SECOND AMENDMENT

TO AGREEMENT FOR SERVICES OF CONTRACTOR ON PAYROLL

This is an amendment (hereafter referred to as the "Second Amended Contract") to the Agreement for Services of a **CONTRACTOR ON PAYROLL**, number **BC 05-020**, by and between the **County of Santa Barbara** (**COUNTY**) and **Aileen Kroll** (**CONTRACTOR**), for the continued provision of Patient Rights Advocate Services.

Whereas, this Second Amended Contract incorporates the terms and conditions set forth in the contract approved by the **COUNTY** Board of Supervisors in June 2007, the First Amendment approved by the ADMHS Director in March 2008, except as modified by this Second 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 Exhibit B, Compensation, and replace with the following:

COUNTY shall pay **CONTRCTOR** for professional services pursuant to this Agreement upon biweekly submission by **CONTRACTOR** of a timesheet, and such payment shall be subject to deductions and withholding of state and federal taxes. In no event shall the compensation payable exceed the total sum of $78500 without written amendment. This not to exceed amount includes the following:

- $73,800 for 1882 hours of work by **CONTRACTOR** at the rate of $39.21 per hour.
- $4,700 for 120 hours of paid leave paid via payroll.

SECOND AMENDMENT

SIGNATURE PAGE

Amendment to Agreement for Services of Independent **CONTRACTOR** between the COUNTY of Santa Barbara and Aileen Kroll.

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

ATTEST:
MICHAEL F. BROWN
CLERK OF THE BOARD

By: _____
Deputy
Date: _____

COUNTY OF SANTA BARBARA

By: _____
Chair, Board of Supervisors
Date: _____

APPROVED AS TO FORM:
CEO/HUMAN RESOURCES

By:_____
Human Resources Director
Date: _____

CONTRACTOR

By:_____
Tax Id No 050-48-8107.
Date: _____

APPROVED AS TO FORM:
DANIEL J. WALLACE,
COUNTY COUNSEL

By_____
Deputy County Counsel
Date: _____

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

By_____
Deputy
Date: _____

APPROVED AS TO FORM :
ALCOHOL, DRUG, AND MENTAL HEALTH SERVICES
ANN DETRICK, PH.D.
DIRECTOR

By_____
Director
Date: _____

APPROVED AS TO INSURANCE FORM:
RAY AROMATORIO
RISK PROGRAM ADMINISTRATOR

By: _____

Date: _____

SECOND AMENDMENT

CONTRACT SUMMARY PAGE **BC 05-020**

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 07-08
D2. Budget Unit Number 043
D3. Requisition Number .....
D4. Department Name ..... Alcohol, Drug, & Mental Health Services
D5. Contact Person ..... Christy Toma
D6. Telephone ..... (805) 681-4090

K1. Contract Type *(check one)*: ρ Personal Service ρ Capital
K2. Brief Summary of Contract Description/Purpose ..... Serves as Patients Rights Advocate
K3. Contract Amount $78500
K4. Contract Begin Date 7/1/07
K5. Original Contract End Date 6/30/08
K6. Amendment History ……

Seq#	Effective Date	ThisAmndtAmt	CumAmndtToDate	NewTotalAmt	NewEndDate	Purpose
1	7/1/07			61,200	6/30/08	Renew for 07-08
2	7/1/07	3,480	5,880	64,680	6/30/08	Add hours & funds
3	7/1/07	13,820	17,300	78,500	6/30/08	Add hours & funds

B1. Is this a Board Contract? *(Yes/No)* ..... True
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 Paragraph)* ...

F1. Encumbrance Transaction Code 1701
F2. Current Year Encumbrance Amount $78500
F3. Fund Number 0044
F4. Department Number 043
F5. Division Number *(if applicable)* .....
F6. Account Number 6177
F7. Cost Center number *(if applicable)* 2120
F8. Payment Terms .....

V1. Vendor Numbers (A=Auditor; P=Purchasing) EID .....
V2. Payee/Contractor Name ..... Aileen Kroll
V3. Mailing Address ..... 9002 McCloud Road.
V4. City, State (two-letter) Zip (include +4 if known) ..... Ventura, CA 93004
V5. Telephone Number 8056814735
V6. Contractor's Federal Tax ID Number *(EIN or SSN)* .....
V7. Contact Person ..... Aileen Kroll
V8. Workers Comp Insurance Expiration Date ..... N/A
V9. Liability Insurance Expiration Date[s] ..... N/A
V10. Professional License Number .....
V11. Verified by (name of county staff) ..... Erin Jeffery
V12 Company Type *(Check one):* ☒ Individual ρ Sole Proprietorship ρ Partnership ρ Corporation

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

Date: _____ Authorized Signature: _____