

AMENDMENT 2006-2007

TO AGREEMENT FOR SERVICES OF INDEPENDENT CONTRACTOR

This is an amendment (hereafter referred to as the "Amended Contract") to the Agreement for Services of Independent **CONTRACTOR**, number **BC05-016** by and between the **COUNTY of Santa Barbara (COUNTY)** and **People Helping People (CONTRACTOR)**, for the continued provision of Medi-Cal mental health services.

Whereas, **COUNTY** intends to extend the term of the existing contract through Fiscal Year 06-07 and to compensate **CONTRACTOR** for the services to be provided during that Fiscal Year; and

Whereas, this Amended Contract incorporates the terms and conditions set forth in the original contract, approved by the **COUNTY** Board of Supervisors on 8/3/04, except as modified by this Amended Contract.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, **COUNTY** and **CONTRACTOR** agree as follows:

- I. **Delete Item 4, TERM, of the Agreement and replace with the following:**
 4. **TERM. CONTRACTOR** shall commence performance on **July 1, 2006**, and end performance upon completion, but no later than **June 30, 2007**, unless otherwise directed by **COUNTY** or unless earlier terminated.
- II. **Delete Item 1, (Paragraph 1 and 2) of Exhibit B, Payment Arrangements, and replace with the following:**

EXHIBIT B PAYMENT ARRANGEMENTS

1. **CONTRACTOR SERVICES.** For **CONTRACTOR** services to be rendered under this Agreement, **CONTRACTOR** shall be paid at the rate specified in the Schedule of Fees (Exhibit B-1), attached hereto and with this reference made a part hereof, with a maximum value not to exceed \$120,000.

- III. **Delete Exhibit B-1, Payment Arrangements, and replace with the following:**

EXHIBIT B-1 SCHEDULE OF RATES:

AMENDMENT 2006-2007
SIGNATURE PAGE

Amended Contract for Services of Independent Contractor between the County of Santa Barbara and People Helping People for FY 2006-2007.

IN WITNESS WHEREOF, the parties have executed this Amended Contract to be effective on the date executed by COUNTY.

COUNTY OF SANTA BARBARA

By: _____

Chair, Board of Supervisors

Date: _____

CONTRACTOR:

By: _____

Tax ID No. 77-0338060

ATTEST:

MICHAEL F. BROWN
CLERK OF THE BOARD

By: _____
Deputy

APPROVED AS TO FORM:
STEPHEN SHANE STARK
COUNTY COUNSEL

By: _____
Deputy COUNTY Counsel

APPROVED AS TO FORM:
ROBERT W. GEIS, CPA
AUDITOR-CONTROLLER

By: _____
Deputy

APPROVED AS TO FORM:
ALCOHOL, DRUG, AND MENTAL HEALTH
SERVICES
JAMES L. BRODERICK, Ph.D.
DIRECTOR

By: _____
Director

APPROVED AS TO INSURANCE FORM:
RAY AROMATORIO
RISK PROGRAM ADMINISTRATOR

By: _____
Risk Program Administrator

AMENDMENT 2006-2007

Complete data below, print, obtain signature of authorized departmental representative, and submit this form (and attachments) to the Clerk of the Board (>\$25,000) or Purchasing (<\$25,000). See also "Contracts for Services" policy. Form is not applicable to revenue contracts.

D1. Fiscal Year..... 06-07
 D2. Budget Unit Number 043
 D3. Requisition Number
 D4. Department Name Alcohol, Drug, & Mental Health
 D5. Contact Person Jack Juntunen
 D6. Telephone..... (805) 681-4090

K1. Contract Type (check one): Personal Service Capital
 K2. Brief Summary of Contract Description/Purpose Medi-Cal mental health services
 K3. Contract Amount..... \$120,000
 K4. Contract Begin Date 7/1/2006
 K5. Original Contract End Date 6/30/2006
 K6. Amendment History

Seq#	Effective Date	ThisAmndtAmt	CumAmndtToDate	NewTotalAmt	NewEndDate	Purpose
1	7/1/06	\$120,000	\$120,000	\$120,000	6/30/07	Add funds and change date

B1. Is this a Board Contract? (Yes/No)..... Yes
 B2. Number of Workers Displaced (if any)..... N/A
 B3. Number of Competitive Bids (if any)..... N/A
 B4. Lowest Bid Amount (if bid)..... N/A
 B5. If Board waived bids, show Agenda Date N/A
 and Agenda Item Number.....
 B6. Boilerplate Contract Text Unaffected? (Yes / or cite

F1. Encumbrance Transaction Code 1701
 F2. Current Year Encumbrance Amount..... \$120,000
 F3. Fund Number..... 0044
 F4. Department Number 043
 F5. Division Number (if applicable)
 F6. Account Number 7460
 F7. Cost Center number (if applicable)
 F8. Payment Terms

V1. Vendor Numbers (A=Auditor; P=Purchasing)
 V2. Payee/Contractor Name People Helping People
 V3. Mailing Address 545 N. Alisal Rd., Suite 102
 V4. City, State (two-letter) Zip (include +4 if known) Solvang, CA 93463
 V5. Telephone Number 8056860295
 V6. Contractor's Federal Tax ID Number (EIN or SSN) 77-0338060
 V7. Contact Person Dean Palius
 V8. Workers Comp Insurance Expiration Date..... 4/1/2007
 V9. Liability Insurance Expiration Date(s) (G=Genl; GL 7/16/2006; PL 7/16/2006
 V10. Professional License Number.....
 V11. Verified by (name of county staff) Jack Juntunen
 V12. Company Type (Check one): Sole Proprietorship Partnership Corporation

I certify information complete and accurate; designated funds available; required concurrences evidenced on signature page.

Date: _____ Authorized Signature: _____

**ALCOHOL DRUG AND MENTAL HEALTH SERVICES
EXHIBIT B -1
SCHEDULE OF RATES & CONTRACT MAXIMUM
FY0607**

FEE FOR SERVICE

SANTA YNEZ VALLEY PEOPLE HELPING PEOPLE	Amount						
<p style="text-align: center;"><u>TOTAL CONTRACT GROSS VALUE</u></p> <p style="text-align: right;">Children System of Care - MHS 120,000 Less Administrative Fee (15%) 18,000 NET CONTRACT AMOUNT: <u>102,000</u></p>	<p>\$ 120,000</p>						
<p style="text-align: center;"><u>MEDI-CAL PRODUCTIVITY TARGET</u></p> <p style="text-align: right;">Children System of Care - MHS 120,000</p>	<p>\$ 120,000</p>						
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><u>Location</u></th> <th style="text-align: left;"><u>Reporting Unit</u></th> <th style="text-align: left;"><u>Name</u></th> </tr> </thead> <tbody> <tr> <td style="text-align: center;">9152</td> <td style="text-align: center;">91521</td> <td>MH Outpatient Services</td> </tr> </tbody> </table>	<u>Location</u>	<u>Reporting Unit</u>	<u>Name</u>	9152	91521	MH Outpatient Services	<p>N/A</p>
<u>Location</u>	<u>Reporting Unit</u>	<u>Name</u>					
9152	91521	MH Outpatient Services					

NEGOTIATED RATES FY 0506

Category	Mode of Service	Service Function Code	Negotiated Rates/Per min FY 0506 **
Case Management, Brokerage	15	01 - 09	1.95
Mental Health Services	15	10 - 19	2.52
Mental Health Services	15	30 - 59	2.52
Crisis Intervention	15	70 - 79	3.75

**** To be revised upon receipt of State approved rates for FY 0607**