State of California - Health and Human Services Agency **REQUEST FOR RATE ADJUSTMENT -- STAFFING CHANGE** Form DS 1967 (Rev 3/05)

Facility:	Vendor #:	Date:
Contact:	Title:	Phone:
Reason for Request:	Effective date of the change:	
Average daily consumer enrollment (Include ALL consumers for ALL WAC programs	3)	

Proposed New Positions

Title	Full Time	Part Time	Est Hire	Estimated Annual Expense		
		%	Date	Gross	Tax/FB	Total

ADDITIONAL ANNUAL PERSONNEL COSTS

(Attach Tab A showing cost distribution)

STAFF CHANGES DUE TO ADJUSTMENT IN SUBSIDIES:

Current Positions

Title	Current Annual	Source of Subsidy	Current Annual Subsidy	Current Net Annual Expense			
	Gross			Gross	Tax/FB	Total	

CURRENT ANNUAL COST

Subsidy Adjustment:

Title		Date New Subsidy Annual	Revised Net Annual Expense			
	Gross	Changed	Subsidy	Gross	Tax/FB	Total
NEW ANNUAL COST						
NET ADDITIONAL ANNUAL COST						
(Attach Tab A showing cos					st distribution)	

(Do not write in this space. For Habilitation computations.)