

LOS ANGELES COUNTY - DEPARTMENT OF MENTAL HEALTH

LEGAL ENTITY (LE) FUNDED PROGRAM/SUBPROGRAM REALLOCATION REQUEST FORM

LE Name _____ LE # _____ FY _____ Last Amendment # _____

In accordance with guidelines set forth in the DMH Policy, *Shifting Guidelines for the Legal Entity Agreement*, the above LE is requesting to shift within subprograms as shown below. The requested shift effective date is _____.

Shift From:

Funded Program	Subprogram	Beneficiary (e.g. EPSDT)	Original Alloc	Req Shift Amt	Proposed Alloc	
Report Name	Report Date	Claim Amt	as of Cutoff Date	% Utilization	SA(s) affected	Est. # of Clients Affected

Why is this allocation not being spent as intended?

Shift To:

Funded Program	Subprogram	Beneficiary (e.g. EPSDT)	Original Alloc	Req Shift Amt	Proposed Alloc	
Report Name	Report Date	Claim Amt	as of Cutoff Date	% Utilization	SA(s) affected	Est. # of Clients Affected

Why is this shift needed?

DMH use only:

	Print Name	Signature	Date	Recommendation
Lead DC	_____	_____	_____	☐ Approve as requested
Other	_____	_____	_____	☐ Approve with modification
Affected	_____	_____	_____	modified shift amount _____
DC(s)	_____	_____	_____	modified effective date _____
	_____	_____	_____	☐ Deny

Comments/Analysis:**Deputy Director Approval:**

Print Name _____ Signature _____ Date _____