

CONTRACT AMENDMENT A

This CONTRACT AMENDMENT is made and entered into between SALISH BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION, through Kitsap County, as its administrative entity, a political subdivision of the State of Washington, with its principal offices at 614 Division Street, Port Orchard, Washington 98366, hereinafter "SBHASO", and West Sound Treatment Center, hereinafter "CONTRACTOR."

In consideration of the mutual benefits and covenants contained herein, the parties agree that their Contract, numbered as Kitsap County Contract No. KC-359-22, and executed on August 8, 2022, shall be amended as follows:

1. **Page 1: Contract Term** is amended as follows:
July 1, 2022 – June 30, 2024

2. **Page 1: Amount** is amended as follows:
\$762,418

3. **Attachment C: Budget** is deleted entirely and replaced as attached.

4. If this Contract Amendment extends the expiration date of the Contract, then the Contractor shall provide an updated certificate of insurance evidencing that any required insurance coverages are in effect through the new contract expiration date. The Contractor shall submit the certificate of insurance to:

Program Lead, Salish Behavioral Health Administrative Services Organization
Kitsap County Department of Human Services
614 Division Street, MS-23
Port Orchard, WA 98366

Upon receipt, the Human Services Department will ensure the submission of all insurance documentation to the Risk Management Division, Kitsap County Department of Administrative Services.

5. Except as expressly provided in this Contract Amendment, all other terms and conditions of the original Contract, and any subsequent amendments, addenda or modifications thereto, remain in full force and effect.

This amendment shall be effective July 1, 2023.

Dated this 24 day of July, 2023.

**SALISH BEHAVIORAL HEALTH
ADMINISTRATIVE SERVICES
ORGANIZATION, By
KITSAP COUNTY BOARD OF
COMMISSIONERS, Its Administrative
Entity**

Charlotte Garrido

Charlotte Garrido, Chair

NOT PRESENT

Katherine T. Walters, Commissioner

Christine Rolfes

Christine Rolfes, Commissioner

DATE 7-24-23

ATTEST

Dana Daniels

Dana Daniels, Clerk of the Board

**CONTRACTOR:
West Sound Treatment Center**

Keneth D. Wilson

Name: Ken Wilson
Title: Executive Director

Rob Divelbess

Name: Rob Divelbess
Title: Board President

I attest that I have the authority to sign
this contract on behalf of West Sound
Treatment Center.

6-27-2023

DATE



ATTACHMENT C: BUDGET

Budget Summary			
Contractor: West Sound Treatment Center			
Contract No:		KC-359-22-A	
Contract Period:		7/1/2022 - 6/30/2024	
Expenditure	Previous	Changes this Contract	Current
Period 1: 7/1/22 -06/30/23			
R.E.A.L. Program (GFS)	381,209.00	0.00	381,209.00
Period 1 Budget Total	381,209.00	0.00	381,209.00
Period 2: 7/1/23 -06/30/24			
R.E.A.L. Program (GFS)	0.00	381,209.00	381,209.00
Period 2 Budget Total	0.00	381,209.00	381,209.00
Contract Total	381,209.00	381,209.00	762,418.00

Administration Fund limit: 10%



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

09/07/2022

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER		CONTACT NAME: Cory Coryell	
Fortune Insurance		PHONE (A/C, No, Ext): (253) 200-6633	FAX (A/C, No): (253) 200-6626
705 S. 9th St. #302		E-MAIL ADDRESS: cory@fmgins.com	
Tacoma WA 98405		INSURER(S) AFFORDING COVERAGE	
		INSURER A: Philadelphia Indemnity Insurance Company	
INSURED		INSURER B:	
West Sound Treatment Center		INSURER C:	
4060 Wheaton Way, #F		INSURER D:	
Bremerton WA 98310		INSURER E:	
		INSURER F:	

COVERAGES CERTIFICATE NUMBER: 22-23 GL, Auto, UMB REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

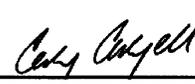
INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	<input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:	Y		PHPK2462129	09/09/2022	09/09/2023	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 3,000,000 PRODUCTS - COMP/OP AGG \$ 3,000,000 Employee Benefits \$ 1,000,000
A	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY			PHPK2462129	09/09/2022	09/09/2023	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ Uninsured motorist \$ 1,000,000
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input type="checkbox"/> EXCESS LIAB OCCUR CLAIMS-MADE DED RETENTION \$			PHUB831739	09/09/2022	09/09/2023	EACH OCCURRENCE \$ 1,000,000 AGGREGATE \$ 1,000,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	Y/N	N/A	PHPK2462129	09/09/2022	09/09/2023	<input type="checkbox"/> PER STATUTE <input checked="" type="checkbox"/> OTH-ER WA Stop Gap E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000
A	Professional Liability			PHPK2462129	09/09/2022	09/09/2023	Each Incident Limit \$1,000,000 Aggregate Limit \$3,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

Kitsap County, its officers, elected officials, agents, employees and volunteers are Additional insureds at the following address: 614 Division St. MS-1 Port Orchard, WA 98366

Kitsap County will be notified at least 15 days in advance of any reduction in or cancellation of the coverage.

CERTIFICATE HOLDER**CANCELLATION**

Kitsap County 614 Division St. MS-1 Port Orchard WA 98366	SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE 
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ADDITIONAL COVERAGES

Ref #	Description Professional Liability	Coverage Code PROF	Form No.	Edition Date
Limit 1 1,000,000	Limit 2 3,000,000	Limit 3	Deductible Amount	Deductible Type
Premium				
Ref #	Description Stop Gap Employer Liab	Coverage Code SGELI	Form No.	Edition Date
Limit 1 1,000,000	Limit 2	Limit 3	Deductible Amount	Deductible Type
Premium				
Ref #	Description Medical payments	Coverage Code MEDPM	Form No.	Edition Date
Limit 1 5,000	Limit 2	Limit 3	Deductible Amount	Deductible Type
Premium				
Ref #	Description	Coverage Code	Form No.	Edition Date
Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type
Premium				
Ref #	Description	Coverage Code	Form No.	Edition Date
Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type
Premium				
Ref #	Description	Coverage Code	Form No.	Edition Date
Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type
Premium				
Ref #	Description	Coverage Code	Form No.	Edition Date
Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type
Premium				
Ref #	Description	Coverage Code	Form No.	Edition Date
Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type
Premium				
Ref #	Description	Coverage Code	Form No.	Edition Date
Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type
Premium				
Ref #	Description	Coverage Code	Form No.	Edition Date
Limit 1	Limit 2	Limit 3	Deductible Amount	Deductible Type
Premium				

Philadelphia Indemnity Insurance Company

Additional Insured Schedule

Policy Number: PHPK2325510

Additional Insured

Department of Social Health Svcs
Central Contract Services
Insurance Services
PO Box 45811
Olympia, WA 98504-5811

CG2026 - WA - Loc #1

Additional Insured

Kitsap County Department of
Administrative Services CDBG
(CG2026/Contracted Services)
345 6th St Ste 400
Bremerton, WA 98337-1869

CG2026 - WA - Loc #1 - 334 (SHELTER/MISSION/STTLMNT/HALF H)
Work Performed/Contracted Services - Refer to Form CG2026

Additional Insured

Kitsap County
345 6th St Ste 400
Bremerton, WA 98337-1869

WA - Loc #ALL - ADDL INS PRIMARY & NON-CONTRIBUTORY INS
Re: Homeless Housing Program Grant Agreement

Additional Insured

Robin & Karen Waite
400 Warren Ave Ste 450
C/O Bradley Scott, Inc.
Bremerton, WA 98337-6009

CG2011 - WA - Loc #5

Exclusions Search Results: Entities

No Results were found for

- West Sound Treatment Center

 **If no results are found, this individual or entity (if it is an entity search) is not currently excluded. Print this Web page for your documentation**

[Search Again](#)

Search conducted 6/14/2023 3:12:15 PM EST on OIG LEIE Exclusions database.

Source data updated on 6/8/2023 8:00:00 AM EST

[Return to Search](#)