

**State of North Carolina  
Department of Health and Human Services  
Division of Services for the Deaf and Hard of Hearing**

**AMENDMENT #2**

**Date:** January 25, 2023

**Contract Name:** Request for Application – Captioning Services

**Contract Number:** #30-DSDHH-95092-22

**Contract Description:** Contract Changes

**TERM:** The expiration of this contract remains January 2, 2024.

**REVISIONS:** The mileage rate for this contract is increased to 65.5 cents per mile. The invoice for the contract is revised and adjoined as Attachment A. A Microsoft Excel file of the invoice will be sent to each applicant that returns this Amendment #2.

All other terms and conditions of the RFA released on December 14, 2021, remain the same.

**INSTRUCTIONS:**

Return one properly executed copy of the amendment by completing the information below:

<b>Execute Amendment</b>	
<b>Contractor</b>	
<b>Authorized Signature</b>	
<b>Name Typed or Printed</b>	
<b>Date</b>	

Mail by USPS or email one (1) copy of all documents to:

<b>DHHS/DSDHH</b> <b>Dianne Shearer, Assistant Director - <a href="mailto:dianne.shearer@dhhs.nc.gov">dianne.shearer@dhhs.nc.gov</a></b> <b>820 S. Boylan Avenue – 2301 MSC - Raleigh, NC 27699-2301</b>
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**Amendment # 2 Acceptance (For DHHS use only)**

By my undersigned signature, as an authorized representative of the Division of Services for the Deaf and Hard of Hearing, I hereby accept this executed Amendment #2.

By:

\_\_\_\_\_  
Signature of Authorized Representative

Jan Withers  
\_\_\_\_\_  
Printed Name of Authorized Representative

\_\_\_\_\_  
Director  
Title of Authorized Representative

\_\_\_\_\_  
Date

ATTACHMENT A

DHHS Captioning Invoice for Agency/Individual Contractor				
Agency Name: _____ Captionist Name: _____ Address: _____ City: _____ State: _____ Zip: _____	<b>INVOICE #</b> _____  <b>DATE SUBMITTED:</b> First Submission <input checked="" type="checkbox"/> Re-Submission <input type="checkbox"/> Past Due or Late <input type="checkbox"/>			
<b>BILL TO:</b> DHHS Division or Office Name: _____ DSDHH Attention: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Email: _____	<i>Questions pertaining to the Captioning RFA and any resulting addendums should be referred to the Hard of Hearing Services Coordinator at the Division of Services for the Deaf and the Hard of Hearing at 919.351.2206 (VP) or tony.davis@dhhs.nc.gov</i>  <i>Questions regarding the invoice and/or the assignment should be referred to the requestor.</i>			
ASSIGNMENT INFORMATION				
Date of Assignment: _____	Requestor: _____			
Consumer Name: _____				
Description of Assignment: _____				
Original Hours Scheduled: _____	Start Time: _____	End Time: _____		
Hours Billed: _____	Start Time: _____	End Time: _____		
Services Provided (Select from drop down box)				
Remote CART \$100 hr Standard/\$105 hr Enhanced				
	Total Hours	Rate Per Hour		Services Total
Standard Rate (M-F 7am to 5pm)	0	0	\$	-
Enhanced Rate (Evenings, Weekends, Holidays):		0		\$0.00
Flat Rate				\$0.00
<b>SERVICES TOTAL:</b>				<b>\$0.00</b>
Travel and Other Expenses				
<input type="checkbox"/> One Way <input type="checkbox"/> Roundtrip		Number of Miles	Rate Per Mile	Mileage Total
From: _____			0.655	
To: _____				\$0.00
Meals				
Meals will be reimbursed based on state rates. For any service taking place in North Carolina, the rate is Breakfast (8.40), Lunch (11), Dinner (18.90). For any service out of North Carolina, the rate is Breakfast (8.40), Lunch (11), Dinner (21.60)		Breakfast	Lunch	Dinner
				Meal Total
				\$0.00
				\$0.00
Other Expenses (e.g., Hotel, Parking), please attach receipt.				\$0.00
<b>TRAVEL TOTAL:</b>				<b>\$0.00</b>
GRAND TOTAL				
Total Services Provided:				<b>\$0.00</b>
Total Mileage & Other Expenses:				<b>\$0.00</b>
<b>TOTAL INVOICED:</b>				<b>\$0.00</b>
For DHHS Agency Use Only				
Reviewed By: _____				
Title: _____				
Date: _____				
Approved By: _____				
Title: _____				
Date: _____				
Budget Code: 2601 1261 1836 2T 532199035				
Ver 1/25/2023				