

**CERTIFICATION OF SOLE SOURCE STATUS FOR
CONTINUITY OF CARE IN HUMAN SERVICES PROGRAMS**

RE: _____ Name of Provider DHMH Vendor
No. _____

Service Provided

_____ Period of Original Contract
Period of Renewal Request

Amount of New Contract

By my signature, I certify that a change in the human services provider will have a detrimental effect on the client population served under this contract. This determination is based either on independent utilization reviews, or on periodic evaluations and reviews performed by the contracting agencies. The authority for renewing this contract without competition is section 13-107 of the Maryland State Finance and Procurement Article, and COMAR 21.14.01.06C(1)(b).

_____ Signature of Program Head or
Title _____
Designee

_____ Name (printed)
Date _____

