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
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Commissioner

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

05/29/2025

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

Attn: Katjana Ballantyne

R/E: Contract #: INTF2354M78220129158

This letter is to inform you that the Massachusetts Department of Public Health, Bureau of Substance Addiction Services is amending your contract as indicated below:

Amendment Reason: Renewal

The contract total maximum obligation is $1,241,666.00.

The contract will be in effect through 06/30/2027 with options for renewal in accordance with RFR# 220129 - Massachusetts Collaborative for Action, Leadership, and Learning 3 (MassCALL3) Substance Misuse Prevention Grant Program through 06/30/2029. 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	07/01/2021	06/30/2024	$741,666.00
Current Year	07/01/2024	06/30/2025	$250,000.00
Future Years	07/01/2025	06/30/2027	$250,000.00

If you have questions about your **award** please contact your program manager **Andrew Robinson at andrew.robinson@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 **Deandra Russo at Deandra.russo@mass.gov.**

Please sign with an **authorized signature** and return the contract package via email scan to **Deandra Russo at Deandra.russo@mass.gov,** no later than close of business **06/09/2025.**

Sincerely,
Deirdre Calvert
Bureau Director
Bureau of Substance Addiction Services

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 #: INTF2354M78220129158

This contract is funded by Federal Award Identification Numbers B08TI087044, B08TI085812, and B08TI083946 for the award period of July 1, 2024 to June 30, 2025. This contract is funded by Federal Award Identification Numbers B08TI087044 and B08TI088111 for the award period of July 1, 2025 to June 30, 2026.

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 Standard Contract Form Instructions and Contractor Certifications, the Commonwealth Terms and Conditions, the Commonwealth Terms and Conditions for Human and Social Services or the Commonwealth IT Terms and Conditions 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.

CONTRACTOR INFORMATION

Contractor Legal Name CITY OF SOMERVILLE

Legal Address 93 HIGHLAND AVE SOMERVILLE, MA 02143-1740
As entered on Form W-9 or Form W-4

Contract Manager Name Katjana Ballantyne

Phone	**Email**	**Fax**
617-625-6600x	mayor@somervillema.gov	

Vendor Code VC VC6000192138

Vendor Code Address ID AD 001
e.g. "AD001". Note: The Address ID must be set up for Electronic Funds Transfer (EFT) payments.

COMMONWEALTH INFORMATION

Department Department of Public Health | **MMARS Code** DPH

Contract Manager Name Deandra Russo

Business Mailing Address 250 Washington Street, Boston MA 02108

Billing Address
If Different

Phone	**Email**	**Fax**
857-363-0475	Deandra.russo@mass.gov	617-624-5017

MMARS Doc ID(s) INTF2354M78220129158

RFR/Procurement or Other ID Number 220129

☐ NEW CONTRACT

Procurement or Exception Type (Check one option only)

- ☐ **Statewide Contract** (OSD or an OSD-designated department.)
- ☐ **Collective Purchase** (Attach OSD approval, scope, and budget.)
- ☐ **Department Procurement** - Includes all Grants 815 CMR 2.00. (Attach Solicitation Notice or RFR, and Response or other procurement supporting documentation.)
- ☐ **Emergency Contract** (Attach justification for emergency, scope, and budget.)
- ☐ **Contract Employee** (Attach Employee Status Form, scope, and budget.)
- ☐ **Interim Contract with new Contractor** (Attach justification for Interim Contract and updated scope/budget.)
- ☐ **Other Procurement Exception** (Attach authorizing language, legislation with specific exemption or earmark, and exception justification, scope, and budget.)

☒ CONTRACT AMENDMENT

Current Contract End Date *PRIOR* to Amendment 06/30/2025

Amendment Amount Or Enter "No Change" $250,000.00

Amendment Type (Check one option only. Attach details of amendment changes.)

- ☒ **Amendment to Date, Scope, or Budget** (Attach updated scope and budget.)
- ☐ **Interim Contract with Current Contractor** (Attach justification for Interim Contract and updated scope/budget.)
- ☐ **Contract Employee** (Attach any updates to scope or budget.)
- ☐ **Other Procurement Exception** (Attach authorizing language/justification and updated scope/budget.)

TERMS AND CONDITIONS

The Standard Contract Form Instructions and Contractor Certifications and the following document are incorporated by reference into this Contract and are legally binding (Check ONE option):

☒ Commonwealth Terms and Conditions ☐ Commonwealth Terms and Conditions for Human and Social Services ☐ Commonwealth IT Terms and Conditions

COMPENSATION (Check ONE option)

The Department certifies that payments for authorized performance accepted in accordance with the terms of this Contract will be supported in the state accounting system by sufficient appropriations or other non-appropriated funds, subject to intercept for Commonwealth owed debts under 815 CMR 9.00.

☐ Rate Contract (No Maximum Obligation). (Attach details of all rates, units, calculations, conditions or terms and any changes if rates or terms are being amended.)

☒ Maximum Obligation Contract. Total maximum obligation for total duration of this contract (or new total if contract is being amended): $ 1,241,666.00

PROMPT PAYMENTDISCOUNT (PPD)

Commonwealth payments are issued through Electronic Funds Transfer (EFT) 45 days from invoice receipt. See Prompt Pay Discounts Policy.

Contractors requesting **accelerated** payments must identify a PPD as follows: Payment issued within: 10 days % PPD. 15 days % PPD. 20 days % PPD. 30 days % PPD.

If PPD percentages are left blank, identify reason:

☒ **Statutory/legal** ☐ **Ready Payments** (M.G.L. c. 29, § 23A) ☐ **Agree to standard 45-day cycle** ☐ **Only initial payment**

BRIEF DESCRIPTION OF CONTRACT PERFORMANCE or REASON FOR AMENDMENT

Enter the Contract title, purpose, fiscal year(s) and a detailed description of the scope of performance or what is being amended for a Contract Amendment. Attach all supporting documentation and justifications.

Renewal with Maximum Obligation Change

SUPPLIER DIVERSITY PROGRAM (SDP) PLAN

Does the Supplier Diversity Program apply? ☐ **YES** ☒ **NO**

If YES, the Contractor's annual SDP commitment for this Contract is

If NO, and the department is an Executive Department, enter the appropriate exemption: SDP Plan Info pending IT system upgrades.

ANTICIPATED START DATE (Complete ONE option only.)

The Department and Contractor certify for this Contract, or Contract Amendment, that Contract obligations:

1. may be incurred as of the Effective Date (latest signature date below) and **no** obligations have been incurred **prior** to the Effective Date.
2. may be incurred as of 07/01 , **20** 25 , a date **LATER** than the Effective Date below and **no** obligations have been incurred **prior** to the Effective Date.
3. were incurred as of , **20** , a date **PRIOR** to the Effective Date below, and the parties agree that payments for any obligations incurred prior to the Effective Date are authorized to be made either as settlement payments or as authorized reimbursement payments, and that the details and circumstances of all obligations under this Contract are attached and incorporated into this Contract. Acceptance of payments forever releases the Commonwealth from further claims related to these obligations.

CONTRACT END DATE

Contract performance shall terminate as of 06/30 , **20** 27 , with no new obligations being incurred after this date unless the Contract is properly amended, provided that the terms of this Contract and performance expectations and obligations shall survive its termination for the purpose of resolving any claim or dispute, for completing any negotiated terms and warranties, to allow any close out or transition performance, reporting, invoicing or final payments, or during any lapse between amendments.

CERTIFICATIONS

Notwithstanding verbal or other representations by the parties, the **"Effective Date"** of this Contract or Amendment shall be the latest date that this Contract or Amendment has been executed by an authorized signatory of the Contractor, the Department, or a later Contract or Amendment Start Date specified above, subject to any required approvals. The Contractor certifies that they have accessed and reviewed all documents incorporated by reference as electronically published and the Contractor makes all certifications required under the Standard Contract Form Instructions and Contractor Certifications under the pains and penalties of perjury, and further agrees to provide any required documentation upon request to support compliance, and agrees that all terms governing performance of this Contract and doing business in Massachusetts are attached or incorporated by reference herein according to the following hierarchy of document precedence, the applicable Commonwealth Terms and Conditions, this Standard Contract Form, the Standard Contract Form Instructions and Contractor Certifications, the Request for Response (RFR) or other solicitation, the Contractor's Response (excluding any language stricken by a Department as unacceptable, and additional negotiated terms, provided that additional negotiated terms will take precedence over the relevant terms in the RFR and the Contractor's Response only if made using the process outlined in 801 CMR 21.07, incorporated herein, provided that any amended RFR or Response terms result in best value, lower costs, or a more cost effective Contract.

AUTHORIZING SIGNATURE FOR THE CONTRACTOR Signature and date must be captured at time of signature.		AUTHORIZING SIGNATURE FOR THE COMMONWEALTH Signature and date must be captured at time of signature.	
Signature	**Date**	**Signature**	**Date**
Print Name	**Print Title**	**Print Name**	**Print Title**

FY: 2025 **Amendment # (if Applicable):** _____ **If Federal Funds,** CFDA#93.959

PURCHASE OF SERVICE – ATTACHMENT 1: PROGRAM COVER PAGE

PROGRAM INFORMATION

Contractor Name: CITY OF SOMERVILLE	**Department Name:** Massachusetts Department of Public Health
Program Type: Mass Collaborative for Action, Leadership and Learning 2	**Document ID #:** INTF2354M78220129158
Program Name: MASS CALL 3	**UFR Program:**
Program Address: 93 HIGHLAND AVE	**MMARS Program Code:** 4940
City/State/Zip: SOMERVILLE MA 02143-1740	**Other Reference Information (Information Purposes Only):**
Contact Person: Katjana Ballantyne **Telephone:** 617-625-6600x2100	**Contact Person:** Deandra Russo **Telephone:** 857-363-0475

RFR INFORMATION: ☐ Attached ☐ Legislative Exception ☐ Emergency ☐ Interim ☐ Amendment **RFR Reference #** 220129 ☐ Collective Purchase

SCOPE OF SERVICES: ☑ Bidders Response Attached ☐ Description of Services Attached RFR Info CH257

TOTAL ANTICIPATED CONTRACT DURATION: 7/1/2025 **to** 6/30/2029

INITIAL DURATION: 7/1/2021 **to** 6/30/2025

OPTIONS TO RENEW: ******Refer to RFR for options to renew and for the years for each option*******

FISCAL TERMS

Price is established through: (Check 1, 2, or 3)

☐ **OPTION 1: PRICE AGREEMENT (list price)**

$_____

Rate Regulation (if any) N/A

[ ] OPTION 2: SUMMARY BUDGET ("T" Lines only)

[ ] Unit Rate

[ ] Cost Reimbursement

[ ] Other _____

☑ **OPTION 3: COMPLETED BUDGET**

☐ Unit Rate

☑ Cost Reimbursement

[ ] Other _____

FUNDING SUMMARY

Prior Years		Current Years		Future Years	
FY	**Amount**	**FY**	**Amount**	**FY**	**Amount**
2022	$125,000.00	2025	$250,000.00	2026	$125,000.00
2023	$366,666.00			2027	$125,000.00
2024	$250,000.00				
Total:	$741,666.00	Total:	$250,000.00	Total:	$250,000.00
				Multi Years Total:	$1,241,666.00

Current Max Obligation: $_____ **Unit Rate: $**_____ **per** _____ **# Billable Units:** _____

Additional Payment or Price Specifications:

Commonwealth of Massachusetts
CONTRACTOR AUTHORIZED SIGNATORY LISTING

This form is jointly issued and published by the Office of the Comptroller (CTR) and the Operational Services Division (OSD) as the default form for all Commonwealth Departments when another form is not prescribed by regulation or policy.

Signature for Corporation (C or S), Partnership, Trust/Estate, Limited Liability Company (must match Form W-9 tax classification)

Contractor Legal Name	Contractor Vendor/Customer Code (if available, not the Taxpayer Identification Number or Social Security Number)

INSTRUCTIONS: Any Contractor (other than a sole-proprietor or an individual contractor) must provide a listing of individuals who are authorized as legal representatives of the Contractor who can sign contracts and other legally binding documents related to the contract on the Contractor's behalf. In addition to this listing, any state department may require additional proof of authority to sign contracts on behalf of the Contractor, or proof of authenticity of signature (a notarized signature that the Department can use to verify that the signature and date that appear on the Contract or other legal document was actually made by the Contractor's authorized signatory, and not by a representative, designee or other individual.)

For privacy purposes **DO NOT ATTACH** any documentation containing personal information, such as bank account numbers, social security numbers, driver's licenses, home addresses, social security cards or any other personally identifiable information that you do not want released as part of a public record. The Commonwealth reserves the right to publish the names and titles of authorized signatories of contractors.

There are three types of electronic signatures that will be accepted on this form: **1) Traditional "wet signature" (ink on paper); 2) Electronic signature that is either: a. hand drawn using a mouse or finger if working from a touch screen device; or b. An upload picture of the signatory's hand drawn signature; 3) Electronic signature affixed using a digital tool such as Adobe Sign or DocuSign.** Typed text of a name not generated by a digital tool, computer generated cursive, or an electronic symbol are not acceptable forms of electronic signature.

Authorized Signatory Name	Signature (Signature as it will appear on contract or other documents)	Title	Phone Number	Email Address

Acceptance of any payment under a Contract or Grant shall operate as a waiver of any defense by the Contractor challenging the existence of a valid Contract due to an alleged lack of actual authority to execute the document by the signatory.

I certify that I am a responsible authorized officer of the Contractor and as an authorized officer of the Contractor I certify that the names of the individuals identified on this listing are current as of the date of execution and that these individuals are authorized to sign contracts and other legally binding documents related to contracts with the Commonwealth of Massachusetts on behalf of the Contractor. I understand and agree that the Contractor has a duty to ensure that this listing is immediately updated and communicated to any state department with which the Contractor does business whenever the authorized signatories above retire, are otherwise terminated from the Contractor's employ, have their responsibilities changed resulting in their no longer being authorized to sign contracts with the Commonwealth or whenever new signatories are designated.

Please note you cannot self-certify your own signature as a single signer listed above.

Signature	Date
Print Name	Phone Number
Title	Email Address

A copy of this listing must be attached to the "record copy" of a contract filed with the department.

Scope of Services

Contract ID #: INTF2354M78220129158

Contract Amendment - Increase

MassCALL supports local planning and implementation of strategies to prevent substance use among youth.

Contract Conditions

Contract ID#: INTF2354M78220129158

We have read and will adhere and comply to the requirements in the attached Contract Conditions and Attachments.

Provider Name: CITY OF SOMERVILLE

Signature: _____

Date: _____

BSAS Terms and Conditions

Billing Requirements:

- Billing is to be submitted for services rendered each month on the 15th of the following month
- Payment is not guaranteed for invoices submitted greater than 90 days past the service date due to grant and funding restrictions/limitations.

Funding Notifications:

All vendors are required to provide detailed itemized unit cost breakdown and narrative information of the cost components that make up the summary total for the individual cost allocation line items listed under each Budget Cost category as part of their contract.

All funds must be spent in accordance with the approved budget for this contract, or subsequent approved line-item amendment.

Any funds designated in the budget that are unspent in any fiscal year will not be available for expenditure in the subsequent fiscal year.

All SAMSA Grant Funded Programs - Medication specific requirements:

a. Only U.S. Food and Drug Administration (FDA) – approved products that address opioid use disorder and/or opioid overdose can be purchased with these funds.
b. Funds may not be expended through the grant or a subaward by any agency which would deny any eligible client, patient or individual access to their program because of their use of FDA-approved medications for the treatment of 26 substance use disorders (e.g., methadone, buprenorphine products including buprenorphine/naloxone combination formulations and buprenorphine monoproduct formulations, naltrexone products including extended-release and oral formulations or long acting products such as extended release injectable or buprenorphine.) Specifically, patients must be allowed to participate in methadone treatment rendered in accordance with current federal and state methadone dispensing regulations from an Opioid Treatment Program and ordered by a physician who has evaluated the client and determined that methadone is an appropriate medication treatment for the individual's opioid use disorder. Similarly, medications available by prescription or office-based implantation must be permitted if it is appropriately authorized through prescription by a licensed prescriber or provider. In all cases, MOUD must be permitted to be continued for as long as the prescriber or treatment provider determines that the medication is clinically beneficial. Recipients must assure that clients will not be compelled to no longer use MOUD as part of the conditions of any programming if stopping is inconsistent with a licensed prescriber's recommendation or valid prescription.
c. No funding may be used to procure DATA waiver training by recipients or subrecipients of this funding. SAMHSA recipients must also comply with SAMHSA's standard funding restrictions. The current fiscal year standard terms and conditions for all SAMSHA funds are viewable at: Standard Terms and Conditions | SAMHSA

Your signature below indicates you have reviewed, and agree to comply with, all terms and conditions included in your contract as well as those listed above:

Signature: _____ Date: _____

Contract
» Contract Summary
» Fund Allocations
» Amendments
» Line Item Budgets
» Affiliates
» Activities
» Participating Organizations
» Account Mapping Rules

Contract# INTF2354M78220129158 - 2025 - CT - City of Somerville

Master Contract Number:	INTF2354M78220129158		
Fiscal Year:	2025	Contract Type:	COST
MMARS Version Number:	7	EIM Version Number:	60

Budget Number	Activity Code	Activity Name
1	4940	MOAPC

Select Accounting Line	Current Amount	Commodity Line Number	Accounting Line Number	Appropriation Number	Effective From	Effective To
☐	$0.00	9	1	45129058	07/01/2024	06/30/2025
☐	$130,472.94	8	1	45129069	07/01/2024	06/30/2025

Add Accounting Line Delete Accounting Line

Line Item Budget Components

Budget Maximum Obligation:	$250,000.00
Line Item Budget Total:	$250,000.00
Remaining Amount:	$0.00
Modified By:	Deinma Dikibo
Modified Date:	04/07/2025 07:50 AM
Created By:	Derek Westhaver
Created Date:	06/12/2023 11:46 AM
Comments:	

201 - Direct Care Program Consultants (Category 2. Other Direct Care/Program Resources)

Original FTE:		Original Amount:	$6,000.00
Expended Amount:	$0.00	Balance:	$6,000.00
Deficiency Amount:	$0.00		
Reimbursable Cost:	$6,000.00	Status:	Final

Current FTE:	N/A	Current Amount:	6000
Offset:	0	Source:	
	Delete		

203 - Provider Reimbursement/Stipends (Category 2. Other Direct Care/Program Resources)

Original FTE:		Original Amount:	$15,000.00
Expended Amount:	$4,375.00	Balance:	$12,625.00
Deficiency Amount:	$0.00		
Reimbursable Cost:	$17,000.00	Status:	Final

Current FTE:	N/A	**Current Amount:**	17000
Offset:	0	**Source:**	
	Delete		

204 - Staff Training (Category 2. Other Direct Care/Program Resources)

Original FTE:		**Original Amount:**	$6,704.00
Expended Amount:	$0.00	**Balance:**	$16,000.00
Deficiency Amount:	$0.00		
Reimbursable Cost:	$16,000.00	**Status:**	Final

Current FTE:	N/A	**Current Amount:**	16000
Offset:	0	**Source:**	
	Delete		

205 - Staff Mileage/Travel (Category 2. Other Direct Care/Program Resources)

Original FTE:		**Original Amount:**	$3,250.00
Expended Amount:	$0.00	**Balance:**	$3,250.00
Deficiency Amount:	$0.00		
Reimbursable Cost:	$3,250.00	**Status:**	Final

Current FTE:	N/A	**Current Amount:**	3250
Offset:	0	**Source:**	
	Delete		

206 - Subcontracted Direct Care (Category 2. Other Direct Care/Program Resources)

Original FTE:		**Original Amount:**	$200,196.00
Expended Amount:	$108,099.00	**Balance:**	$62,949.21
Deficiency Amount:	$0.00		
Reimbursable Cost:	$171,048.50	**Status:**	Final

Current FTE:	N/A	**Current Amount:**	171048.5
Offset:	0	**Source:**	
	Delete		

211 - Client Personal Allowances (Category 2. Other Direct Care/Program Resources)

Original FTE:		**Original Amount:**	$5,000.00
Expended Amount:	$0.00	**Balance:**	$5,000.00
Deficiency Amount:	$0.00		
Reimbursable Cost:	$5,000.00	**Status:**	Final

Current FTE:	N/A	**Current Amount:**	5000
Offset:	0	**Source:**	
	Delete		

215 - Program Supplies, Materials and Expendable Items of Equipment and Furnishings (Category 2. Other Direct Care/Program Resources)

Original FTE:		**Original Amount:**	$8,100.00
Expended Amount:	$2,052.00	**Balance:**	$19,648.73
Deficiency Amount:	$0.00		
Reimbursable Cost:	$21,701.50	**Status:**	Final

Current FTE:	N/A	**Current Amount:**	21701.5

Offset:	0	**Source:**	
	Delete		

410 - Agency and Program Administration and Support (Category 4. Administrative Support)

Original FTE:		**Original Amount:**	$20,000.00
Expended Amount:	$5,000.00	**Balance:**	$5,000.00
Deficiency Amount:	$0.00		
Reimbursable Cost:	$10,000.00	**Status:**	Final

Current FTE:	N/A	**Current Amount:**	10000
Offset:	0	**Source:**	
	Delete		

Finalize | Save Changes | Delete Line Item Budget | Add Line Item Budget Component

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: INTF2354M78220129158

Vendor Name - FEIN: CITY OF SOMERVILLE - 046001414

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	$125,000.00
				Grand Total of 2022			**$125,000.00**

Fiscal Year	CFDA	Appropriation	Grant Name	Agency Name	Start Date	End Date	Amount
2023		4512-9059	SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT	SAMHSA	07/01/2022	06/30/2023	$70,000.00
2023		4512-9069	SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT	SAMHSA	07/01/2022	06/30/2023	$125,000.00
2023	93.136	4512-9089	MASSACHUSETTS OVERDOSE DATA TO ACTION (MA OD2A) GRANT	CDC	07/01/2022	06/30/2023	$116,666.00
2023	93.959	4512-9058	SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT	SAMHSA	07/01/2022	06/30/2023	$55,000.00

				Grand Total of 2023			**$366,666.00**

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	$125,000.00
2024	93.959	4512-9058	SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT	SAMHSA	07/01/2023	06/30/2024	$125,000.00
				Grand Total of 2024			**$250,000.00**

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	$250,000.00
2025	93.959	4512-9058	SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT	SAMHSA	07/01/2024	06/30/2025	$0.00
				Grand Total of 2025			**$250,000.00**

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	$125,000.00
				Grand Total of 2026			**$125,000.00**

Fiscal Year	CFDA	Appropriation	Grant Name	Agency Name	Start Date	End Date	Amount
2027		4512-9069	SUBSTANCE ABUSE PREVENTION & TREATMENT BLOCK GRANT	SAMHSA	07/01/2026	06/30/2027	$125,000.00
				Grand Total of 2027			**$125,000.00**

M04 Standard Contract and M04/M78 Engagement Contract Budget Form

Fiscal Year: 2026	Vendor Name:	CITY OF SOMERVILLE
	Contract ID:	INTF2354M78220129158
	Budget #	1

NEW ONLY

BRIEF ENGAGEMENT SUMMARY - Enter Below					
UFR# Program Component -UFR# Codes Below on tab	**FTE**	**New Amount**	**Offset Amount**	***Offset Funding Source**	**New Budget Reimbursement Total**
101 Program Manager					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
150 Payroll Taxes					$0.00
151 Fringe Benefits					$0.00
Total Program Staff		**$0.00**	**$0.00**	**$0.00**	**$0.00**
301 Program Facilities					$0.00
390 Facilities Operations					$0.00
Total Occupancy		**$0.00**	**$0.00**	**$0.00**	**$0.00**
201 Consultant					$0.00
202 Temporary Help					$0.00
203 Prov. Reimb/Stipends					$0.00
204 Staff Training					$0.00
205 Staff mileage/travel					$0.00
206 Subcontract					$0.00
207 Meals					$0.00
208A Vehicle					$0.00
208B Vehicle Expenses					$0.00
208C Vehicle Depreciation					$0.00
211 Client Personal Allowances					$0.00
212 Provision of Material Goods					$0.00
213 Data Processing					$0.00
214 Commercial Income Resources					$0.00
215 Program Supplies					$0.00
Total Non Personal Exp.		**$0.00**	**$0.00**	**$0.00**	**$0.00**
216 Program Support					$0.00
Total Direct Administrative Exp.		**$0.00**	**$0.00**		**$0.00**
SUBTOTAL PROGRAM COSTS		**$0.00**	**$0.00**		**$0.00**
410 Agency Admin. Support Allocation					$0.00
PROGRAM TOTAL		**$0.00**	**$0.00**		**$0.00**

*If mulitiple funding sources, please indicate "various" on the column and provide backup listing all funding sources.
If any funds allocated to UFR# **206** Subcontract, a Subcontractor Identification List must be completed and submit to DPH by the provider/vendor

M04 Standard Contract and M04/M78 Engagement Contract Budget Form

Fiscal Year: 2027	Vendor Name:	CITY OF SOMERVILLE
	Contract ID:	INTF2354M78220129158
	Budget #	1

NEW ONLY

BRIEF ENGAGEMENT SUMMARY - Enter Below					
UFR# Program Component -UFR# Codes Below on tab	**FTE**	**New Amount**	**Offset Amount**	***Offset Funding Source**	**New Budget Reimbursement Total**
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202 Temporary Help					$0.00
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205 Staff mileage/travel					$0.00
206 Subcontract					$0.00
207 Meals					$0.00
208A Vehicle					$0.00
208B Vehicle Expenses					$0.00
208C Vehicle Depreciation					$0.00
211 Client Personal Allowances					$0.00
212 Provision of Material Goods					$0.00
213 Data Processing					$0.00
214 Commercial Income Resources					$0.00
215 Program Supplies					$0.00
Total Non Personal Exp.		**$0.00**	**$0.00**	**$0.00**	**$0.00**
216 Program Support					$0.00
Total Direct Administrative Exp.		**$0.00**	**$0.00**		**$0.00**
SUBTOTAL PROGRAM COSTS		**$0.00**	**$0.00**		**$0.00**
410 Agency Admin. Support Allocation					$0.00
PROGRAM TOTAL		**$0.00**	**$0.00**		**$0.00**

*If mulitiple funding sources, please indicate "various" on the column and provide backup listing all funding sources.
If any funds allocated to UFR# **206** Subcontract, a Subcontractor Identification List must be completed and submit to DPH by the provider/vendor

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF PUBLIC HEALTH

FY	
Contract ID	

SUBCONTRACTOR IDENTIFICATION LIST FOR NON-DIRECT CARE SERVICES

Deliverables which are a primary and integral part of the total program but which are furnished to the program, under contract, by another provider.

Vendor Name: **DPH Program Name:**

Submitted by: _____ Date: _____ Phone: _____
Provider/Vendor Authorized Signature

_____
Print Name

Approved by: _____ Date: _____ Phone: _____
DPH Program Manager

_____
Print Name

INSTRUCTIONS:
Vendors must complete and submit to DPH at the time of **initial contract execution** AND when **subcontract dollars and/or vendors are added or deleted**. (Including line item adjustments).This form must be signed by the DPH program representative to indicate program approval PRIOR TO the execution of said subcontract(s).

- Vendors are to complete this form each fiscal year when subcontracted $ are budgeted.
- Vendors are to complete this form with any amendments.
- Identify the Subcontractor and Federal ID number along with $ amounts and description of service provided in less than 200 words (Individuals are not recorded on this form)
- $ identified as TBD will require status updates which POS will request quarterly

Subcontractor Name	FEIN	Subcontract Amount	Deliverable	TBD
		$		☐
		$		☐
		$		☐
		$		☐
		$		☐

Subcontractors must agree to the Terms and Conditions set forth in the supportive procurement, which is part of this contract. Subcontracts must be in writing, in accordance with Section 9 of the Commonwealth Terms and Conditions or the Commonwealth Terms and Conditions for Human and Social Services. Vendors may use a standard subcontract template available through DPH contract managers. All subcontracts must be available for review by authorized agents of the Commonwealth. DPH may require the submission of any subcontract at any time during the contract period.

Updated: 9/25/2020