IDOA 3343

IMPORTANT DIRECTIONS REGARDING YOUR EXTENSION AMENDMENT:

You will need to **print and/or copy an additional Extension Amendment for EACH Agreement #** - giving you two (2) hard-copies of the same document; **BOTH** of which will need to be signed in **Blue Ink** and returned to the Department (please see mailing instructions below).

If you accept the extension offer, please correctly complete the following on each copy of the Extension Amendment(s) according to the relevant instruction. *Any incomplete or incorrect information entered by the Provider will require re-submission of the Extension Amendment and may result in a delayed effective date for the Extension Amendment.*

1. Check the "Accept" box on the Extension Amendment(s).
2. Confirm that your agency's **Taxpayer Identification Number** and the **legal status of your agency** are CORRECT. If this has been left blank this must be entered accordingly.
3. Confirm that the address of your administrative office is CORRECT (please include the nine-digit zip code if this is not already entered for you).
4. Confirm that the typed name and title of the authorized representative is ACCURATE.
5. TO RECEIVE PAYMENTS at an address other than your administrative office, please enter this address on the payee address lines below the typed name and title of the authorized representative. Should this section already be filled in for you, please CONFIRM accuracy as payments will be sent accordingly.
6. After verifying that all information is correct, originally sign and date **(WITH BLUE INK)** each copy of the Extension Amendment where indicated.

IMPORTANT:
Should you find a discrepancy/error, please strike one line through that which is incorrect and then write in the correct information. DO NOT USE ANY FORM OF CORRECTION TAPE AND/OR FLUID UNDER ANY CIRCUMSTANCES - or you WILL have to re-submit your Amendment!
It is IMPORTANT that you ***initial ALL areas*** in which changes may have been made. Failure to do so may result in a delay of executing your Extension Amendment. No additions, changes or deletions, other than entry and confirmation of the above required information, may be made to this Extension Amendment.

If you ***reject*** the Extension Amendment, please complete the following:

1. Check the "Refuse" box on the Extension Amendment(s).
2. Originally sign and date **(WITH BLUE INK)** both copies of the Extension Amendment where indicated.

Please be advised that refusal of this Extension Amendment will result in termination of the above referenced CCP Agreement, effective close of business on June 30, 2009. Failure to return this signed Extension Amendment will be considered a refusal of the extension offer.

IMMEDIATELY, return both originally signed and completed copies of the Extension Amendment(s) for receipt at the Department. One dually signed copy of this Extension Amendment will be returned to you for your files.

PLEASE MAIL to:

Illinois Department on Aging
ATTN: OFFICE OF SERVICE DEVELOPMENT AND PROCUREMENT
c/o Jeanette Bartlett, Contract / Grant Consultant
421 East Capitol Avenue, #100
Springfield, IL 62701-1789

If you have questions or concerns regarding this Amendment to your Agreement, please contact Jeanette Bartlett, Contract/Grant Consultant, Office of Service Development and Procurement at (217) 785-8109.

PLEASE NOTE:
I would appreciate a quick return reply confirming that you did receive this e-mail. . . AND should you have any questions and/or concerns you may email me back at Jeanette.Bartlett@illinois.gov or you may call me @ (217) 785-8109.

Thank you.

IDoA No. U129905912

FY10
AMENDMENT
ILLINOIS DEPARTMENT ON AGING
CASE COORDINATION UNIT AGREEMENT

Whereas, it is mutually agreed that the ILLINOIS DEPARTMENT ON AGING and any successor agency (hereinafter referred to as IDoA) and **VERMILION COUNTY HEALTH DEPARTMENT** (hereinafter referred to as CCU) entered into an Agreement **October 01, 2005**.

Whereas, paragraph 30 of said original Agreement states the Agreement may be amended by the mutual consent of both parties, the following paragraph(s) is amended to read as follows:

"1. This Agreement becomes effective October 01, 2005 and, absent prior notice of termination shall **terminate September 30, 2010**. CCU will ensure an orderly transition of clients, their respective case files and pertinent information as required by IDoA prior to the date of termination."

All other terms and conditions of the original Agreement and any previous amendments remain in full force and effect and constitute the entire Agreement of the parties hereto.

This Amendment is **effective October 01, 2009**

* * * *

Pursuant to this offer of the Illinois Department on Aging to amend the above-referenced Community Care Program - *Case Coordination Unit Agreement,* I;

(CHECK (✓) ONE)

☒ **ACCEPT** the provisions of this Amendment, which extends the terms, conditions and provisions of the original Community Care Program - *Case Coordination Unit Agreement,* and any subsequent Amendments to date. Payments under this Agreement shall be subject to the availability of a sufficient appropriation from State and/or Federal funds for the Community Care Program.

☐ **REFUSE** the provisions of this Amendment. I understand that my refusal will cause the current caseload to be opened to emergency solicitation or other action determined appropriate by the Department and that the above – referenced Community Care Program - *Case Coordination Unit Agreement,* will terminate close of business on **September 30, 2009** .

TAXPAYER IDENTIFICATION NUMBER

I certify that:

1) 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
2) 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
2) I am a U.S. person (including a U.S. resident alien).

Name: VERMILION COUNTY HEALTH DEPARTMENT

Taxpayer Identification Number:

Social Security Number _____

or

Employer Identification Number 37-6002224

(If you are an individual, enter your name and SSN as it appears on your Social Security Card. If completing this certification for a sole proprietorship, enter the owner's name followed by the name of the business and the owner's SSN or EIN. For all other entities, enter the name of the entity as used to apply for the entity's EIN and the EIN.)

4) **Legal Status** (*check* (✓) *one*):

____ Individual
____ Sole Proprietor
____ Partnership/Legal Corporation
____ Tax-exempt
____ Corporation providing or billing medical and/or health care services
____ Corporation NOT providing or billing medical and/or health care services

Other: ____ _____

✓ Governmental
____ Nonresident alien
____ Estate or trust
____ Pharmacy (Non-Corp.)
____ Pharmacy/Funeral Home/Cemetery (Corp.)

____ Limited Liability Company (select applicable tax classification.)
□ D = disregarded entity
□ C = corporation
□ P = partnership

All notices required or desired to be sent by either party shall be sent to the following respective addresses:

ILLINOIS DEPARTMENT ON AGING
421 East Capitol Avenue, Suite #100
Springfield, Illinois 62701-1789

VERMILION COUNTY HEALTH DEPARTMENT
200 South College
Danville, Illinois 61832-6700

SIGNATURES

In witness whereof, the parties hereto have caused this Amendment or refusal of same to be executed by their duly authorized representative(s):

_____ _____
Signature Date

CHARLES D. JOHNSON
IDoA DIRECTOR

Stephen Laker 9/2/09
Signature Date

STEPHEN LAKER, PUBLIC HEALTH ADMINISTRATOR
Typed Name(s) and Title(s) of Authorized Representative(s)

PAYEE ADDRESS
(If different from above)

_____
_____
_____
_____
City, State, Nine-Digit Zip Code

This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under 20 ILCS 435/5 and 435/5.1. Disclosure of this information is MANDATORY as required by Federal Office of Management and Budget OMB Circulars A-102 and A-122. Failure to comply will result in Federal and/or State funding being withheld. The Illinois Department on Aging does not discriminate in admission to programs or treatment of employment in programs or activities in compliance with appropriate State and Federal Statutes. If you feel you have been discriminated against, you have a right to file a complaint with the Illinois Department on Aging. For information, call the Senior HelpLine: 1-800-252-8966 (Voice) 1-888-206-1327 (TTY).
Printed on Recycled Paper