FIRST AMENDMENT 2009-10

TO AGREEMENT FOR SERVICES OF INDEPENDENT CONTRACTOR

This is an amendment (hereafter referred to as the "First Amended Contract") to the Agreement for Services of Independent Contractor, number **BC 09-113**, by and between the **County of Santa Barbara** (**County**) and **Maxim Healthcare Services, Inc.** (**Contractor**), for the continued provision of **Temporary personnel.**

Whereas, this First Amended Contract incorporates the terms and conditions set forth in the contract approved by the County Board of Supervisors in April 2009, except as modified by this First 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 4, Term, of the Agreement and replace with the following:

4. **TERM.** Contractor shall commence performance on **July 1, 2009,** and end performance upon completion, but no later than **June 30, 2010,** unless otherwise directed by County or unless earlier terminated.

II. Delete Item 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 **$149150.**

III. Delete Exhibit B-1, Schedule of Fees, and replace with the following:

FIRST AMENDMENT 2009-10

EXHIBIT B-1

SCHEDULE OF FEES

Service	Weekday Rate	Night/ Weekend Rate
RN	$65	$67
LVN/LPT/Other Approved PUFF Unit Modalities	$47	$49
CNA	$26	$28
Caregiver	$22	$24

Total Contract not to exceed: $149150

Weekend. Weekend rates will apply to shifts beginning at 11:00 p.m. on Friday and ending at 7:00 a.m. on Monday.

Overtime. Overtime rates are charged for all hours worked in excess of forty (40) hours per week or according to applicable state law. Overtime shall be pre-approved by designated County supervisor. The overtime rate is one and one-half (1.5) times the regular billing rate for such hours.

FIRST AMENDMENT 2009-10

SIGNATURE PAGE

Amendment to Agreement for Services of Independent Contractor between the County of Santa Barbara and Maxim Healthcare Services, Inc.

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: _____

ATTEST:
MICHAEL F. BROWN
CLERK OF THE BOARD

By: _____
Deputy
Date: _____

Contractor

By:_____
Tax Id No ._____
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: _____

FIRST AMENDMENT 2009-10

CONTRACT SUMMARY PAGE **BC 09-113**

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	09-10
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)*: ρ Personal Service ρ Capital	
K2.	Brief Summary of Contract Description/Purpose	Temporary personnel
K3.	Contract Amount	$149150
K4.	Contract Begin Date	7/1/2009
K5.	Original Contract End Date	6/30/2007
K6.	Amendment History ……	

Seq#	Effective Date	ThisAmndtAmt	CumAmndtToDate	NewTotalAmt	NewEndDate	Purpose
1	7/1/09			$149150	6/30/10	09-10 renewal

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 Paragraph)*	

F1.	Encumbrance Transaction Code	1701
F2.	Current Year Encumbrance Amount	$149150
F3.	Fund Number	0044
F4.	Department Number	043
F5.	Division Number *(if applicable)*	
F6.	Account Number	
F7.	Cost Center number *(if applicable)*	3500
F8.	Payment Terms	

V1.	Vendor Numbers (A=Auditor; P=Purchasing) EID	A 544099
V2.	Payee/Contractor Name	Maxim Healthcare Services, Inc.
V3.	Mailing Address	7227 Lee DeForest Drive.
V4.	City, State (two-letter) Zip (include +4 if known)	Columbia, MD 21046
V5.	Telephone Number	4109101357
V6.	Contractor's Federal Tax ID Number *(EIN or SSN)*	
V7.	Contact Person	Mike Hemelt Controller
V8.	Workers Comp Insurance Expiration Date	11/30/2009
V9.	Liability Insurance Expiration Date[s]	11/30/2009
V10.	Professional License Number	
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: _____