AMENDMENT

TO AGREEMENT FOR SERVICES OF INDEPENDENT CONTRACTOR

This is an amendment (hereafter referred to as the "Third Amended Contract") to the Agreement for Services of Independent Contractor, number **BC 07-054**, by and between the **County of Santa Barbara (County)** and **Good Samaritan Shelter (Contractor**), for the continued provision of **DMC Treatment**.

Whereas, this Third Amended Contract incorporates the terms and conditions set forth in the contract approved by the County Board of Supervisors in June 2006, the First Amendment approved by the County Board of Supervisors in June 2007, the Second Amendment approved by the County Board of Supervisors in June 2008, except as modified by this Third 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.A, Paragraph i of Exhibit A, Statement of Work, and replace with the following:

i. Services will be provided at the following certified Drug Medi-Cal (D/MC) sites:

a. 412 E. Tunnel Street, Santa Maria, CA 93454 – Project Premie (D/MC Certified Site #4277)

b. 731 S. Lincoln Street, Suites A and 1-4, Santa Maria, CA 93458 (D/MC Certified Site #4225)

c. 604 W. Ocean Avenue, Lompoc, CA 93436 (D/MC Certified Site # 426028)

II. Delete Item 1.B, Paragraph i of Exhibit A, Statement of Work, and replace with the following:

i. Services will be provided at the following Drug Medi-Cal Site(s)

a. 412 E. Tunnel Street, Santa Maria, CA 93454 – Project Premie (D/MC Certified Site #4277)

b. 604 W. Ocean Avenue, Lompoc, CA 93436 (D/MC Certified Site #426028)

III. 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 Fees (Exhibit B-1), attached hereto and with this reference made a part hereof, with a maximum value not to exceed $**328000**.

IV. Delete Exhibit B-1, Schedule of Services, and replace with the following:

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EXHIBIT B-1

SCHEDULE OF SERVICES

Program services, as described in Exhibit A and in the Provider Workbook, will conform to the California Department of Alcohol and Drug Programs service code definition (Exhibit A). Treatment services shall be reimbursed according to the California State Medi-Cal Guidelines (Title 22 CCR).

It is agreed that County shall provide a copy of the signed Provider Workbook to Contractor.

TYPE OF SERVICE Drug Medi-Cal (D/MC)	Provider Rate	Billing Rate (Maximum	County Administrative Cost	Total Estimated Revenue
D/MC - Outpatient Drug-Free Treatment consisting of individual (Including collateral sessions) and Group Counseling (including family sessions) and D/MC Perinatal Day Care Rehabilitative (Perinatal DCR) Services (for eligible pregnant and postpartum women.) (In accordance with Title 22 and the Perinatal Services Guidelines at certified sites per Exhibit A.)	The Drug Medi-Cal Rate shall follow the published State ADP guidelines, or as negotiated with County, as reflected in the Provider Workbook.			**$328,000**
			Total FY08-09 Drug Medi-Cal Funding	**$328,000**

The Drug Medi-Cal maximum rate allowable, or the negotiated rate with County, is based upon Contractor's program budget, contained in the Provider Workbook, and Contractor's prior year cost report.

The Monthly Reimbursement is based on the number of 50 minute individual and 90 minute group (per person) counseling sessions delivered during the month (or pro-rated as needed). These services shall follow the D/MC guidelines and shall be reported electronically to ADMHS - MIS, per Exhibit B.

A County Administrative Support Cost shall be automatically deducted from the monthly reimbursement paid to Contractor, per Exhibit B. Based upon the total monthly amount billed to Drug Medi-Cal, County shall retain 15% for Administrative Support Cost and shall pay Contractor 85%.

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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: _____
Joseph Centeno
Chair, Board of Supervisors
Date: _____

ATTEST:
MICHAEL F. BROWN
CLERK OF THE BOARD

By: _____
Deputy
Date: _____

CONTRACTOR

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

APPROVED AS TO FORM:
DENNIS MARSHALL
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: _____

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CONTRACT SUMMARY PAGE **BC 07-054**

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 ..... N/A
D4. Department Name ..... Alcohol, Drug, & Mental Health
D5. Contact Person ..... Danielle Spahn
D6. Telephone ..... (805) 681-5229

K1. Contract Type *(check one)*: ρ Personal Service ρ Capital
K2. Brief Summary of Contract Description/Purpose ..... DMC Treatment
K3. Contract Amount $328000
K4. Contract Begin Date 6/30/2009
K5. Original Contract End Date 6/30/2007
K6. Amendment History ……

Seq#	Effective Date	ThisAmndtAmt	CumAmndtToDate	NewTotalAmt	NewEndDate	Purpose
1	7/1/08	250000		250000	6/30/09	Renew for 08-09
2	1/1/09	78000	328000	328000	6/30/09	Add funds for new location

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 and Agenda Item Number ..... N/A
B6. Boilerplate Contract Text Unaffected? *(Yes / or cite* Yes

F1. Encumbrance Transaction Code 1701
F2. Current Year Encumbrance Amount $328000
F3. Fund Number 0049
F4. Department Number 043
F5. Division Number *(if applicable)* ..... N/A
F6. Account Number 7461
F7. Cost Center number *(if applicable)* 6242
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 ..... 731 S. Lincoln St.
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 BarnardExecutive Director
V8. Workers Comp Insurance Expiration Date 6/15/2009
V9. Liability Insurance Expiration Date[s] ..... GL 9/18/2009; AL 9/18/2009
V10. Professional License Number ..... M/C # 4277, 4225, 426028
V11. Verified by (name of county staff) ..... Danielle Spahn
V12 Company Type *(Check one):* Individual ρ Sole Proprietorship ρ Partnership ☒ Corporation

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

Date: _____ Authorized Signature: _____