STATE OF CALIFORNIA
# STANDARD AGREEMENT
STD 213_DHCS (Rev. 03/18)

| REGISTRATION NUMBER | AGREEMENT NUMBER |
|---|---|
| | 17-94616 |

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)
Shasta County Health and Human Services Agency

2. The term of this Agreement is: July 1, 2017 through June 30, 2022

3. The maximum amount of this Agreement is: $ 0 Zero dollars

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 | 2 pages |
| Attachment 1 Organization And Administration | 6 pages |
| Attachment 2 Scope Of Services | 9 pages |
| Attachment 3 Financial Requirements | 6 pages |
| Attachment 4 Management Information Systems | 2 pages |
| Attachment 5 Quality Improvement System | 6 pages |
| Attachment 6 Utilization Management Program | 3 pages |
| Attachment 7 Access And Availability Of Services | 4 pages |
| Attachment 8 Provider Network | 11 pages |

See Exhibit E, Provision 1 for additional incorporated exhibits.

**Approved as to form:**
**RUBIN E. CRUSE, JR**
**County Counsel**
7/6/18
**Alan B. Cox**
**Deputy County Counsel**

**RISK MANAGEMENT APPROVAL**
7/6/18
**James Johnson**
**Risk Management Analyst**

**INFORMATION TECHNOLOGY APPROVAL**
7/10/18
**Gretchen Allen**
**IT Deputy Director**

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.)*
Shasta County Health and Human Services Agency

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

PRINTED NAME AND TITLE OF PERSON SIGNING
Donnell Ewert, MPH, Director

ADDRESS
P.O. Box 496048
Redding, CA 96049-6048

## 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

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

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

[X] Exempt per: W&I Code §14703