

Ohio Department of Medicaid
REQUEST FOR CONTRACT RESOURCES TEMPLATE

Section A: General Information

Submission Date: [Click here to enter date](#)
Submitter's Name: [Click here to enter name](#)
Submitter's Phone Number: [Click here to enter telephone number](#)
Submitter's Office/Bureau Name: [Click here to enter name](#)
Contract: [Choose an item](#)
Specify if "Other" is selected: [Click here to enter text](#)

Section B: Request Specifications

Type of Request: [Choose an item](#)

Detailed description of Contract Resource Need:

Description should include: start and end dates for the requested contract resource. Federal or state authorization. Identify whether contract resource request is associated with larger Medicaid project, and if yes, describe it and explain how this contract resource request supports the project.

[Click here to enter description](#)

Narrative description of the type of contract resource needed and details of the specific work needed. Available contract resources: financial analysis and modeling; reimbursement system development; waiver construction/modification; regulatory analysis, stakeholder negotiations; program development/modeling; technical writing including RFP, grant application, business requirements; project management; business transformation, communications.)

[Click here to enter description](#)

Estimated hours associated with the request: [Click here to enter hours](#)

If applicable, identify an associated Advanced Planning Document: [Choose an item](#)

Identify OHP Project Manager and Team members: [Click here to enter text](#)

Section C: Approvals (Sign and Date)

Bureau Chief: _____

Resource Contract Manager/Supervisor: _____

OHP Assistant Deputy Director: _____

Section D: Contract Resource Manager Use Only

	SFY12	SFY13
Total Approved Hours	Click here to enter hours	Click here to enter hours
Estimated Cost (all funds)	Click here to enter cost	Click here to enter cost
Estimated state share	Click here to enter text	Click here to enter text
Est. federal share @ 50%	Click here to enter text	Click here to enter text
Est. federal share @ 75%	Click here to enter text	Click here to enter text
Est. federal share @ 90%	Click here to enter text	Click here to enter text
Fund/ALI	Click here to enter text	Click here to enter text

Purchase Order Line: [Choose an item](#)

Task Number: [Enter text](#)

Vendor Resource:

- | | Hours |
|---|-----------------------------|
| <input type="checkbox"/> Medicaid Regulatory Analyst | Enter Hours |
| <input type="checkbox"/> Medicaid Financial/Budget Analyst | Enter Hours |
| <input type="checkbox"/> Medicaid Program Specialist | Enter Hours |
| <input type="checkbox"/> Medicaid Program Researcher | Enter Hours |
| <input type="checkbox"/> Medicaid Program Evaluator | Enter Hours |
| <input type="checkbox"/> Medicaid Communications, Outreach, Training Specialist | Enter Hours |
| <input type="checkbox"/> Medicaid Business Transformation Facilitator | Enter Hours |
| <input type="checkbox"/> Medicaid Business Researcher | Enter Hours |
| <input type="checkbox"/> Medicaid Technical Writer | Enter Hours |
| <input type="checkbox"/> Medicaid Program Evaluator | Enter Hours |

Date of Impact Analysis approval: [Click here to enter date](#)