

BOH CONTRACT SUMMARY

- New Contract**
 Renewal
 Amended Renewal

NAME OF ORGANIZATION	Illinois Department of Public Health, Illinois Breast and Cervical Cancer Program					
EFFECTIVE DATES	Two Years: July 1, 2023-June 30, 2025					
BRIEF DESCRIPTION/ PURPOSE	Reduce breast and cervical cancer mortality among uninsured, underinsured, and underserved women in McHenry County by providing breast and cervical cancer screening services that may be delayed or unavailable to the population without the program.					
TERMS	Amendment 46180016L-A1 revises contract 46180016L. Reduces total award by \$46,795 from \$1,028,734 to \$981,939 FY2025 reduces grant award					
MCDH DEPT/STAFF INVOLVED	Women's Health Program					
FINANCIAL TERMS	FY24/FY25 Total: \$981,939 (2-year contract) FY24 \$488,225 FY25 \$493,714			FY23 Total \$401,866 (1 year contract)		
	Federal FY24 \$170,879	State FY24 \$317,346	Local \$0	Federal \$152,709	State \$249,157	Local \$0
	FY25 \$177,737	FY25 \$315,977				
INDEMNIFICATION CLAUSE?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
SPECIAL ARRANGEMENTS, REQUIREMENTS, CONDITIONS	Termination: This Agreement may be terminated, in whole or in part, by either Party for any or no reason upon thirty (30) calendar days' prior written notice to the other Party.					

STATE OF ILLINOIS

GRANT AMENDMENT 1

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
PROGRAM NAME : Breast and Cervical Cancer Program

Grant # : 46180016L

Amendment # : 46180016L-A1

The undersigned Agency and Grantee (the Parties) agree that the following shall amend the Grant Agreement referenced herein. All terms and conditions set forth in the original Grant Agreement, not amended herein, shall remain in full force and effect as written. In the event of conflict, the terms of this Amendment shall prevail.

IN WITNESS WHEREOF, the Agency and the Grantee cause this Amendment to be executed on the dates shown below by representatives authorized to bind the respective PARTIES.

GRANTEE

Grantee Name : County of McHenry	Address : 2200 N. Seminary Avenue, Woodstock, IL 60098-2637
Signature:	Phone : (815) 334-4575
Printed Name : Melissa Adamson	Fax :
Title :	Email : mhadamson@mchenrycountyil.gov
Date :	

STATE OF ILLINOIS

Procuring Agency: Illinois Department of Public Health	
Street Address: 525 - 535 W. Jefferson	Phone :
City, State ZIP: Springfield, IL 62761-0002	Fax :
Printed Name: Sameer Vohra, MD, JD, MA	Official's Title: Director of Public Health
Official Signature:	Date:
Signature of Second Grantor Approver, if applicable:	
Street Address:	Phone :
City, State ZIP:	Fax :
Printed Name:	Printed Title:
Official Signature:	Date:
Signature of Third Grantor Approver, if applicable:	
Street Address:	Phone :

City, State ZIP:	Fax :
Printed Name:	Printed Title:
Official Signature:	Date:

STATE USE ONLY**NOT PART OF CONTRACTUAL PROVISIONS**

PBC# :	Project Title : Breast and Cervical Cancer Program	
Contract # : 46180016L	Procurement Method (IFB, RFP, Small, etc):	
IPB Ref. #	IPB Publication Date:	Award Code:
Subcontractor Utilization?	Subcontractor Disclosure?	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Funding Source: NU58DP007162	Obligation # 46180016L-A1	
General Counsel Approval:		
Signature	Printed Name	Date

1. **GRANT DESCRIPTION** (including Original Purchase Order or Contract Number): 46180016L

2. **DESCRIPTION OF AMENDMENT** (Check all that apply, complete blanks and explain as necessary):

2.1. The completion date will be extended, shortened or remain the same.

2.1.1. Original completion date: 06/30/2025

2.1.2. Revised completion date: 06/30/2025

2.2. The method of determining compensation (e.g., hourly rate, fixed fee, etc.) will stay the same or change as follows:

2.3. The cost will be increased, decreased or remain the same.

2.3.1. Original cost: 1,028,734.00

2.3.2. Amount of change: -46,795.00

2.3.3. Revised cost: 981,939.00

Amend Section 2.2 Shall now read Amount of Agreement "Grant Funds are estimated at \$981,939.00, which is broken down to an estimated \$488,225.00 for FY2024, of which \$170,879.00 are federal funds, and an estimated \$493,714.00 for FY2025, of which \$177,737.00 are federal funds.

Amend Section 32.3 Shall now read Amount of Agreement "Grant Funds are estimated at \$981,939.00, which is broken down to an estimated \$488,225.00 for FY2024, of which \$170,879.00 are federal funds, and an estimated \$493,714.00 for FY2025, of which \$177,737.00 are federal funds.

2.4. The supplies or services to be provided will stay the same or be changed as follows:

3. **EFFECTIVE DATE OF AMENDMENT:** upon execution

4. **WHY IS CHANGE NEEDED?** (Check all that apply and explain.)

4.1 The circumstances said to necessitate the change in performance were not reasonably foreseeable at the time the grant agreement was signed.

4.2 The change is germane to the original grant agreement as signed.

4.3 The change order is in the best interest of the State and authorized by law.

Explanation of why change is needed:

CDC allowed the State to reset its federal caseload projection, which requires an amendment in the funding amounts for each grantee. The State is also amending the grants to avoid a funding lapse caused by unspent clinical funds.

5. **WHAT PROVISION OF THE GRANT OR OTHER LAW AUTHORIZED THIS CHANGE?**

Section 4.6 of the Grant Agreement allows for modifications to the estimated amount.

Section 22.4 of the Grant Agreement allows for modifications or amendments.

TAXPAYER IDENTIFICATION NUMBER

I certify that:

The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and

I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and

I am a U.S. person (including a U.S. resident alien).

- If you are an individual, enter your name and SSN as it appears on your Social Security Card.
- If you are a sole proprietor, enter the owner’s name on the name line followed by the name of the business and the owner’s SSN or EIN.
- If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner’s name on the name line and the D/B/A on the business name line and enter the owner’s SSN or EIN.
- If the LLC is a corporation or partnership, enter the entity’s business name and EIN and for corporations, attach IRS acceptance letter (CP261 or CP277).
- For all other entities, enter the name of the entity as used to apply for the entity’s EIN and the EIN.

Name : _____

Business Name : County of McHenry

Taxpayer Identification Number :

Social Security Number : _____

or

Employer Identification Number : 36-6006623

Legal Status : Government Entity

Signature of Authorized Representative : _____

Date : _____