CALIFORNIA MENTAL HEALTH SERVICES AUTHORITY
PARTICIPATION AGREEMENT AMENDMENT
COVER SHEET

This Participation Agreement Amendment is contracted between the California Mental Health Services Authority ("CalMHSA") and Santa Barbara County acknowledging their continued desire to participate in the Inter-Member Transfer Program.

This Participation Agreement Amendment No. 511-2018-PT-SBC-A3 amends the initial Agreement No. 414-2018-PT-SBC, the First Amendment No. 511-2018-PT-SBC-A1, and Second Amendment No. 511-2018-PT-SBC-A2 by adding the changes described below:

1. **Term of Service**: Extends the terms of service from July 1, 2021 to June 30, 2024;
2. **Deposit:** Increase the deposit amount of this Agreement for FYs 21-24, in a total amount not to exceed $200,000, with the annual deposit amount to vary based on actual transactions performed for a total maximum funding amount of $262,673.46, inclusive of the $59,689.75 initial funding amount and the initial 5% administrative fee of $2,984.46.
3. **Administrative Fee:** Pay a 5% Administration Fee of $2,984.45 for FY 21-22, payable upon execution of this amendment, and thereafter pay a 5% administration fee annually based on the County's current deposit into the banking pool, for the administration and operation of the program, which may range from $2,984.45 to $12,984.46 annually.
4. All other terms and provisions of the initial Agreement, the First Amendment and the Second Amendment not cited in this Agreement shall remain in full force and effect.

AUTHORIZED SIGNATURES:

COUNTY OF SANTA BARBARA:

Signed: _____ Name: Bob Nelson

Title: Chair, Board of Supervisors Date: _____

Signed: _____ Name: Pamela Fisher

Title: Acting Director, Behavioral Wellness Date: _____

ATTEST: COUNTY EXECUTIVE OFFICER CLERK OF THE BOARD

Signed: _____ Name: _____

Title: Deputy Clerk Date: _____

APPROVE AS TO FORM: COUNTY COUNSEL

Signed: _____ Name: _____

Title: Deputy County Counsel Date: _____

APPROVE AS TO ACCOUNTING FORM: AUDITOR-CONTROLLER

Signed: _____ Name: _____

Title: Deputy Date: _____

APPROVE AS TO INSURANCE FORM: RISK MANAGEMENT

Signed: _____ Name: _____

Title: Risk Manager Date: _____

CONTRACTOR: CalMHSA

Signed: _____ Name: Dr. Amie Miller

Title: Executive Director Date: _____