OMB Control Number: 2900-XXXX
Estimated burden: 15 minutes
Expiration Date: XX/XX/20XX

Department of Veterans Affairs

U.S. Department of Veterans Affairs

TELEHEALTH GRANT PROGRAM (THGP)

Program and Budget Changes

VA Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 2900-XXXX, and it expires XX/XX/20XX. Public reporting burden for this collection of information is estimated to average 15 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden, to VA Reports Clearance Officer at VACOPaperworkReduAct@va.gov. Please refer to OMB Control No. 2900-XXXX in any correspondence. Do not send your completed VA Form 10-398 to this email address.

Privacy Act Statement: VA is asking you to provide the information requested in this form under the authority of section 701 of Public Law 116-171 for VA to determine your eligibility to receive a grant under the Telehealth Grant Program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information for: civil or criminal law enforcement; congressional communications; the collection of money owed to the United States; litigation in which the United States is a party or has interest; the administration of VA grant programs, including verification of your eligibility to participate; and personnel administration. You do not have to provide the requested information to VA; but if you do not, VA may be unable to process your request for consideration in this program. If you provide VA with your Employer Identification Number (EIN), VA will use it to obtain information relevant to determining whether to award a grant and to administer your grant, if awarded. This information also may be used for other purposes as authorized or required by law.

Grantee Name: _____
Grant Award Number: _____
Grant Amount: _____
Name and Title of Contact Completing Form:
_____
Contact Email: _____

Date of Request: _____

Service Area:

Current Geographical Area Served:

Are you requesting a change to your geographical service area?

Please list new Counties and provide justification for this change using current statistics, demand for serving new area, and a description of outreach attempts in the space below:

Community Partner Management

Are you terminating an agreement with a funded community partner?

☐ Yes ☐ No

Removed Agency 1 _____

Provide a justification for removing service and how service provision will continue.

Removed Agency 2 _____

Provide a justification for removing service and how service provision will continue.

Are you requesting to add a funded Community Partner not previously in this year's grant resolution?

☐ Yes ☐ No

New Agency 1 _____

Proposed funded amount _____

List all suicide prevention services to be provided by this Agency.

New Agency 2 _____

Proposed funded amount _____

List all suicide prevention services to be provided by this Agency.

Budget Modification

Are you adding a new position/service that will result in an additional line item on your approved budget?

☐ Yes ☐ No

Line item 1 _____

FTE _____ FTE % _____ Amount _____

Line-item description (duties or service)

Are you adding a new position/service that will result in an additional line item on your approved budget?

☐ Yes ☐ No

Line item 1 _____

FTE _____ FTE % _____ Amount _____

Line-item description (duties or service)

I certify that I am authorized to submit this program changes for the above Telehealth Grant Program agreement.

_____ _____

Signature Date