

The Commonwealth of Massachusetts

Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

MAURA T. HEALEY Governor

KIMBERLEY DRISCOLL Lieutenant Governor KATHLEEN E. WALSH Secretary

ROBERT GOLDSTEIN, MD, PhD Commissioner

> Tel: 617-624-6000 www.mass.gov/dph

06/12/2025

CITY OF SOMERVILLE 93 HIGHLAND AVE SOMERVILLE, MA 02143-1740

Attn: Fina (d)

R/E: Contract #: INTF2903P01190128214

This letter is to inform you that the Massachusetts Department of Public Health, Bureau of Community Health and Prevention is amending your contract as indicated below:

Amendment Reason: Renewal

The contract total maximum obligation is \$847,618.06.

The contract will be in effect through 06/30/2026 with options for renewal in accordance with RFR# 190128 - Municipal Board of Health Tobacco and Public Health Policy Programs through 06/30/2028. The effective start date of the contract amendment shall be the anticipated start date specified in the Standard Contract Form or a later date the Standard Contract Form has been executed by an authorized signatory of the Department of Public Health.

Listed below is the contract budgeted funding amounts:

Previous Years	07/01/2018	06/30/2024	\$627,058.06
Current Year	07/01/2024	06/30/2025	\$110,280.00
Future Years	07/01/2025	06/30/2026	\$110,280.00

If you have questions about your award please contact your program manager Alex Gomez at alex.gomez@mass.gov.

Enclosed please find a Standard Contract package for you to review, sign and return via email scan. Please take note of the following:

• STANDARD CONTRACT FORM

This form must be signed with an authorized signature, dated and returned via email scan. Do not use correction fluid anywhere on the forms.

All attachments must be completed for your contract package to be processed.

• CONTRACTOR AUTHORIZED SIGNATORY LISTING (CASL)

The Department of Public Health has moved to an annual Contractor Authorized Listing (CASL) Form for signing contracts. The CASL form will be filled out annually in lieu of having to submit a CASL form with every new contract or amendment.

If you have any questions about your contract package, please contact

Please sign with an **authorized signature** and return the contract package via email scan to no later than close of business

Sincerely,

Bureau Director

Acceptable forms of Authorized signatures:

- 1. Traditional hand drawn "wet signature" (ink on paper);
- 2. Scan Copy of hand drawn signature
- 3. Electronic signature that is either:
 - a. Hand drawn using a mouse or finger if working from a touch screen device;
 - b. An uploaded picture of the signatory's hand drawn signature
- 4. Electronic signatures affixed using a digital tool such as Adobe Sign or DocuSign

Please Note:

The typed text of a signature even in computer-generated cursive script, or an electronic symbol, **are not acceptable forms** of electronic signature.

Award Letter Additional Information

Contract ID #:

COMMONWEALTH OF MASSACHUSETTS | STANDARD CONTRACT FORM

This form is jointly issued and published by the Office of the Comptroller, the Executive Office for Administration and Finance, and the Operational Services Division as the default contract for all Commonwealth Departments when another form is not prescribed by regulation or policy. The Commonwealth deems void any changes made on or by attachment (in the form of addendum, engagement letters, contract forms or invoice terms) to the terms in this published form or to the <u>Standard Contract Form Instructions and Contractor Certifications</u>, the <u>Commonwealth Terms and Conditions</u>, the <u>Commonwealth Terms and Conditions</u> or the <u>Commonwealth IT Terms and Conditions</u> which are incorporated by reference herein. Additional non-conflicting terms may be added by Attachment. Contractors are required to access forms at macomptroller.org/forms or mass.gov/lists/osd-forms.



			COMMONWEALTH	INFORMATION			
Contractor Legal Name CITY OF SOMERVILL		Department Department of Public Health MMARS Code DPH					
Legal Address 93 HIGHLAND AVE SOMERVI As entered on Form W-9 or Form W-4		1740	Contract Manager Name Allysia Peng Business Mailing Address 250 Washington Street, Boston MA 021			ess eet. Boston MA 02108	
Contract Manager Name Tina Los			Billing Address If Different				
Phone 617-625-6600> Email tlos@somerville	ma dov	Fax	Phone 978-423-0591	Email Allysia.Peng@	@mass dov	/	Fax 617-624-5017
Vendor Code vc VC60001			MMARS Doc ID(s)	INTF2903P0119	90128214		017 024 0017
Vendor Code Address ID AD 001 e.g. "AD001". Note: The Address ID must be set up	a for Electronic Eu	nds Transfor (EET) navments	RFR/Procurement	or Other ID Number	er 190128		
NEW CON		nus mansiei (Er r) payments.		X CON	TRACT AME	NDMENT	
Procurement or Exception Type (Check one op			Current Contract E	and Date	11VAOT AIVILI	Amendmer	nt Amount \$110,280.00
■ Statewide Contract (OSD or an OSD-designat	ed department.)		PRIOR to Amendm	ent 06/30/2			
Collective Purchase (Attach OSD approval, so							amendment changes.)
Department Procurement - Includes all Grants RFR, and Response or other procurement			Amendment to				
Emergency Contract (Attach justification for e			updated scop		itractor (Atta	cn justificatio	on for Interim Contract and
Contract Employee (Attach Employee Status I				yee (Attach any up	dates to scop	e or budaet.)
Interim Contract with new Contractor (Attach							/ /justification and updated
scope/budget.)			scope/budget	.)			
Other Procurement Exception (Attach authori							
exemption or earmark, and exception justif	ication, scope, and	a budget.)					
TERMS AND CONDITIONS The Standard Contract Form Instructions and Contract Form Instructions	tractor Certification	as and the following document a	e incorporated by ref	aranca into this Cor	atract and are	legally bindi	ing (Check ONE option):
Commonwealth Terms and Conditions		alth Terms and Conditions for Hu			nmonwealth l		
COMPENSATION (Check ONE option)							
The Department certifies that payments for authori				t will be supported in	n the state ac	counting sys	stem by sufficient
appropriations or other non-appropriated funds, su							
Rate Contract (No Maximum Obligation). (Attach Maximum Obligation Contract. Total maximum of	n details of all rates	s, units, calculations, conditions of	r terms and any chang	ges it rates or terms	are being am	nenaea.)	
PROMPT PAYMENTDISCOUNT (PPD)	bligation for total t	adiation of this contract for new t	otal il contract is bellig	g amenaca). ψ 041	,010.00		
Commonwealth payments are issued through Elec	tronic Funds Tran	sfer (FFT) 45 days from invoice i	receint See Prompt P	av Discounts Policy	V		
						J 0/	DDD 20 davis 0/ DDD
Contractors requesting accelerated payments must	st identify a PPD a	is follows: Payment issued within	1: 10 days % PF	D. 15 days %	% PPD. 20 c	iays %	PPD. 30 days % PPD.
If PPD percentages are left blank, identify reason: Statutory/legal Ready Payme	nto (M.C.L. o. 20	S 22A) Agree to stand	dard 45-day cycle	Only initial nave	nont		
BRIEF DESCRIPTION OF CONTRACT PERFORM			aaru 45-uay cycle	10 my miliai payn	ileiit		
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			or what is being ame	ended for a Contrac	t Amendment	t. Attach all s	supporting documentation and
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Scope of Services

Contract ID #: INTF2903P01190128214

Contract Amendment - Increase

FY26 - MO Increase/Renewal

Board of Health (BOH) programs will be responsible for promoting health equity, addressing health inequities, and use a health equity lens while implementing this scope of service. Strategies carried out by BOH programs will also be consistent with best practices around tobacco prevention and control and should focus on policy, systems, and environmental change strategies to reduce the prevalence of tobacco use, prevent youth initiation of smoking, and reduce exposure to secondhand smoke

Sub Recipient Notification

The purpose of this communication is to fulfill the requirement established in 2 CFR 200. 331 (a) Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

Your organization is receiving this communication because it receives federal funds from DPH in the form of a sub-award, and DPH's relationship with your organization is defined as a sub-recipient relationship.

A sub recipient is defined as a non-federal entity that receives a sub-award from a pass-thru-entity to carry out part of a federal program; but does not include an individual that is a beneficiary of such program. A sub-recipient may also be a recipient of other federal awards directly from a federal awarding agency.

The attached report identifies information that DPH is required to provide to all entities that meet the description of a sub-recipient.

This communication will be sent:

- 1. Whenever federal sub-awards are a part of the contractual relationship between DPH and the entities that it contracts with to provide services; and
- 2. Whenever the amount of those federal sub-awards change during the course of the contractual relationship.

Your organization may have other contracts with DPH that are not sub-awards because they do not include federal funds. This communication does not pertain to any state funds your organization may have received from DPH.

Your organization's contract may be a combination of federal and state funds. In this case, this communication only pertains to the federal funds portion of your contract.

For a list of other requirements and information that your organization is required to adhere to as a sub-recipient of DPH, please see:

- 1. Commonwealth of Massachusetts Standard Contract form:
- 2. Purchase of Service Attachment 3 Fiscal Year Program Budget (if applicable);
- 3. The appropriate Commonwealth Terms and Conditions; and
- 4. The Request for Response (RFR) and related documents.

Please be advised that DPH should have access to your organization's records and financial statements as is necessary to meet the requirements of this sub-award.

Contract Number: INTF2903P01190128214

Vendor Name - FEIN: CITY OF SOMERVILLE - 046001414

Fiscal Year	CFDA	Appropriation	Grant Name	Agency Name	Start Date	End Date	Amount
2019		4512-9069	SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT	SAMHSA	07/01/2018	06/30/2019	\$47,356.00
				Grand Total of	2019		\$47,356.00
Fiscal Year	CFDA	Appropriation	Grant Name	Agency Name	Start Date	End Date	Amount
2020		4512-9069	SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT	SAMHSA	07/01/2019	06/30/2020	\$47,000.00
				Grand Total of	2020		\$47,000.00
Fiscal Year	CFDA	Appropriation	Grant Name	Agency Name	Start Date	End Date	Amount
2021		4512-9069	SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT	SAMHSA	07/01/2020	06/30/2021	\$47,000.00

				Grand Total of	2021		\$47,000.00
Fiscal Year	CFDA	Appropriation	Grant Name	Agency Name	Start Date	End Date	Amount
2022		4512-9069	SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT	SAMHSA	07/01/2021	06/30/2022	\$47,000.00
				Grand Total of	2022		\$47,000.00
Fiscal Year	CFDA	Appropriation	Grant Name	Agency Name	Start Date	End Date	Amount
2023		4512-9069	SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT	SAMHSA	07/01/2022	06/30/2023	\$47,000.00
				Grand Total of	2023		\$47,000.00
Fiscal Year	CFDA	Appropriation	Grant Name	Agency Name	Start Date	End Date	Amount
2024		4512-9069	SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT	SAMHSA	07/01/2023	06/30/2024	\$55,140.00
2024	93.959	4512-9058	SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT	SAMHSA	07/01/2023	06/30/2024	\$0.00
				Grand Total of	2024		\$55,140.00
Fiscal Year	CFDA	Appropriation	Grant Name	Agency Name	Start Date	End Date	Amount
2025		4512-9069	SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT	SAMHSA	07/01/2024	06/30/2025	\$55,140.00
				Grand Total of 2025		\$55,140.00	
Fiscal Year	CFDA	Appropriation	Grant Name	Agency Name	Start Date	End Date	Amount
2026		4512-9069	SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT	SAMHSA	07/01/2025	06/30/2026	\$55,140.00
				Grand Total of	2026		\$55,140.00

Department of Public Health

Department of Public Health New Budget Only

Workbook Should be saved as .XLSM file Format (workbook contains MACROS)

OITY OF COMEDVILLE		
CITY OF SOMERVILLE		
DPH Bureau/Program Name		
BCHAP/Tobacco Enforcement		
Vendor Code	Fiscal Year	Today's Date
VC6000192138	2026	06/12/25
Contract Number	RFR#	
INTF2903P01190128214	190128	
Program Component FTE	NEW BUDGET	Brief Justification
1. Program Staff		
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	\$	
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	Φ	
	\$	
	\$	
	\$ -	
	\$	
SUB TOTAL 0.00		
Fringe Benefits #DIV/0!	-	Enter the total dollar amount of Fringe Benefits (the percentage will be calculated)
1. TOTAL PROGRAM STAFF	\$ -	
Program Component	New Budget	Brief Justification
	_	
2. NON PERSONNEL (Consultants - Consultant worksheet required), subcontractors, supplies,		
Consultant: Individual	\$	
Consultant: Organization	\$	
Subcontractors (Attach Subcontractor Identification List For Direct or Non-Direct Care Services	\$	
,	\$	
	\$	
	\$	
	\$	
	\$	
	\$ \$	
	\$ \$ \$ \$	
	\$ \$ \$ \$	
	\$ \$ \$ \$ \$	
2 TOTAL MONIPERSONNEL	\$ \$ \$ \$ \$	
2. TOTAL NON PERSONNEL	\$ \$ \$ \$ \$	
2. TOTAL NON PERSONNEL	\$ \$ \$ \$ \$	
	\$ \$ \$ \$ \$	
2. TOTAL NON PERSONNEL 3. OCCUPANCY	\$ \$ \$ \$ \$	Brief Justification
3. OCCUPANCY Program Facility	\$ \$ \$ \$ \$ \$	Brief Justification
3. OCCUPANCY	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	Brief Justification
3. OCCUPANCY Program Facility Facility Operations, Maint. and Furn.	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	Brief Justification
3. OCCUPANCY Program Facility	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	Brief Justification
3. OCCUPANCY Program Facility Facility Operations, Maint. and Furn. 3. TOTAL OCCUPANCY	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	Brief Justification
3. OCCUPANCY Program Facility Facility Operations, Maint. and Furn.	\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$	Brief Justification
3. OCCUPANCY Program Facility Facility Operations, Maint. and Furn. 3. TOTAL OCCUPANCY	\$ - \$ -	Brief Justification
3. OCCUPANCY Program Facility Facility Operations, Maint. and Furn. 3. TOTAL OCCUPANCY SUB TOTAL: 1 + 2 + 3	\$ - \$ -	Brief Justification
3. OCCUPANCY Program Facility Facility Operations, Maint. and Furn. 3. TOTAL OCCUPANCY SUB TOTAL: 1 + 2 + 3 Administrative Support	\$ - \$ -	Brief Justification
3. OCCUPANCY Program Facility Facility Operations, Maint. and Furn. 3. TOTAL OCCUPANCY SUB TOTAL: 1 + 2 + 3 Administrative Support Max Cap Amount: #DIV/0!	\$ - \$ - \$ -	
3. OCCUPANCY Program Facility Facility Operations, Maint. and Furn. 3. TOTAL OCCUPANCY SUB TOTAL: 1 + 2 + 3 Administrative Support	\$ - \$ - \$ -	Brief Justification Enter the total dollar amount of Administrative Support (the percentage will be calculated)
3. OCCUPANCY Program Facility Facility Operations, Maint. and Furn. 3. TOTAL OCCUPANCY SUB TOTAL: 1 + 2 + 3 Administrative Support Max Cap Amount: #DIV/0! 4. AGENCY ADMIN. SUPPORT	\$ - \$ - \$ -	
3. OCCUPANCY Program Facility Facility Operations, Maint. and Furn. 3. TOTAL OCCUPANCY SUB TOTAL: 1 + 2 + 3 Administrative Support Max Cap Amount: #DIV/0!	\$ - \$ - \$ -	

^{*}Program Support: This component is for direct administrative program support that is associated with a single program(s) and NOT allocated across programs as an indirect cost or identified in admin support.

PLEASE NOTE: Only fill out this worksheet if you listed CONSULTANTS in your budget						
CONTRACT ID:						
FISCAL YEAR:						
PROJECT DELIVERABLE*	KEY DATE*	PROJECT DELIVERABLE COST*				
		\$				
		\$				
		\$				
		\$				
		\$				
		\$				
		\$				
		\$				
		\$				
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		\$				
		\$				
		\$				
		\$				
		\$				
		\$				
		\$				
	TOTAL CONSULTANTS**	\$0.00				

^{*} List Project Deliverables for each Consultant, the dates and cost of the deliverable when completed

PLEASE NOTE: This worsheet is not needed for SUBCONTRACTORS

^{**} This amount should equal the total amount you have allocated for CONSULTANTS in your budget