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| **DEPARTMENT OF HEALTH SERVICES**Division of Care and Treatment ServicesF-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      |
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| Justification for Increased Cost of Services      |
|  | **SIGNATURE** - Provider |  | Date Signed |  |
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|  | **SIGNATURE** – DHS Representative |  | Date Signed |  |