

SEVENTH AMENDMENT 2008-2009

TO AGREEMENT FOR SERVICES OF INDEPENDENT CONTRACTOR

This is an amendment (hereafter referred to as the "Seventh Amended Contract") to the Agreement for Services of Independent Contractor, number **BC 05-086**, by and between the **County of Santa Barbara** (County) and **Good Samaritan Shelter** (Contractor), for the continued provision of **Treatment, detox, perinatal case management, transitional living services**.

Whereas, this Seventh Amended Contract incorporates the terms and conditions set forth in the contract approved by the County Board of Supervisors in August 2004, the First Amendment approved by the County Board of Supervisors in January 2005, the Second Amendment approved by the County Board of Supervisors in July 2005, the Third Amendment approved by the County Board of Supervisors in June 2006, the Fourth Amendment approved by the County Board of Supervisors in July 2007, the Fifth Amendment approved by the ADMHS Director in February 2008, and the Sixth Amendment approved by the County Board of Supervisors in June 2008, except as modified by this Seventh 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 1, Paragraph 1, of Exhibit B, Payment Arrangements, and replace with the following:**
 1. **CONTRACTOR SERVICES.** For Contractor services to be rendered under this Agreement, Contractor shall be paid at the rate specified in the Schedule of Services (Exhibit B-1), attached hereto and with this reference made a part hereof, with a maximum value not to exceed **\$1272987**.
- II. **Delete Exhibit B-1, Schedule of Services, and replace with the following:**

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**EXHIBIT B-1
SCHEDULE OF SERVICES**

The program services, as listed below, described in Exhibit A and the Provider Workbook, will be reimbursed according to rates shown on County's invoice and in the Provider Workbook. County and Contractor have mutually agreed to the program services as outlined in the Provider Workbook; County shall provide Contractor with a signed copy of the Provider Workbook.

Specific services shall conform to California Department of Alcohol and Drug Programs service code as defined in Exhibit A.

TYPE OF SERVICE	Total Annual Provisional Amount
NON-RESIDENTIAL	
Outpatient Drug Free (ODF) services – (Adult) consisting of individual (including crisis visits) and group counseling (including family counseling), and SATTA Drug Testing (NNA, SACPA and SATTA)	\$531,675
RESIDENTIAL DETOX	
Residential Detox and SATTA Drug Testing: (NNA, SACPA, ADP CalWORKs and SATTA)	
CRISIS AND RECOVERY EMERGENCY SERVICES (CARES) NORTH COUNTY	
PERINATAL TREATMENT SERVICES	
Transitional Living Center – Perinatal (NNA Only)	
Outpatient Drug Free (ODF) services for pregnant & parenting women (beyond 60 days postpartum), consisting of individual and group counseling (NNA)	\$741,312
Transportation – for perinatal clients to and from treatment services (NNA Only)	
Perinatal Child Care services (NNA Only)	
SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION (SAMHSA) GRANT	
First Steps System of Care Perinatal Residential Treatment Project (begun December 1, 2004)	
Total Funding in FY 08-09	\$1272987
The negotiated rate, units of service and maximum monthly billable amount is reflected on the invoice form and based upon Contractor's program budget, prior year cost report and contract negotiations with County, all contained in the Provider Workbook.	

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SIGNATURE PAGE

Amendment to Agreement for Services of Independent Contractor between the County of Santa Barbara and Good Samaritan Shelter.

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

COUNTY OF SANTA BARBARA

By: _____
SALUD CARBAJAL
CHAIR, BOARD OF SUPERVISORS
Date: _____

ATTEST:
MICHAEL F. BROWN
CLERK OF THE BOARD

CONTRACTOR

By: _____
Deputy
Date: _____

By: _____
Tax Id No 77-0133375.
Date: _____

APPROVED AS TO FORM:
DENNIS MARSHALL
COUNTY COUNSEL

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

By _____
Deputy County Counsel
Date: _____

By _____
Deputy
Date: _____

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

APPROVED AS TO INSURANCE FORM:
RAY AROMATORIO
RISK PROGRAM ADMINISTRATOR

By _____
Director
Date: _____

By: _____
Date: _____

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CONTRACT SUMMARY PAGE

BC 05-086

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..... 08-09
 D2. Budget Unit Number 043
 D3. Requisition Number.....
 D4. Department Name Alcohol, Drug, & Mental Health Services
 D5. Contact Person..... Erin Jeffery
 D6. Telephone..... (805) 681-5168

K1. Contract Type (check one): Personal Service Capital
 K2. Brief Summary of Contract Description/Purpose Treatment, detox, perinatal case
 K3. Contract Amount..... \$1272987
 K4. Contract Begin Date 7/1/2008
 K5. Original Contract End Date 6/30/05
 K6. Amendment History

Seq#	Effective Date	ThisAmndtAmt	CumAmndtToDate	NewTotalAmt	NewEndDate	Purpose
1	7/1/08	1151519		1151519	6/30/09	Renew for 08-09
2	7/1/08	121468	1272987	1272987	6/30/09	Add expansion 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)... Yes
 F1. Encumbrance Transaction Code..... 1701
 F2. Current Year Encumbrance Amount \$1272987
 F3. Fund Number..... 0044
 F4. Department Number..... 043
 F5. Division Number (if applicable)..... N/A
 F6. Account Number..... 7460
 F7. Cost Center number (if applicable)..... 6240
 F8. Payment Terms Net 30

V1. Vendor Numbers (A=Auditor; P=Purchasing) EID A= 324348
 V2. Payee/Contractor Name Good Samaritan Shelter
 V3. Mailing Address 401 B W. Morrison.
 V4. City, State (two-letter) Zip (include +4 if known) Santa Maria, CA 93458
 V5. Telephone Number..... 8053468185
 V6. Contractor's Federal Tax ID Number (EIN or SSN) 77-0133375
 V7. Contact Person..... Sylvia Barnard Executive Director
 V8. Workers Comp Insurance Expiration Date 6/15/2009
 V9. Liability Insurance Expiration Date[s] 9/18/2008
 V10. Professional License Number Recovery Point Detox -
 V11. Verified by (name of county staff)..... Erin Jeffery
 V12. Company Type (Check one): Individual Sole Proprietorship Partnership Corporation

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

Date: _____ Authorized Signature: _____