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| **DEPARTMENT OF HEALTH SERVICES**  Division of Care and Treatment Services  F-25527 (01/2017) | | STATE OF WISCONSIN | | | | |
| **REQUEST FOR INCREASED CONTRACT ALLOCATION**  Completion of this form is voluntary. If not completed, an increase in the contract cannot be made.  The information provided is used only for processing this request and developing budgets. | | | | | | |
| Name – Client (Last, First, MI) | | | | | | |
| Name – Provider | | Telephone Number - Provider | | | | |
| Address | | Amount – Current Contract | | | Date – End Current Contract | |
| Amount – Requested | | | FEIN Number | |
|  | | | | | | |
| List Current Services Provided | | | | | | |
|  | | | | | | |
| Briefly Describe Change in Services | | | | | | |
|  | | | | | | |
| Justification for Increased Cost of Services | | | | | | |
|  | **SIGNATURE** - Provider | |  | Date Signed | |  |
|  | | | | | | |
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|  |  | |  |  | |  |
|  | **SIGNATURE** – DHS Representative | |  | Date Signed | |  |