AMENDMENT 2006-2007

TO AGREEMENT FOR SERVICES OF INDEPENDENT CONTRACTOR

This is an amendment (hereafter referred to as the "Amended Contract") to the Agreement for Services of Independent Contractor, number BC 04-197, by and between the **County of Santa Barbara** (**COUNTY**) and **Santa Maria Valley Youth and Family Center** (**CONTRACTOR**), for the continued provision of **DMC Treatment Services**.

Whereas, **COUNTY** intends to extend the term of the existing contract through the Fiscal Year 06-07 and to compensate **CONTRACTOR** for the services to be provided during that Fiscal Year; and

Whereas, this Amended Contract incorporates the terms and conditions set forth in the original contract, approved by the County Executive Office with authority from the County Board of Supervisors on 6/1/04, except as modified by this 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. This Amended Contract is effective **July 1, 2006**. **CONTRACTOR** shall commence performance on that date and shall end performance upon completion, but no later than **June 30, 2007** unless otherwise directed by **COUNTY** or unless earlier terminated.

II. Delete Item 1, Paragraph 1, of Exhibit B, Payment Arrangements, and replace with the following:

EXHIBIT B
PAYMENT ARRANGEMENTS
DRUG MEDI-CAL (DMC)

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 **$166,000.**

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

EXHIBIT B-1
SCHEDULE OF SERVICES

Treatment 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), or as negotiated with **COUNTY**.

It is agreed that **COUNTY** has provided a copy of the signed Provider Workbook to **CONTRACTOR**.

TYPE OF SERVICE Drug Medi-Cal (D/MC)- NON RESIDENTIAL	Provider Rate	Billing Rate (Maximum	County Administrative Cost	Total Estimated Revenue **Term: 7/01/06 to 6/30/07**
D/MC – NON RESIDENTIAL				
D/MC - Outpatient Drug-Free Treatment consisting of individual (Including collateral sessions) and Group Counseling (including family sessions). [In accordance with Title 22 Guidelines at certified site(s), per Exhibit A.]	The D/MC Rate shall follow the published State ADP guidelines, or as negotiated with **COUNTY**.			**$166,000**
			Total Drug Medi-Cal Funding for FY 06-07	**$166,000**

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%.

SIGNATURE PAGE

Amended Contract for Services of Independent **CONTRACTOR** between the **COUNTY** of Santa Barbara and **Santa Maria Valley Youth and Family Center**

IN WITNESS WHEREOF, the parties have executed this Amended Contract 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

CONTRACTOR

By:_____
Tax ID No. 95-3144808

APPROVED AS TO FORM:
STEPHEN SHANE STARK
COUNTY COUNSEL

By:_____ Deputy
County Counsel

APPROVED AS TO 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 MANAGER

By: _____
Risk Program Manager

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 ..... ADMHS – Alcohol & Drug
D5. Contact Person ..... Jack Juntunen
D6. Telephone ..... (805) 681-4090

K1. Contract Type *(check one)*: ρ Personal Service ρ Capital
K2. Brief Summary of Contract Description/Purpose ..... Amended Contract for DMC Treatment Services
K3. Contract Amount ..... $ 166,000
K4. Contract Begin Date 7/1/2006
K5. Original Contract End Date 6/30/2006
K6. Amendment History

Seq#	Effective Date	ThisAmndtAmt	CumAmndtToDate	NewTotalAmt	NewEndDate	Purpose
1	07/01/06	$166,000		$166,000	06/30/07	Inc. amount and extend term

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*

F1. Encumbrance Transaction Code 1701
F2. Current Year Encumbrance Amount $166,000
F3. Fund Number 0044
F4. Department Number 043
F5. Division Number *(if applicable)* 6
F6. Account Number 7460
F7. Cost Center number *(if applicable)* ..... 6243,6352 (Program Code)
F8. Payment Terms ..... Net 30

V1. Vendor Numbers (A=Auditor; P=Purchasing) 722764
V2. Payee/Contractor Name ..... Santa Maria Valley Youth and Family Center
V3. Mailing Address ..... 105 North Lincoln Street
V4. City, State (two-letter) Zip (include +4 if known) ..... Santa Maria, CA 93454
V5. Telephone Number 805-928-1707
V6. Contractor's Federal Tax ID Number *(EIN or SSN)* 95-3144808
V7. Contact Person ..... William Rogers
V8. Workers Comp Insurance Expiration Date 07/01/06
V9. Liability Insurance Expiration Date[s] *(G=Genl;* GL, =07/01/06, Auto=07/01/06
V10. Professional License Number ..... N/A
V11. Verified by (name of county staff) ..... Jack Juntunen
V12 Company Type *(Check one):* Sole Proprietorship Partnership ☒ Corporation

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

Date: _____ Authorized Signature: _____