
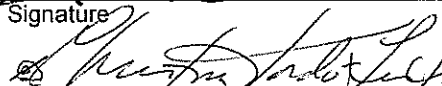
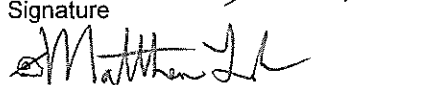

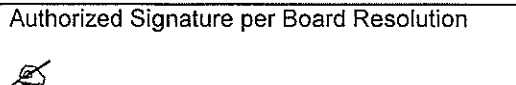


GRANTEE/CONTRACTOR: STATE OF CALIFORNIA Department of Rehabilitation 721 Capitol Mall Sacramento, California 95814	SUBGRANTEE/CONTRACTEE: (Legal Corporation/Public Agency Name & Address) EL DORADO COUNTY Mental Health Department (MHD) 670 Placerville Drive Placerville, CA 95667
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The following persons are authorized to request reimbursement of expenses incurred as a result of the agreement between the Grantee/Contractor and Subgrantee/Contractee named above:

Signature 	Name (Please Type or Print) John Bachman, Ph.D.	Title (Please Type or Print) Director, MHD
Signature 	Name (Please Type or Print) Christine Kondo-Lister	Title (Please Type or Print) Deputy Director, MHD
Signature 	Name (Please Type or Print) Matthew LePore	Title (Please Type or Print) Fiscal Administration Manager
Signature 	Name (Please Type or Print)	Title (Please Type or Print)

I hereby delegate authority to request reimbursement of expenses as shown above.

Authorized Signature per Board Resolution 	Name (Please Type or Print)	Date Signed
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