STATE OF CALIFORNIA
# STANDARD AGREEMENT
STD 213_DHCS (Rev. 06/16)

| REGISTRATION NUMBER | AGREEMENT NUMBER |
|---|---|
| | 17-94644 |

1. This Agreement is entered into between the State Agency and the Contractor named below:

STATE AGENCY'S NAME (Also known as DHCS, CDHS, DHS or the State)
Department of Health Care Services

CONTRACTOR'S NAME (Also referred to as Contractor)
County of Mendocino

2. The term of this Agreement is: October 12, 2017 through June 30, 2018

3. The maximum amount of this Agreement is: **$** 123,794.99
One Hundred Twenty Three Thousand, Seven Hundred Ninety Four Dollars, and Ninety Nine Cents

4. The parties agree to comply with the terms and conditions of the following exhibits, which are by this reference made a part of this Agreement.

| | |
|---|---|
| Exhibit A – Scope of Work | 6 pages |
| Exhibit B – Budget Detail and Payment Provisions | 3 pages |
| Exhibit B Attachment I – Budget | 1 page |
| Exhibit C * – General Terms and Conditions | GTC 04/2017 |
| Exhibit D (C) – Special Terms and Conditions (Attached hereto as part of this agreement) Notwithstanding provisions 9, 10, and 13 which do not apply to this agreement. | 17 pages |
| Exhibit E – Additional Provisions | 2 pages |
| Exhibit F – HIPAA Business Associate Addendum | 15 pages |
| Exhibit G – Travel Reimbursement Information | 2 pages |
| Exhibit H – Contractor's Release | 1 page |
| Exhibit I – Contractor Equipment Purchased with DHCS Funds | 2 pages |
| Exhibit J – Inventory/Disposition of DHCS-Funded Equipment | 2 pages |

Items shown above with an Asterisk (*), are hereby incorporated by reference and made part of this agreement as if attached hereto. *These documents can be viewed at* http://www.dgs.ca.gov/ols/Resources/StandardContractLanguage.aspx.

**IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.**

## CONTRACTOR

CONTRACTOR'S NAME *(if other than an individual, state whether a corporation, partnership, etc.)*
County of Mendocino

BY *(Authorized Signature)* ✍ | DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING
Jenine Miller, PsyD, BH and Recovery Services Director

ADDRESS
1120 S. Dora Street
Ukiah, CA 95482

## STATE OF CALIFORNIA

AGENCY NAME
Department of Health Care Services

BY *(Authorized Signature)* ✍ | DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING
Don Rodriguez, Chief, Contract Management Unit

ADDRESS
1501 Capitol Avenue, Suite 71.2048, MS 1400, P.O. Box 997413,
Sacramento, CA 95899-7413

***California Department of General Services Use Only***

☐ Exempt per: