NORTH SOUND BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION, LLC
(NORTH SOUND BH-ASO)
CONTRACT AMENDMENT 3

CONTRACT #NORTH SOUND BH-ASO-ISLAND COUNTY RNP-23

Based on the Agreement of the parties to the above-referenced Contract between the North Sound Behavioral Health Administrative Services Organization, LLC (North Sound BH-ASO) and Island County (Provider) dated September 5, 2023, (as amended by North Sound BH-ASO and Provider dated September 3, 2024, collectively the "Contract") is hereby amended as follows:

The purpose of this amendment is to provide additional Recovery Navigator Program (RNP) funding in the amount for $43,530.50 for January 1, 2025 to June 30, 2025:

By mutual agreement of the parties, the following language is added to the agreement:

- Replace *Exhibit B(b) - Island County RNP Budget* with *Exhibit B(c) - Island County RNP Budget*

ALL TERMS AND CONDITIONS OF CONTRACT SHALL REMAIN IN FULL FORCE AND EFFECT.

THIS AMENDMENT IS EXECUTED BY THE PERSONS SIGNING BELOW, WHO WARRANT THAT THEY HAVE THE AUTHORITY TO EXECUTE THIS AMENDMENT.

THIS AMENDMENT SHALL BECOME EFFECTIVE ON THE DATE OF FINAL SIGNATURE BY THE PARTIES.

NORTH SOUND BH-ASO, LLC		**ISLAND COUNTY**	
JanRose Ottaway Martin Executive Director	Date	Melanie Bacon Chair	Date

North Sound Behavioral Health
Administrative Services Organization
Blake Recovery Navigator
Cost Reimbursement Budget
Island County

Annual Budget July 1, 2024 to June 30, 2025

Revenues		
Blake Navigator Program	$	528,855.00
January 1, 2025 - June 30, 2025 Additional RNP Funds	$	43,530.50
RNP Reserve Funds	$	232,500.00
Total	**$**	**804,885.50**

Expenses		
Blake Navigator Program Expenses	$	804,885.50
Total	**$**	**804,885.50**

Budget Amount	$	804,885.50
Expenses		-
Balance	$	804,885.50

***RNP Reserve Funds Inlude:**
$92,500 Second half of 7/1/23-6/30/24 budget allocation.
$140,000 Full year of 7/1/24-60/30/25 budget.

GENERAL REQUIREMENTS FOR INVOICES

NORTH SOUND BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION

Effective: 1/1/2025

A. Billing Invoice

1. The Contractor shall submit a ***Billing Invoice*** (Invoice Tab) and ***General Ledger Summary*** form (General Ledger Sumr the service month including a ***General Ledger report or a Profit and Loss statement*** and any applicable reporting req noted in the NS BH ASO Supplemental Provider Guide and signed NS BH ASO Contract.
2. The Invoice shall be signed by an authorized signer on file with NS BH ASO. The Contractor shall provide NS BH ASO a Contractor-authorized signers and shall update the list as needed.
3. The Contractor shall complete the Invoice according to the NS BH ASO general requirements and Supplemental Provide
4. The Contractor shall submit an invoice for all service months. The Contractor shall submit an Invoice even for service mo there are no services provided or no reimbursements payable to the Contractor.
5. **The Invoice is due within 15 days after the end of each month**, unless otherwise specified on the Invoice. An earlier be required at the end of NS BH ASO's calendar year, the end of the State fiscal year, the end of the Federal fiscal year.
6. An invoice and required reporting documents **received 45 days or more** after the service month may not be accepted fo For Federal Funds, any Invoices and reporting documents received **30 days or more** after the service month may not be payment.
7. Monthly payment shall not be made until all reporting requirements (as noted in the Contract and Supplemental Provider been satisfied.
8. The Contractor shall not invoice and charge NS BH ASO for services which are specifically paid for by another source of
9. ***The Contractor shall notify NS BH ASO Fiscal Department before submitting supplemental invoices.*** The Contrac in the notes section of the invoice the reason for submitting a supplemental Invoice.

B. Additional Requirements for Invoices Specific to Scopes of Work

1. The Contractor shall complete the Invoice appropriate to the specific scope of work, using the most recent version issued NS BH ASO.
2. The Contractor must complete the Invoice including:

   a. Entering **month** and **year** being invoiced.

   b. Indicating whether this is an **original** or **supplemental** invoice.

   c. Entering data into appropriate fields.

   d. A signature from an individual who is on the authorized signers list on file with NS BH ASO, as well as the date signed
3. The Method of Payment (**MOP**) may vary according to the scope of work. Examples include:

   a. Equal monthly amounts, e.g., 1/12th of allocation for services each month
   b. FTE cost reimbursement
   c. Bed day/census day/dose day (rates per site)
   d. Room and board
   e. Case rate
   f. Actual cost reimbursement, paid retroactively
   g. Incentive-based payments, paid retroactively
   h. Fee for Service rates

4. The Contractor must follow the MOP and any additional requirements listed on the invoice.

North Sound Behavioral Health Administrative Services Organization

Agency Name:
Island County Human Services

Reimbursement Request

Invoice Version: **Original**

Month & Year Invoiced: **Month** **Year:**

Please indicate funding source

Description	**Funding Source PROVISO Recovery Navigator**	**Amount Requested**
Recovery Navigator Program Expenses		
TOTAL:		**$0.00**

I, the undersigned, do hereby certify under penalty of perjury, that this is a true and correct claim for reimbursement for services rendered. I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal and state laws. This certification includes any attachments which serve as supporting documentation to this reimbursement request.

Contractor Authorized Signature **Date**

Report(s) Submitted: **Yes / No**

Notes:

Method of Payment:

1. Reimbursement from the State PROVISO Recovery Navigator Program funding allocation will be made monthly based on actual costs for Recovery Navigator program expenditures for July 1, 2024 -June 30, 2025 in the budgeted amounts of:

   Recovery Navigator Proviso Funds $572,385.50

   Recovery Navigator Reserve Funds $232,500.00

   TOTAL BUDGET: $804,885.50

2. A ***general ledger or profit and loss statement*** verifying actual program related costs and expenditures incurred must accompany the reimbursement invoice.
3. If requested supporting documentation must accompany the reimbursement invoice. The agency retains all records and supporting documentation (including receipts) related to program expenses, costs, and expenditures.
4. Submit Invoices to:
   fiscal@nsbhaso.org

Additional Requirements:

1. Unallowable costs are according to the funding sources, i.e., Federal Block Grant and State Funding.
2. If the Provider claims and NS BH ASO reimburses for expenditures under this contract that are later found to be claimed in error or to be for unallowable costs, NS BH ASO will recover those costs and the Provider shall fully cooperate with the recovery.

North Sound Behavioral Health Administrative Services Organization

Agency Name:
Island County Human Services

Reimbursement Request

Month & Year Invoiced: **Month** **Year:**

Invoice Version: **Original**

Please indicate funding source

Description	Funding Source PROVISO Recovery Navigator RESERVE	Amount Requested
Recovery Navigator Program Expenses		
	TOTAL:	**$0.00**

I, the undersigned, do hereby certify under penalty of perjury, that this is a true and correct claim for reimbursement for services rendered. I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal and state laws. This certification includes any attachments which serve as supporting documentation to this reimbursement request.

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NORTH SOUND BEHAVIORAL HEALTH ADMINISTRATIVE SERVICES ORGANIZATION PROGRAM INFORMATION

Agency Name:	
Contact Person Name:	
NS BH ASO Full Program Name:	
Funding Source:	
NS BH ASO Contract Number:	
Grant/Contract Period:	

Enter Information in Green Highlighted Cells

INVOICE SUMMARY

Eligible Expense Category	Requested Funds
Salaries	$-
Fringe Benefits	$-
Small Tools & Equipment (> $5,000 per unit)	$-
Office & Operating Supplies	$-
Professional Services	$-
Communications & Postage	$-
Travel: Lodging/Mileage/Fares	$-
Meals	$-
Advertising & Printing	$-
Operating Lease/Rentals	$-
Insurance	$-
Utilities	$-
Repairs & Maintenance	$-
Dues & Subscriptions	$-
Machinery & Equipment	$-
Assistance to Individuals	$-
Capital	$-
Other Direct Costs	$-
Indirect Costs	$-
Miscellaneous	$-
Total Expenses	**$0.00**