Contract Summary Form: Contract Number : 05 - 01094 - - -

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*

D1. Fiscal Year .....: FY 06/07
D2. Budget Unit # ***(****plus -Ship/-Bill codes in paren's* ***)***: 044
D3. Requisition Number .....:
D4. Department Name.....: Social Services
D5. Contact Person .....: Davida Willis
D6. Phone .....: 614-1251

K1. Contract Type *(check one)*: [X] Personal Service [ ] Capital Project/Construction
K2. Brief Summary of Contract Description/Purpose .: Provides health insurance for qualified IHSS caregivers
K3. Original Contract Amount .....: $1,286,400
K4. Contract Begin Date.....: 1-1-05
K5. Original Contract End Date.....: 12-31-05
K6. Amendment History *(leave blank if no prior amendments)*:

Seq#	*EffectiveDate*	*ThisAmndtAmt*	*CumAmndtToDate*	*NewTotalAmt*	*NewEndDate*	*Purpose (2-4 words)*
1	1-1-06	$1,262,280	$1,262,280	$2,600,505	12-31-06	Contract Renewal
2	1-1-07	$1,286,400	$2,548,680	$5,149,185	12-31-07	Contract Renewal

K7. Department Project Number .....:

B1. Is this a Board Contract? *(Yes/No)* .....: Yes
B2. Number of Workers Displaced *(if any)*.....: none
B3. Number of Competitive Bids *(if any)* .....: none
B4. Lowest Bid Amount *(if bid)* .....: $
B5. If Board waived bids, show Agenda Date.....: N/A
B6. ... and Agenda Item Number.....: N/A
B7. Boilerplate Contract Text Unaffected? *(Yes / or cite ¶¶)*: Due to the specific Knox-Keene requirements, Santa Barbara Regional Health Authority provided the contract language.

F1. Encumbrance Transaction Code .....: 1701
F2. Current Year Encumbrance Amount .....: $
F3. Fund Number.....: 0056
F4. Department Number.....: 044
F5. Program Number.....: 3048
F6. Account Number.....: 7662
F7. Org. Unit Number .....: 5328
F8. Payment Terms ..... Net 30

V1. Vendor Numbers *(A=uditor; P=urchasing)* .....: A 425183
V2. Payee/Contractor Name.....: Santa Barbara Regional Health Authority
V3. Mailing Address.....: 110 Castilian Dr.
V4. City State *(two-letter)* Zip *(include +4 if known)*: Goleta, CA 93117
V5. Telephone Number.....: 805-685-9525
V6. Contractor's Federal Tax ID Number *(EIN or SSN)*: 95-3865941
V7. Contact Person.....: R. Lyle Luman
V8. Workers Comp Insurance Expiration Date.....: n/a
V9. Liability Insurance Expiration Date[s] *(G=enl; P=rofl)*:n/a
V10. Professional License Number.....: n/a
V11. Verified by *(name of County staff)* .....: Davida Willis
V12. Company Type *(Check one)*: [ ] Individual [ ] Sole Proprietorship [ ] Partnership [X] Corporation [ ] Educational Institution

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

Authorized Signature: _____

(Co of SB Std Terms Ver 4-21-95)