

**AGREEMENT  
PROFESSIONAL SERVICES CONTRACT  
BETWEEN SANTA BARBARA COUNTY ALCOHOL, DRUG & MENTAL HEALTH  
SERVICES  
AND  
IRWIN LUNIANSKI, MD.**

**BC # 07-128**

COP less than half-time

The County of Santa Barbara, a political subdivision of the State of California, hereinafter called "**COUNTY**", does hereby enter into agreement with **Irwin Lunianski, MD** hereinafter called "**CONTRACTOR**", as follows:

1. **TERM**

The term of this Agreement shall be **2/26/2007** through **6/30/2007**, subject to extension or termination as hereinafter provided.

2. **DIRECTION AND SUPERVISION**

**CONTRACTOR** will report to the Director of Alcohol, Drug & Mental Health Services or his designee(s). Designee(s) will be named in writing and may be changed from time-to-time, as necessary.

3. **CONTRACTOR DUTIES.** Specific duties are listed in Exhibit A, which is attached hereto and made a part of this Agreement by reference.

4. **COMPENSATION OF CONTRACTOR.** **CONTRACTOR** shall be paid for performance under this Agreement in accordance with the terms of EXHIBIT B attached hereto and incorporated herein by reference. The maximum payment under this Agreement shall not be exceeded without a written notice from **COUNTY**.

5. **CONTRACTOR ON PAYROLL STATUS.** **CONTRACTOR** understands and agrees that **CONTRACTOR'S** term of employment is governed solely by this Agreement; and that no right of tenure is created hereby; and that **CONTRACTOR** does not and will not, by virtue of this Agreement, hold a position in any department or office of the **COUNTY** under this Agreement; and that **CONTRACTOR'S** services to the **COUNTY** under this Agreement are authorized pursuant to Government Code §31000. **CONTRACTOR** warrants that **CONTRACTOR** is fully licensed to perform all work contemplated in this Agreement, and **CONTRACTOR** agrees to submit verification of licensure.

6. **BENEFITS**

Benefits payable to **CONTRACTOR** pursuant to this Agreement are limited to:

A. Standard benefits: Employer's share of either Social Security (aka FICA) or the Social Security alternative Plan (aka SSAP); employer's share of federal Medicare health insurance; County workers' compensation insurance; State unemployment insurance; and travel expense reimbursement for mileage claims with prior written authorization.



## **AGREEMENT**

requirements of the Community Mental Health Services plan and policy as administered by the **COUNTY'S** Director of Alcohol, Drug & Mental Health Services.

### 13. **CONSERVATORSHIPS**

**CONTRACTOR** agrees to appear for testimony for court and jury trials as determined necessary by the Conservator for purposes of establishing or reestablishing Conservatorships for clients they have previously or are currently serving.

**AGREEMENT**

Agreement for Services of Independent **CONTRACTOR** between the County of Santa Barbara and **Irwin Lunianski, MD.**

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

COUNTY OF SANTA BARBARA

By: \_\_\_\_\_

Chair, Board of Supervisors

Date: \_\_\_\_\_

**CONTRACTOR:**

By: \_\_\_\_\_

Tax Id No.95-25976265

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 ACCOUNTING 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: \_\_\_\_\_

# EXHIBIT A

IRWIN LUNIANSKI, MD

## CONTRACTOR'S SPECIFIC DUTIES

### Statement of Work

**CONTRACTOR** shall serve as a Licensed, Board-certified or Board-eligible psychiatrist for, and on behalf of, **COUNTY** under the general direction of the Director of Alcohol, Drug & Mental Health Services or designee, and will perform the following duties **12 to 14 hours per week** as scheduled:

1. Provide as needed all psychiatric services allowed under the scope of licensure as a licensed physician and surgeon in California.
2. Perform diagnostic, suicide, Tarasoff, involuntary admission, medication, and other evaluations.
3. Prescribe and administer, as needed, psychiatric medication(s).
4. Provide medication education for staff, clients, and families.
5. Participate in review, revision, and approval of assessments of clients.
6. Participate in the development, review, revision, and approval of treatment plans.
7. Provide consultation, training, and support of multi-disciplinary team members, as needed.
8. Participate in utilization review, medication monitoring, quality improvement protocols, and peer review.
9. Adhere to documentation and reporting requirements established by **COUNTY**.
10. Perform other relevant work within the scope of **CONTRACTOR'S** license.
11. The following summarizes the **COUNTY'S** expectations of the psychiatrist. The psychiatrist shall:
  - A. Accept training on the use of Online Progress Notes (OLPN) and document patient contacts using the OLPN format;
  - B. Efficiently provide bridge orders for medications previously prescribed based on input from the clinic staff and , when necessary, patient's record;
  - C. Shall schedule new patients for 1.5 hours during which assessment, initial treatment plan, appropriate documentation and dictation of case shall be completed;
  - D. Shall schedule follow-up appointments for 30 minutes. It is expected that a minimum of two (2) clients per hour will be seen and their care documented using the OLPN format.
  - E. Shall accommodate urgent or emergent concerns, walk-ins, medication refills, or other requests made by the Psychiatric Technicians or program manager in the event of a client "no-show".

## **EXHIBIT A**

12. Productivity expectations are 60% for the first month of employment; 70% for the following two (2) months and 75% or above thereafter.

## EXHIBIT B

### EXHIBIT B

**COUNTY** shall pay **CONTRACTOR** for professional services pursuant to this Agreement upon biweekly submission by **CONTRACTOR** of a timesheet, and such payment shall be subject to deductions and include withholding of state and federal taxes. In no event shall the compensation payable exceed the total sum of \$ 26000 without written amendment. This not to exceed amount includes the following:

- \$26000 for 234 CON hours of work by **CONTRACTOR** at a rate of \$110 per hour.

## CONTRACTOR ON PAYROLL

### CONTRACT SUMMARY PAGE

BC \_\_\_\_\_

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..... Cathy Fox  
 D6. Telephone ..... (805) 681-5168

K1. Contract Type (check one):  Personal Service  Capital  
 K2. Brief Summary of Contract Description/Purpose ..... Psychiatrist  
 K3. Original Contract Amount ..... \$26000  
 K4. Contract Begin Date ..... 2/26/2007  
 K5. Original Contract End Date ..... 6/30/2007  
 K6. Amendment History

Seq#	Effective Date	ThisAmndtAmt	CumAmndtToDate	NewTotalAmt	NewEndDate	Purpose

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 ..... \$26000  
 F3. Fund Number ..... 0044  
 F4. Department Number..... 043  
 F5. Division Number (if applicable).....  
 F6. Account Number..... 6177  
 F7. Cost Center number (if applicable)..... 3352  
 F8. Payment Terms.....

V1. Vendor Numbers (A=Auditor; P=Purchasing)..... NEW  
 V2. Payee/Contractor Name..... Irwin Lunianski, MD  
 V3. Mailing Address..... 5345 Aqana Dr.  
 V4. City, State (two-letter) Zip (include +4 if known)..... Santa Barbara, CA 93111  
 V5. Telephone Number.....  
 V6. Contractor's Federal Tax ID Number (EIN or SSN)..... 95-25976265  
 V7. Contact Person..... Irwin Lunianski, MD  
 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)..... Cathy Fox  
 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: \_\_\_\_\_