

		<b>COUNTY PROGRAM AGREEMENT AMENDMENT</b> <b>09 Medicaid Administrative Match-LHJ</b>		DSHS Agreement Number 0963-53332  Amendment No. 0963-53332-02
This Program Agreement Amendment is by and between the State of Washington Department of Social and Health Services (DSHS) and the County identified below.				Administration or Division Agreement Number  County Agreement Number
DSHS ADMINISTRATION Health and Recovery Services Administration	DSHS DIVISION Healthcare Services	DSHS INDEX NUMBER 1225	CCS CONTRACT CODE 1225	
DSHS CONTACT NAME AND TITLE William McCandless		DSHS CONTACT ADDRESS P O Box 45508  Olympia, WA 98504-5508		
DSHS CONTACT TELEPHONE (360) 725-1657 Ext:	DSHS CONTACT FAX (360) 586-9585	DSHS CONTACT E-MAIL mccanwm@dshs.wa.gov		
COUNTY NAME Kittitas County		COUNTY ADDRESS 507 North Nanum Street, Suite 102  Ellensburg, WA 98926-		
COUNTY FEDERAL EMPLOYER IDENTIFICATION NUMBER 916001349		COUNTY CONTACT NAME Candi Blackford		
COUNTY CONTACT TELEPHONE (509) 962-7515 Ext:	COUNTY CONTACT FAX (509) 962-7581	COUNTY CONTACT E-MAIL candi.blackford@co.kittitas.wa.us		
IS THE COUNTY A SUBRECIPIENT FOR PURPOSES OF THIS PROGRAM AGREEMENT? Yes		CFDA NUMBERS 93.778		
AMENDMENT START DATE 1/1/2011	PROGRAM AGREEMENT END DATE 12/31/2019			
PRIOR MAXIMUM PROGRAM AGREEMENT AMOUNT \$0.00	AMOUNT OF INCREASE OR DECREASE \$0.00	TOTAL MAXIMUM PROGRAM AGREEMENT AMOUNT \$0.00		
REASON FOR AMENDMENT; CHANGE OR CORRECT PERIOD OF PERFORMANCE				
<b>EXHIBITS.</b> When the box below is marked with a check (4) or an X, the following Exhibits are attached and are incorporated into this Program Agreement Amendment by reference: <input type="checkbox"/> Exhibits (specify):				
This Program Agreement Amendment, including all Exhibits and other documents incorporated by reference, contains all of the terms and conditions agreed upon by the parties as changes to the original Program Agreement. No other understandings or representations, oral or otherwise, regarding the subject matter of this Program Agreement Amendment shall be deemed to exist or bind the parties. All other terms and conditions of the original Program Agreement remain in full force and effect. The parties signing below warrant that they have read and understand this Program Agreement Amendment, and have authority to enter into this Program Agreement Amendment.				
COUNTY SIGNATURE(S)  		PRINTED NAME(S) AND TITLE(S)  Catherine Bambrick		DATE(S) SIGNED  8/23/10
DSHS SIGNATURE  		PRINTED NAME AND TITLE Charles Pugh, Manager Contracts and Supplemental Rebate Agreements Medical Assistance Divisions		DATE SIGNED 31. AUG. 10

This Program Agreement between the County and the State of Washington Department of Social and Health Services (DSHS) is hereby amended as follows:

Extend period of performance to December 31, 2019.

All other terms and conditions of this Program Agreement remain in full force and effect.

**Address DSHS should use for this Contract**  
**(If you have additional addresses for this Contract, attach a listing of additional addresses.)**

<input checked="" type="checkbox"/> Billing Address <input checked="" type="checkbox"/> Facility Address <input checked="" type="checkbox"/> Mailing Address	ADDRESS FOR THIS CONTRACT (NUMBER, STREET, AND APARTMENT OR SUITE NUMBER) <b>507 N. Nanum Street, Suite 102</b>	
	CITY, STATE, AND ZIP CODE <b>Ellensburg, WA 98926</b>	
PHONE NUMBER (INCLUDE AREA CODE) <b>(509) 962-7515</b>		COUNTY WHERE ADDRESS IS (FOR OUT-OF-STATE CONTRACTORS) <b>Kittitas County</b>
FAX NUMBER (INCLUDE AREA CODE) <b>(509) 962-7581</b>		EMAIL ADDRESS <b>candi.blackford@co.kittitas.wa.us</b>

**Contact Person DSHS should use for this Contract**  
**(If you have additional contact persons for this Contract, attach a listing of additional contact persons.)**

Contact person for this Contract is a(n): <input type="checkbox"/> Officer or Board Member <input type="checkbox"/> Partner <input checked="" type="checkbox"/> Staff Member <input type="checkbox"/> Elected Official <input type="checkbox"/> Other (please identify) _____ (DSHS staff enter as applicable on ACD)			
Is the contact person a current or former State Employee? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    If yes, complete Ethics Certification enclosed with this form.			
Is the contact person authorized to sign contracts? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
Is the contact person a contact for this DSHS contract? <input checked="" type="checkbox"/> Yes			
CONTACT PERSON'S NAME <b>Candi Blackford</b>		CONTACT PERSON'S EMAIL ADDRESS <b>candi.blackford@co.kittitas.wa.us</b>	
PHONE NUMBER (INCLUDE AREA CODE) <b>(509) 962-7515</b>	FAX NUMBER (INCLUDE AREA CODE) <b>(509) 962-7581</b>	PAGER NUMBER (INCLUDE AREA CODE) (    )	CELLULAR PHONE NUMBER (INCLUDE AREA CODE) (    )

**Person who will be signing this Contract**  
**(If the contact person entered above will also sign this Contract, you don't need to enter their information again.)**

Person authorized to sign this Contract is a(n): <input type="checkbox"/> Officer or Board Member <input type="checkbox"/> Partner <input checked="" type="checkbox"/> Staff Member <input type="checkbox"/> Elected Official <input type="checkbox"/> Other (please identify) _____ (DSHS staff enter as applicable on ACD)			
Is person a current or former State Employee? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    If yes, complete Ethics Certification enclosed with this form.			
Is person authorized to sign this contract? <input checked="" type="checkbox"/> Yes			
Is person a contact for this DSHS contract? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
CONTACT PERSON'S NAME <b>Cathy Bambrick</b>		CONTACT PERSON'S EMAIL ADDRESS <b>cathy.bambrick@co.kittitas.wa.us</b>	
PHONE NUMBER (INCLUDE AREA CODE) <b>(509) 962-7515</b>	FAX NUMBER (INCLUDE AREA CODE) <b>(509) 962-7581</b>	PAGER NUMBER (INCLUDE AREA CODE) (    )	CELLULAR PHONE NUMBER (INCLUDE AREA CODE) (    )