

V. This Amendment is effective on June 12, 2015.

By signing this Amendment, the undersigned certify that they have the authority to bind their respective party to this Amendment's terms and conditions.

Department of State Health Services	**Contractor**
By:_____	By:_____
Evelyn Delgado	Name:_____
Assistant Commissioner, Family & Community Health Services	Title:_____
Date:_____	Date:_____