

**CONTRACT AMENDMENT
B**

This contract for Human Services (the Contract) is entered into by Kitsap County, a municipal corporation, having its principal offices at 614 Division Street, Port Orchard, Washington, 98366 (the County) and Geras, LLC dba Family Resource Home Care, having its principal office at 23403 E Mission Ave Ste 150, Liberty Lake, WA 99019, 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-247-24 and executed on April 8, 2024, amendment KC-247-24-A executed on February 10, 2025 shall be amended as follows:

1. **Kitsap County Face Sheet** is included to record federal funding information.
2. **ATTACHMENT C: BUDGET SUMMARY.** The Budget Table shall be amended as follows: The contract amount will increase caregiver training pass through funding by \$144,000, from \$140,000 to \$284,000 for caregiver training. The total contract amount is increased from \$225,000 for a new contract total of \$369,000. The total amount payable under the contract, by the County to the Contactor in no event will exceed the budget line items outlined in the budget table.

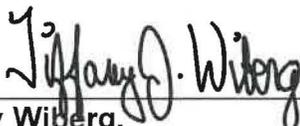
This amendment shall be effective as of October 1, 2025.

Dated this 28 day of January, 2026

Dated this 23 day of Feb, 2026

Geras, LLC dba Family Resource Home Care

BOARD OF COUNTY COMMISSIONERS
KITSAP COUNTY, WASHINGTON



Tiffany Wilberg,
Director of Revenue Cycle Management



ORAN ROOT, Chair



CHRISTINE ROLFES, Commissioner



NOT PRESENT

KATHERINE WALTERS, Commissioner

ATTEST:


Dana Daniels, Clerk of the Board

Kitsap County Face Sheet

For Sub-recipient Contracts Using Federal Awards

*CFR 200.332 Ensure that every subaward is clearly identified to the subrecipient as a subaward and includes the information provided below. A pass-through entity must provide the best available information when some of the information below is unavailable. A pass-through entity must provide unavailable information when it is obtained. Required information includes:
(Fill in)*

Subrecipient's unique entity identifier: JNSVUNBMLEL7

Federal Award Identification Number (FAIN): NA- Medicaid funds are claimed through Provider 1

Federal Revenue Award Date: NA- Medicaid funds are claimed through Provider 1

Subaward Period of Performance Start and End Date: NA

Check to verify the information is in contract:

Subrecipient's name (must match the name associated with its unique entity identifier):

Federal award identification:

Subaward Budget Period Start and End Date:

Amount of Federal Funds Obligated in the subaward:

Amount of Federal Funds Obligated to the sub by the pass-through entity, including the current financial obligation:

Total Amount of the Federal Award committed to the subrecipient by the pass-through entity:

Federal award project description, as required by the Federal Funding Accountability and Transparency Act (FFATA):

Name of the Federal agency, pass-through entity, and contact information for awarding official of the pass-through entity:

Dollar amount made available under each Federal award and the Assistance Listings Number at the time of disbursement:

Indirect cost rate for the Federal award (including if the de minimis rate is used in accordance with § 200.414):

ATTACHMENT C: BUDGET SUMMARY

Budget Table

Family Resource Home Care

March 1, 2024 - June 30, 2026

Program/Funding Source	Total	MAR-JUN 2024	Q1 JULY-SEP 2024	Q2 OCT-DEC 2024	Q3 JAN-MAR 2025	Q4 APR-JUN 2025	Q1 JULY-SEP 2025	Q2 OCT-DEC 2025	Q3 JAN-MAR 2026	Q4 APR-JUN 2026
Caregiver Training	\$ 284,000	\$ 20,000	\$ 15,000	\$ 15,000	\$ 15,000	\$ 15,000	\$ 15,000	\$ 63,000	\$ 63,000	\$ 63,000
State Family Caregiver	\$ 75,000	\$ 10,712	\$ 8,036	\$ 8,036	\$ 8,036	\$ 8,036	\$ 8,036	\$ 8,036	\$ 8,036	\$ 8,036
AWHI	\$ 10,000	\$ 1,430	\$ 1,072	\$ 1,071	\$ 1,072	\$ 1,071	\$ 1,071	\$ 1,071	\$ 1,071	\$ 1,071
Total Project	\$ 369,000	\$ 32,142	\$ 24,108	\$ 24,107	\$ 24,108	\$ 24,107	\$ 24,107	\$ 72,107	\$ 72,107	\$ 72,107

Funding Source	CFDA #	AMOUNT
N/A		



GERALLC-01

W1KMAGILL

CERTIFICATE OF LIABILITY INSURANCEDATE (MM/DD/YYYY)
9/5/2025

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 AssuredPartners of Oregon, LLC 3125 Chad Drive, Suite120 Eugene, OR 97408	CONTACT NAME: Kaity Magill	
	PHONE (A/C, No, Ext): (541) 687-4799	FAX (A/C, No): (541) 687-4718
E-MAIL ADDRESS: info.APOregon@assuredpartners.com		
INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A : Hanover Insurance Company		22292
INSURER B : Progressive Casualty Insurance Company		24260
INSURER C : Accident Fund Insurance Co		
INSURER D :		
INSURER E :		
INSURER F :		

INSURED
Geras, LLC
23403 East Mission Ave
Liberty Lake, WA 99019

COVERAGES**CERTIFICATE NUMBER:****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 <input checked="" type="checkbox"/> \$0 Deductible GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC OTHER:			TBD	9/6/2025	9/6/2026	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
B	<input type="checkbox"/> AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO OWNED AUTOS ONLY <input checked="" type="checkbox"/> SCHEDULED AUTOS <input checked="" type="checkbox"/> HIRED AUTOS ONLY \$500 Comp Ded. <input checked="" type="checkbox"/> NON-OWNED AUTOS ONLY \$1000 Comp Ded			862702306	9/6/2025	9/6/2026	COMBINED SINGLE LIMIT (Ea accident) \$ 1,000,000 BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
A	<input checked="" type="checkbox"/> UMBRELLA LIAB <input checked="" type="checkbox"/> OCCUR <input type="checkbox"/> EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED <input checked="" type="checkbox"/> RETENTION \$ 0			TBD	9/6/2025	9/6/2026	EACH OCCURRENCE \$ 2,000,000 AGGREGATE \$ 2,000,000
C	<input type="checkbox"/> WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) <input type="checkbox"/> Y/N N/A If yes, describe under DESCRIPTION OF OPERATIONS below			AFWCP100125913	4/1/2025	4/1/2026	PER STATUTE OTH-ER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000
A	<input type="checkbox"/> Professional Liab			TBD	9/6/2025	9/6/2026	Per Occurrence 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)
30 days written notice of cancellation, except 10 days notice for non-payment of premium.

Kitsap County Aging and Long-Term Care (ALTC), the County, its officers, officials, employees, and agents are additional insureds for General Liability. State of Washington, Department of Social & Health Services (DSHS), its Elected and Appointed officials, agents and employees are additional insureds for General Liability.

CERTIFICATE HOLDER

Kitsap County ALTC State of Washington DSHS
614 Division St. MS-5
Port Orchard, WA 98366

CANCELLATION

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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Office of Inspector General
 U.S. Department of Health & Human Services

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