

Agenda

HELEN FARABEE CENTERS BOARD OF TRUSTEES

March 5, 2026

11:00 AM

Sue Nunn conference Room, 1000 Brook Ave., Wichita Falls, TX

Agenda Topics

MEETING STARTS AT 11:00 A.M.

030526-1 CALL TO ORDER

J. Brian Eby

A. INTRODUCTION OF GUESTS

030526-2 PRESENTATIONS

A. OPEN CITIZEN COMMENT TO THE BOARD *“Texas law in the Open Meetings Act permits a member of the public or a member of the governmental body to raise a subject that has not been included in the notice for the meeting, but any discussion of the subject must be limited to a proposal to place the subject on the agenda for a future meeting.”*

030526-3 APPROVAL OF MINUTES

J. Brian Eby

Recommended Action: That the Board of Trustees approves the minutes of the January 2026 Board of Trustee meetings.

Page 4

Citizen Comment:

030526-4 TRAINING

Behavioral Health Services.....**Andy Martin**

Page 10

Child and Adolescent Services.....**Amanda Cantu**

Page 19

030526-5 RECOMMENDATIONS

A. BOARD OF TRUSTEES

1) Place 4 Vacancy

Melissa Collins

Recommended Action: Information Only Item.

Page 27

Citizen Comment:

2) Place 5 Vacancy

Melissa Collins

Recommended Action: Information Only Item

Page 28

Citizen Comment:

3) Veteran on the Board

Melissa Collins

Recommended Action: Information Only Item.

Page 29

Citizen Comment:

B. BUDGET AND FINANCE	
1) <i>Financial Statements</i>	Linda Poenitzsch
Recommended Action: That the Board of Trustees approves the financial statements for December 2025 and January 2026. Citizen Comment:	Page 32 December Page 41 January
2) <i>Additional Fees for Vehicle Purchase</i>	Linda Poenitzsch
Recommended Action: That the Board of Trustees ratify the expenditure of additional \$2,116.71 for vehicle purchase fees. Citizen Comment:	Page 50
3) <i>Auditors Letter of Engagement</i>	Linda Poenitzsch
Recommended Action: That the Board of Trustees accept the attached Letter of Engagement (LOE) from Condley and Company, LLP and authorize the Chair to sign the letter. Citizen Comment:	Page 51
C. CONTRACTS AND PLANS	
1) <i>QM Plan Review</i>	Sandra Rapson
Recommended Action: Information Only Item Citizen Comment:	Page 70
D. FACILITIES AND EQUIPMENT	
<i>No Agenda Items</i>	
E. POLICIES AND PROCEDURES	
1) <i>Policy Statement Summary</i>	Cara Mullenix-Artigue
Recommended Action: That the Board of Trustees review and approve the Policy Statements. 800.2 General Services for Individuals Policy Statement Citizen Comment:	Page 152
F. PROGRAM AND PERSONNEL	
<i>No Agenda Items</i>	
030526-6 QUARTERLY REPORTS	
A. ESSENTIAL SERVICES AND CLINICAL ACCOUNTABILITY	
<i>No Agenda Items</i>	
B. PLANNING AND NETWORK ADVISORY COMMITTEE	
<i>No Agenda Item</i>	

C. EXTERNAL AUDITS	
<i>1) Superior MCO External Audit Report</i>	Cara Mullenix-Artigue
Recommended Action: Information Only Item	Page 156
Citizen Comment:	
D. TEXAS COUNCIL BOARD OF DIRECTORS MEETING	
<i>No Agenda Items</i>	
E. FACILITIES MANAGEMENT	
<i>No Agenda Items</i>	
030526-7 EXECUTIVE DIRECTOR'S REPORT	Gianna Harris
A. ADMINISTRATION AND BOARD OF TRUSTEES	
B. BUDGET	
C. LEGISLATIVE ISSUES	
D. SERVICES	
E. HUMAN RESOURCES	
030526-8 CLOSED SESSION	
<i>No Agenda Items</i>	
030526-9 OPEN SESSION	
<i>No Agenda Items</i>	
030526-10 ANNOUNCEMENTS	J. Brian Eby
A. NEXT MEETING	
<i>11 a.m., Thursday, May 7, 2026 at the Administration Building, Sue Nunn Conference Room, 1000 Brook Ave., Wichita Falls, TX.</i>	
030526-11 OTHER BUSINESS	
030526-12 ADJOURN	J. Brian Eby

Minutes	<h1 style="margin: 0;">HELEN FARABEE CENTERS</h1> <h2 style="margin: 0;">BOARD OF TRUSTEES</h2>
	<p>January 8, 2026 11:00 AM TELEVIDEO & 1000 Brook Ave., Sue Nunn Conference, Wichita Falls, TX</p>

Board of Trustee Members Present:	J. Brian Eby, Chairman; Cindy Barksdale, David Cook, Kathy Thorp, Jessica Traw; Jan Driver Ward
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Board of Trustee Members Absent:	Tom Johnson, VACANT, VACANT, Sheriff-VACANT, Sheriff Babcock
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Staff Present:	Gianna Harris, Executive Director; Andy Martin, Associate Executive Director; Linda Poenitzsch, Director Financial Operations; Kelly Wooldridge, Human Resources Director; Sandra Rapson, Quality Assurance Coordinator, Dr. Carol Nati, Chief Medical Officer, Erin Perkins, IDD, Cara Mullenix-Artigue QM Director, Michael Stephenson, IT Director
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Other Staff and Guests Present:	Tom Taylor, City Councilman and Liaison Cynthia Kessler, Place 4 candidate Judge Don Thompson, Knox County Ryan Gibson, Condley & Co., CPA Luz Espinal & Brittany Myles, with Texas Workforce Solutions Melissa Collins, Board of Trustee Liaison, Recorder
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AGENDA TOPICS

010826-1 CALL TO ORDER

J. Brian Eby, Board Chair, called meeting to order at 11:00 A.M. with six (6) Board Members in attendance.

010826-2 PRESENTATIONS

A. Open Citizen Comment to The Board

No comments were presented to the Board.
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010826-3 APPROVAL OF MINUTES

Recommended Action: That the Board of Trustees approves the minutes of the November Board of Trustee meeting.
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The Board of Trustees reviewed and approved the minutes of the November Board of Trustee meeting.

Motion: Jessica Traw	Affirmative: 6
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Second: Jan Driver Ward	Negative: 0
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Citizen Comment: None

010826-4 TRAINING

Dr. Carol Nati, Chief Medical Officer provided training on the Medical Services. Presentations were distributed to all members in the board packet, available for review upon request.

Erin Perkins, Director IDD provided training on Intellectual & Developmental Disabilities. Presentations were distributed to all members in the board packet, available for review upon request.

010826 - 5 RECOMMENDATIONS

A. BOARD OF TRUSTEES

1) Place 4 Vacancy

Recommended Action: Information Only Item

The candidate, Cindy Kessler who was in attendance as a guest, has had all the Counties Commissioners Courts appoint her to the position. Next she will meet with Gianna to receive onboarding and will then become full board member.

Citizen Comment: None

2) Place 5 Vacancy

Recommended Action: That the Chair of the Board of Trustees appoint a three member ad-hoc committee to interview applicant for Place 5 and make a recommendation to the Commissioner’s Courts.

The Chair appointed a three member ad hoc committee to interview applicant for Place 5. Jessica Traw, Kathy Thorp, and Jan Driver Ward will comprise the committee.

Citizen Comment: None

3) Sheriff on the Board

Recommended Action: Welcome Sheriff Darcy White to the Board.

Baylor Co Sheriff Darcy White is now serving as our sheriff on the board.

Citizen Comment: None

4) Veteran on the Board

Recommended Action: Information Only Item

Senate Bill 1580 indicates we have to place a Veteran on the board. Elliot with the HFC Vets Dept has recommended a couple of candidates. We have until Sept 2026 to get someone in place.

Citizen Comment: None

B. BUDGET AND FINANCE

1) Fiscal Year 2025 Audit

Recommended Action: That the Board of Trustees approve and authorize the chair to sign the resolution indicating the Fiscal Year 2025 audit performed by Condley and Company, LLP, has been reviewed and approved.

Ryan Gibson, Condley & Co., CPA presented the audit results. The Board of Trustees reviewed and approved the Audit results for FY25. The chair was approved to sign the resolution.

Motion: **Jessica Traw**

Affirmative: 6

Second: **Jan Driver Ward**

Negative: 0

Citizen Comment: None

2) *Financial Statements*

Recommended Action: That the Board of Trustees approves the financial statements for October and November 2025.

The Board of Trustees reviewed and approved the financial statements for October and November 2025.

Motion: David Cook	Affirmative: 6
Second: Jessica Traw	Negative: 0
Citizen Comment: None	

3) *Status of Investments*

Recommended Action: That the Board of Trustees review and approve the status of investments.

The Board of Trustees reviewed and approved the status of Investments.

Motion: Jessica Traw	Affirmative: 6
Second: Cindy Barksdale	Negative: 0
Citizen Comment: None	

LETTER OF ENGAGEMENT

Recommended Action: That the Board of Trustees review and approve.

The Board of Trustees reviewed and approved

Motion: Jessica Traw	Affirmative: 6
Second: Cindy Barksdale	Negative: 0
Citizen Comment: None	

C. CONTRACTS AND PLANS

1) *USDA Distance Learning Grant Security Administrator Resolution*

Recommended Action: That the Board of Trustees reviews and approves the assigned security roles outlined in the resolution.

The Board of Trustees reviewed and ratified the lease renewal for 1709 10th Street with ASBA Enterprises, LTD.

Motion: David Cook	Affirmative: 6
Second: Cindy Barksdale	Negative: 0
Citizen Comment: None	

2) *Quality Management Plan and Attachments*

Recommended Action: That the Board of Trustees approves the amended Quality Management Plan and amended attachment for FY 2026.

The Board of Trustees reviewed and approved the amended Quality Management Plan and amended attachment for FY 2026.

Motion: Jan Driver Ward	Affirmative: 6
Second: Cindy Barksdale	Negative: 0
Citizen Comment: None	

D. FACILITIES AND EQUIPMENT

No Agenda Items

E. POLICY AND PROCEDURE

1) Policy Statement Summary

Recommended Action: That the Board of Trustees review and approve these Policy Statements:

- 100.1 Board of Trustees Policy Statement
- 400 Substance Abuse Services Policy Statement
- 600 Information Systems Policy Statement – MIS
- 900.2 Continuity of Care Policy Statement
- 900.3 Behavioral Health Services – Adult – Policy Statement
- 900.4 Child and Adolescent Services Policy Statement
- 900.10 Transition Home Policy Statement

Please review and approve the Board of Trustees Procedures.

- 100.1.1 Policy and Procedure Manual
- 100.1.2 Organizational Structure
- 100.1.3 Public Information – No Revisions
- 100.1.4 Open Meetings – No Revisions
- 100.1.5 Conflict of Interest – No Revisions
- 100.1.6 Executive Director – No Revisions
- 100.1.7 Accessing the Board of Trustees – No Revisions
- 100.1.9 Sheriff Ex-Officio Board Members – No Revisions
- 100.1.10 Board Travel – No Revisions

The Board of Trustees reviewed and approved all Policy Statements as presented.

Motion: David Cook	Affirmative: 6
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Second: Cindy Barksdale	Negative: 0
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Citizen Comment: None

F. PROGRAM AND PERSONNEL

3) Status of Investments

Recommended Action: That the Board of Trustees review and approve the status of investments.

The Board of Trustees reviewed and approved the status of Investments.

Motion: Jessica Traw	Affirmative: 6
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Second: Cindy Barksdale	Negative: 0
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Citizen Comment: None

010826-6 QUARTERLY REPORTS

A. ESSENTIAL SERVICES AND CLINICAL ACCOUNTABILITY

1) 1st Quarter Report

Recommended Action: Information Only Item

Cara Mullenix Artigue reported.

2) *Death Review Report*

Recommended Action: Information Only Item

Cara Mullenix Artigue reported.

B. PLANNING AND NETWORK ADVISORY COMMITTEE

No Agenda Items

C. EXTERNAL AUDITS

1) *TCOOMMI External Audit Report*

Recommended Action: Information Only Item

Cara Mullenix-Artigue reported.

1) *Behavioral Health QM External Audit*

Recommended Action: Information Only Item

Cara Mullenix-Artigue reported.

D. TEXAS COUNCIL BOARD OF DIRECTORS MEETING

No Agenda items

E. FACILITIES MANAGEMENT

No Agenda Items

010826 - 7 EXECUTIVE DIRECTOR'S REPORT

TX Council and the Legislature webinar

Texas Council will host the webinar, "Texas Council and the Legislature," January 21, 2026. This is the first event in a new educational series, the 90-minute webinar will give an inside look at how Texas Council advocates for our statewide system at the Capitol. Whether you are a trustee, administrator, clinician, advocate, or simply interested in the legislative landscape shaping mental health and IDD in Texas, this is your opportunity to deepen your knowledge. This event is open to anyone who may benefit from the information. The content will be tailored to the work of LMHAs/LBHAs and Local IDD Authorities.

Grant Funding for Opioid Abatement

Brad Fisk Director of SUD Dept. explains that we received funding from the City of WF for opioid abatement. HFC has been dispersing Narcan since 2016, but have ramped up the program over the past year. In April we received funds from the City and purchased the first two Narcan vending machines, one on Broad St. and one at Denver St. clinic. They notified the community that these machines are available for anyone in the community. In June they developed a free Narcan/Opioid Overdose Education Campaign and worked with an advertising agency (DesignWorks) to get the information out for Overdose help and where individuals could get free Narcan/Naloxone. There is a link on each page of the HFC website called (Narcan Wichita Falls, Free Narcan vending Machines) and the link takes you to a page where you can get information about opioid use and overdose education and where/how to use Narcan. The link also includes a map to locate the vending machines. In August, the next two machines were purchased and placed in Graham and Decatur. As of November, free Narcan boxes are at all HFC locations and are open to the public. Since April 2025, the two locations distributed 1,868 doses and it is the nasal version. The boxes include instructions on how to recognize overdose and how to administer the dose. They are also providing education to community partners about opioid overdose and how to use the Narcan.

010826-8 CLOSED SESSION

No Agenda Items

010826-9 OPEN SESSION

No Agenda Items

010826-10 ANNOUNCEMENTS

A. *Next Meeting* - The next meeting will be held at 11 A.M., Thursday, **March 5, 2026** at the **Young County MH Center Conference Room, Graham, TX.**

010826-11 OTHER BUSINESS

No other business

010826-12 ADJOURN

The Board of Trustees meeting was adjourned by **Board Chairman, J. Brian Eby** at 12:24 pm.

Approved as presented:

Approved as corrected:

March 5, 2026

March 5, 2026



Behavioral Health Services

Adult Mental Health



AMH Service Trends FY25

- ▶ Last year we discussed the downward trend of AMH services (Seeing 1000 less than we were 10 Fiscal Years ago)
- ▶ FY25,
 - ▶ unduplicated count down again slightly (5409 from 5498)
 - ▶ But number of services increased from 49,786 to 51,657



Our Focus in FY25/26

- ▶ We have been re-certified as a Texas Certified Community Behavioral Health Center for four years!
- ▶ Our Crisis Aid Response Team has been a major success
 - ▶ Now sustainable post-grant
 - ▶ More teams?
 - ▶ Meadows MH Policy Institute considers us a national best practice location and wants to document this!
- ▶ Opportunities for Integrated BH and Primary Care
 - ▶ New CCBHC Expansion Grants this Spring
 - ▶ Increased partnership with United Regional (their CHNA Priorities = BH)



Routine Levels of Care

- ▶ Services Provided
 - ▶ Case Management
 - ▶ Skills Training
 - ▶ Medication Management Services
 - ▶ 24 Hour Crisis Response
- ▶ Lots of Assessments and Planning
 - ▶ TRR/ANSA (Adult Needs and Strengths Assessment)
 - ▶ PHQ9 (Depression screening over last two weeks)
 - ▶ CSSRS (Depression Screening)
 - ▶ Person Centered Recovery Plans



Intensive Outpatient Services

- ▶ Assertive Community Treatment (ACT)
 - ▶ Interdisciplinary Teams
 - ▶ Close Collaborations
 - ▶ More encounters per month
 - ▶ Coordinating with outside agencies
- ▶ Psychiatric Rehab Services
 - ▶ Intensive Case Management
 - ▶ Illness Management & Recovery



Adjunct Services

- ▶ Counseling (CBT, TF-CBT, CBTp, CPT)
- ▶ Supported Employment
- ▶ Care Coordination
- ▶ Peer Services
- ▶ Benefits Assistance
- ▶ Flexible Funds



Other Adult MH Programs

- ▶ Trauma Informed Care (TIC)
- ▶ Mental Health First Aid
- ▶ Region 9 Education Service Center (for both students and staff support/education)



New Programs

- ▶ Jail-Based Competency Restoration (JBCR), Wichita County
 - ▶ HHS Funding released March 2025 (over a year late)
 - ▶ Services are Operational
 - ▶ So far, 31 unduplicated clients
 - ▶ 25 in JBCR Continuity of Care (screening, monitoring, court request)
 - ▶ 6 in JBCR proper (court-ordered restoration)



New Collaborations

- ▶ City/County Homeless Initiative Committee
- ▶ United Regional Health Care System, Behavioral Health Coalition
 - ▶ Community Education/ Awareness
 - ▶ Integrating Behavioral Health and Primary Care
 - ▶ Access and Navigation
- ▶ Wichita Falls Police Department, Mental Health Policy Review Panel

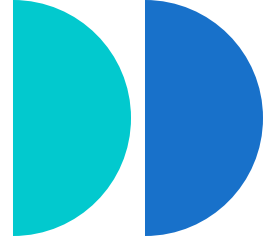
Child & Adolescent Services

Amanda Cantu, Director



Department Overview

- 10 Routine Services Case Managers
- 2 Intensive Case Managers
- 2 Prescribers (Psychiatrist, PMHNP)
- 1 Certified Family Partner (CFP)
- 1 CFP dually certified as Adult Peer Specialist
- 1 Dedicated CAS Clerk
- 1 Behavioral Health Partnership Program Liaison



What does CAS do?

Provide services to youth and family

- Assessment and Recovery Planning
- Routine Case Management
- Intensive Case Management (Wraparound)
- Skills Training
- Family Partner
- Patient & Family Education
- Medication Management
- Medication Training & Support
- Cognitive Behavioral Therapy
- Trauma-Focused CBT
- Crisis Intervention
- Benefits Eligibility Program
- Care Coordination
- YES Waiver
- RTC Project

And more

- ARD meetings
- Community Resource Collaboration Groups (CRCG)
- Child Fatality Review Teams
- Education and support in community and school events
- Continuous Quality Improvement
- Rural LMHA Collaboratives
- Intern and volunteer education

Skills Training Evidence Based and Best Practice Curriculum

01 Skillstreaming – Early, Elementary, Adolescent

Teaches pro-social skills through modeling, role play, feedback, and generalization.

02 Aggression Replacement Training

Helps youth improve social skills, moral reasoning, better manage anger, and reduce aggressive behaviors.

03 Preparing Adolescents for Young Adulthood

Used with youth ages 14+ to address issues related to transitioning from adolescence into adulthood.

04 Seeking Safety

Present-focused protocol to help youth attain safety from trauma and substance use.

05 Nurturing Programs

Develops caregivers' pro-social skills to help improve the child-caregiver relationship and reduce abusive or neglectful interactions.

06 Defiant Children/Teens

Step by step protocol for caregivers to reduce arguing, defiance, and other disruptive behaviors.

Intensive Services and Special Programs



Wraparound

A family centered, strengths-based process that provides intensive and creative mental health services for youth and their families. The process is led by an ICM and managed by a team of supports in the youth's life who work together to develop an individualized care plan. The overall goal is to ensure that families realize their goals and experience success in their homes, communities, and schools.



YES Waiver

The Youth Empowerment Services (YES) Waiver is a Medicaid waiver that provides comprehensive home and community-based services to youth who are at risk of out-of-home placement due to a serious emotional disturbance. YES Waiver includes all Wraparound services in addition to many non-traditional services and supports.



RTC Project

A partnership between HHSC and DFPS to provide treatment support for families with a child who may be placed into DFPS custody solely because of their mental health needs. While the youth is in the RTC, the ICM participates in weekly treatment team meetings with the RTC and the family. The caregivers receive Family Partner supports to ensure readiness for the transition of the youth back into the home after RTC placement.

Youth Served



Location		#Currently Enrolled	
Region I: Vernon/Childress/Quanah		42	
Region II: Haskell/Seymour		34	
Region III: Graham		18	
Region IV: Bowie		37	
Region V: Wichita Falls		162	
Region VI: Decatur		110	
		#Currently Enrolled	Past Year
Wraparound		11	24
YES Waiver		1	7
RTC Project		2	6

New This Year

- Developed 6-hour QMHP trainings for providers using PAYA and Defiant Children & Teens to meet new HHSC and Medicaid requirements
- Developed training for Certified Family Partners to meet new Medicaid requirements
- Expanded YES Waiver service array

Service Type	Provider	Location
Respite – Camp	Camp Summit	Wise (Paradise)
Art Therapy	Sacred Space Counseling	Wichita Falls
Music Therapy, Art Therapy	Thinking Above Average	Virtual, all locations

In the Community

WFISD Community Resource Parade

Bridgeport High School Parent Engagement Night

McCord Elementary Back to School Roundup, Vernon

Boys & Girls Club Closing the Pipeline Fair, Wichita Falls

Rolling Plains Child Services, Quanah

Boys & Girls Club, staff and youth awareness, Wichita Falls

Decatur Suicide Walk

MSU Social Work Fair, Wichita Falls

Haynes Headstart Parent Meeting, Wichita Falls



5 RECOMMENDATIONS

A. BOARD OF TRUSTEES

1) PLACE 4 NEW MEMBER

RECOMMENDED ACTION: Information Only Item

BACKGROUND INFORMATION:

- A. Board Member Lou Vail representing Place 4 on the Board of Trustees indicated she was not interested in renewing her appointment for the Place 4 position.
- B. Board vacancy notifications and application packets were sent to the appropriate appointing entity in Baylor, Haskell, and Knox County. "Opportunity to Serve" notices were posted in Center service sites. Public notices of the Board of Trustee vacancy were run in the corresponding (Baylor, Haskell, Knox) County Newspapers.
- C. An applicant has been received.
- D. The Chairman of the board has appointed a three member ad-hoc committee to interview Board of Trustee applicant for Place 4 and make a recommendation to the Commissioner's Courts.
- E. The ad hoc committee interviewed the applicant, Ms. Cynthia Kessler and made their recommendation to the Commissioners Courts to appoint her.
- F. All the appointing Counties have made their appointment, and we welcome Ms. Cynthia Kessler to the board.

SPECIFIC REASONS WHY THESE ACTIONS ARE NECESSARY FOR THE CENTER:

- A. To meet the requirements established in Attachment A of the Helen Farabee Centers' Interlocal Agreement.
- B. To help ensure that Board of Trustee composition meets state and interlocal membership requirements and remains reflective and representative of the communities and persons served by the Helen Farabee Centers.

5 RECOMMENDATIONS

A. BOARD OF TRUSTEES

2) PLACE 5 VACANCY

RECOMMENDED ACTION: Information Only Item

BACKGROUND INFORMATION:

- A.** Joan Murray representing Place 5 on the Board of Trustees indicated she does not wish to be considered for reappointment.
- B.** Board vacancy notifications and application packets were sent to the appropriate appointing entity in Cottle, Dickens, King and Stonewall Counties. "Opportunity to Serve" notices were posted in Helen Farabee Centers' service sites.
- C.** Public notices of the Board of Trustee vacancy were run in the, Paducah Post, Stonewall County Courier, and The Texas Spur.
- D.** One potential candidate has applied. Application Form attached.
- E.** The Board Chairman will appoint a three member ad hoc committee to interview the candidate.
- F.** The ad hoc committee has interviewed the candidate and made their recommendation to the appointing commissioners courts.

SPECIFIC REASONS WHY THESE ACTIONS ARE NECESSARY FOR THE CENTER:

- A.** To meet the requirements established in Attachment A of the Helen Farabee Centers' Interlocal Agreement.
- B.** To help ensure that Board of Trustee composition meets state and interlocal membership requirements and remains reflective and representative of the communities and persons served by the Helen Farabee Centers.

5 RECOMMENDATIONS

A. BOARD OF TRUSTEES

4) VETERAN ON THE BOARD

RECOMMENDED ACTION: Information Only Item.

BACKGROUND INFORMATION:

- A. Senate Bill (SB) 1580 passed the 89th Legislature and was signed into law by Governor Abbott. This law requires the governing body of the Centers to include a veteran selected by a majority of the governing body members.
- B. Local Mental Health Authorities will have until September 1, 2026 to implement this change, and the bill takes effect on September 1, 2025.
- C. This addition aims to ensure that veterans have representation in local mental health authority governance, potentially bringing a unique perspective to community health decision making bodies.
- D. The Director of Veterans Services, Elliot Bonner is assisting with locating a suitable Veteran to join the board.

SUPPORTING INFORMATION:

- A. Senate Bill (SB) 1580 of the 89th Texas Legislature.
- B. The Bill does not specify criteria for the veteran's qualifications beyond military service, nor does it elaborate on the veteran's role, whether voting or advisory, within the governing body.

SPECIFIC REASONS WHY THESE ACTIONS ARE NECESSARY FOR THE CENTER:

This allows Helen Farabee Centers to ensure compliance with a new Governing Body requirement by the State of Texas, to ensure veteran representation in local mental health governance and to enhance the relevance and responsiveness of LMHAs to populations that often experience distinct mental health challenges.

AN ACT

relating to the composition of the governing body of a local mental health authority.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 533.0351 (a), Health and Safety Code, is amended to read as follows:

(a) If a local mental health authority has a governing body, the governing body must include:

(1) for a local authority that serves only one county, the sheriff of the county as an ex officio nonvoting member; ~~and~~

(2) for a local authority that serves two or more counties, two sheriffs chosen in accordance with Subsection (b) as ex officio nonvoting members; and

(3) a veteran selected by a majority of the governing body members.

SECTION 2. A local mental health authority that has a governing body must be in compliance with Section 533.0351 (a), Health and Safety Code, as amended by this Act, not later than September 1, 2026.

SECTION 3. This Act takes effect September 1, 2025.

President of the Senate

Speaker of the House

I hereby certify that S.B. No. 1580 passed the Senate on April 24, 2025, by the following vote: Yeas 31, Nays 0; and that the Senate concurred in House amendment on May 30, 2025, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

I hereby certify that S.B. No. 1580 passed the House, with amendment, on May 28, 2025, by the following vote: Yeas 128, Nays 2, one present not voting.

Chief Clerk of the House

Approved:

Date

Governor

5 RECOMMENDATIONS

B. BUDGET AND FINANCE

1) FINANCIAL STATEMENTS - DECEMBER 2025

RECOMMENDED ACTION: That the Board of Trustees approves the financial statements for December 2025.

BACKGROUND INFORMATION: Board of Trustee policy requires the periodic presentation of financial and statistical information. Our Performance Contracts with the Texas Health and Human Service Commission require the Board of Trustee Chair, Executive Director, and Financial Officer to certify the accuracy of the financial statements on a quarterly basis. Although this certification does not require Board of Trustee approval, we will continue to present these to the Board of Trustees.

SUPPORTING INFORMATION:

- ❖ Number of Days of Operation in Fund Balance *143*.
- ❖ Accounts Receivable *increased* by \$92,796, going from \$1,588,886 to \$1,681,682.
- ❖ Accounts Payable *decreased* by \$70,461, going from \$1,997,252 to \$1,926,791. Most of this amount is due to the state giving us PPB money late last fiscal year, and the Center was unable to use it. We received word in early March of 2025 that the money will have to be returned. The amount is \$937,600. The Center will receive an invoice from the state for recoupment. Until then, it will stay in our Accounts Payable amount. If not for that, Accounts Payable would have been \$989,191.
- ❖ **FINANCIAL STATUS:** The Center had a loss of \$78,136 for December and a cumulative loss of \$804,635 for the year.
- ❖ **REVENUE:** Overall Revenue December 2025 was \$149,603 more than budgeted.
 - **Total County and City Revenue** was \$3,977 less than budgeted. We have 3 counties and 1 city that have not given us a signed MOA for FY2026. We will wait to record revenue when the MOAs are signed. We also had one county give us support for FY2026 when they did not give support for FY2024 or FY2025.
 - **Patient Fees** were \$50,926 more than budgeted.
 - This is based on actual cash received in December for services.
 - **Miscellaneous** was \$81,923 more than budgeted.
 - In-kind Match was \$90,206 more than budgeted due to the actual usage of the psychiatric bed days at Red River and our other contracted hospitals. This is based on the PESC in-kind match for psychiatric bed days and is provided by Red River.

5 RECOMMENDATIONS

B. BUDGET AND FINANCE

1) FINANCIAL STATEMENTS - DECEMBER 2025

This is also based on the Justice Involved Grant, also known as Senate Bill 292 contract, that has increased the Center's Mental Health and Substance Abuse bed usage at Red River. We now have the PPB, or Private Psychiatric Bed revenue through the MH General revenue fund, that also uses bed days from various contracted hospitals where we are receiving in-kind.

- CART earned revenue was \$13,695.00 less than budgeted. I anticipated more expenses for our grant which in turn would be reimbursed. This is the last month and year for this grant. The Center will still be providing CART services and expenses will be paid by a portion of the Wichita Falls County support money.
 - **Other State Funding** was \$40,587 less than budgeted.
 - DARS-ECI Revenue was \$24,214 more than budgeted. Less Locally Collected Funds were collected than budgeted; therefore, we ask for more from the state to cover expenses.
 - OSAR revenue is \$13,965 less than budgeted. This budget is mostly influenced by our subcontractor, Abilene Recovery Council, and the way they utilize the resources of the contract.
 - SB292 Revenue was \$46,142 less than budgeted. This is based on client need for the psychiatric beds, and usage will fluctuate.
 - **Other Federal Funding** was \$13,467 more than budgeted.
 - Not one program stands out as making more than budgeted. These revenues are mostly based on cash receipts received in December.
 - **General Revenue** was \$47,851 more than budgeted.
 - Private Psychiatric Beds MH/PPB revenue was \$48,126 more than budgeted. PPB revenue fluctuates based on client need for psychiatric beds.
 - PESC revenue was \$276 less than budgeted. Just like PPB revenue, PESC revenue fluctuates based on client need for the psychiatric beds.
 - **Allocated Federal Funds** were right on budget.
- ❖ **EXPENSES:** Overall expense for December 2025 was \$128,150 more than budgeted.
- **Personnel** cost was \$28,062 more than budgeted.
 - Salaries were \$19,304 more than budgeted.
 - Benefits were \$8,758 more than budgeted.

5 RECOMMENDATIONS

B. BUDGET AND FINANCE

1) FINANCIAL STATEMENTS - DECEMBER 2025

- **Contract** cost was \$2,235 more than budgeted.
 - PESC expense was \$4,914 more than budgeted, Justice Involved Bed Days was \$38,373 less than budgeted, and PPB Bed Days was \$43,307 more than budgeted. All these expenses fluctuate based on client need for the psychiatric beds.
 - OSAR expense was \$13,034 less than budgeted. This budget is mostly influenced by our subcontractor, Abilene Recovery Council, and the way they utilize the resources of the contract.
- **Travel and Training** expenses were \$2,346 more than budgeted.
- **Capital Outlay** expense was \$969 less than budgeted.
- **Non-Capitalized Equipment** expense was \$687 more than budgeted.
- **Pharmaceutical** expense was \$3,885 more than budgeted. This is based upon actual expenses and will fluctuate with patient care. As of January 2021, Community Benefit and Uncompensated Care expired. This means the Center now pays for all medical invoices from Clinical Pathology Laboratories and Integrated Prescription Management that were being paid by SONT, Service Organization of North Texas. The Wood Group invoices will still be paid by SONT up to the time they no longer can or will pay for them.
- **Other Operating** expense was \$91,631 more than budgeted. In-Kind Expense was \$90,206 more than budgeted. This is attributed to the contract with Red River for the PESC contract, the Justice Involved Bed Days contract (SB292), and the Private Psychiatric Bed Days contract. It is based on bed day usage and will fluctuate based on client need. No actual dollars are exchanged; and there is a corresponding revenue, so the net difference is zero.

Helen Farabee Centers
Balance Sheet - As Of December 2025

Assets	Actual
CASH GENERAL OPERATING FUND	\$ 7,749,625.40
CASH INTERNAL SERVICE FUND	\$ 2,277,554.70
CASH SELF FUNDED INSURANCE	\$ 460,090.65
SAVINGS	\$ 17,192.84
PETTY CASH FUNDS-CENTERWIDE	\$ 798.17
INVESTMENTS GENERAL OPERATING FUND	\$ 8,701,770.44
INVESTMENTS INTERNAL SERVICE FUND	\$ 705,341.02
ACCOUNTS RECEIVABLE	\$ 1,681,682.38
PREPAID	\$ 647,648.01
PREPAID MISCELLANEOUS-SELF INSURED FUNDS	\$ 1,833.32
DEPOSITS	\$ 253,349.88
DEPOSITS-SELF INSURED FUNDS	\$ 25,000.00
AMTS PROVIDED-PERSONAL LEAVE	\$ 947,522.78
LAND	\$ 1,057,659.65
BUILDINGS & IMPROVEMENTS	\$ 2,738,293.76
LEASEHOLD IMPROVEMENTS	\$ 132,631.17
EQUIP/FURN/FIX	\$ 431,222.35
COMPUTERS & PERIPHERALS	\$ 929,641.99
VEHICLES & CONTRACTORS EQ	\$ 1,721,265.08
COMPUTER SOFTWARE	\$ 610,961.56
ACCUMULATED DEPRECIATION	\$ (5,526,984.73)
CLINICAL SOFTWARE PROJECT	\$ -
WICHITA FALLS BUILDING PROJECT	\$ 386,012.69
ISF-MAJOR PROJECTS WORK-IN-PROGRESS	\$ (1,228.23)
Total Assets	\$ 25,948,884.88
Liabilities and Net Assets	
Liabilities	
ACCOUNTS PAYABLE GENERAL OPERATING FUND	\$ 785,718.20
ACCOUNTS PAYABLE INTERNAL SERVICE FUND	\$ 5,363.76
ACCOUNTS PAYABLE-SELF INSURED FUND	\$ 25,551.97
ACCOUNTS PAYABLE-PAYABLE TO STATE	\$ 1,110,157.00
PAYROLL PAYABLE	\$ 509,787.26
UMR PAYABLE	\$ 87,163.86
EMPLOYEE DEDUCTION PAYBLE	\$ 10,067.48
DEFERRED REVENUE	\$ 3,815,650.63
ACCUM PERSONAL LEAVE-CURRENT	\$ 19,117.92
ACCUM PERSONAL LEAVE-LONGTERM	\$ 947,522.78
UMR CLAIMS PAYABLE - IBNR	\$ 140,000.00
Total Liabilities	\$ 7,456,100.86
Net Assets	
UNRESERVED-FUND BALANCE	\$ 12,212,262.39
UNRESERVED-ACCUM PERSONNEL LEAVE	\$ 947,522.78
INCOME SUMMARY-OPERATING FUND	\$ (124,008.40)
INCOME SUMMARY-INTERNAL SERVICE FUND	\$ 5,553,925.68
CONTRIBUTED CAPITAL	\$ (248,219.49)
RETAINED EARNINGS	\$ 151,301.06
Total Net Assets	\$ 18,492,784.02
Total Liabilities and Net Assets	\$ 25,948,884.88

Helen Farabee Centers
DECEMBER 2025 Income Statement

		DECEMBER 2025					YEAR TO DATE				
		DEC FY26	DEC FY26	DEC FY25	Variance	Variance	FY2026 Y-T-D	FY2025 Y-T-D	FY2025 Y-T-D	Variance	Variance
		Actual	Budget	Actual	Budget	FY 2025	Actual	Budget	Actual	Y-T-D Budget	Y-T-D FY 2025
Revenue											
City Revenue - Deferred Revenue											
2-7000	CITY OF WICHITA FALLS	\$8,333.33	\$8,333.33	\$8,333.32	\$0.00	\$0.01	\$33,333.33	\$33,333.33	\$33,333.32	\$0.00	\$0.01
2-7001	CITY OF CHILLICOTHE	\$27.50	\$27.50	\$27.50	\$0.00	\$0.00	\$110.00	\$110.00	\$110.00	\$0.00	\$0.00
2-7002	CITY OF QUANAH	\$0.00	\$55.00	\$55.00	(\$55.00)	(\$55.00)	\$0.00	\$220.00	\$220.00	(\$220.00)	(\$220.00)
2-7004	CITY OF BURKBURNETT	\$417.67	\$417.67	\$417.69	\$0.00	(\$0.02)	\$1,670.66	\$1,670.66	\$1,670.68	\$0.00	(\$0.02)
2-7005	CITY OF GRAHAM	\$1,250.00	\$1,250.00	\$833.37	\$0.00	\$416.63	\$5,000.00	\$5,000.00	\$5,000.00	\$0.00	\$0.00
2-7006	CITY OF NOCONA	\$125.00	\$125.00	\$125.00	\$0.00	\$0.00	\$500.00	\$500.00	\$500.00	\$0.00	\$0.00
2-7007	CITY OF BOWIE	\$666.66	\$666.66	\$666.69	\$0.00	(\$0.03)	\$2,666.66	\$2,666.66	\$2,666.68	\$0.00	(\$0.02)
Total City Revenue		\$10,820.16	\$10,875.16	\$10,458.57	(\$55.00)	\$361.59	\$43,280.65	\$43,500.65	\$43,500.68	(\$220.00)	(\$220.03)
County Revenue - Deferred Revenue											
2-7020	WICHITA COUNTY	\$13,333.37	\$13,333.33	\$10,000.00	\$0.04	\$3,333.37	\$53,333.36	\$53,333.32	\$40,000.00	\$0.04	\$13,333.36
2-7021	HASKEL COUNTY	\$1,387.68	\$1,387.68	\$1,009.17	\$0.00	\$378.51	\$5,550.68	\$5,550.68	\$3,784.51	\$0.00	\$1,766.17
2-7022	STONEWALL COUNTY	\$211.89	\$211.89	\$176.82	\$0.00	\$35.07	\$847.56	\$847.56	\$707.32	\$0.00	\$140.24
2-7023	KNOX COUNTY	\$554.16	\$554.16	\$551.40	\$0.00	\$2.76	\$2,216.64	\$2,216.64	\$2,205.60	\$0.00	\$11.04
2-7024	DICKENS COUNTY	\$0.00	\$149.81	\$149.81	(\$149.81)	(\$149.81)	\$0.00	\$599.24	\$599.24	(\$599.24)	(\$599.24)
2-7025	YOUNG COUNTY	\$0.00	\$400.00	\$2,862.00	(\$400.00)	(\$2,862.00)	\$0.00	\$1,600.00	\$11,448.00	(\$1,600.00)	(\$11,448.00)
2-7026	THROCKMORTON COUNTY	\$273.26	\$273.26	\$156.05	\$0.00	\$117.21	\$1,093.04	\$1,093.04	\$624.20	\$0.00	\$468.84
2-7027	HARDEMAN COUNTY	\$353.44	\$353.44	\$0.00	\$0.00	\$353.44	\$1,413.76	\$1,413.76	\$0.00	\$0.00	\$1,413.76
2-7028	WISE COUNTY	\$0.00	\$4,616.66	\$4,616.69	(\$4,616.66)	(\$4,616.69)	\$0.00	\$18,466.64	\$18,466.68	(\$18,466.64)	(\$18,466.68)
2-7029	BAYLOR COUNTY	\$433.33	\$433.33	\$433.33	\$0.00	\$0.00	\$1,733.32	\$1,733.32	\$1,733.32	\$0.00	\$0.00
2-7030	FOARD COUNTY	\$110.00	\$110.00	\$205.99	\$0.00	(\$95.99)	\$440.00	\$440.00	\$823.96	\$0.00	(\$383.96)
2-7031	MONTAGUE COUNTY	\$8,388.04	\$8,107.84	\$8,107.84	\$280.20	\$280.20	\$33,552.16	\$32,431.36	\$32,431.36	\$1,120.80	\$1,120.80
2-7032	JACK COUNTY	\$1,706.19	\$1,706.19	\$1,250.00	\$0.00	\$456.19	\$6,824.73	\$6,824.73	\$5,000.00	\$0.00	\$1,824.73
2-7033	CLAY COUNTY	\$333.33	\$333.33	\$241.70	\$0.00	\$91.63	\$1,333.32	\$1,333.32	\$966.68	\$0.00	\$366.64
2-7034	COTTLE COUNTY	\$199.75	\$199.75	\$199.75	\$0.00	\$0.00	\$799.00	\$799.00	\$799.00	\$0.00	\$0.00
2-7035	CHILDRESS COUNTY	\$347.91	\$347.91	\$347.95	\$0.00	(\$0.04)	\$1,391.64	\$1,391.64	\$1,391.68	\$0.00	(\$0.04)
2-7036	ARCHER COUNTY SUPPORT	\$964.58	\$0.00	\$208.33	\$964.58	\$756.25	\$3,858.32	\$0.00	\$833.32	\$3,858.32	\$3,025.00
Total County Revenue		\$28,596.93	\$32,518.58	\$30,516.83	(\$3,921.65)	(\$1,919.90)	\$114,387.53	\$130,074.25	\$121,814.87	(\$15,686.72)	(\$7,427.34)
Other Taxing Authority Funds - Deferred Revenue											
2-7038	INDEPENDENT SCHOOL DISTRICT	\$265.00	\$265.00	\$265.00	\$0.00	\$0.00	\$1,060.00	\$1,060.00	\$1,060.00	\$0.00	\$0.00
Total Other Taxing Authority Funds		\$265.00	\$265.00	\$265.00	\$0.00	\$0.00	\$1,060.00	\$1,060.00	\$1,060.00	\$0.00	\$0.00
Patient Fees - Cash Basis Only											
2-7050	CONSUMER FEES	\$33,366.29	\$22,361.28	\$18,361.28	\$11,005.01	\$15,005.01	\$63,643.51	\$52,979.47	\$49,979.47	\$10,664.04	\$13,664.04
2-7060	PRIVATE INSURANCE MCO CARD SERVICES	\$50,457.69	\$38,676.64	\$25,676.64	\$11,781.05	\$24,781.05	\$107,360.49	\$104,112.52	\$100,262.29	\$3,247.97	\$7,098.20
2-7070	PRIVATE INSURANCE MCO CASE MANAGEMENT	\$25,797.04	\$8,396.08	\$6,649.60	\$17,400.96	\$19,147.44	\$59,168.69	\$33,899.13	\$32,454.31	\$25,269.56	\$26,714.38
2-7080	PRIVATE INSURANCE MCO REHAB	\$21,463.39	\$10,724.19	\$6,756.53	\$10,739.20	\$14,706.86	\$46,659.12	\$32,519.91	\$31,552.25	\$14,139.21	\$15,106.87
Total Patient Fees		\$131,084.41	\$80,158.19	\$57,444.05	\$50,926.22	\$73,640.36	\$276,831.81	\$223,511.03	\$214,248.32	\$53,320.78	\$62,583.49
Miscellaneous - Cash Basis											
2-7037	IN-KIND MATCH	\$736,613.30	\$646,407.12	\$665,585.39	\$90,206.18	\$71,027.91	\$2,726,943.21	\$2,585,628.48	\$2,877,791.56	\$141,314.73	(\$150,848.35)
2-7100	MEDICARE - TITLE XVII	\$9,899.38	\$6,463.77	\$6,463.77	\$3,435.61	\$3,435.61	\$14,776.09	\$12,483.44	\$12,483.44	\$2,292.65	\$2,292.65
2-7260	RENT	\$1,225.00	\$1,327.60	\$4,955.75	(\$102.60)	(\$3,730.75)	\$3,587.50	\$6,312.75	\$19,710.50	(\$2,725.25)	(\$16,123.00)
2-7270	DONATIONS/CONTRIBUTIONS	\$2,933.33	\$233.33	\$333.33	\$2,700.00	\$2,600.00	\$3,739.72	\$944.44	\$1,344.44	\$2,795.28	\$2,395.28
2-7272	CART EARNED REVENUE	\$10,215.05	\$23,900.00	\$82,576.79	(\$13,684.95)	(\$72,361.74)	\$52,309.96	\$97,600.00	\$82,576.79	(\$45,290.04)	(\$30,266.83)
2-7273	WF OPIOID GRANT	\$1,430.77	\$1,000.00	\$0.00	\$430.77	\$1,430.77	\$5,183.71	\$4,000.00	\$0.00	\$1,183.71	\$5,183.71
2-7275	INTEREST INCOME	\$37,400.17	\$39,345.36	\$39,709.29	(\$1,945.19)	(\$2,309.12)	\$61,134.79	\$38,915.03	\$30,616.68	\$22,219.76	\$30,518.11
2-7280	MISCELLANEOUS	\$3,190.76	\$2,307.90	\$2,307.90	\$882.86	\$882.86	\$16,363.07	\$12,810.40	\$6,795.21	\$3,552.67	\$9,567.86
Total Miscellaneous		\$802,907.76	\$720,985.08	\$801,932.22	\$81,922.68	\$975.54	\$2,884,038.05	\$2,758,694.54	\$3,031,318.62	\$125,343.51	(\$147,280.57)

			DECEMBER 2025					YEAR TO DATE				
			DEC FY26	DEC FY26	DEC FY25	Variance	Variance	FY2026 Y-T-D	FY2025 Y-T-D	FY2025 Y-T-D	Variance	Variance
			Actual	Budget	Actual	Budget	FY 2025	Actual	Budget	Actual	Y-T-D Budget	Y-T-D FY 2025
Other State Funding - Accrued Basis Only												
2-7120	MH FIRST AID		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$31,200.00	\$17,700.00	\$22,700.00	\$13,500.00	\$8,500.00
2-7122	TCOOMMI EARNED INCOME		\$28,138.25	\$29,365.62	\$28,322.73	(\$1,227.37)	(\$184.48)	\$122,132.97	\$121,621.19	\$117,843.03	\$511.78	\$4,289.94
2-7124	SUBSTANCE ABUSE SERVICES		\$33,258.25	\$26,669.67	\$23,088.29	\$6,588.58	\$10,169.96	\$117,106.37	\$91,424.28	\$90,832.42	\$25,682.09	\$26,273.95
2-7125	SUD COMMUNITY MH GRANT PROGRAM		\$4,250.76	\$3,521.66	\$1,963.43	\$729.10	\$2,287.33	\$13,369.58	\$14,086.64	\$7,870.95	(\$717.06)	\$5,498.63
2-7127	OSAR - OUTREACH, SCREENING ASSESSMENT, REFFERAL		\$22,578.73	\$36,543.32	\$39,040.77	(\$13,964.59)	(\$16,462.04)	\$110,603.70	\$136,211.40	\$165,858.04	(\$25,607.70)	(\$55,254.34)
2-7128	RSS - RECOVERY SUPPORT SERVICES		\$9,051.45	\$6,134.79	\$6,134.79	\$2,916.66	\$2,916.66	\$32,009.81	\$32,297.48	\$25,903.53	(\$287.67)	\$6,106.28
2-7150	MFP/ECC REVENUE		(\$0.14)	\$2,707.50	\$1,361.94	(\$2,707.64)	(\$1,362.08)	\$10,829.86	\$10,829.98	\$10,830.00	(\$0.12)	(\$0.14)
2-7152	PASSR IDD SPECIALIZED SERVICES		\$1,764.78	\$1,065.26	\$1,065.26	\$699.52	\$699.52	\$3,224.52	\$2,419.65	\$2,419.65	\$804.87	\$804.87
2-7153	PASRR IDD SPECIALIZED SERVICES - OBRA - LIDDA		\$0.00	\$0.00	\$350.00	\$0.00	(\$350.00)	\$350.00	\$1,750.00	\$2,100.00	(\$1,400.00)	(\$1,750.00)
2-7132	CMHG LPHA EXPANSION		\$4,873.77	\$4,873.77	\$9,747.55	\$0.00	(\$4,873.78)	\$19,495.09	\$19,495.08	\$17,058.22	\$0.01	\$2,436.87
2-7216	MHGJII NCA - JBCR		\$20,209.43	\$31,902.15	\$0.00	(\$11,692.72)	\$20,209.43	\$70,915.99	\$127,608.60	\$0.00	(\$56,692.61)	\$70,915.99
2-7218	JUSTICE INVOLVED GRANT PROGRAM		\$150,176.84	\$196,318.82	\$164,041.72	(\$46,141.98)	(\$13,864.88)	\$728,775.37	\$785,275.28	\$1,065,848.49	(\$56,499.91)	(\$337,073.12)
2-7245	DARS-ECI REVENUE		\$114,077.44	\$89,863.77	\$93,027.32	\$24,213.67	\$21,050.12	\$478,772.15	\$398,608.36	\$436,754.84	\$80,163.79	\$42,017.31
Total Other State Funding			\$388,379.56	\$428,966.33	\$368,143.80	(\$40,586.77)	\$20,235.76	\$1,738,785.41	\$1,759,327.94	\$1,966,019.17	(\$20,542.53)	(\$227,233.76)
Other Federal Funding												
2-7102	MEDICAID-CARD SERVICES		\$2,504.29	\$556.91	\$581.82	\$1,947.38	\$1,922.47	\$5,134.16	\$731.28	\$806.01	\$4,402.88	\$4,328.15
2-7104	MEDICAID-CASE MANAGEMENT		\$3,939.26	\$4,432.77	\$4,529.05	(\$493.51)	(\$589.79)	\$10,348.84	\$16,856.30	\$17,051.73	(\$6,507.46)	(\$6,702.89)
2-7106	MEDICAID-IDD SERV COORDINATION		\$56,313.50	\$52,113.20	\$54,113.20	\$4,200.30	\$2,200.30	\$223,237.30	\$229,977.80	\$235,977.80	(\$6,740.50)	(\$12,740.50)
2-7108	MEDICAID REHAB		\$28,857.69	\$22,614.21	\$17,056.89	\$6,243.48	\$11,800.80	\$73,017.76	\$60,149.46	\$54,592.14	\$12,868.30	\$18,425.62
2-7110	MEDICAID PASRR		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$661.96	\$1,616.71	\$2,011.34	(\$954.75)	(\$1,349.38)
2-7112	MEDICAID-ADMIN CLAIMING		\$40,343.15	\$40,000.00	\$40,000.00	\$343.15	\$343.15	\$203,169.35	\$172,444.46	\$172,893.60	\$30,724.89	\$30,275.75
2-7114	MEDICAID-HABILITATION COORDINATION		\$9,578.58	\$5,293.21	\$5,293.21	\$4,285.37	\$4,285.37	\$34,149.72	\$27,594.64	\$27,594.64	\$6,555.08	\$6,555.08
2-7120	MH FIRST AID		\$5,637.56	\$5,233.73	\$5,233.73	\$403.83	\$403.83	\$22,860.79	\$23,666.50	\$23,666.50	(\$805.71)	(\$805.71)
2-7126	STATE HOSPITAL STEP-DOWN PROGRAM		\$54,931.83	\$57,181.11	\$57,181.11	(\$2,249.28)	(\$2,249.28)	\$219,200.97	\$228,556.36	\$228,556.36	(\$9,355.39)	(\$9,355.39)
2-7130	MH OUTPATIENT CAPACITY EXPANSION		\$0.00	\$0.00	\$16,571.10	\$0.00	(\$16,571.10)	\$0.00	\$0.00	\$67,387.18	\$0.00	(\$67,387.18)
2-7252	DIRECTED PAYMENT PROGRAM - BEHAVIORAL HEALTH SERVICES		\$45,538.36	\$46,852.11	\$48,465.12	(\$1,313.75)	(\$2,926.76)	\$110,267.07	\$147,408.44	\$83,493.18	(\$37,141.37)	\$26,773.89
2-7254	PUBLIC HEALTH PROVIDER - CHARITY CARE PROGRAM		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
2-7258	TRANSITION SUPPORT LIAISON		\$5,360.01	\$5,260.33	\$0.00	\$99.68	\$5,360.01	\$21,203.40	\$21,041.32	\$0.00	\$162.08	\$21,203.40
Total Other Federal Funding			\$253,004.23	\$239,537.58	\$249,025.23	\$13,466.65	\$3,979.00	\$923,251.32	\$930,043.27	\$914,030.48	(\$6,791.95)	\$9,220.84
General Revenue - Deferred Revenue												
2-7215	PESC		\$181,209.72	\$181,485.66	\$157,177.62	(\$275.94)	\$24,032.10	\$756,798.11	\$725,942.64	\$645,742.98	\$30,855.47	\$111,055.13
2-7217	Private Psychiatric Beds MH/PPB		\$126,259.83	\$78,133.33	\$112,436.50	\$48,126.50	\$13,823.33	\$365,963.31	\$312,533.32	\$112,436.50	\$53,429.99	\$253,526.81
2-7220	GENERAL REVENUE - MH		\$600,876.24	\$600,876.24	\$600,876.25	\$0.00	(\$0.01)	\$2,403,504.96	\$2,403,504.96	\$2,403,505.01	\$0.00	(\$0.05)
2-7222	GENERAL REVENUE - VETERANS SERVICES		\$5,833.33	\$5,833.33	\$5,833.34	\$0.00	(\$0.01)	\$23,333.33	\$23,333.33	\$23,333.36	\$0.00	(\$0.03)
2-7224	GENERAL REVENUE - BH SVCS IN EDUC SVC CTR		\$9,583.33	\$9,583.33	\$9,583.34	\$0.00	(\$0.01)	\$38,333.33	\$38,333.33	\$38,333.36	\$0.00	(\$0.03)
2-7230	GENERAL REVENUE - IDD		\$93,036.53	\$93,036.53	\$93,036.53	\$0.00	\$0.00	\$372,146.12	\$372,146.12	\$372,146.13	\$0.00	(\$0.01)
2-7232	GENERAL REVENUE-CRISIS REDESIG		\$39,884.50	\$39,884.50	\$39,884.50	\$0.00	\$0.00	\$159,538.00	\$159,538.00	\$159,538.01	\$0.00	(\$0.01)
2-7235	GENERAL REVENUE - IDD ARPA		\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2,795.39	\$0.00	\$0.00	\$2,795.39	\$2,795.39
2-7236	IDD GR-CRISIS RESPITE-CIS		\$17,980.66	\$17,980.66	\$17,980.67	\$0.00	(\$0.01)	\$71,922.66	\$71,922.66	\$71,922.66	\$0.00	\$0.00
2-7238	PERMANENCY PLANNING		\$1,854.75	\$1,854.75	\$1,854.75	\$0.00	\$0.00	\$7,419.00	\$7,419.00	\$7,419.00	\$0.00	\$0.00
Total General Revenue			\$1,076,518.89	\$1,028,668.33	\$1,038,663.50	\$47,850.56	\$37,855.39	\$4,201,754.21	\$4,114,673.36	\$3,834,377.01	\$87,080.85	\$367,377.20
Allocated Federal Funds - Accrued Basis Only												
2-7200	TANF-CAS		\$14,565.75	\$14,565.75	\$14,565.75	\$0.00	\$0.00	\$58,263.00	\$58,263.00	\$58,263.00	\$0.00	\$0.00
2-7201	TANF-ADULT		\$3,207.58	\$3,207.58	\$3,207.59	\$0.00	(\$0.01)	\$12,830.33	\$12,830.33	\$12,830.35	\$0.00	(\$0.02)
2-7202	TANF-TITLE XX-ADULT		\$3,663.66	\$3,663.66	\$3,663.66	\$0.00	\$0.00	\$14,654.66	\$14,654.66	\$14,654.65	\$0.00	\$0.01
2-7203	TRANSITION-TITLE XX-CRISIS		\$5,992.25	\$5,992.25	\$5,992.25	\$0.00	\$0.00	\$23,969.00	\$23,969.00	\$23,969.00	\$0.00	\$0.00
2-7210	MENTAL HEALTH BLOCK GRANT		\$36,511.92	\$36,511.92	\$36,511.91	\$0.00	\$0.01	\$146,047.67	\$146,047.67	\$146,047.62	\$0.00	\$0.05
Total Allocated Federal Funds			\$63,941.16	\$63,941.16	\$63,941.16	\$0.00	(\$0.00)	\$255,764.66	\$255,764.66	\$255,764.62	\$0.00	\$0.04
Total Revenue			\$2,755,518.10	\$2,605,915.41	\$2,620,390.36	\$149,602.69	\$135,127.74	\$10,439,153.64	\$10,216,649.70	\$10,382,133.77	\$222,503.94	\$57,019.87

		DECEMBER 2025					YEAR TO DATE				
		DEC FY26	DEC FY26	DEC FY25	Variance	Variance	FY2026 Y-T-D	FY2025 Y-T-D	FY2025 Y-T-D	Variance	Variance
		Actual	Budget	Actual	Budget	FY 2025	Actual	Budget	Actual	Y-T-D Budget	Y-T-D FY 2025
Expense											
Salaries											
2-8000	SALARIES	\$965,284.87	\$944,604.78	\$907,365.11	\$20,680.09	\$57,919.76	\$3,900,205.46	\$3,904,291.13	\$3,755,923.68	(\$4,085.67)	\$144,281.78
2-8001	OVERTIME	\$7,292.34	\$8,668.87	\$8,809.38	(\$1,376.53)	(\$1,517.04)	\$32,783.48	\$27,628.23	\$40,887.21	\$5,155.25	(\$8,103.73)
Total Salaries		\$1,009,310.77	\$1,012,295.37	\$954,461.49	\$19,303.56	\$56,402.72	\$1,974,172.10	\$1,966,350.34	\$1,891,678.48	\$1,069.58	\$136,178.05
Benefits											
2-8002	EMPLOYER'S FICA/MEDICARE	\$69,411.22	\$71,323.49	\$65,259.57	(\$1,912.27)	\$4,151.65	\$283,507.06	\$290,935.35	\$272,932.31	(\$7,428.29)	\$10,574.75
2-8003	TEC UNEMPLOYMENT TAX	\$296.17	\$368.18	\$653.33	(\$72.01)	(\$357.16)	\$1,471.85	\$1,760.41	\$3,351.99	(\$288.56)	(\$1,880.14)
2-8004	WORKER'S COMPENSATION	\$1,895.00	\$1,854.47	\$1,711.00	\$40.53	\$184.00	\$7,706.00	\$7,698.36	\$7,261.00	\$7.64	\$445.00
2-8005	RETIREMENT EMPLOYER CONTRIBUTION 401A	\$51,656.16	\$49,826.81	\$48,069.59	\$1,829.35	\$3,586.57	\$208,635.46	\$207,026.75	\$198,265.71	\$1,608.71	\$10,369.75
2-8006	HEALTH INSURANCE	\$163,404.50	\$154,579.45	\$137,188.80	\$8,825.05	\$26,215.70	\$632,141.98	\$618,317.80	\$542,753.19	\$13,824.18	\$89,388.79
2-8008	EMPLOYER FUNDED BASIC LIFE	\$991.78	\$943.79	\$0.00	\$47.99	\$991.78	\$3,864.51	\$3,775.16	\$0.00	\$89.35	\$3,864.51
Total Benefits		\$284,233.15	\$285,526.89	\$256,608.09	\$8,758.64	\$34,772.54	\$564,672.54	\$565,309.08	\$509,788.70	\$7,813.03	\$112,762.66
Contracts											
2-8300	PSYCHIATRIST	\$24,600.00	\$21,156.25	\$22,275.00	\$3,443.75	\$2,325.00	\$93,375.00	\$95,425.00	\$91,800.00	(\$2,050.00)	\$1,575.00
2-8304	PSYCHOLOGIST	\$150.00	\$500.00	\$500.00	(\$350.00)	(\$350.00)	\$850.00	\$2,700.00	\$2,700.00	(\$1,850.00)	(\$1,850.00)
2-8306	RN NURSES	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$130.00	\$0.00	\$65.00	\$130.00	\$65.00
2-8318	CRISIS-CONTRACTED	\$12,462.00	\$12,516.41	\$12,462.00	(\$54.41)	\$0.00	\$49,848.00	\$50,019.92	\$49,848.00	(\$171.92)	\$0.00
2-8320	PESC BED DAYS	\$146,140.00	\$141,225.99	\$138,585.00	\$4,914.01	\$7,555.00	\$611,995.00	\$564,903.96	\$545,815.00	\$47,091.04	\$66,180.00
2-8321	PPB BED DAYS	\$109,720.00	\$66,413.33	\$102,215.00	\$43,306.67	\$7,505.00	\$317,965.00	\$265,653.32	\$102,215.00	\$52,311.68	\$215,750.00
2-8322	OSAR-SUBSTANCE ABUSE	\$22,003.58	\$35,037.82	\$35,037.82	(\$13,034.24)	(\$13,034.24)	\$102,753.24	\$128,707.39	\$148,707.39	(\$25,954.15)	(\$45,954.15)
2-8326	LABORATORY CONTRACTS	\$939.64	\$1,017.09	\$1,017.09	(\$77.45)	(\$77.45)	\$9,291.81	\$4,453.84	\$4,453.84	\$4,837.97	\$4,837.97
2-8336	RESPIRE-CONTRACTED	\$4,286.75	\$2,185.00	\$2,185.00	\$2,101.75	\$2,101.75	\$17,157.25	\$19,246.00	\$19,246.00	(\$2,088.75)	(\$2,088.75)
2-8338	SOFTWARE WEB-BASED	\$27,890.76	\$23,904.74	\$27,399.06	\$3,986.02	\$491.70	\$113,096.22	\$94,225.99	\$99,284.82	\$18,870.23	\$13,811.40
2-8344	JUSTICE INVOLVED BED DAYS (SB292)	\$135,395.00	\$173,767.74	\$147,990.00	(\$38,372.74)	(\$12,595.00)	\$658,275.00	\$695,070.96	\$963,620.00	(\$36,795.96)	(\$305,345.00)
2-8346	STATE HOSPITAL STEP-DOWN PROGRAM CONTRACTED	\$45,500.00	\$45,500.00	\$45,500.00	\$0.00	\$0.00	\$182,000.00	\$182,000.00	\$182,000.00	\$0.00	\$0.00
2-8348	BH SVCS IN ESC-REGION 9	\$477.25	\$704.00	\$704.00	(\$226.75)	(\$226.75)	\$1,909.00	\$2,813.29	\$2,813.29	(\$904.29)	(\$904.29)
2-8350	OTHER CONTRACTED CONSULTANTS	\$4,030.40	\$3,940.13	\$3,940.13	\$90.27	\$90.27	\$17,125.39	\$15,466.97	\$15,466.97	\$1,658.42	\$1,658.42
2-8352	WFPD - CART	\$372.12	\$8,496.43	\$0.00	(\$8,124.31)	\$372.12	\$2,344.24	\$33,985.72	\$0.00	(\$31,641.48)	\$2,344.24
2-8353	TECHNICAL ASSISTANCE - CART	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$12,490.00	\$13,000.00	\$7,875.00	(\$510.00)	\$4,615.00
2-8354	WFFD - CART	\$5,000.00	\$5,000.00	\$0.00	\$0.00	\$5,000.00	\$20,000.00	\$20,000.00	\$0.00	\$0.00	\$20,000.00
2-8355	Other Contracted/Non-Contracted Consultants-G & A Services	\$9,005.33	\$4,373.33	\$4,373.33	\$4,632.00	\$4,632.00	\$35,483.92	\$21,238.69	\$21,242.88	\$14,245.23	\$14,241.04
Total Contracts		\$547,972.83	\$545,738.26	\$544,183.43	\$2,234.57	\$3,789.40	\$2,246,089.07	\$2,208,911.05	\$2,257,153.19	\$37,178.02	(\$11,064.12)
Travel and Training											
2-8021	EMPLOYEE MILEAGE	\$899.99	\$1,709.41	\$1,709.41	(\$809.42)	(\$809.42)	\$6,393.98	\$7,090.65	\$7,445.13	(\$696.67)	(\$1,051.15)
2-8022	EMPLOYEE PER DIEM (MEALS AND HOTEL)	\$3,155.90	\$258.27	\$605.27	\$2,897.63	\$2,550.63	\$16,214.94	\$10,709.67	\$13,031.46	\$5,505.27	\$3,183.48
2-8023	EMPLOYEE TRAVEL-AIRFARE & CAR RENTAL	\$494.61	\$10.00	\$130.42	\$484.61	\$364.19	\$4,601.88	\$2,546.66	\$2,419.31	\$2,055.22	\$2,182.57
2-8024	EMPLOYEE TRAVEL OVER STATE RATE	\$592.00	\$42.49	\$116.36	\$549.51	\$475.64	\$929.59	\$112.75	\$186.62	\$816.84	\$742.97
2-8025	EMPLOYEE DEVELOPMENT & TRAINING	\$2,112.00	\$2,888.00	\$1,887.00	(\$776.00)	\$225.00	\$12,446.04	\$10,187.03	\$9,189.00	\$2,259.01	\$3,257.04
Total Travel and Training		\$7,254.50	\$4,908.17	\$4,448.46	\$2,346.33	\$2,806.04	\$40,586.43	\$30,646.76	\$32,271.52	\$9,939.67	\$8,314.91
Capital Outlay											
2-8106	BUILDING USE FEE	\$8,882.02	\$7,966.87	\$7,968.14	\$915.15	\$913.88	\$34,290.26	\$32,031.85	\$32,037.98	\$2,258.41	\$2,252.28
2-8126	EQUIP/FURN/FIX USE FEE	\$2,049.26	\$2,332.64	\$2,332.64	(\$283.38)	(\$283.38)	\$8,032.94	\$9,355.45	\$9,355.45	(\$1,322.51)	(\$1,322.51)
2-8146	VEHICLE USE FEE	\$5,434.74	\$5,899.17	\$5,899.17	(\$464.43)	(\$464.43)	\$21,739.00	\$23,596.70	\$23,596.70	(\$1,857.70)	(\$1,857.70)
2-8156	SOFTWARE USE FEE	\$0.00	\$0.00	\$208.33	\$0.00	(\$208.33)	\$208.33	\$624.99	\$833.32	(\$416.66)	(\$624.99)
2-8166	COMPUTER & PRINTER USE FEE	\$3,949.71	\$4,813.17	\$4,844.63	(\$863.46)	(\$894.92)	\$18,166.60	\$20,223.44	\$20,349.31	(\$2,056.84)	(\$2,182.71)
2-8170	CAPITAL OUTLAY	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$5,506.04	\$0.00	\$0.00	\$5,506.04	\$5,506.04
Total Capital Outlay		\$20,315.73	\$21,011.85	\$21,252.91	(\$696.12)	(\$937.18)	\$87,943.17	\$85,832.43	\$86,172.76	\$2,110.74	\$1,770.41
Non-Capitalized Equipment											
2-8190	MINOR EQUIPMENT PURCHASES	\$2,186.64	\$1,500.00	\$0.00	\$686.64	\$2,186.64	\$3,713.36	\$5,803.99	\$18,193.16	(\$2,090.63)	(\$14,479.80)
Total Non-Capitalized Equipment		\$2,186.64	\$1,500.00	\$0.00	\$686.64	\$2,186.64	\$3,713.36	\$5,803.99	\$18,193.16	(\$2,090.63)	(\$14,479.80)

		DECEMBER 2025					YEAR TO DATE				
		DEC FY26	DEC FY26	DEC FY25	Variance	Variance	FY2026 Y-T-D	FY2025 Y-T-D	FY2025 Y-T-D	Variance	Variance
		Actual	Budget	Actual	Budget	FY 2025	Actual	Budget	Actual	Y-T-D Budget	Y-T-D FY 2025
Pharmaceutical											
2-8316	PHARMACIST	\$62,260.76	\$58,375.46	\$58,372.89	\$3,885.30	\$3,887.87	\$229,958.60	\$221,180.48	\$221,180.58	\$8,778.12	\$8,778.02
Total Pharmaceutical		\$62,260.76	\$58,375.46	\$58,372.89	\$3,885.30	\$3,887.87	\$229,958.60	\$221,180.48	\$221,180.58	\$8,778.12	\$8,778.02
Other Operating											
2-8007	EAP EXPENSE	\$408.00	\$406.40	\$372.30	\$1.60	\$35.70	\$1,646.40	\$1,625.60	\$1,493.58	\$20.80	\$152.82
2-8020	HIRING RELATED EXPENSES	\$3,574.40	\$2,972.38	\$3,026.00	\$602.02	\$548.40	\$12,983.51	\$11,170.33	\$13,065.60	\$1,813.18	(\$82.09)
2-8026	EMPLOYEE AWARDS & BANQUETS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$14,827.58	\$17,000.00	\$14,757.15	(\$2,172.42)	\$70.43
2-8027	EMPLOYEE FLU SHOTS AND TB	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$556.56	\$1,143.59	\$1,143.59	(\$587.03)	(\$587.03)
2-8040	PROFESSIONAL/ERROR&OMMISSIONS	\$2,174.49	\$2,174.49	\$2,410.61	\$0.00	(\$236.12)	\$8,697.96	\$8,697.96	\$9,642.44	\$0.00	(\$944.48)
2-8041	LIABILITY COVERAGE	\$203.67	\$103.67	\$107.24	\$100.00	\$96.43	\$514.68	\$414.68	\$428.99	\$100.00	\$85.69
2-8042	OTHER INSURANCE COVERAGE	\$1,777.85	\$1,777.85	\$1,713.36	\$0.00	\$64.49	\$7,111.40	\$7,111.40	\$6,853.44	\$0.00	\$257.96
2-8050	ADVERTISING EXPENSE	\$1,617.30	\$1,576.52	\$576.52	\$40.78	\$1,040.78	\$8,273.56	\$6,643.06	\$2,643.06	\$1,630.50	\$5,630.50
2-8055	DUES AND MEMBERSHIPS	\$5,679.41	\$3,721.42	\$3,721.42	\$1,957.99	\$1,957.99	\$22,209.34	\$16,010.74	\$16,062.74	\$6,198.60	\$6,146.60
2-8057	LICENSES	\$1,856.30	\$717.79	\$732.58	\$1,138.51	\$1,123.72	\$7,366.40	\$2,917.10	\$3,772.76	\$4,449.30	\$3,593.64
2-8060	BOARD ACTIVITY EXPENSE	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,001.29	\$1,032.22	\$1,032.22	(\$30.93)	(\$30.93)
2-8065	DPP-BHS RISK AND ADMIN EXPENSE	\$2,044.17	\$2,044.17	\$2,044.16	\$0.00	\$0.01	\$8,176.68	\$8,176.68	\$8,176.64	\$0.00	\$0.04
2-8070	UTILITIES	\$17,279.17	\$12,555.30	\$12,706.57	\$4,723.87	\$4,572.60	\$73,482.51	\$72,735.44	\$73,681.32	\$747.07	(\$198.81)
2-8072	TELECOMMUNICATIONS	\$21,834.31	\$26,322.44	\$27,741.60	(\$4,488.13)	(\$5,907.29)	\$86,098.54	\$104,131.47	\$109,355.43	(\$18,032.93)	(\$23,256.89)
2-8076	TELEPHONE-BASIC SERVICE EXPENSE	\$2,046.74	\$2,352.29	\$2,349.91	(\$305.55)	(\$303.17)	\$8,148.77	\$9,615.64	\$9,660.63	(\$1,466.87)	(\$1,511.86)
2-8078	CELL PHONE SERVICE EXPENSE	\$2,015.49	\$2,185.29	\$2,163.65	(\$169.80)	(\$148.16)	\$7,917.91	\$8,694.50	\$8,694.50	(\$776.59)	(\$776.59)
2-8080	LONG DISTANCE TELEPHONE SERVICE EXPENSE	\$247.03	\$341.38	\$341.38	(\$94.35)	(\$94.35)	\$1,790.22	\$1,027.76	\$1,027.76	\$762.46	\$762.46
2-8100	BUILDING RENT	\$57,117.81	\$57,002.58	\$120,808.74	\$115.23	(\$63,690.93)	\$228,207.04	\$222,261.59	\$288,486.23	\$5,945.45	(\$60,279.19)
2-8101	P.O. BOX/STORAGE RENTAL/LEASE	\$82.65	\$80.00	\$80.00	\$2.65	\$2.65	\$330.10	\$319.83	\$319.83	\$10.27	\$10.27
2-8102	PROPERTY DAMAGE COVERAGE	\$11,732.53	\$11,732.53	\$10,163.60	\$0.00	\$1,568.93	\$46,930.12	\$46,930.12	\$40,654.40	\$0.00	\$6,275.72
2-8104	BUILDING REPAIR & MAINTENANCE	\$15,354.95	\$15,686.53	\$15,390.13	(\$331.58)	(\$35.18)	\$56,362.01	\$61,277.61	\$65,192.42	(\$4,915.60)	(\$8,830.41)
2-8120	EQUIPMENT RENTAL/LEASE	\$7,260.56	\$7,364.92	\$7,412.95	(\$104.36)	(\$152.39)	\$28,705.92	\$28,325.46	\$28,511.31	\$380.46	\$194.61
2-8124	EQUIPMENT REPAIR & MAINTENANCE	\$2,045.52	\$2,369.21	\$2,369.21	(\$323.69)	(\$323.69)	\$8,142.10	\$8,792.56	\$8,961.96	(\$650.46)	(\$819.86)
2-8140	VEHICLE LEASE	\$2,278.46	\$2,611.11	\$2,611.11	(\$332.65)	(\$332.65)	\$10,111.79	\$10,444.44	\$10,444.44	(\$332.65)	(\$332.65)
2-8142	AUTO LIABILITY/PHYS DAMAGE INS	\$8,398.33	\$8,398.33	\$8,566.35	\$0.00	(\$168.02)	\$33,593.32	\$33,593.32	\$34,265.40	\$0.00	(\$672.08)
2-8143	INSURANCE EXP-Deductibles PAID	\$0.00	\$0.00	(\$600.00)	\$0.00	\$600.00	\$0.00	\$1,000.00	\$400.00	(\$1,000.00)	(\$400.00)
2-8144	VEHICLE REPAIR & MAINTENANCE	\$2,878.07	\$2,026.53	\$2,026.53	\$851.54	\$851.54	\$15,693.13	\$9,768.16	\$9,768.83	\$5,924.97	\$5,924.30
2-8145	GAS-VEHICLE & EQUIPMENT	\$5,044.32	\$5,327.36	\$5,431.60	(\$283.04)	(\$387.28)	\$25,572.72	\$23,596.90	\$23,719.57	\$1,975.82	\$1,853.15
2-8200	OFFICE SUPPLIES	\$3,952.03	\$3,487.65	\$15,488.80	\$464.38	(\$11,536.77)	\$30,798.56	\$27,419.46	\$39,327.48	\$3,379.10	(\$8,528.92)
2-8202	BOOKS & SUBSCRIPTIONS	\$9,384.70	\$1,988.09	\$1,988.09	\$7,396.61	\$7,396.61	\$20,856.51	\$8,282.34	\$8,282.34	\$12,574.17	\$12,574.17
2-8204	JANITORIAL/CLEANING SUPPLIES	(\$1,633.35)	\$1,230.68	\$1,322.75	(\$2,864.03)	(\$2,956.10)	\$3,127.34	\$3,332.20	\$3,505.46	(\$204.86)	(\$378.12)
2-8206	OTHER CONSUMABLE SUPPLIES	\$1,485.95	\$1,523.34	\$1,523.89	(\$37.39)	(\$37.94)	\$5,560.35	\$4,755.29	\$4,773.58	\$805.06	\$786.77
2-8208	MEDICAL SUPPLIES	\$224.93	\$2,038.00	\$2,038.00	(\$1,813.07)	(\$1,813.07)	\$5,075.13	\$3,049.32	\$3,160.28	\$2,025.81	\$1,914.85
2-8210	FOOD	\$88.49	\$105.44	\$111.00	(\$16.95)	(\$22.51)	\$941.29	\$839.91	\$1,414.13	\$101.38	(\$472.84)
2-8214	PERSONAL CARE/HYGENE SUPPLIES	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
2-8216	TRAINING/BEHAVIOR MODIFICATION	\$41.48	\$0.00	\$0.00	\$41.48	\$41.48	\$41.48	\$0.00	\$0.00	\$41.48	\$41.48
2-8218	CONSUMER ASSISTANCE	\$849.47	\$4,365.77	\$3,597.95	(\$3,516.30)	(\$2,748.48)	\$2,382.17	\$10,875.56	\$14,107.74	(\$8,493.39)	(\$11,725.57)
2-8220	PRINTING SERVICES	\$1,991.12	\$1,794.59	\$1,676.67	\$196.53	\$314.45	\$11,244.36	\$8,958.61	\$8,993.43	\$2,285.75	\$2,250.93
2-8221	COURIER DELIVERY SERVICES	\$113.57	\$0.00	\$0.00	\$113.57	\$113.57	\$370.64	\$96.53	\$96.53	\$274.11	\$274.11
2-8222	POSTAGE & DELIVERY CHARGES	\$1,513.48	\$1,557.91	\$1,557.91	(\$44.43)	(\$44.43)	\$6,150.55	\$5,620.99	\$5,624.44	\$529.56	\$526.11
2-8226	SANCTIONS	\$0.00	\$0.00	\$3,000.00	\$0.00	(\$3,000.00)	\$0.00	\$0.00	\$3,000.00	\$0.00	(\$3,000.00)
2-8228	BNK CHRGS & CREDIT CRD FEES	\$323.56	\$1,308.14	\$1,308.14	(\$984.58)	(\$984.58)	\$3,027.21	\$4,781.61	\$4,785.04	(\$1,754.40)	(\$1,757.83)
2-8232	MISCELLANEOUS CHARGE & EXPENSE	\$31.68	\$1,143.57	\$1,155.28	(\$1,111.89)	(\$1,123.60)	\$712.28	\$4,758.04	\$4,799.10	(\$4,045.76)	(\$4,086.82)
2-8237	IN-KIND EXPENSES	\$736,613.30	\$646,407.12	\$665,585.39	\$90,206.18	\$71,027.91	\$2,726,943.21	\$2,585,628.48	\$2,877,791.56	\$141,314.73	(\$150,848.35)
2-8340	CPA FIRM	\$3,500.00	\$3,000.00	\$3,000.00	\$500.00	\$500.00	\$23,500.00	\$16,500.00	\$10,000.00	\$7,000.00	\$13,500.00
2-8342	ATTORNEY-CONTRACTED/NON-CONTR	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
2-8359	NON-CONTRACTED RESPITE	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$81.00	\$0.00	(\$81.00)	\$0.00
2-8360	NON-CONTRACTED CONSULTANTS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$590.29	\$0.00	(\$590.29)
Total Other Operating		\$933,431.94	\$841,800.79	\$937,621.39	\$91,631.15	(\$4,189.45)	\$3,565,182.64	\$3,409,437.50	\$3,782,467.64	\$155,745.14	(\$217,285.00)
Total Expense		\$2,833,654.44	\$2,705,504.37	\$2,734,935.86	\$128,150.07	\$98,718.58	\$11,243,789.07	\$11,023,245.40	\$11,218,813.94	\$220,543.67	\$24,975.13

	DECEMBER 2025					YEAR TO DATE				
	DEC FY26	DEC FY26	DEC FY25	Variance	Variance	FY2026 Y-T-D	FY2025 Y-T-D	FY2025 Y-T-D	Variance	Variance
	Actual	Budget	Actual	Budget	FY 2025	Actual	Budget	Actual	Y-T-D Budget	Y-T-D FY 2025
BEGINNING NET ASSETS	\$12,789,318.11	\$12,789,318.11	\$12,629,360.66	\$0.00	\$159,957.45	\$13,515,817.20	\$13,515,817.20	\$13,351,495.33	\$0.00	\$164,321.87
NET SURPLUS/(DEFICIT)	(\$78,136.34)	(\$99,588.96)	(\$114,545.50)	\$21,452.62	\$36,409.16	(\$804,635.43)	(\$806,595.70)	(\$836,680.17)	\$1,960.27	\$32,044.74
ENDING NET ASSETS	\$12,711,181.77	\$12,689,729.15	\$12,514,815.16	\$21,452.62	\$196,366.61	\$12,711,181.77	\$12,709,221.50	\$12,514,815.16	\$1,960.27	\$196,366.61

5 RECOMMENDATIONS

B. BUDGET AND FINANCE

1) FINANCIAL STATEMENTS - JANUARY 2026

RECOMMENDED ACTION: That the Board of Trustees approves the financial statements for January 2026.

BACKGROUND INFORMATION: Board of Trustee policy requires the periodic presentation of financial and statistical information. Our Performance Contracts with the Texas Health and Human Service Commission require the Board of Trustee Chair, Executive Director, and Financial Officer to certify the accuracy of the financial statements on a quarterly basis. Although this certification does not require Board of Trustee approval, we will continue to present these to the Board of Trustees.

SUPPORTING INFORMATION:

- ❖ Number of Days of Operation in Fund Balance *143*.
- ❖ Accounts Receivable *decreased* by \$75,174 going from \$1,681,682 to \$1,606,508.
- ❖ Accounts Payable *decreased* by \$116,004, going from \$1,926,791 to \$1,810,787. Most of this amount is due to the state giving us PPB money late last fiscal year of FY2024, and the Center was unable to use it. We received word in early March of 2025 that the money will have to be returned. The amount is \$937,600. The Center will receive an invoice from the state for recoupment. Until then, it will stay in our Accounts Payable amount. If not for that, Accounts Payable would have been \$873,187.
- ❖ **FINANCIAL STATUS:** The Center had a loss of \$167,202 for January and a cumulative loss of \$971,837 for the year.
- ❖ **REVENUE:** Overall Revenue January 2026 was \$64,291 less than budgeted.
 - **Total County and City Revenue** was \$43,938 more than budgeted. We have 2 counties that have now signed the MOA for FY2026. We have recorded 5 months of revenue to catch up. Also, when the budget was voted on, the amount of Wichita County support was unknown. We received word in November that they are giving us an additional \$60,000 in support over last year. This is reflected in the \$5,000 budget amount. We also had one county give us support for FY2026 when they did not give us support for FY2024 or FY2025.
 - **Patient Fees** were \$5,700 less than budgeted.
 - This is based on actual cash received in January for services.

5 RECOMMENDATIONS

B. BUDGET AND FINANCE

1) FINANCIAL STATEMENTS - JANUARY 2026

- **Miscellaneous** was \$84,241 less than budgeted.
 - In-kind Match was \$79,894 less than budgeted due to the actual usage of the psychiatric bed days at Red River and our other contracted hospitals. This is based on the PESC in-kind match for psychiatric bed days and is provided by Red River. It is also based on the Justice Involved Grant, also known as Senate Bill 292 contract, that has increased the Center’s Mental Health and Substance Abuse bed usage at Red River. We now also have the PPB, or Private Psychiatric Bed revenue through the MH General revenue fund, that also uses bed days from various contracted hospitals where we are receiving in-kind.
 - **Other State Funding** was \$73,943 less than budgeted.
 - DARS-ECI Revenue was \$35,913 more than budgeted. Less Locally Collected Funds were collected than budgeted; therefore, we ask for more from the state to cover expenses.
 - JBCR revenue is \$11,983 less than budgeted. This program started in October of this year, and it’s still going through the growth period.
 - SB292 Revenue was \$92,980 less than budgeted. This is based on client need for the psychiatric beds, and usage will fluctuate.
 - **Other Federal Funding** was \$22,636 more than budgeted.
 - No specific program stands out as making more than budgeted. These revenues are mostly based on cash receipts received in January.
 - **General Revenue** was \$33,056 more than budgeted.
 - Private Psychiatric Beds MH/PPB revenue was \$3,595 more than budgeted. PPB revenue fluctuates based on client need for psychiatric beds.
 - PESC revenue was \$29,463 more than budgeted. Just like PPB revenue, PESC revenue fluctuates based on client need for the psychiatric beds.
 - **Allocated Federal Funds** were right on budget.
- ❖ **EXPENSES:** Overall expense for January 2026 was \$133,572 less than budgeted.
- **Personnel** cost was \$4,570 more than budgeted.
 - Salaries were \$7,606 less than budgeted.
 - Benefits were \$3,037 more than budgeted.

5 RECOMMENDATIONS

B. BUDGET AND FINANCE

1) FINANCIAL STATEMENTS - JANUARY 2026

- **Contract** cost was \$41,952 less than budgeted.
 - PESC expense was \$30,529 more than budgeted, Justice Involved Bed Days was \$80,618 less than budgeted, and PPB Bed Days was \$4,297 more than budgeted. All these expenses fluctuate based on client need for the psychiatric beds.
 - OSAR expense was \$13,034 less than budgeted. This budget is mostly influenced by our subcontractor, Abilene Recovery Council, and the way they utilize the resources of the contract.
- **Travel and Training** expense was \$2,055 less than budgeted.
- **Capital Outlay** expense was \$1,097 less than budgeted.
- **Non-Capitalized Equipment** expense was \$2 more than budgeted.
- **Pharmaceutical** expense was \$93 less than budgeted. This is based upon actual expenses and will fluctuate with patient care. As of January 2021, Community Benefit and Uncompensated Care expired. This means the Center now pays for all medical invoices from Clinical Pathology Laboratories and Integrated Prescription Management that were being paid by SONT, Service Organization of North Texas. The Wood Group invoices will still be paid by SONT up to the time they no longer can or will pay for them.
- **Other Operating** expense was \$83,809 more than budgeted. In-Kind Expense was \$79,894 more than budgeted. This is attributed to the contract with Red River for the PESC contract, the Justice Involved Bed Days contract (SB292), and the Private Psychiatric Bed Days contract. It is based on bed day usage and will fluctuate based on client need. No actual dollars are exchanged; and there is a corresponding revenue, so the net difference is zero.

Helen Farabee Centers
Balance Sheet - As Of January 2026

Assets	Actual
CASH GENERAL OPERATING FUND	\$ 6,712,349.80
CASH INTERNAL SERVICE FUND	\$ 2,291,991.95
CASH SELF FUNDED INSURANCE	\$ 483,549.67
SAVINGS	\$ 18,249.68
PETTY CASH FUNDS-CENTERWIDE	\$ 798.17
INVESTMENTS GENERAL OPERATING FUND	\$ 8,722,037.40
INVESTMENTS INTERNAL SERVICE FUND	\$ 706,866.50
ACCOUNTS RECEIVABLE	\$ 1,606,508.07
PREPAID	\$ 585,773.14
PREPAID MISCELLANEOUS-SELF INSURED FUNDS	\$ 1,604.15
DEPOSITS	\$ 249,995.04
DEPOSITS-SELF INSURED FUNDS	\$ 25,000.00
AMTS PROVIDED-PERSONAL LEAVE	\$ 947,522.78
LAND	\$ 1,057,659.65
BUILDINGS & IMPROVEMENTS	\$ 2,738,293.76
LEASEHOLD IMPROVEMENTS	\$ 132,631.17
EQUIP/FURN/FIX	\$ 421,090.57
COMPUTERS & PERIPHERALS	\$ 900,423.66
VEHICLES & CONTRACTORS EQ	\$ 1,721,265.08
COMPUTER SOFTWARE	\$ 610,961.56
ACCUMULATED DEPRECIATION	\$ (5,507,856.67)
CLINICAL SOFTWARE PROJECT	\$ -
WICHITA FALLS BUILDING PROJECT	\$ 386,012.69
ISF-MAJOR PROJECTS WORK-IN-PROGRESS	\$ (1,228.23)
Total Assets	\$ 24,811,499.59
Liabilities and Net Assets	
Liabilities	
ACCOUNTS PAYABLE GENERAL OPERATING FUND	\$ 725,783.02
ACCOUNTS PAYABLE INTERNAL SERVICE FUND	\$ -
ACCOUNTS PAYABLE-SELF INSURED FUND	\$ 38,659.74
ACCOUNTS PAYABLE-PAYABLE TO STATE	\$ 1,046,344.44
PAYROLL PAYABLE	\$ 509,787.26
UMR PAYABLE	\$ 87,235.86
EMPLOYEE DEDUCTION PAYBLE	\$ 10,002.07
DEFERRED REVENUE	\$ 2,953,460.53
ACCUM PERSONAL LEAVE-CURRENT	\$ 19,117.92
ACCUM PERSONAL LEAVE-LONGTERM	\$ 947,522.78
UMR CLAIMS PAYABLE - IBNR	\$ 140,000.00
Total Liabilities	\$ 6,477,913.62
Net Assets	
UNRESERVED-FUND BALANCE	\$ 12,051,959.90
UNRESERVED-ACCUM PERSONNEL LEAVE	\$ 947,522.78
INCOME SUMMARY-OPERATING FUND	\$ (124,008.40)
INCOME SUMMARY-INTERNAL SERVICE FUND	\$ 5,553,925.68
CONTRIBUTED CAPITAL	\$ (247,115.05)
RETAINED EARNINGS	\$ 151,301.06
Total Net Assets	\$ 18,333,585.97
Total Liabilities and Net Assets	\$ 24,811,499.59

Helen Farabee Centers JANUARY 2026 Income Statement

		JANUARY 2026					YEAR TO DATE				
		JAN FY26 Actual	JAN FY26 Budget	JAN FY25 Actual	Variance Budget	Variance FY 2025	FY2026 Y-T-D Actual	FY2025 Y-T-D Budget	FY2025 Y-T-D Actual	Variance Y-T-D Budget	Variance Y-T-D FY 2025
Revenue											
City Revenue - Deferred Revenue											
2-7000	CITY OF WICHITA FALLS	\$8,333.33	\$8,333.33	\$8,333.33	\$0.00	\$0.00	\$41,666.66	\$41,666.66	\$41,666.65	\$0.00	\$0.01
2-7001	CITY OF CHILLICOTHE	\$27.50	\$27.50	\$27.50	\$0.00	\$0.00	\$137.50	\$137.50	\$137.50	\$0.00	\$0.00
2-7002	CITY OF QUANAH	\$0.00	\$55.00	\$55.00	(\$55.00)	(\$55.00)	\$0.00	\$275.00	\$275.00	(\$275.00)	(\$275.00)
2-7004	CITY OF BURKBURNETT	\$417.67	\$417.67	\$417.67	\$0.00	\$0.00	\$2,088.33	\$2,088.33	\$2,088.35	\$0.00	(\$0.02)
2-7005	CITY OF GRAHAM	\$1,250.00	\$1,250.00	\$1,250.00	\$0.00	\$0.00	\$6,250.00	\$6,250.00	\$6,250.00	\$0.00	\$0.00
2-7006	CITY OF NOCONA	\$125.00	\$125.00	\$125.00	\$0.00	\$0.00	\$625.00	\$625.00	\$625.00	\$0.00	\$0.00
2-7007	CITY OF BOWIE	\$666.67	\$666.67	\$666.67	\$0.00	\$0.00	\$3,333.33	\$3,333.33	\$3,333.35	\$0.00	(\$0.02)
Total City Revenue		\$10,820.17	\$10,875.17	\$10,875.17	(\$55.00)	(\$55.00)	\$54,100.82	\$54,375.82	\$54,375.85	(\$275.00)	(\$275.03)
County Revenue - Deferred Revenue											
2-7020	WICHITA COUNTY	\$18,333.33	\$13,333.33	\$13,333.33	\$5,000.00	\$5,000.00	\$71,666.69	\$66,666.65	\$53,333.33	\$5,000.04	\$18,333.36
2-7021	HASKEL COUNTY	\$1,387.66	\$1,387.66	\$2,775.34	\$0.00	(\$1,387.68)	\$6,938.34	\$6,938.34	\$6,559.85	\$0.00	\$378.49
2-7022	STONEWALL COUNTY	\$211.89	\$211.89	\$176.83	\$0.00	\$35.06	\$1,059.45	\$1,059.45	\$884.15	\$0.00	\$175.30
2-7023	KNOX COUNTY	\$554.17	\$554.17	\$551.40	\$0.00	\$2.77	\$2,770.81	\$2,770.81	\$2,757.00	\$0.00	\$13.81
2-7024	DICKENS COUNTY	\$0.00	\$149.81	\$149.81	(\$149.81)	(\$149.81)	\$0.00	\$749.05	\$749.05	(\$749.05)	(\$749.05)
2-7025	YOUNG COUNTY	\$19,791.67	\$400.00	\$2,862.00	\$19,391.67	\$16,929.67	\$19,791.67	\$2,000.00	\$14,310.00	\$17,791.67	\$5,481.67
2-7026	THROCKMORTON COUNTY	\$273.28	\$273.28	\$156.05	\$0.00	\$117.23	\$1,366.32	\$1,366.32	\$780.25	\$0.00	\$586.07
2-7027	HARDEMAN COUNTY	\$353.44	\$353.44	\$0.00	\$0.00	\$353.44	\$1,767.20	\$1,767.20	\$0.00	\$0.00	\$1,767.20
2-7028	WISE COUNTY	\$23,083.31	\$4,616.67	\$4,616.67	\$18,466.64	\$18,466.64	\$23,083.31	\$23,083.31	\$23,083.35	\$0.00	(\$0.04)
2-7029	BAYLOR COUNTY	\$433.33	\$433.33	\$433.33	\$0.00	\$0.00	\$2,166.65	\$2,166.65	\$2,166.65	\$0.00	\$0.00
2-7030	FOARD COUNTY	\$110.00	\$110.00	\$205.99	\$0.00	(\$95.99)	\$550.00	\$550.00	\$1,029.95	\$0.00	(\$479.95)
2-7031	MONTAGUE COUNTY	\$8,388.04	\$8,107.84	\$8,107.84	\$280.20	\$280.20	\$41,940.20	\$40,539.20	\$40,539.20	\$1,401.00	\$1,401.00
2-7032	JACK COUNTY	\$1,706.19	\$1,706.19	\$1,250.00	\$0.00	\$456.19	\$8,530.92	\$8,530.92	\$6,250.00	\$0.00	\$2,280.92
2-7033	CLAY COUNTY	\$333.33	\$333.33	\$241.67	\$0.00	\$91.66	\$1,666.65	\$1,666.65	\$1,208.35	\$0.00	\$458.30
2-7034	COTTLE COUNTY	\$199.75	\$199.75	\$199.75	\$0.00	\$0.00	\$998.75	\$998.75	\$998.75	\$0.00	\$0.00
2-7035	CHILDRESS COUNTY	\$347.93	\$347.93	\$347.92	\$0.00	\$0.01	\$1,739.57	\$1,739.57	\$1,739.60	\$0.00	(\$0.03)
2-7036	ARCHER COUNTY SUPPORT	\$964.58	\$0.00	\$208.33	\$964.58	\$756.25	\$4,822.90	\$0.00	\$1,041.65	\$4,822.90	\$3,781.25
Total County Revenue		\$76,471.90	\$32,518.62	\$35,616.26	\$43,953.28	\$40,855.64	\$190,859.43	\$162,592.87	\$157,431.13	\$28,266.56	\$33,428.30
Other Taxing Authority Funds - Deferred Revenue											
2-7038	INDEPENDENT SCHOOL DISTRICT	\$265.00	\$265.00	\$265.00	\$0.00	\$0.00	\$1,325.00	\$1,325.00	\$1,325.00	\$0.00	\$0.00
Total Other Taxing Authority Funds		\$265.00	\$265.00	\$265.00	\$0.00	\$0.00	\$1,325.00	\$1,325.00	\$1,325.00	\$0.00	\$0.00
Patient Fees - Cash Basis Only											
2-7050	CONSUMER FEES	\$25,206.95	\$17,722.48	\$17,722.48	\$7,484.47	\$7,484.47	\$88,850.46	\$70,701.95	\$67,701.95	\$18,148.51	\$21,148.51
2-7060	PRIVATE INSURANCE MCO CARD SERVICES	\$27,437.22	\$30,894.88	\$30,894.88	(\$3,457.66)	(\$3,457.66)	\$134,797.71	\$135,007.40	\$131,157.17	(\$209.69)	\$3,640.54
2-7070	PRIVATE INSURANCE MCO CASE MANAGEMENT	\$9,426.29	\$14,197.91	\$14,197.91	(\$4,771.62)	(\$4,771.62)	\$68,594.98	\$48,097.04	\$46,652.22	\$20,497.94	\$21,942.76
2-7080	PRIVATE INSURANCE MCO REHAB	\$8,292.17	\$13,247.65	\$13,247.65	(\$4,955.48)	(\$4,955.48)	\$54,951.29	\$45,767.56	\$44,799.90	\$9,183.73	\$10,151.39
Total Patient Fees		\$70,362.63	\$76,062.92	\$76,062.92	(\$5,700.29)	(\$5,700.29)	\$347,194.44	\$299,573.95	\$290,311.24	\$47,620.49	\$56,883.20
Miscellaneous - Cash Basis											
2-7037	IN-KIND MATCH	\$566,513.30	\$646,407.13	\$790,935.39	(\$79,893.83)	(\$224,422.09)	\$3,293,456.51	\$3,232,035.61	\$3,668,726.95	\$61,420.90	(\$375,270.44)
2-7100	MEDICARE - TITLE XVII	\$6,620.06	\$4,603.70	\$4,603.70	\$2,016.36	\$2,016.36	\$21,396.15	\$17,087.14	\$17,087.14	\$4,309.01	\$4,309.01
2-7260	RENT	\$1,050.00	\$576.30	\$3,780.75	\$473.70	(\$2,730.75)	\$4,637.50	\$6,889.05	\$23,491.25	(\$2,251.55)	(\$18,853.75)
2-7270	DONATIONS/CONTRIBUTIONS	\$334.03	\$233.33	\$333.33	\$100.70	\$0.70	\$4,073.75	\$1,177.77	\$1,677.77	\$2,895.98	\$2,395.98
2-7272	CART EARNED REVENUE	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$52,309.96	\$97,600.00	\$82,576.79	(\$45,290.04)	(\$30,266.83)
2-7273	WF OPIOID GRANT	\$1,962.30	\$1,000.00	\$0.00	\$962.30	\$1,962.30	\$7,146.01	\$5,000.00	\$0.00	\$2,146.01	\$7,146.01
2-7275	INTEREST INCOME	\$20,847.47	\$29,040.44	\$49,040.44	(\$8,192.97)	(\$28,192.97)	\$81,982.26	\$67,955.47	\$79,657.12	\$14,026.79	\$2,325.14
2-7280	MISCELLANEOUS	\$1,843.98	\$1,551.20	\$1,551.20	\$292.78	\$292.78	\$18,207.05	\$14,361.60	\$8,346.41	\$3,845.45	\$9,860.64
Total Miscellaneous		\$599,171.14	\$683,412.10	\$850,244.81	(\$84,240.96)	(\$251,073.67)	\$3,483,209.19	\$3,442,106.64	\$3,881,563.43	\$41,102.55	(\$398,354.24)

	JANUARY 2026					YEAR TO DATE					
	JAN FY26	JAN FY26	JAN FY25	Variance	Variance	FY2026 Y-T-D	FY2025 Y-T-D	FY2025 Y-T-D	Variance	Variance	
	Actual	Budget	Actual	Budget	FY 2025	Actual	Budget	Actual	Y-T-D Budget	Y-T-D FY 2025	
Other State Funding - Accrued Basis Only											
2-7120	MH FIRST AID	\$2,200.00	\$10,700.00	\$7,700.00	(\$8,500.00)	(\$5,500.00)	\$33,400.00	\$28,400.00	\$30,400.00	\$5,000.00	\$3,000.00
2-7122	TCOOMMI EARNED INCOME	\$27,482.81	\$31,692.79	\$31,692.79	(\$4,209.98)	(\$4,209.98)	\$149,615.78	\$153,313.98	\$149,535.82	(\$3,698.20)	\$79.96
2-7124	SUBSTANCE ABUSE SERVICES	\$27,655.16	\$24,711.77	\$29,754.74	\$2,943.39	(\$2,099.58)	\$144,761.53	\$116,136.05	\$120,587.16	\$28,625.48	\$24,174.37
2-7125	SUD COMMUNITY MH GRANT PROGRAM	\$3,585.01	\$3,521.67	\$1,785.70	\$63.34	\$1,799.31	\$16,954.59	\$17,608.31	\$9,656.65	(\$653.72)	\$7,297.94
2-7127	OSAR - OUTREACH, SCREENING ASSESSMENT, REFERRAL	\$35,853.96	\$37,240.56	\$28,818.66	(\$1,386.60)	\$7,035.30	\$146,457.66	\$173,451.96	\$194,676.70	(\$26,994.30)	(\$48,219.04)
2-7128	RSS - RECOVERY SUPPORT SERVICES	\$9,967.25	\$6,851.46	\$6,851.46	\$3,115.79	\$3,115.79	\$41,977.06	\$39,148.94	\$32,754.99	\$2,828.12	\$9,222.07
2-7150	MFP/ECC REVENUE	\$5,950.16	\$2,707.50	\$3,247.45	\$3,242.66	\$2,702.71	\$16,780.02	\$13,537.48	\$14,077.45	\$3,242.54	\$2,702.57
2-7152	PASSR IDD SPECIALIZED SERVICES	\$1,086.88	\$548.71	\$548.71	\$538.17	\$538.17	\$4,311.40	\$2,968.36	\$2,968.36	\$1,343.04	\$1,343.04
2-7153	PASRR IDD SPECIALIZED SERVICES - OBRA - LIDDA	\$0.00	\$700.00	\$700.00	(\$700.00)	(\$700.00)	\$350.00	\$2,450.00	\$2,800.00	(\$2,100.00)	(\$2,450.00)
2-7132	CMHG LPHA EXPANSION	\$4,873.77	\$4,873.77	\$4,873.77	\$0.00	\$0.00	\$24,368.86	\$24,368.85	\$21,931.99	\$0.01	\$2,436.87
2-7216	MHGJII NCA - JBCR	\$19,918.93	\$31,902.15	\$0.00	(\$11,983.22)	\$19,918.93	\$90,834.92	\$159,510.75	\$0.00	(\$68,675.83)	\$90,834.92
2-7218	JUSTICE INVOLVED GRANT PROGRAM	\$103,338.91	\$196,318.84	\$70,801.01	(\$92,979.93)	\$32,537.90	\$832,114.28	\$981,594.12	\$1,136,649.50	(\$149,479.84)	(\$304,535.22)
2-7245	DARS-ECI REVENUE	\$124,836.68	\$88,923.78	\$115,995.43	\$35,912.90	\$8,841.25	\$603,608.83	\$487,532.14	\$552,750.27	\$116,076.69	\$50,858.56
Total Other State Funding		\$366,749.52	\$440,693.00	\$302,769.72	(\$73,943.48)	\$63,979.80	\$2,105,534.93	\$2,200,020.94	\$2,268,788.89	(\$94,486.01)	(\$163,253.96)
Other Federal Funding											
2-7102	MEDICAID-CARD SERVICES	\$2,473.00	\$274.01	\$323.83	\$2,198.99	\$2,149.17	\$7,607.16	\$1,005.29	\$1,129.84	\$6,601.87	\$6,477.32
2-7104	MEDICAID-CASE MANAGEMENT	\$4,404.16	\$3,836.29	\$3,836.29	\$567.87	\$567.87	\$14,753.00	\$20,692.59	\$20,888.02	(\$5,939.59)	(\$6,135.02)
2-7106	MEDICAID-IDD SERV COORDINATION	\$64,351.90	\$58,259.16	\$70,977.71	\$6,092.74	(\$6,625.81)	\$287,589.20	\$288,236.96	\$306,955.51	(\$647.76)	(\$19,366.31)
2-7108	MEDICAID REHAB	\$17,612.44	\$16,405.46	\$16,405.46	\$1,206.98	\$1,206.98	\$90,630.20	\$76,554.92	\$70,997.60	\$14,075.28	\$19,632.60
2-7110	MEDICAID PASRR	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$661.96	\$1,616.71	\$2,011.34	(\$954.75)	(\$1,349.38)
2-7112	MEDICAID-ADMIN CLAIMING	\$40,000.00	\$40,000.00	\$40,000.00	\$0.00	\$0.00	\$243,169.35	\$212,444.46	\$212,893.60	\$30,724.89	\$30,275.75
2-7114	MEDICAID-HABILITATION COORDINATION	\$7,496.28	\$8,845.61	\$8,845.61	(\$1,349.33)	(\$1,349.33)	\$41,646.00	\$36,440.25	\$36,440.25	\$5,205.75	\$5,205.75
2-7120	MH FIRST AID	\$8,814.84	\$6,078.04	\$6,078.04	\$2,736.80	\$2,736.80	\$31,675.63	\$29,744.54	\$29,744.54	\$1,931.09	\$1,931.09
2-7126	STATE HOSPITAL STEP-DOWN PROGRAM	\$55,014.11	\$53,451.11	\$53,451.11	\$1,563.00	\$1,563.00	\$274,215.08	\$282,007.47	\$282,007.47	(\$7,792.39)	(\$7,792.39)
2-7130	MH OUTPATIENT CAPACITY EXPANSION	\$0.00	\$0.00	\$16,723.17	\$0.00	(\$16,723.17)	\$0.00	\$0.00	\$84,110.35	\$0.00	(\$84,110.35)
2-7252	DIRECTED PAYMENT PROGRAM - BEHAVIORAL HEALTH SERVICES	\$56,077.58	\$46,852.11	\$36,004.18	\$9,225.47	\$20,073.40	\$166,344.65	\$194,260.55	\$119,497.36	(\$27,915.90)	\$46,847.29
2-7254	PUBLIC HEALTH PROVIDER - CHARITY CARE PROGRAM	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
2-7258	TRANSITION SUPPORT LIAISON	\$5,654.24	\$5,260.33	\$0.00	\$393.91	\$5,654.24	\$26,857.64	\$26,301.65	\$0.00	\$555.99	\$26,857.64
Total Other Federal Funding		\$261,898.55	\$239,262.12	\$252,645.40	\$22,636.43	\$9,253.15	\$1,185,149.87	\$1,169,305.39	\$1,166,675.88	\$15,844.48	\$18,473.99
General Revenue - Deferred Revenue											
2-7215	PESC	\$210,948.88	\$181,485.66	\$66,589.43	\$29,463.22	\$144,359.45	\$967,746.99	\$907,428.30	\$712,332.41	\$60,318.69	\$255,414.58
2-7217	Private Psychiatric Beds MH/PPB	\$81,728.66	\$78,133.33	\$327,844.00	\$3,595.33	(\$246,115.34)	\$447,691.97	\$390,666.65	\$440,280.50	\$57,025.32	\$7,411.47
2-7220	GENERAL REVENUE - MH	\$600,876.25	\$600,876.25	\$600,876.25	\$0.00	\$0.00	\$3,004,381.21	\$3,004,381.21	\$3,004,381.21	\$0.00	(\$0.05)
2-7222	GENERAL REVENUE - VETERANS SERVICES	\$5,833.33	\$5,833.33	\$5,833.33	\$0.00	\$0.00	\$29,166.66	\$29,166.66	\$29,166.69	\$0.00	(\$0.03)
2-7224	GENERAL REVENUE - BH SVCS IN EDUC SVC CTR	\$9,583.33	\$9,583.33	\$9,583.33	\$0.00	\$0.00	\$47,916.66	\$47,916.66	\$47,916.69	\$0.00	(\$0.03)
2-7230	GENERAL REVENUE - IDD	\$93,036.53	\$93,036.53	\$93,036.53	\$0.00	\$0.00	\$465,182.65	\$465,182.65	\$465,182.66	\$0.00	(\$0.01)
2-7232	GENERAL REVENUE-CRISIS REDESIG	\$39,884.50	\$39,884.50	\$39,884.50	\$0.00	\$0.00	\$199,422.50	\$199,422.50	\$199,422.51	\$0.00	(\$0.01)
2-7235	GENERAL REVENUE - IDD ARPA	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2,795.39	\$0.00	\$0.00	\$2,795.39	\$2,795.39
2-7236	IDD GR-CRISIS RESPITE-CIS	\$17,980.67	\$17,980.67	\$17,980.67	\$0.00	\$0.00	\$89,903.33	\$89,903.33	\$89,903.33	\$0.00	\$0.00
2-7238	PERMANENCY PLANNING	\$1,854.75	\$1,854.75	\$1,854.75	\$0.00	\$0.00	\$9,273.75	\$9,273.75	\$9,273.75	\$0.00	\$0.00
Total General Revenue		\$1,061,726.90	\$1,028,668.35	\$1,163,482.79	\$33,058.55	(\$101,755.89)	\$5,263,481.11	\$5,143,341.71	\$4,997,859.80	\$120,139.40	\$265,621.31
Medicaid Waiver											
2-7137	ICF-QAF	\$0.00	\$0.00	(\$105.20)	\$0.00	\$105.20	\$0.00	\$0.00	(\$105.20)	\$0.00	\$105.20
Total Medicaid Waiver		\$0.00	\$0.00	(\$105.20)	\$0.00	\$105.20	\$0.00	\$0.00	(\$105.20)	\$0.00	\$105.20
Allocated Federal Funds - Accrued Basis Only											
2-7200	TANF-CAS	\$14,565.75	\$14,565.75	\$14,565.75	\$0.00	\$0.00	\$72,828.75	\$72,828.75	\$72,828.75	\$0.00	\$0.00
2-7201	TANF-ADULT	\$3,207.58	\$3,207.58	\$3,207.58	\$0.00	\$0.00	\$16,037.91	\$16,037.91	\$16,037.93	\$0.00	(\$0.02)
2-7202	TANF-TITLE XX-ADULT	\$3,663.67	\$3,663.67	\$3,663.67	\$0.00	\$0.00	\$18,318.33	\$18,318.33	\$18,318.32	\$0.00	\$0.01
2-7203	TRANSITION-TITLE XX-CRISIS	\$5,992.25	\$5,992.25	\$5,992.25	\$0.00	\$0.00	\$29,961.25	\$29,961.25	\$29,961.25	\$0.00	\$0.00
2-7210	MENTAL HEALTH BLOCK GRANT	\$36,511.91	\$36,511.91	\$36,511.92	\$0.00	(\$0.01)	\$182,559.58	\$182,559.58	\$182,559.54	\$0.00	\$0.04
Total Allocated Federal Funds		\$63,941.16	\$63,941.16	\$63,941.17	\$0.00	(\$0.01)	\$319,705.82	\$319,705.82	\$319,705.79	\$0.00	\$0.03
Total Revenue		\$2,511,406.97	\$2,575,698.44	\$2,755,798.04	(\$64,291.47)	(\$244,391.07)	\$12,950,560.61	\$12,792,348.14	\$13,137,931.81	\$158,212.47	(\$187,371.20)

Expense	JANUARY 2026					YEAR TO DATE					
	JAN FY26	JAN FY26	JAN FY25	Variance	Variance	FY2026 Y-T-D	FY2025 Y-T-D	FY2025 Y-T-D	Variance	Variance	
	Actual	Budget	Actual	Budget	FY 2025	Actual	Budget	Actual	Y-T-D Budget	Y-T-D FY 2025	
Salaries											
2-8000	SALARIES	\$1,005,009.24	\$1,013,916.32	\$1,013,477.03	(\$8,907.08)	(\$8,467.79)	\$4,905,214.70	\$4,918,207.45	\$4,769,400.71	(\$12,992.75)	\$135,813.99
2-8001	OVERTIME	\$5,127.71	\$3,826.76	\$3,387.36	\$1,300.95	\$1,740.35	\$37,911.19	\$31,454.99	\$44,274.57	\$6,456.20	(\$6,363.38)
Total Salaries		\$1,009,310.77	\$1,012,295.37	\$954,461.49	(\$7,606.13)	(\$6,727.44)	\$1,974,172.10	\$1,966,350.34	\$1,891,678.48	(\$6,536.55)	\$129,450.61
Benefits											
2-8002	EMPLOYER'S FICA/MEDICARE	\$74,727.37	\$78,005.80	\$75,358.10	(\$3,278.43)	(\$630.73)	\$358,234.43	\$368,941.15	\$348,290.41	(\$10,706.72)	\$9,944.02
2-8003	TEC UNEMPLOYMENT TAX	\$6,673.75	\$7,290.52	\$12,351.06	(\$616.77)	(\$5,677.31)	\$8,145.60	\$9,050.93	\$15,703.05	(\$905.33)	(\$7,557.45)
2-8004	WORKER'S COMPENSATION	\$2,010.00	\$3,519.79	\$2,040.00	(\$1,509.79)	(\$30.00)	\$9,716.00	\$11,218.15	\$9,301.00	(\$1,502.15)	\$415.00
2-8005	RETIREMENT EMPLOYER CONTRIBUTION 401A	\$54,255.89	\$55,677.79	\$54,045.21	(\$1,421.90)	\$210.68	\$262,891.35	\$262,704.54	\$252,310.92	\$186.81	\$10,580.43
2-8006	HEALTH INSURANCE	\$173,534.34	\$163,686.66	\$155,000.84	\$9,847.68	\$18,533.50	\$805,676.32	\$782,004.46	\$697,754.03	\$23,671.86	\$107,922.29
2-8008	EMPLOYER FUNDED BASIC LIFE	\$959.62	\$943.79	\$0.00	\$15.83	\$959.62	\$4,824.13	\$4,718.95	\$0.00	\$105.18	\$4,824.13
Total Benefits		\$284,233.15	\$285,526.89	\$256,608.09	\$3,036.62	\$13,365.76	\$564,672.54	\$565,309.08	\$509,788.70	\$10,849.65	\$126,128.42
Contracts											
2-8300	PSYCHIATRIST	\$24,150.00	\$20,756.25	\$23,400.00	\$3,393.75	\$750.00	\$117,525.00	\$116,181.25	\$115,200.00	\$1,343.75	\$2,325.00
2-8304	PSYCHOLOGIST	\$500.00	\$0.00	\$0.00	\$500.00	\$500.00	\$1,350.00	\$2,700.00	\$2,700.00	(\$1,350.00)	(\$1,350.00)
2-8306	RN NURSES	\$65.00	\$0.00	\$0.00	\$65.00	\$65.00	\$195.00	\$0.00	\$65.00	\$195.00	\$130.00
2-8318	CRISIS-CONTRACTED	\$12,462.00	\$12,516.42	\$12,462.00	(\$54.42)	\$0.00	\$62,310.00	\$62,536.34	\$62,310.00	(\$226.34)	\$0.00
2-8320	PESC BED DAYS	\$171,755.00	\$141,226.00	\$26,325.00	\$30,529.00	\$145,430.00	\$783,750.00	\$706,129.96	\$572,140.00	\$77,620.04	\$211,610.00
2-8321	PPB BED DAYS	\$70,710.00	\$66,413.33	\$298,040.00	\$4,296.67	(\$227,330.00)	\$388,675.00	\$332,066.65	\$400,255.00	\$56,608.35	(\$11,580.00)
2-8322	OSAR-SUBSTANCE ABUSE	\$35,379.38	\$35,722.05	\$25,722.05	(\$342.67)	\$9,657.33	\$138,132.62	\$164,429.44	\$174,429.44	(\$26,296.82)	(\$36,296.82)
2-8326	LABORATORY CONTRACTS	\$2,381.70	\$337.60	\$337.60	\$2,044.10	\$2,044.10	\$11,673.51	\$4,791.44	\$4,791.44	\$6,882.07	\$6,882.07
2-8336	RESPIRE-CONTRACTED	\$4,070.00	\$3,042.00	\$3,042.00	\$1,028.00	\$1,028.00	\$21,227.25	\$22,288.00	\$22,288.00	(\$1,060.75)	(\$1,060.75)
2-8338	SOFTWARE WEB-BASED	\$30,331.66	\$22,075.12	\$24,570.92	\$8,256.54	\$5,760.74	\$143,427.88	\$116,301.11	\$123,855.74	\$27,126.77	\$19,572.14
2-8344	JUSTICE INVOLVED BED DAYS (SB292)	\$93,150.00	\$173,767.75	\$63,685.00	(\$80,617.75)	\$29,465.00	\$751,425.00	\$868,838.71	\$1,027,305.00	(\$117,413.71)	(\$275,880.00)
2-8346	STATE HOSPITAL STEP-DOWN PROGRAM CONTRACTED	\$45,500.00	\$45,500.00	\$45,500.00	\$0.00	\$0.00	\$227,500.00	\$227,500.00	\$227,500.00	\$0.00	\$0.00
2-8348	BH SVCS IN ESC-REGION 9	\$477.25	\$386.83	\$386.83	\$90.42	\$90.42	\$2,386.25	\$3,200.12	\$3,200.12	(\$813.87)	(\$813.87)
2-8350	OTHER CONTRACTED CONSULTANTS	\$3,095.23	\$5,022.74	\$5,022.74	(\$1,927.51)	(\$1,927.51)	\$20,220.62	\$20,489.71	\$20,489.71	(\$269.09)	(\$269.09)
2-8352	WFPD - CART	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$2,344.24	\$33,985.72	\$0.00	(\$31,641.48)	\$2,344.24
2-8353	TECHNICAL ASSISTANCE - CART	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$12,490.00	\$13,000.00	\$7,875.00	(\$510.00)	\$4,615.00
2-8354	WFFD - CART	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$20,000.00	\$20,000.00	\$0.00	\$0.00	\$20,000.00
2-8355	Other Contracted/Non-Contracted Consultants-G & A Services	\$9,573.08	\$18,786.27	\$18,786.27	(\$9,213.19)	(\$9,213.19)	\$45,057.00	\$40,024.96	\$40,029.15	\$5,032.04	\$5,027.85
Total Contracts		\$503,600.30	\$545,552.36	\$547,280.41	(\$41,952.06)	(\$43,680.11)	\$2,749,689.37	\$2,754,463.41	\$2,804,433.60	(\$4,774.04)	(\$54,744.23)
Travel and Training											
2-8021	EMPLOYEE MILEAGE	\$1,129.37	\$1,970.13	\$2,027.81	(\$840.76)	(\$898.44)	\$7,523.35	\$9,060.78	\$9,472.94	(\$1,537.43)	(\$1,949.59)
2-8022	EMPLOYEE PER DIEM (MEALS AND HOTEL)	\$2,854.85	\$4,534.83	\$1,368.97	(\$1,679.98)	\$1,485.88	\$19,069.79	\$15,244.50	\$14,400.43	\$3,825.29	\$4,669.36
2-8023	EMPLOYEE TRAVEL-AIRFARE & CAR RENTAL	\$688.79	\$293.63	\$351.93	\$395.16	\$336.86	\$5,290.67	\$2,840.29	\$2,771.24	\$2,450.38	\$2,519.43
2-8024	EMPLOYEE TRAVEL OVER STATE RATE	\$0.00	\$0.00	(\$73.87)	\$0.00	\$73.87	\$929.59	\$112.75	\$112.75	\$816.84	\$816.84
2-8025	EMPLOYEE DEVELOPMENT & TRAINING	\$1,616.00	\$1,545.00	\$1,545.00	\$71.00	\$71.00	\$14,062.04	\$11,732.03	\$10,734.00	\$2,330.01	\$3,328.04
Total Travel and Training		\$6,289.01	\$8,343.59	\$5,219.84	(\$2,054.58)	\$1,069.17	\$46,875.44	\$38,990.35	\$37,491.36	\$7,885.09	\$9,384.08
Capital Outlay											
2-8106	BUILDING USE FEE	\$8,324.89	\$7,852.99	\$7,854.26	\$471.90	\$470.63	\$42,615.15	\$39,884.84	\$39,892.24	\$2,730.31	\$2,722.91
2-8126	EQUIP/FURN/FIX USE FEE	\$2,049.33	\$2,332.74	\$2,332.74	(\$283.41)	(\$283.41)	\$10,082.27	\$11,688.19	\$11,688.19	(\$1,605.92)	(\$1,605.92)
2-8146	VEHICLE USE FEE	\$5,434.77	\$5,899.20	\$5,899.20	(\$464.43)	(\$464.43)	\$27,173.77	\$29,495.90	\$29,495.90	(\$2,322.13)	(\$2,322.13)
2-8156	SOFTWARE USE FEE	\$0.00	\$0.00	\$208.34	\$0.00	(\$208.34)	\$208.33	\$624.99	\$1,041.66	(\$416.66)	(\$833.33)
2-8166	COMPUTER & PRINTER USE FEE	\$3,992.02	\$4,813.29	\$4,844.76	(\$821.27)	(\$852.74)	\$22,158.62	\$25,036.73	\$25,194.07	(\$2,878.11)	(\$3,035.45)
2-8170	CAPITAL OUTLAY	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$5,506.04	\$0.00	\$0.00	\$5,506.04	\$5,506.04
Total Capital Outlay		\$19,801.01	\$20,898.22	\$21,139.30	(\$1,097.21)	(\$1,338.29)	\$107,744.18	\$106,730.65	\$107,312.06	\$1,013.53	\$432.12
Non-Capitalized Equipment											
2-8190	MINOR EQUIPMENT PURCHASES	\$467.23	\$464.94	\$569.65	\$2.29	(\$102.42)	\$4,180.59	\$6,268.93	\$18,762.81	(\$2,088.34)	(\$14,582.22)
Total Non-Capitalized Equipment		\$467.23	\$464.94	\$569.65	\$2.29	(\$102.42)	\$4,180.59	\$6,268.93	\$18,762.81	(\$2,088.34)	(\$14,582.22)

		JANUARY 2026					YEAR TO DATE				
		JAN FY26	JAN FY26	JAN FY25	Variance	Variance	FY2026 Y-T-D	FY2025 Y-T-D	FY2025 Y-T-D	Variance	Variance
		Actual	Budget	Actual	Budget	FY 2025	Actual	Budget	Actual	Y-T-D Budget	Y-T-D FY 2025
Pharmaceutical											
2-8316	PHARMACIST	\$54,694.92	\$54,787.47	\$54,812.16	(\$92.55)	(\$117.24)	\$284,653.52	\$275,967.95	\$275,992.74	\$8,685.57	\$8,660.78
Total Pharmaceutical		\$54,694.92	\$54,787.47	\$54,812.16	(\$92.55)	(\$117.24)	\$284,653.52	\$275,967.95	\$275,992.74	\$8,685.57	\$8,660.78
Other Operating											
2-8007	EAP EXPENSE	\$398.40	\$406.40	\$403.20	(\$8.00)	(\$4.80)	\$2,044.80	\$2,032.00	\$1,896.78	\$12.80	\$148.02
2-8020	HIRING RELATED EXPENSES	\$3,532.20	\$3,059.00	\$3,060.00	\$473.20	\$472.20	\$16,515.71	\$14,229.33	\$16,125.60	\$2,286.38	\$390.11
2-8026	EMPLOYEE AWARDS & BANQUETS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$14,827.58	\$17,000.00	\$14,757.15	(\$2,172.42)	\$70.43
2-8027	EMPLOYEE FLU SHOTS AND TB	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$556.56	\$1,143.59	\$1,143.59	(\$587.03)	(\$587.03)
2-8040	PROFESSIONAL/ERROR&COMMISSIONS	\$2,174.49	\$2,174.49	\$2,410.61	\$0.00	(\$236.12)	\$10,872.45	\$10,872.45	\$12,053.05	\$0.00	(\$1,180.60)
2-8041	LIABILITY COVERAGE	\$103.67	\$103.67	\$107.24	\$0.00	(\$3.57)	\$618.35	\$518.35	\$536.23	\$100.00	\$82.12
2-8042	OTHER INSURANCE COVERAGE	\$1,777.85	\$1,777.85	\$1,713.36	\$0.00	\$64.49	\$8,889.25	\$8,889.25	\$8,566.80	\$0.00	\$322.45
2-8050	ADVERTISING EXPENSE	\$1,617.30	\$1,576.52	\$576.52	\$40.78	\$1,040.78	\$9,890.86	\$8,219.58	\$3,219.58	\$1,671.28	\$6,671.28
2-8055	DUES AND MEMBERSHIPS	\$6,495.41	\$4,746.42	\$4,746.42	\$1,748.99	\$1,748.99	\$28,704.75	\$20,757.16	\$20,809.16	\$7,947.59	\$7,895.59
2-8057	LICENSES	\$2,006.80	\$362.47	\$890.63	\$1,644.33	\$1,116.17	\$9,373.20	\$3,279.57	\$4,663.39	\$6,093.63	\$4,709.81
2-8060	BOARD ACTIVITY EXPENSE	\$0.00	\$0.00	\$731.46	\$0.00	(\$731.46)	\$1,001.29	\$1,032.22	\$1,763.68	(\$30.93)	(\$762.39)
2-8065	DPP-BHS RISK AND ADMIN EXPENSE	\$2,044.17	\$2,044.17	\$2,044.16	\$0.00	\$0.01	\$10,220.85	\$10,220.85	\$10,220.80	\$0.00	\$0.05
2-8070	UTILITIES	\$19,127.90	\$20,362.33	\$20,505.73	(\$1,234.43)	(\$1,377.83)	\$92,610.41	\$93,097.77	\$94,187.05	(\$487.36)	(\$1,576.64)
2-8072	TELECOMMUNICATIONS	\$19,230.50	\$25,799.86	\$27,150.01	(\$6,569.36)	(\$7,919.51)	\$105,329.04	\$129,931.33	\$136,505.44	(\$24,602.29)	(\$31,176.40)
2-8076	TELEPHONE-BASIC SERVICE EXPENSE	\$2,016.17	\$2,423.87	\$2,429.42	(\$407.70)	(\$413.25)	\$10,164.94	\$12,039.51	\$12,090.05	(\$1,874.57)	(\$1,925.11)
2-8078	CELL PHONE SERVICE EXPENSE	\$1,996.64	\$2,198.87	\$2,231.98	(\$202.23)	(\$235.34)	\$9,914.55	\$10,893.37	\$10,926.48	(\$978.82)	(\$1,011.93)
2-8080	LONG DISTANCE TELEPHONE SERVICE EXPENSE	\$309.70	\$212.67	\$212.67	\$97.03	\$97.03	\$2,099.92	\$1,240.43	\$1,240.43	\$859.49	\$859.49
2-8100	BUILDING RENT	\$57,117.81	\$55,103.18	\$55,909.34	\$2,014.63	\$1,208.47	\$285,324.85	\$277,364.77	\$344,395.57	\$7,960.08	(\$59,070.72)
2-8101	P.O. BOX/STORAGE RENTAL/LEASE	\$82.65	\$71.66	\$71.67	\$10.99	\$10.98	\$412.75	\$391.49	\$391.50	\$21.26	\$21.25
2-8102	PROPERTY DAMAGE COVERAGE	\$11,732.53	\$11,732.53	\$10,163.60	\$0.00	\$1,568.93	\$58,662.65	\$58,662.65	\$50,818.00	\$0.00	\$7,844.65
2-8104	BUILDING REPAIR & MAINTENANCE	\$13,926.21	\$17,641.98	\$17,343.06	(\$3,715.77)	(\$3,416.85)	\$70,288.22	\$78,919.59	\$82,535.48	(\$8,631.37)	(\$12,247.26)
2-8120	EQUIPMENT RENTAL/LEASE	\$7,152.12	\$7,131.11	\$7,177.35	\$21.01	(\$25.23)	\$35,858.04	\$35,456.57	\$35,688.66	\$401.47	\$169.38
2-8124	EQUIPMENT REPAIR & MAINTENANCE	\$2,269.04	\$2,510.11	\$6,510.11	(\$241.07)	(\$4,241.07)	\$10,411.14	\$11,302.67	\$15,472.07	(\$891.53)	(\$5,060.93)
2-8140	VEHICLE LEASE	\$2,278.46	\$2,611.11	\$2,611.11	(\$332.65)	(\$332.65)	\$12,390.25	\$13,055.55	\$13,055.55	(\$665.30)	(\$665.30)
2-8142	AUTO LIABILITY/PHYS DAMAGE INS	\$8,398.33	\$8,398.33	\$8,566.35	\$0.00	(\$168.02)	\$41,991.65	\$41,991.65	\$42,831.75	\$0.00	(\$840.10)
2-8143	INSURANCE EXP-Deductibles Paid	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1,000.00	\$400.00	(\$1,000.00)	(\$400.00)
2-8144	VEHICLE REPAIR & MAINTENANCE	\$3,264.52	\$4,229.13	\$4,370.66	(\$964.61)	(\$1,106.14)	\$18,957.65	\$13,997.29	\$14,139.49	\$4,960.36	\$4,818.16
2-8145	GAS-VEHICLE & EQUIPMENT	\$4,535.76	\$6,241.97	\$6,281.02	(\$1,706.21)	(\$1,745.26)	\$30,108.48	\$29,838.87	\$30,000.59	\$269.61	\$107.89
2-8200	OFFICE SUPPLIES	\$12,828.07	\$10,166.56	\$3,167.37	\$2,661.51	\$9,660.70	\$43,626.63	\$37,586.02	\$42,494.85	\$6,040.61	\$1,131.78
2-8202	BOOKS & SUBSCRIPTIONS	\$6,261.68	\$5,293.67	\$4,293.67	\$968.01	\$1,968.01	\$27,118.19	\$13,576.01	\$12,576.01	\$13,542.18	\$14,542.18
2-8204	JANITORIAL/CLEANING SUPPLIES	\$673.19	\$115.75	\$119.70	\$557.44	\$553.49	\$3,800.53	\$3,447.95	\$3,625.16	\$352.58	\$175.37
2-8206	OTHER CONSUMABLE SUPPLIES	\$1,380.89	\$1,025.04	\$1,025.35	\$355.85	\$355.54	\$6,941.24	\$5,780.33	\$5,798.93	\$1,160.91	\$1,142.31
2-8208	MEDICAL SUPPLIES	\$226.86	\$457.99	\$458.90	(\$231.13)	(\$232.04)	\$5,301.99	\$3,507.31	\$3,619.18	\$1,794.68	\$1,682.81
2-8210	FOOD	\$426.00	\$370.02	\$371.74	\$55.98	\$54.26	\$1,367.29	\$1,209.93	\$1,785.87	\$157.36	(\$418.58)
2-8214	PERSONAL CARE/HYGENE SUPPLIES	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
2-8216	TRAINING/BEHAVIOR MODIFICATION	\$185.02	\$0.00	\$0.00	\$185.02	\$185.02	\$226.50	\$0.00	\$0.00	\$226.50	\$226.50
2-8218	CONSUMER ASSISTANCE	\$1,817.53	\$1,500.00	\$1,500.40	\$317.53	\$317.13	\$4,199.70	\$8,142.74	\$15,608.14	(\$3,943.04)	(\$11,408.44)
2-8220	PRINTING SERVICES	\$3,446.04	\$2,349.83	\$2,357.31	\$1,096.21	\$1,088.73	\$14,690.40	\$11,308.44	\$11,350.74	\$3,381.96	\$3,339.66
2-8221	COURIER DELIVERY SERVICES	\$0.00	\$81.13	\$81.13	(\$81.13)	(\$81.13)	\$370.64	\$177.66	\$177.66	\$192.98	\$192.98
2-8222	POSTAGE & DELIVERY CHARGES	\$2,388.58	\$1,964.26	\$1,964.26	\$424.32	\$424.32	\$8,539.13	\$7,585.25	\$7,588.70	\$953.88	\$950.43
2-8226	SANCTIONS	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$3,000.00	\$0.00	(\$3,000.00)
2-8228	BNK CHRGS & CREDIT CRD FEES	\$1,529.98	\$604.47	\$604.47	\$925.51	\$925.51	\$4,557.19	\$5,386.08	\$5,389.51	(\$828.89)	(\$832.32)
2-8232	MISCELLANEOUS CHARGE & EXPENSE	\$192.38	\$1,159.09	\$1,147.39	(\$966.71)	(\$955.01)	\$904.66	\$5,917.13	\$5,946.49	(\$5,012.47)	(\$5,041.83)
2-8237	IN-KIND EXPENSES	\$566,513.30	\$646,407.13	\$790,935.39	(\$79,893.83)	(\$224,422.09)	\$3,293,456.51	\$3,232,035.61	\$3,668,726.95	\$61,420.90	(\$375,270.44)
2-8340	CPA FIRM	\$0.00	\$0.00	\$14,000.00	\$0.00	(\$14,000.00)	\$23,500.00	\$25,000.00	\$24,000.00	(\$1,500.00)	(\$500.00)
2-8342	ATTORNEY-CONTRACTED/NON-CONTR	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
2-8359	NON-CONTRACTED RESPITE	\$0.00	\$280.00	\$0.00	(\$280.00)	\$0.00	\$0.00	\$361.00	\$0.00	(\$361.00)	\$0.00
2-8360	NON-CONTRACTED CONSULTANTS	\$0.00	\$572.16	\$572.16	(\$572.16)	(\$572.16)	\$0.00	\$572.16	\$1,162.45	(\$572.16)	(\$1,162.45)
Total Other Operating		\$771,458.15	\$855,266.80	\$1,010,816.92	(\$83,808.65)	(\$239,358.77)	\$4,336,640.79	\$4,268,971.48	\$4,793,284.56	\$67,669.31	(\$456,643.77)
Total Expense		\$2,678,608.54	\$2,812,180.81	\$2,955,497.88	(\$133,572.27)	(\$276,889.34)	\$13,922,397.61	\$13,839,693.39	\$14,174,311.82	\$82,704.22	(\$251,914.21)

	JANUARY 2026					YEAR TO DATE				
	JAN FY26	JAN FY26	JAN FY25	Variance	Variance	FY2026 Y-T-D	FY2025 Y-T-D	FY2025 Y-T-D	Variance	Variance
	Actual	Budget	Actual	Budget	FY 2025	Actual	Budget	Actual	Y-T-D Budget	Y-T-D FY 2025
BEGINNING NET ASSETS	\$12,711,181.77	\$12,711,181.77	\$12,514,815.16	\$0.00	\$196,366.61	\$13,515,817.20	\$13,515,817.20	\$13,351,495.33	\$0.00	\$164,321.87
NET SURPLUS/(DEFICIT)	(\$167,201.57)	(\$236,482.37)	(\$199,699.84)	\$69,280.80	\$32,498.27	(\$971,837.00)	(\$1,047,345.25)	(\$1,036,380.01)	\$75,508.25	\$64,543.01
ENDING NET ASSETS	\$12,543,980.20	\$12,474,699.40	\$12,315,115.32	\$69,280.80	\$228,864.88	\$12,543,980.20	\$12,468,471.95	\$12,315,115.32	\$75,508.25	\$228,864.88

AGENDA ITEM: 030526-5B3

MEETING DATE:

MARCH 5, 2026

5 RECOMMENDATIONS

B. BUDGET AND FINANCE

3) VEHICLE PURCHASE ADDITIONAL FEES

Page 1 of 1

RECOMMENDED ACTION: That the Board of Trustees ratify the expenditure of additional \$2,116.71 for vehicle purchase fees.

BACKGROUND INFORMATION:

- A. The Board approved \$200,700.00 for the purchase of vehicles in the September 2025 meeting.
- B. Fees not originally included in the request added up to \$2116.71.

SUPPORTING INFORMATION:

- A. Nine (9) 2026 Chevrolet Trax were purchased at Lipscomb Chevrolet.

5 RECOMMENDATIONS

B. BUDGET AND FINANCE

4) AUDITORS LETTER OF ENGAGEMENT

RECOMMENDED ACTION: That the Board of Trustees accept the attached Letter of Engagement (LOE) from Condley and Company, LLP and authorize the Chair to sign the letter.

BACKGROUND INFORMATION:

- A. The Letter of Engagement is basically the contract between the audit firm and the Board, outlining responsibilities, due dates, and costs.
- B. The Center is required by our contracts with Health and Human Services Commission to have an annual audit performed by an external audit firm.
- C. An audit firm can perform the audit of the Center for a maximum of six consecutive years, and then the Center must send out an RFP for hiring an audit company. The Center can rehire the same audit firm that performed the single audit for the previous six years.
- D. Condley and Company, LLP, will be the audit firm for FY2025 through FY2030. For the last eight years (2017-2024) Scott, Singleton, Fincher, and Company performed the audit. Before that, it was Davis, Kinard, and Company.

SUPPORTING INFORMATION:

- A. Fiscal Year 2026 will be the second year that the firm Condley and Company, LLP will perform the audit.
- B. This Letter of Engagement reflects all the requirements in our Request for Proposal which Ryan Gibson responded to. Their proposal was previously approved by a committee of the Board, PNAC (Policy and Network Advisory Committee) and Center Staff.
- C. The cost of the audit for Fiscal Year 2025 was \$39,000.00. This year the cost will be \$42,000.00 plus \$5,500 for each major program selected over four major programs, plus out-of-pocket expenses.



February 18, 2026

To the Board of Trustees
Helen Farabee Centers
Wichita Falls, Texas 76301

The Objective and Scope of the Audit of the Financial Statements

You have requested that Condley and Company, L.L.P. (“Condley”, “we”, “us”, or “our”) audit Helen Farabee Centers’ (the “Center”, “you”, or “your”) governmental activities, each major fund, the aggregate remaining fund information and the budgetary comparison as of and for the year ending August 31, 2026, which collectively comprise the basic financial statements. We are pleased to confirm our acceptance and our understanding of this audit engagement by means of this letter (“Engagement Letter”).

The objectives of our audit are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor’s report that includes our opinion. Reasonable assurance is a high level of assurance but is not absolute assurance and, therefore is not a guarantee that an audit conducted in accordance with auditing standards generally accepted in the United States of America (“GAAS”) and *Government Auditing Standards* issued by the Comptroller General of the United States (“GAS”) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users made on the basis of these financial statements. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of controls.

You have also requested that Condley perform the audit of the Center as of August 31, 2026, to satisfy the audit requirements imposed by the Single Audit Act and Subpart F of Title 2 U.S. Code of Federal Regulations (“CFR”) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (the Uniform Guidance) and Texas Grant Management Standards (“TxGMS”).

The Responsibilities of the Auditor

We will conduct our audit in accordance with GAAS, GAS, the Uniform Guidance, TxGMS, and the U.S. Office of Management and Budget’s (“OMB”) Compliance Supplement. Those standards require that we comply with applicable ethical requirements. As part of an audit in accordance with GAAS, GAS, the Uniform Guidance, and TxGMS, we exercise professional judgment and maintain professional skepticism throughout the audit. We also:

- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, based on an understanding of the entity and its environment, the applicable financial reporting framework, and the entity’s system of internal control, design and perform audit procedures responsive to those risks, and obtain audit evidence that is sufficient and appropriate to provide a basis for our opinion.
- Consider the Center’s system of internal control in order to design audit procedures that are appropriate in the circumstances but not for the purpose of expressing an opinion on the effectiveness of the Center’s internal control. However, we will communicate to you in writing concerning any significant deficiencies or material weaknesses in internal control relevant to the audit of the financial statements that we have identified during the audit.

- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements, including the disclosures, and whether the financial statements represent the underlying transactions and events in a manner that achieves fair presentation.
- Conclude, based on the audit evidence obtained, whether there are conditions or events considered in the aggregate that raise substantial doubt about the Center's ability to continue as a going concern for a reasonable period of time.

Because of the inherent limitations of an audit, together with the inherent limitations of internal control, an unavoidable risk exists that some material misstatements may not be detected, even though the audit is properly planned and performed in accordance with GAAS and GAS. Because determining waste or abuse is subjective, GAS does not require auditors to perform specific procedures to detect waste or abuse in financial statement audits.

We will communicate to the Board of Trustees (a) any fraud involving senior management and fraud (whether caused by senior management or other employees) that causes a material misstatement of the financial statements that becomes known to us during the audit, and (b) any instances of noncompliance with laws and regulations that we become aware of during the audit (unless they are clearly inconsequential).

We are responsible for the compliance audit of major programs under the Uniform Guidance and TxGMS, including the determination of major programs, the consideration of internal control over compliance, and reporting responsibilities.

Our report(s) on internal control over financial reporting and compliance for major programs will include any significant deficiencies and material weaknesses in internal control over financial reporting and over compliance for major programs of which we become aware as a result of obtaining an and over compliance for major programs of which we become aware as a result of obtaining an understanding of internal control and performing tests of internal control over financial reporting and over compliance for major programs consistent with requirements of the standards and regulations identified above. Our report(s) on compliance matters will address material errors, fraud, violations of compliance obligations, and other responsibilities imposed by state and federal statutes and regulations or assumed by contracts; and any state or federal grant, entitlement, or loan program questioned costs of which we become aware, consistent with requirements of the standards and regulations identified above.

We will maintain our independence in accordance with the standards of the American Institute of Certified Public Accountants ("AICPA") and GAS.

The Responsibilities of Management and Identification of the Applicable Financial Reporting Framework

Management is responsible for:

1. Identifying and ensuring that the Center complies with the laws and regulations applicable to its activities and informing us about all known violations of such laws or regulations, other than those that are clearly inconsequential;
2. The design and implementation of programs and controls to prevent and detect fraud and to inform us about all known or suspected fraud affecting the Center involving management, employees who have significant roles in internal control, and others where the fraud could have a material effect on the financial statements; and
3. Informing us of its knowledge of any allegations of fraud or suspected fraud affecting the Center received in communications from employees, former employees, analysts, regulators, short sellers, vendors, customers, or others.

Management is responsible for the preparation of the required supplementary information (“RSI”), which accounting principles generally accepted in the United States of America (“U.S. GAAP”) require to be presented to supplement the basic financial statements. Management is also responsible for the preparation of supplementary information presented in relation to the financial statements as a whole in accordance with U.S. GAAP. Management agrees to include the auditor’s report on the supplementary information in any document that contains the supplementary information and indicates that the auditor has reported on such supplementary information. Management also agrees to present the supplementary information with the audited financial statements or, if the supplementary information will not be presented with the audited financial statements, to make the audited financial statements readily available to the intended users of the supplementary information no later than the date of issuance of the supplementary information and the auditor’s report thereon.

The Board of Trustees is responsible for informing us of their views on the risks of fraud, waste, or abuse within the Center and of any fraud, waste, or abuse, or suspected fraud, waste, or abuse, affecting the Center.

Our audit will be conducted on the basis that management and, when appropriate, those charged with governance acknowledge and understand that they have responsibility:

1. For the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America (“U.S. GAAP”);
2. To evaluate subsequent events through the date the financial statements are issued or available to be issued and to disclose the date through which subsequent events were evaluated in the financial statements. Management also agrees that it will not conclude on subsequent events earlier than the date of the management representation letter referred to below;
3. For the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error;
4. For report distribution; and
5. To provide us with:
 - a. Access to all information of which management is aware is relevant to the preparation and fair presentation of the financial statements, including information relevant to disclosures;
 - b. Draft financial statements, including information relevant to their preparation and fair presentation, when needed, to allow for the completion of the audit in accordance with the proposed timeline;
 - c. Additional information that we may request from management for the purpose of the audit; and
 - d. Unrestricted access to persons within the Center from whom we determine it necessary to obtain audit evidence.

As part of our audit process, we will request from management and, when appropriate, those charged with governance, written confirmation concerning representations made to us in connection with the audit, including, among other items:

1. That management has fulfilled its responsibilities as set out in the terms of this Engagement Letter, and
2. That it believes the effects of any uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements taken as a whole.

Because the audit will be performed in accordance with the Single Audit Act, the Uniform Guidance, and TxGMS, management is responsible for (a) identifying all federal awards received and expended, (b) preparing and the fair presentation of the schedule of expenditures of federal awards (including notes and noncash assistance received) in accordance with Uniform Guidance and TxGMS requirements; (c) internal control over compliance; (d) compliance with federal statutes, regulations, and the terms and conditions of federal awards; (e) making us aware of significant vendor relationships where the vendor is responsible for program compliance; (f) following up and taking corrective action on audit findings, including the preparation of a summary schedule of prior audit findings and a corrective action plan; (g) timely and accurate completion of the data collection form and (h) submitting the reporting package and data collection form.

Reporting

We will issue a written report upon completion of our audit of the Center's financial statements. Our report will be addressed to the Board of Trustees of the Center. Circumstances may arise in which our report may differ from its expected form and content based on the results of our audit. Depending on the nature of these circumstances, it may be necessary for us to modify our opinion or add an emphasis-of-matter paragraph or other-matter paragraph to our auditor's report.

If circumstances arise relating to the condition of the Center's records, the availability of appropriate audit evidence or indications of a significant risk of material misstatement of the financial statements because of error, fraudulent financial reporting, or misappropriation of assets which, in our professional judgment, prevent us from completing the audit or forming an opinion, we retain the unilateral right to take any course of action permitted by professional standards, including, but not limited to, declining to express an opinion or issue a report, or withdrawing from the engagement.

In addition to our report on the Center's financial statements, we will also issue the following reports:

1. A report on the fairness of the presentation of the Center's schedule of expenditures of federal and state awards for the year ended August 31, 2026;
2. Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with GAS;
3. Report on Compliance for Each Major Federal Program and Report on Internal Control Over Compliance Required by the Uniform Guidance and Texas Grant Management Standards; and
4. An accompanying schedule of findings and questioned costs.

Records and Assistance

During the course of our engagement, we may accumulate records containing data that should be reflected in the Center's books and records. The Center will determine that all such data, if necessary, will be so reflected. Accordingly, the Center will not expect us to maintain copies of such records in our possession.

The assistance to be supplied by the Center personnel, including the preparation of schedules and analyses of accounts, has been discussed and coordinated with Linda Poenitzsch, Chief Financial Officer. The timely and accurate completion of this work is an essential condition for our completion of the audit and issuance of our audit report.

Non-audit Services

In connection with our audit, you have requested us to perform certain non-audit services:

1. Drafting financial statements and related notes
2. Assistance with certain account reconciliations, if applicable

3. Proposing adjusting journal entries, if applicable
4. Assistance with lease and SBITA schedules

GAS independence standards require that the auditor maintain independence so that opinions, findings, conclusions, judgments, and recommendations are impartial and are viewed as such by reasonable and informed third parties. Before we agree to provide a non-audit service to the Center, we determine whether providing such a service would create a significant threat to our independence for GAS audit purposes, either by itself or in aggregate with other non-audit services provided. A critical component of our determination is consideration of management's ability to effectively oversee the non-audit services to be performed. The Center has agreed that Linda Poenitzsch, Chief Financial Officer, possesses suitable skill, knowledge, or experience and that the individual understands the services listed above to be performed sufficiently to oversee them. Accordingly, Helen Farabee Centers agrees to the following:

1. Helen Farabee Centers has designated Linda Poenitzsch, Chief Financial Officer, as a senior member of management who possesses suitable skill, knowledge, and experience to oversee the services;
2. Linda Poenitzsch, Chief Financial Officer, will assume all management responsibilities for the subject matter and scope of the Non-Audit Services listed above;
3. The Center will evaluate the adequacy and results of the services performed; and
4. The Center accepts responsibility for the results and ultimate use of the services.

GAS further requires that we establish an understanding with the Center's management and those charged with governance of the objectives of the non-audit services, the services to be performed, the Center's acceptance of its responsibilities, the auditor's responsibilities, and any limitations of the non-audit services. We believe this Engagement Letter documents that understanding.

Other Relevant Information

In accordance with GAS, a copy of our most recent peer review report has been provided to you for your information.

Fees and Costs

Our fees for the services described above are based upon the value of the services performed and the time required by the individuals assigned to the engagement, plus directly billed expenses, including report processing, travel, meals, and fees for services from other professionals, as well as a charge of a percentage of fees for all other expenses, including indirect administrative expenses such as technology, research and library databases. Our fee for the services described in this letter is not expected to exceed \$42,000 for the audit, \$5,500 for each major program selected over four (4) major programs, plus out-of-pocket expenses. Additional fees in excess of our fee estimate and beyond the agreed-upon scope will be discussed with you before proceeding. Our fee estimate and completion of our work are based on the following criteria:

1. Anticipated cooperation from Center personnel
2. Timely responses to our inquiries
3. Timely completion and delivery of client assistance requests
4. Timely communication of all significant accounting and financial reporting matters
5. The assumption that unexpected circumstances will not be encountered during the engagement

If any of the aforementioned criteria are not met, then fees may increase. Interim billings will be submitted as work progresses and as expenses are incurred. Payment is due upon invoice delivery.

Use of Third-Party Service Providers and Third-Party Products

We may, in our sole discretion, use qualified third-party service providers to assist us in providing professional services to you. In such circumstances, it may be necessary for us to disclose Confidential Information and Personal Information (as such terms are defined below) to them. We may share your information, including Confidential Information and Personal Information, with these third-party service providers, provided that such recipients are bound by written obligations of confidentiality. You acknowledge and agree that our use of a third-party service provider may involve the processing, input, disclosure, movement, transfer, and storage of your information and data, including Confidential Information and Personal Information, outside of our technology infrastructure. We will be responsible to you for the performance of our third-party service providers, solely as related to the services performed under this Engagement Letter, subject to all limitations and disclaimers set forth herein.

We may also provide services to you using certain third-party hardware, software, equipment, or products (collectively, "Third-Party Products," and each, individually, a "Third-Party Product"). You acknowledge that the use of a Third-Party Product may involve the processing, input, disclosure, movement, transfer, and storage of information provided by or on behalf of you to us, including Confidential Information and Personal Information, within the Third-Party Product's infrastructure and not ours which may result in the access, transfer, disclosure, storage or processing of such information and data outside of the United States. You further acknowledge that the terms of use and service, including, but not limited to, applicable laws, set forth in the end-user license, end-user subscription agreement, or other end-user agreement for such Third-Party Product (collectively, "EULA(s)") will govern all obligations of such the licensor of such Third-Party Product relating to data privacy, storage, recovery, security, and processing within such Third-Party Product's infrastructure, as well as, the service levels associated with such Third-Party Product. You hereby consent to the disclosure of your information, including your Confidential Information and Personal Information, to the licensors of such Third-Party Products for the purpose described herein and you acknowledge and agree that such Center-provided data and information may be collected, processed, stored, and used by such licensors for benchmarking, analytics, marketing, and other business purposes in support of the Third-Party Product.

To the extent Condley gives the Center access to a Third-Party Product in connection with the services contemplated herein, the Center agrees to comply with the terms of any applicable EULA for such Third-Party Product, and the Center shall be solely responsible for the improper use of a Third-Party Product or a violation of the applicable EULA for such Third-Party Product by the Center or any user to whom the Center grants access to such Third-Party Product. The Center agrees to indemnify and hold Condley harmless from and against any claims, actions, lawsuits, proceedings, judgments, liens, losses, damages, costs, expenses, fees (including reasonable legal fees, expenses, and costs), and other liabilities relating to, or arising from or out of, the improper use of a Third-Party Product, or a violation of the terms of the applicable EULA for such Third-Party Product by the Center or any user to whom the Center grants access to such Third-Party Product.

You acknowledge that the use of Third-Party Products may be subject to limitations, delays, interruptions, errors, and other problems beyond our control, including, without limitation, internet outages or other issues related to updates, upgrades, patches, fixes, or maintenance. We will not be liable for any damages relating to such limitations, delays, delivery failures, interruptions, errors, or other problems. Nor will we be held responsible or liable for any loss, or unauthorized use or disclosure, of any information or data provided by you, including, without limitation, Personal Information provided by you, resulting from the use of a Third-Party Product.

Use and Ownership; Access to Audit Documentation

The Audit Documentation for this engagement is the property of Condley. For the purposes of this Engagement Letter, the term "Audit Documentation" shall mean the confidential and proprietary records of Condley's audit procedures performed, relevant audit evidence obtained, other audit-related workpapers, and conclusions reached. Audit Documentation shall not include custom-developed documents, data, reports, analyses, recommendations, and deliverables authored or prepared by Condley for the Center under this Engagement Letter or any documents belonging to the Center or furnished to Condley by the Center.

Review of Audit Documentation by a successor auditor or as part of due diligence is subject to applicable Condley policies and will be agreed to, accounted for, and billed separately. Any such access to our Audit Documentation is subject to a successor auditor signing an Access & Release Letter provided by Condley without substantive modifications thereto. Condley reserves the right to decline a successor auditor's request to review our Audit Documentation.

In the event we are required by government regulation, subpoena or other legal process to produce our documents or our personnel as witnesses with respect to our engagement for the Center, the Center will, so long as we are not a party to the proceeding in which the information is sought, reimburse us for our professional time and expenses, as well as the fees and expenses of our counsel, incurred in responding to such requests.

The documentation for this engagement is the property of Condley. However, you acknowledge and grant your assent that representatives of the cognizant or oversight agency or their designee, other government audit staffs, and the U.S. Government Accountability Office shall have access to the Audit Documentation upon their request and that we shall maintain the Audit Documentation for a period of at least three years after the date of the report, or for a longer period if we are requested to do so by the cognizant or oversight agency. Access to the requested Audit Documentation will be provided under the supervision of Condley audit personnel and at a location designated by our firm.

Indemnification, Limitation of Liability, and Claim Resolution

Because Condley and Company, L.L.P. will rely on the Center, its management, and the Board of Trustees to discharge the foregoing responsibilities, the Center agrees to indemnify, hold harmless, and release Condley and Company, L.L.P. and its partners, principals, officers, directors, employees, affiliates, subsidiaries, contractors, Subcontractors, agents, representatives, successors, or assigns from all third-party claims, liabilities, losses and costs arising in circumstances where there has been a knowing misrepresentation by a member of the

THE CENTER AND CONDLEY AND COMPANY AGREE THAT NO CLAIM ARISING OUT OF, FROM, OR RELATING TO THE SERVICES RENDERED PURSUANT TO THIS ENGAGEMENT LETTER SHALL BE FILED MORE THAN TWO YEARS AFTER THE DATE OF THE AUDIT REPORT ISSUED BY CONDLEY OR THE DATE OF THIS ENGAGEMENT LETTER IF NO REPORT HAS BEEN ISSUED. IN NO EVENT SHALL CONDLEY OR THE CENTER OR ANY OF THEIR RESPECTIVE PARTNERS, PRINCIPALS, OFFICERS, DIRECTORS, EMPLOYEES, AFFILIATES, SUBSIDIARIES, CONTRACTORS, SUBCONTRACTORS, AGENTS, REPRESENTATIVES, SUCCESSORS, OR ASSIGNS (COLLECTIVELY, THE "COVERED PARTIES" AND EACH INDIVIDUALLY, A "COVERED PARTY"), BE LIABLE FOR THE INTERRUPTION OR LOSS OF BUSINESS, ANY LOST PROFITS, SAVINGS, REVENUE, GOODWILL, SOFTWARE, HARDWARE, OR DATA, OR THE LOSS OF USE THEREOF (REGARDLESS OF WHETHER SUCH LOSSES ARE DEEMED DIRECT DAMAGES), OR INCIDENTAL, INDIRECT, PUNITIVE, CONSEQUENTIAL, SPECIAL, EXEMPLARY, OR SIMILAR SUCH DAMAGES, EVEN IF ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. EXCEPT FOR A COVERED PARTY'S INDEMNIFICATION OBLIGATIONS UNDER THIS ENGAGEMENT LETTER, TO THE FULLEST EXTENT PERMITTED BY LAW, THE TOTAL AGGREGATE LIABILITY OF THE COVERED PARTIES ARISING OUT OF, FROM, OR RELATING TO THIS ENGAGEMENT LETTER OR THE REPORT ISSUED OR SERVICES PROVIDED HEREUNDER, REGARDLESS OF THE CIRCUMSTANCES OR NATURE OR TYPE OF CLAIM, INCLUDING, WITHOUT LIMITATION, CLAIMS ARISING FROM A COVERED PARTY'S NEGLIGENCE OR BREACH OF CONTRACT OR WARRANTY, OR RELATING TO OR ARISING FROM A GOVERNMENT, REGULATORY OR ENFORCEMENT ACTION, INVESTIGATION, PROCEEDING, OR FINE, WILL NOT EXCEED THE TOTAL AMOUNT OF THE FEES PAID BY THE CENTER TO CONDLEY UNDER THIS ENGAGEMENT LETTER. NOTWITHSTANDING THE FOREGOING, NOTHING IN THIS LIMITATION OF LIABILITY PROVISION SHALL OR SHALL BE INTERPRETED OR CONSTRUED TO RELIEVE THE CENTER OF ITS PAYMENT OBLIGATIONS TO CONDLEY UNDER THIS ENGAGEMENT LETTER.

Confidentiality

Condley and the Center may, from time to time, disclose Confidential Information (as defined below) to one another. Accordingly, Condley and the Center agree as the recipient of such Confidential Information (the "Receiving Party") to keep strictly confidential all Confidential Information provided to it by the disclosing party (the "Disclosing Party") and use, modify, store, and copy such Confidential Information only as necessary to perform its obligations and exercise its rights under this Engagement Letter and for no other purpose or use. Except as otherwise set forth herein, the Receiving Party may only disclose the Confidential Information of the Disclosing Party to its personnel, agents, and representatives who are subject to obligations of confidentiality at least as restrictive as those set forth herein and only for the purpose of exercising its rights and fulfilling its obligations hereunder. To avoid any doubt, Condley is permitted to disclose the Center's Confidential Information to Condley's personnel, agents, and representatives for the purpose of maintaining compliance with applicable laws and professional, regulatory, and/or ethical standards.

"Confidential Information" means, information in any form, consisting of: (i) any nonpublic information provided by the Disclosing Party; (ii) any information that the Disclosing Party identifies as confidential; or (iii) any information that, by its very nature, a person in the same or similar circumstances would understand should be treated as confidential, including, but not limited to, this Engagement Letter. Without limiting the generality of the foregoing, the Center acknowledges and agrees that Documentation constitutes Confidential Information of Condley.

"Confidential Information" will not include information that: (i) is publicly available at the time of disclosure by the Disclosing Party; (ii) becomes publicly available by publication or otherwise after disclosure by the Disclosing Party, other than by breach of the confidentiality obligations set forth herein by the Receiving Party; (iii) was lawfully in the Receiving Party's possession, without restriction as to confidentiality or use, at the time of disclosure by the Disclosing Party; (iv) is provided to the Receiving Party without restriction as to confidentiality or use by a third party without violation of any obligation to the Disclosing Party; or (v) is independently developed by employees or agents of the Receiving Party who did not access or use the Disclosing Party's Confidential Information.

The Receiving Party will treat the Disclosing Party's Confidential Information with the same degree of care as the Receiving Party treats its own confidential and proprietary information, but in no event will such standard of care be less than a reasonable standard of care.

The Center consents to the Condley Parties using Confidential Information and Personal Information provided by or on behalf of the Center to: (i) improve the quality of our services and offerings; and/or (ii) develop or perform internal data analysis, business analytics or insights, or other internal insight generation. Information developed in connection with these purposes may be used or disclosed to current or prospective clients to provide services or offerings. The Condley Parties will not use or disclose such Confidential Information or Personal Information in a way that would permit the Center or an individual to be identified by third parties without your prior written consent.

Personal Information

As used herein, the term "Personal Information" means any personal information or data, as may be defined by applicable privacy, data protection, or cybersecurity laws, that directly or indirectly identifies a natural person.

Each party agrees to transmit Personal Information consistent with applicable laws and any other obligations the respective party may have. We are permitted to use all such Personal Information to perform our obligations and exercise our rights under this Engagement Letter.

You represent and warrant that you have provided all notices and obtained all consents required under applicable data protection laws prior to your collection, use, and disclosure to a Condley Party of such Personal Information and shall take reasonable steps to ensure that such Personal Information does not include irrelevant or unnecessary information about individuals.

Retention of Records

We will return to you all the original records you provide to us in connection with this engagement. Further, in addition to providing you with those deliverables set forth in this Engagement Letter, we will provide you with a copy of any records we prepare or accumulate in connection with such deliverables that are not otherwise reflected in your books and records, without which your books and records would be incomplete. You have the sole responsibility for retaining and maintaining in your possession or custody all of your financial and nonfinancial records related to this engagement. We will not host, and will not accept responsibility to host, any of your records. We, however, may maintain a copy of any records of yours necessary for us to comply with applicable law and/or professional standards. Any such records retained by us will be subject to the confidentiality obligations set forth herein and destroyed in accordance with our record retention policies.

Termination

Your failure to make full payment of any and all undisputed amounts invoiced in a timely manner constitutes a material breach for which we may refuse to provide deliverables and/or, upon written notice, suspend or terminate our services under this Engagement Letter. We will not be liable to you for any loss, damage, or expense arising out of or from, or relating to, such termination or suspension of our services.

Either party hereto may terminate this Engagement Letter for any reason upon fifteen (15) days' prior written notice to the other party. In the event you terminate this engagement, you will pay us for all services rendered (including deliverables and products delivered), expenses incurred, and noncancelable commitments made by us on your behalf through the effective date of termination.

Either party may terminate this Engagement Letter upon written notice if: (i) circumstances arise that in its judgment would cause its continued performance to result in a violation of law, a regulatory requirement, a legal process, a contractual obligation with a third party, applicable professional or ethical standards, or, in the case of Condley, our client acceptance or retention standards; or (ii) if the other party, or any director, executive, partner or principal thereof, is placed on a Sanctioned List (as defined herein), or if any director or executive of, or other person closely associated with such other party or its affiliate, is placed on a Sanctioned List (as defined below).

Neither Condley nor the Center shall be responsible for any delay or failure in its performance resulting from acts beyond its reasonable control (each, a "Force Majeure Event"). Force Majeure Events include, but are not limited to, acts of God, government or war, riots or strikes, disasters, fires, floods, epidemics, pandemics or outbreaks of communicable disease, cyberattacks, and internet or other system or network outages. At your option, you may terminate this Engagement Letter where our services are delayed more than 120 days by a Force Majeure Event; however, you are not excused from paying us for all amounts owed for services rendered and deliverables provided prior to the termination of this Engagement Letter.

When an engagement has been suspended at the request of management, or those charged with governance, and work on that engagement has not recommenced within 120 days of the request to suspend our work, we may, at our sole discretion, terminate this Engagement Letter without further obligation to you. Resumption of our work following termination may be subject to our client acceptance procedures and, if resumed, will require additional procedures not contemplated in this Engagement Letter. Accordingly, the scope, timing, and fee arrangement discussed in this Engagement Letter will no longer apply. In order for us to recommence work, the execution of a new Engagement Letter will be required.

The parties agree that those provisions of this Engagement Letter which, by their context, are intended to survive, including, but not limited to, payment, limitations on liability, claim resolution, use and ownership, and confidentiality obligations, shall survive the termination of this Engagement Letter.

Miscellaneous

We may mention your name and provide a general description of the engagement in our client lists and marketing materials.

You have informed us that you may issue public debt in the future and that you may include our report on your financial statements in the offering statement. You have further informed us that you do not intend for us to be associated with the proposed offering.

We agree that our association with any proposed offering is not necessary, provided the Center agrees to clearly indicate that we are not associated with the contents of any such official statement or memorandum. The Center agrees that the following disclosure will be prominently displayed in any such official statement:

Condley and Company, L.L.P., our independent auditor, has not been engaged to perform and has not performed, since the date of its report included herein, any procedures on the financial statements addressed in that report. Condley and Company, L.L.P. has also not performed any procedures relating to this official statement.

Our professional standards require that we perform certain additional procedures on current and previous years' engagements whenever a partner or professional employee leaves the firm and is subsequently employed by or associated with a client in a key position. Accordingly, you agree to compensate us for any additional costs incurred as a result of your employment of one of our partners, principals, or employees.

Each party hereto affirms it has not been placed on a Sanctioned List (as defined below) and will promptly notify the other party upon becoming aware that it has been placed on a Sanctioned List at any time throughout the duration of this Engagement Letter. The Center shall not and shall not permit third parties to access or use any of the deliverables provided for hereunder, or Third-Party Products provided hereunder, in violation of any applicable sanctions laws or regulations, including but not limited to, accessing or using the deliverables provided for hereunder or any Third-Party Products from any territory under embargo by the United States. The Center shall not knowingly cause Condley to violate any sanctions applicable to Condley. As used herein, "Sanctioned List" means any sanctioned person or entity lists promulgated by the Office of Foreign Assets Control of the U.S. Department of the Treasury, the U.S. State Department, and the United Nations Security Council.

Any term of this Engagement Letter that would be prohibited by or impair our independence under applicable law or regulation shall not apply to the extent necessary only to avoid such prohibition or impairment.

Notices

Unless otherwise expressly agreed upon by the parties in this Engagement Letter, all notices required to be given hereunder will be in writing and addressed to the party at the business address provided in this Engagement Letter, or such other address as such party may indicate by a notice delivered to the other party. A copy of any legal notice (e.g., any claimed breach or termination of this Engagement Letter) sent by the Center to Condley shall also be sent to the following address: Condley and Company, L.L.P., P.O. Box 2993, Abilene, TX 79604-2993. Except as otherwise expressly provided in this Engagement Letter, notices hereunder will be deemed given and effective: (i) if personally delivered, upon delivery; (ii) if sent by registered or certified mail or by overnight courier service with tracking capabilities, upon receipt; and, (iii) if sent by electronic mail (without indication of delivery failure), at such time as the party that sent the notice receives confirmation of receipt, whether by read-receipt confirmation or otherwise.

Governing Law

This Engagement Letter, including, without limitation, its validity, interpretation, construction, and enforceability, and any dispute, litigation, suit, action, claim, or other legal proceeding arising out of, from, or relating in any way to this Engagement Letter, any provisions herein, a report issued or the services provided hereunder, will be governed and construed in accordance with the laws of the State of Texas, without regard to its conflict of law principles, and applicable U.S. federal law.

Entire Agreement

This Engagement Letter including any exhibits, policies, schedules, and/or other documents expressly incorporated herein by reference or attached hereto, constitutes the entire of agreement between Condley and the Center, and supersedes all prior agreements, understandings, and proposals, whether oral or written, relating to the subject matter of this Engagement Letter including any separate nondisclosure agreement executed between the parties.

If any term or provision of this Engagement Letter is determined to be invalid or unenforceable, such term or provision will be deemed stricken, and all other terms and provisions will remain in full force and effect.

This Engagement Letter may be amended or modified only by a written instrument executed by both parties.

Electronic Signatures and Counterparts

This Engagement Letter may be executed in one or more counterparts, each of which will be deemed to be an original, but all of which taken together will constitute one and the same instrument. Each party agrees that any electronic signature of a party to this Engagement Letter or any electronic signature to a document contemplated hereby (including any representation letter) is intended to authenticate such writing and shall be as valid, and have the same force and effect as a manual signature.

Acknowledgement and Acceptance

Each party acknowledges that it has read and agrees to all of the terms contained herein, including any exhibits, policies, schedules, and/or other documents expressly incorporated herein by reference or attached hereto. Each party and its signatory below represent that said signatory is a duly authorized representative of such party and has the requisite power and authority to bind such party to the undertakings and obligations contained herein.

AGREED TO AND ACKNOWLEDGED BY:

Condley and Company, L.L.P.

Certified Public Accountants
Ryan Gibson, CPA, Partner

Confirmed on behalf of Helen Farabee Centers:

Name and Title

Date

Additional Communication with the Board of Trustees

This communication is intended to communicate certain matters related to the planned scope and timing of our audit of Helen Farabee Centers' financial statements as of and for the year ended August 31, 2026.

Communication

Effective two-way communication between our firm and the Board of Trustees is important to understanding matters related to the audit and developing a constructive working relationship.

Your insights may assist us in understanding Helen Farabee Centers and its environment, identifying appropriate sources of audit evidence, and providing information about specific transactions or events. We will discuss with you your oversight of the effectiveness of internal control and any areas where you request additional procedures to be undertaken. We expect that you will timely communicate to us any matters you consider relevant to the audit. Such matters might include strategic decisions that may significantly affect the nature, timing, and extent of audit procedures, your suspicion or detection of fraud, or any concerns you may have about the integrity or competence of senior management.

We will timely communicate to you any fraud involving senior management and other known or likely fraud, noncompliance with provisions of laws, statutes, regulations, rules, provisions of contracts or grant agreements, or abuse that is likely to have a material effect on the financial statements. We will also communicate any illegal acts, instances of noncompliance or fraud that come to our attention (unless they are clearly inconsequential), as well as disagreements with management and other serious difficulties encountered in performing the audit. We will also communicate to you and to management any significant deficiencies or material weaknesses in internal control that become known to us during the course of the audit. Additionally, we will communicate significant unusual transactions, matters that are difficult or contentious for which we consulted outside the engagement team, and circumstances that affect the form and content of the auditor's report. Other matters arising from the audit that are, in our professional judgment, significant and relevant to you in your oversight of the financial reporting process will be communicated to you in writing.

Shared Responsibilities for Independence

Independence is a joint responsibility and is managed most effectively when management, audit committees (or their equivalents), and audit firms work together in considering compliance with the American Institute of Certified Public Accountants (AICPA) and the U.S. Government Accountability Office (GAO) independence rules. For Condley to fulfill its professional responsibility to maintain and monitor independence, management, the Board of Trustees, and Condley each play an important role.

Our responsibilities

- AICPA and GAO rules require independence both of mind and in appearance when providing audit and other attestation services. Condley is to ensure that the AICPA and GAO's General Requirements for performing non-attest services are adhered to and included in all letters of engagement.
- Maintain a system of quality management over compliance with independence rules and firm policies.

Your responsibilities

- Timely inform Condley, before the effective date of transactions or other business changes, of the following:
 - New affiliates, directors, or officers.
 - Changes in the organizational structure or the reporting entity impacting affiliates such as subsidiaries, partnerships, related entities, investments, joint ventures, component units, and jointly governed organizations.

- Provide necessary affiliate information, such as new or updated investment structure charts, as well as financial information required to perform materiality calculations needed for making affiliate determinations.
- Understand and conclude on the permissibility, prior to the Center and its affiliates, officers, directors, or persons in a decision-making capacity, engaging in business relationships with Condley.
- Not entering into arrangements for non-attest services, resulting in Condley being involved in making management decisions on behalf of the Center.
- Not entering into relationships resulting in close family members of Condley-covered persons temporarily or permanently acting as an officer, director, or person in an accounting or financial reporting or compliance oversight role at the Center.

Our Independence Policies and Procedures

Our independence policies and procedures are designed to provide reasonable assurance that our firm and its personnel comply with applicable professional independence standards. Our policies address financial interests, business and family relationships, and non-audit services that may be thought to bear on independence. For example, our partners and professional employees are restricted in their ability to own a direct financial interest or a material indirect financial interest in a client or any affiliate of a client. Also, if an immediate family member or close relative of a partner or professional employee is employed by a client in a key position, the incident must be reported and resolved in accordance with firm policy. In addition, our policies prohibit us from providing certain non-attest services and require audit clients to accept certain responsibilities in connection with the provision of permitted non-attest services.

The Audit Planning Process

Our audit approach places a strong emphasis on obtaining an understanding of how your organization functions. This enables us to identify key audit components and tailor our procedures to the unique aspects of your operations. The development of a specific audit plan will begin by meeting with you and with management to obtain an understanding of business objectives, strategies, risks, and performance.

As part of obtaining an understanding of your organization and its environment, we will obtain an understanding of your system of internal control. We will use this understanding to identify risks of material misstatement and noncompliance, which will provide us with a basis for designing and implementing responses to the assessed risks of material misstatement and noncompliance. We will also obtain an understanding of the users of the financial statements in order to establish an overall materiality level for audit purposes. We will conduct formal discussions among engagement team members to consider how and where your financial statements might be susceptible to material misstatement due to fraud or error, or to noncompliance.

The Concept of Materiality in Planning and Executing the Audit

We apply the concept of materiality in both planning and performing the audit, evaluating the effect of identified misstatements or noncompliance on the audit and the effect of uncorrected misstatements, if any, on the financial statements, forming the opinion in our report on the financial statements, and determining our reporting in accordance with *Government Auditing Standards* and other compliance reporting requirements. Our determination of materiality is a matter of professional judgment and is affected by our perception of the financial and compliance informational needs of users of the financial statements. We establish performance materiality at an amount less than materiality for the financial statements as a whole to allow for the risk of misstatements that may not be detected by the audit. We use performance materiality for purposes of assessing the risks of material misstatement and determining the nature, timing, and extent of further audit procedures. Our assessment of materiality throughout the audit will be based on both quantitative and qualitative considerations. Because of the interaction of quantitative and qualitative considerations, misstatements of a relatively small amount could have a material effect on the current financial statements as well as financial statements of future periods. We will accumulate misstatements identified during the audit, other than those that are clearly trivial. At the

end of the audit, we will inform you of all individual uncorrected misstatements aggregated by us in connection with our evaluation of our audit test results.

Significant Risks of Material Misstatement

Our audit of the financial statements includes the performance of risk assessment procedures in order to identify risks of material misstatement, whether due to fraud or error. As part of these risk assessment procedures, we determine whether any risks identified are a significant risk. A significant risk is an identified risk of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum of inherent risk due to the degree to which inherent risk factors affect the combination of the likelihood of a misstatement occurring and the magnitude of the potential misstatement should that misstatement occur, or that is to be treated as a significant risk in accordance with auditing standards generally accepted in the United States of America. As part of our initial risk assessment procedures, we identified the following risks as significant risks. Additional significant risks may be identified as we perform additional audit procedures.

Risk Name	Risk Description	Planned Response
Management override of controls	Management could override controls set by management.	Auditor will test journal entries and evaluate whether management's judgments and decisions in accounting estimates indicate any bias.
Revenue Recognition	Revenue could be recognized that is not substantiated, and could misstate the financial statements.	Experienced staff will test revenue. The transactions will be substantiated and analyzed to verify revenue is properly recorded.
Capital Assets	Listing of assets capitalized is incomplete or inaccurate, possibly overstating expenses with capital additions or depreciation on disposed items.	Auditor will select a sample of additions for testing and search for uncapitalized assets in repair and maintenance accounts.
Deferred Revenue	Revenue could be recorded in the wrong period based on when it is received rather than the period it relates to.	Auditor will perform a search for unrecorded deferred revenue and test existing revenue to determine whether it was recorded in the appropriate period or should be deferred.
Leases and SBITAs	Leases/SBITAs right-of-use assets and liabilities could be incorrectly recorded or not recorded.	Auditor will search for unrecorded leases/SBITAs and test lease activity during the current year.

Our Approach to Internal Control and Compliance Relevant to the Audit

Our audit of the financial statements, including compliance, will include obtaining an understanding of internal control over financial reporting and compliance sufficient to plan the audit and determine the nature, timing, and extent of audit procedures to be performed. An audit is not designed to provide assurance on internal control over financial reporting and compliance or to identify significant deficiencies or material weaknesses. Our review and understanding of the entity's internal control over financial reporting and compliance is not undertaken for the purpose of expressing an opinion on the effectiveness of internal control.

We will issue a report on internal control over financial reporting and compliance, and other matters related to the financial statements. This report describes the scope of testing of internal control over financial reporting and compliance, and the results of our tests of internal control over financial reporting and compliance. Our report on internal control over financial reporting and compliance and other matters will include any significant deficiencies and material weaknesses in the system of which we become aware as a result of obtaining an understanding of internal control and performing tests of internal control over financial reporting and noncompliance and other matters consistent with the requirements of *Government Auditing Standards*, issued by the Comptroller General of the United States.

We will also issue a report on compliance for each major federal program and on internal control over compliance; consistent with the requirements of *the Single Audit Act* and *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* at 2 CFR 200 (Uniform Guidance). This report describes the scope of testing of internal control and compliance and the results of our tests of internal control and compliance, consistent with the Single Audit Act and Uniform Guidance. We will include any significant deficiencies and material weaknesses in the system of which we become aware as a result of obtaining an understanding of internal control and performing tests of internal control over each major program, report any noncompliance that could have a direct and material effect on each major program and report any known or likely fraud affecting a federal award consistent with the Single Audit Act and Uniform Guidance.

Timing of the Audit

We will schedule the fieldwork dates with management and inform the Board of Trustees of those dates. Management's adherence to its closing schedule and timely completion of information used by us in the performance of the audit is essential to the timely completion of the audit.

Closing

We will be pleased to address any questions you may have about the foregoing and appreciate the opportunity to serve Helen Farabee Centers.

This communication is intended solely for the information and use of the Board of Trustees and is not intended to be and should not be used by anyone other than the specified party.

Condley and Company, L.L.P.

Certified Public Accountants

ATTACHMENT

Condley and Company, L.L.P
Peer Review Report



Carr, Riggs & Ingram, LLC
2424 Louisiana Boulevard NE
Suite 300
Albuquerque, NM 87110

(505) 883-2727
(505) 884-6719 (fax)
CRlcpa.com

REPORT ON THE FIRM'S SYSTEM OF QUALITY CONTROL

November 18, 2024

To the Partners of Condley and Company, LLP
and the National Peer Review Committee of the AICPA

We have reviewed the system of quality control for the accounting and auditing practice of Condley and Company, LLP (the "firm") in effect for the year ended May 31, 2024. Our peer review was conducted in accordance with the Standards for Performing and Reporting on Peer Reviews established by the Peer Review Board of the American Institute of Certified Public Accountants (Standards).

A summary of the nature, objectives, scope, limitations of, and the procedures performed in a System Review as described in the Standards may be found at www.aicpa.org/prsummary. The summary also includes an explanation of how engagements identified as not performed or reported in conformity with applicable professional standards, if any, are evaluated by a peer reviewer to determine a peer review rating.

Firm's Responsibility

The firm is responsible for designing and complying with a system of quality control to provide the firm with reasonable assurance of performing and reporting in conformity with the requirements of applicable professional standards in all material respects. The firm is also responsible for evaluating actions to promptly remediate engagements deemed as not performed or reported on in conformity with the requirements of applicable professional standards, when appropriate, and for remediating weaknesses in its system of quality control, if any.

Peer Reviewer's Responsibility

Our responsibility is to express an opinion on the design of and compliance with the firm's system of quality control based on our review.

Required Selections and Considerations

Engagements selected for review included engagements performed under Government Auditing Standards, including compliance audits under the Single Audit Act; audits of employee benefit plans; and audit performed under FDICIA

As a part of our peer review, we considered reviews by regulatory entities as communicated by the firm, if applicable, in determining the nature and extent of our procedures.

Opinion

In our opinion, the system of quality control for the accounting and auditing practice of Condley and Company, LLP in effect for the year ended May 31, 2024, has been suitably designed and complied with to provide the firm with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. Firms can receive a rating of pass, pass with deficiency (ies) or fail. Condley and Company, LLP has received a peer review rating of pass.

Carr, Riggs & Ingram, L.L.C.

Carr, Riggs, & Ingram, LLC

5 RECOMMENDATIONS

C. CONTRACTS AND PLANS

1) **QUALITY MANAGEMENT PLAN RESULTS**

RECOMMENDED ACTION: Review of the Quality Management Plan Annual report.

BACKGROUND INFORMATION: The Quality Management Plan is required by Texas Administrative Code (TAC) and by Certified Community Behavioral Health Clinics (CCBHC). The core document defines the role of the Quality Management and each attachment is designated to a department that details their specific requirements.

SUPPORTING INFORMATION: The Quality Management Plan was enacted in FY 2025. The QM department compiled all the results of the internal audits, department goals and expectations, and continuous quality improvement projects.

SPECIFIC REASONS WHY THESE ACTIONS ARE NECESSARY FOR THE CENTER:
The Quality Management plan is a requirement for TAC and CCBHC certification.

Quality Management Annual Report for Mental Health Services



Helen Farabee
CENTERS
— a commitment to caring —

Fiscal Year 2025

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Attachments:

Intellectual & Development Disability (IDD) Audit Results

Quality Management Plan

Attachment A: Mental Health Adult and Child & Adolescent Services

Attachment C: YES Waiver

Attachment D: IDD Authority Services

Attachment F: Substance Abuse Services

Attachment H: Continuous Quality Improvement

Attachment I: Early Childhood Intervention (ECI)

Attachment J: Subcontracting

Introduction

Quality Management: A year in review

External Audits:

In February 2025, Helen Farabee Centers (HFC) was audited by Texas Health and Human Services (HHS). This was a routine review conducted every two years. HFC had eleven (11) findings at the end of the review. This was an improvement from the previous review in 2023 when HFC had fourteen (14) findings. HFC's corrective action plan (CAP) was submitted and approved in May. Helen Farabee Centers' staff implemented the corrections and completed the CAP items by September 1, 2025.

In July 2025, HFC was notified that the Texas- Certified Community Behavioral Health Clinic would start their re-certification review in August. This is an on-going review slated for completion in February 2026.

During FY 2025, there were Managed Care Organization (MCO) reviews including Superior (quarterly) and Magellan.

Internal Audits:

During FY 2025, the Quality Management department conducted 396 internal chart reviews. Audits are separated into 15 audit tools focused on different areas of charting compliance.

Audit Tool	Number of audits conducted
Case Management – Adult including HTPP	87
TCOOMMI	15
PASRR	38
Peer Provider – Adult	18
Supported Employment	6
Case Management -CAS	35
Wraparound	6
YES Waiver	5
LPHA- Counseling	16
Med Staff- QM audit	26
Med Staff- Peer review	45
Med Training and Support	20
Crisis Assessment	20
Front Desk	20
House Bill 4 (telephone)	39

Department Changes:

Taryn Miller (Fergel) started in the UM/QM department in mid-May. Taryn was a CAS case manager in the Wichita Falls office. Taryn has taken on a dual role of Utilization Management and Quality Management duties. Taryn helps with training, conducting quality management audits, documentation reviews for credentialing new hires.

Shaded boxes are used within the report to signify changes in compliance. When used in a yearly comparison, the green shaded marks improvement from the previous year, orange signifies a decrease in compliance, and white is a new or added criteria. When shaded boxes are not used for comparison, green boxes indicate a score above the compliance target and orange boxes indicate scores below the compliance target.

Adult Mental Health

The adult case management audit contains the following information:

- Recovery Plans
- Case Management Notes
- Psychosocial Rehabilitation Notes/ Skills Training Notes

Fidelity Scales

- Illness Management Recovery (IMR)
- Assertive Community Treatment (ACT)
- Seeking Safety
- Cognitive Adaptation Training (CAT)
- Co-Occurring Psychiatric and Substance Abuse Disorder (COPSD)

Recovery Plan

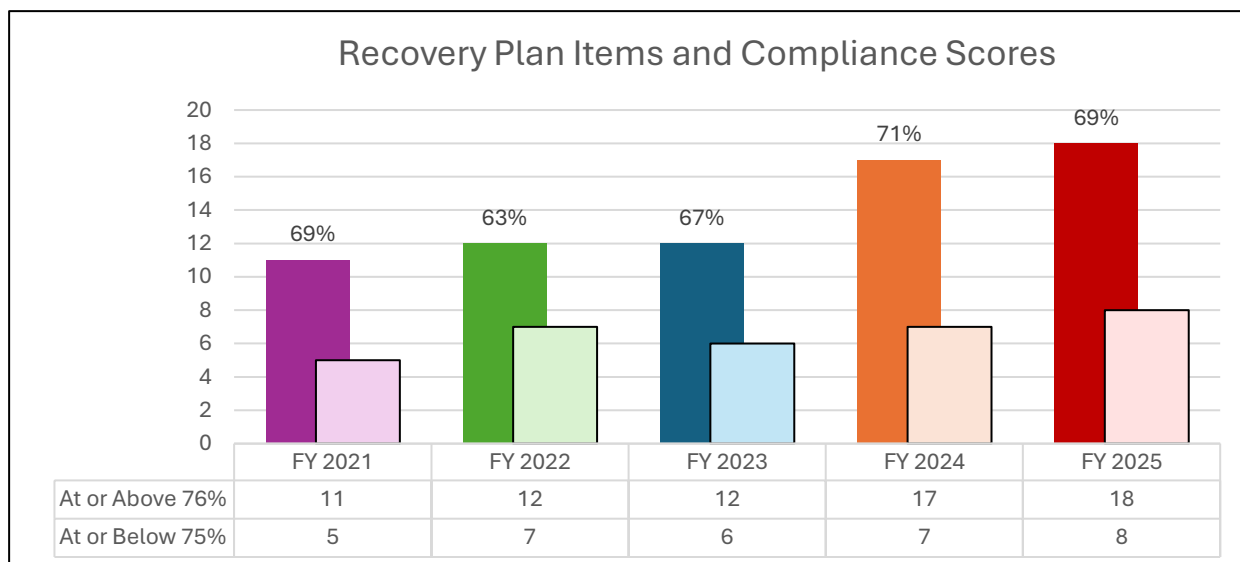
Eighty-seven (87) adult recovery plans were reviewed during FY 2025. The table below shows the progression of scores for the past five (5) years. Questions highlighted in GREEN shows an improvement from the previous year.

RECOVERY PLAN	FY 21	FY 22	FY 23	FY 24	FY 25
The Initial Recovery Plan was completed within 10 business days after the LOC authorization is made.	68%	75%	61%	75%	56%
Current or updated recovery plan effective date and the TRR assessment date should match.	91%	92%	93%	95%	87%
Recovery Plan includes individual's strengths that match the ANSA	100%	100%	99%	44%	52%
Recovery Plan includes resources for recovery supports	77%	88%	98%	96%	88%
Recovery Plan addresses the individual's preference including telephone appts	86%	92%	95%	100%	100%
Recovery Plan specifically addresses the cultural and spiritual information.				95%	69%
Recovery Plan addresses presenting problem (desc. of symptoms)				87%	94%
Recovery Plan has a description of substance use issues. Is this being treated?	83%	82%	82%	93%	91%
Recovery Plan addresses physical health issues. Is this being treated?				89%	85%
Recovery Plan addresses expected outcomes of treatment.	85%	89%	93%	90%	92%
Recovery Plan goals reflected the individual's self-direction, autonomy, and desired outcomes. It is person-centered and answers the What and Why questions.	79%	84%	84%	87%	84%
Recovery Plan Objectives meet SMART model	NA	94%	93%	86%	83%
Recovery Plan Objectives state who is reporting progress	NA	NA	NA	NA	65%
Recovery Plan Objectives are Person Centered	87%	88%	94%	97%	98%
Recovery Plan Objectives are modified or ended correctly	NA	55%	68%	64%	74%
Recovery Plan Objectives are under 2 years old	NA	NA	NA	NA	95%
Recovery Plan Objectives meet all criteria.	NA	NA	NA	72%	43%
Recovery Plan documents progress on all goals and objectives.		64%	75%	62%	76%
Recovery Plan documents recommendations for continuing services, any change from current services, and any discharge from services.	58%	54%	59%	56%	73%
Recovery Plan describes the strategies to be implemented by staff providing the services and achieving goals. Staff Supports and Interventions should match.	68%	78%	72%	76%	81%

Recovery Plan was created in collaboration with the individual or LAR? Client input should change at each review.	82%	69%	82%	71%	76%
Recovery Plan: If COPSD was listed as a presenting problem or in the diagnosis list, is it addressed within the recovery plan with a goal, objective or staff support?	67%	69%	62%	79%	61%
Recovery Plan: If Physical Health was listed as a presenting problem, is it addressed within the recovery plan?	73%	70%	NA	100%	100%
Recovery Plan interventions relate to the type of services provided; Frequency, Units and Duration are appropriate and credentials of the staff member providing the service.	97%	96%	99%	93%	92%
Recovery Plan ensures the crisis plan refers to the most effective and least restrictive available treatment.	87%	96%	98%	99%	97%
Recovery Plan was signed within 24 hours of the begin date?	NA	NA	NA	77%	84%

For FY 2025, ten (10) questions have improved from FY 2024. Criteria from external reviews cause some of the biggest decline in our reviews. For example on the cultural and spiritual information this was reported as needs in previous years, but in FY 25 this was changed to considerations. Asking the individual what their culture and spirituality in order is to use this in the recovery process. This was an adjustment that required training of case managers and update in criteria on the audit tool. New criteria for recovery plan objectives were also added for FY 25 including, who is responsible for reporting progress and are the objective under two (2) years old. Only one “no” answer for any of the criteria would result in the objectives scoring as non-compliant.

As we can see from the chart below, compliance on recovery plan items has decreased from FY 2024. The new criteria referenced above has influenced those scores as expected.



Case Management Notes

One hundred and forty-four (144) case management notes were reviewed for FY 25. Five (5) questions showed improvement (GREEN) from last year where four (4) declined (RED) in compliance. New questions were added for this fiscal year concerning if the note was individualized from previous notes, if it is congruent with the recovery plan goal, and an overall compliance questions. Only 6% of the notes reviewed appeared copy and pasted or templated. Most notes (82%) were related to the recovery plan goal and 97% of notes reach a compliance of 75% or above. This meant that a case management note could miss one or two questions and still pass the 75% compliance target.

FY 25 Adult Case Management		
Questions	FY 2024	FY 2025
Status meets criteria of the UM manual. Must match billing information.	95%	100%
Intervention meets criteria of the UM manual. Could include follow-up, assessing of needs, medication monitored, refer or link to resources, monitoring of goals or objectives.	98%	90%
If needs are identified by the client, the need was documented and address. Could be addressed with referral or a plan to address the need.	89%	94%
Timeline for reevaluating needs was established. Look for next appointment must have medical appt and next appt with CM.	96%	93%
Outcome meets criteria of the UM manual. Look for details on how the individual responded to each intervention.	98%	99%
Progress meets criteria of the UM manual. Progress must address the overall goal. Provide evidence of progress or lack of progress.	71%	74%
COPS-D was addressed if client has substance use disorder diagnosed.	72%	65%
Content of the note matching the procedure code.	99%	99%
Content supports billing duration.	90%	94%
Content is individualized. Look for blanks in information, gender swapping, wrong name in note, etc.	98%	96%
Does the note is not templated or copy and pasted.	NA	94%
Is the CM Note congruent with the goal and each section of the note	NA	82%
Does the CM Note meet 75% of above criteria	NA	97%

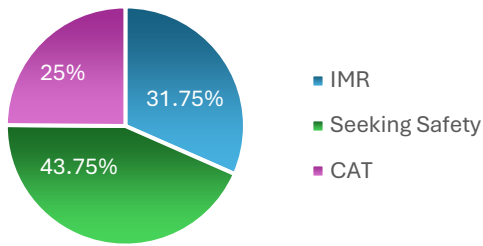
Psychosocial Rehabilitation / Skills Training Notes

Sixty (60) Psychosocial Rehabilitation/ Skills Training notes were reviewed for FY 2025. These notes showed an improvement in three areas, status, progress, and billing duration. Three new questions were added this fiscal year including, is the note congruent with the goal and within the contents, is the note templated or copy and pasted from previous notes and is the overall note meeting compliance.

Adult Skills Training/ PSR		
Questions	FY 2024	FY 2025
Status meets criteria of the UM manual. Must match billing information. If something is marked remarkable there is an explanation.	98%	100%
Intervention meets criteria of the UM manual. Look for skills language.	88%	83%
Outcome meets criteria of the UM manual. Look for details on how the individual responded to each intervention.	95%	87%
Progress meets criteria of the UM manual. Progress must address the overall goal. Provide evidence of progress or lack of progress.	47%	72%
COPS-D was addressed if client has substance use disorder diagnosed.	67%	48%
Content of the note matching the procedure code.	97%	83%
Content supports billing duration.	95%	97%
Content is individualized. Look for blanks in information, gender swapping, wrong name in note, etc.	98%	98%
Does the note appear templated or copy and pasted.	NA	10%
Is the Note congruent with the goal and each section of the note	NA	70%
Does the CM Note meet 75% of above criteria	NA	86%

Fidelity Elements

Skills Curriculum Used



The chart to the left indicates the percentage of curriculum used in FY 2025 psychosocial rehabilitation/ skills training notes. Seeking safety is the most used curriculum, followed by Illness Management Recovery (IMR) and Cognitive Adaptation Therapy (CAT). CAT is the newest curriculum introduced as a stand-alone.

(Note: Most used curriculum does not mean most reviewed notes. Seeking Safety was found used in the most charts but may only include 1 note at the time of review.)

Illness Management Recovery (IMR)

Fourteen (14) PSR/skills training notes were reviewed using IMR as the skills curriculum. In green are the questions that scored at or above the compliance target of 76%.

Questions	Score
Note identified curriculum used	100%
Note identified handout provided	100%
Note identified skills taught	93%
Note addressed natural supports	43%
Note includes personal goal	100%
Note follows up on personal goal	46%
Note includes strategies (motivational, educational, or cognitive-behavioral)	79%
Note includes homework assigned	54%
Note listed coping skills	62%
Note included behavior tailoring skills for medication compliance; if not compliant	100%
Note includes relapse prevention: Note if lesson 7 or 8 is addressed look for skills or safety plans	33%

Seeking Safety

Thirteen (13) PSR/ skills training notes used Seeking Safety curriculum.

Questions	Score
Notes include the use of curriculum?	100%
A "check in" process completed?	100%
Notes identify the "quote" discussed to seek out participation on the topic?	46%
Notes reflect that a home assignment / home practice being assigned?	69%
Notes include a clinical debriefing after the lesson was held?	38%
Notes include discussion about the individual making a commitment to engage in safe activities/ behaviors?	38%

Cognitive Adaptation Training (CAT)

Four (4) notes were reviewed for CAT. CAT is HFC's newest curriculum. As staff are trained and comfortable with the material, UM/QM believes more staff will use the curriculum.

Fidelity Scoring:

- 0= Absence of the attribute, or highly inappropriate performance.
- 1= Evidence of slight competence, but numerous problems and missing feature
- 2= Competent, but some problems and/or missing feature
- 3= Good features, but minor problems
- 4= Excellent performance with no problems evident

Questions	0	1	2	3	4	SCORE
Review of previously established support (review of homework)	1	0	0	0	2	2.60%
Use of Reinforcement (positive reinforcement is used ex: praise)	0	0	1	1	2	3.25%
Problem solving (discussion barriers on use of skill)	0	1	0	0	3	3.25%
Documentation of new support (what was taught in detail)	0	0	1	1	2	3.25%
Selection of new supports (is the skill appropriate for the problem)	0	0	0	1	3	3.75%
Future supports /goals (what is expected at next appt ex: homework)	0	1	0	0	3	3.25%

Supportive Housing

Supportive housing curriculum was not provided during FY 2025.

Assertive Community Treatment

Eleven (11) charts reviewed qualified for ACT. Community based services increased from FY 2024. Percentages are based on weighted scores totaled and averaged.

Criteria	1	2	3	4	5	Score
Small Caseloads: An HFC Rural ACT calculator developed. The Providers direct time achieved: exceeded=5, equaled=3, or did not exceed= 1. Based on a review of the last monthly Staff Report Card-Direct Time.	Did not exceed or equal		Equaled		Exceeded	Direct time is below target
Program meeting: Time dedicated to staff cases. Relates to Monday mornings staffing attended; or individual staffing with Program Manager.	Service planning for each individual usually 1 time (x) per month or less.	At least 2 x/ month but less often then 1 x/ week.	At least 1 x/ week but less than 2 x/week.	At least 2 x/week but less than 4 x/week	Meets 4 days/week and reviews each individual each time.	All LOC 4 clients are staffed weekly.
Community based services: At what location is the service being provided in office or a community setting/home.	Less than 20% of face-to-face contacts in community.	20-39%	40-59%	60-79%	80% +face to face contacts in community.	2.54%
Intensity of service time: Amount of service time offered face to face.	Average 15 min/week or less.	15-49 min/ week	50-84 min/week	85-119 min/week	Average 2 hrs. or more/week	2.27%
Frequency of contact: Number of contacts made in a week.	Average less than 1 contact/ week	1-2 contacts/ week	2-3 contacts/ week	3-4 contacts/ week	Average 4 or more contacts/ week	1.73%
Role of consumers on team: Is there a Peer Provider involved in services?	Not involved.	Provides only a specific service such as self-help.	Works part-time in case management roles with reduced responsibilities.	Works full-time in case management roles with reduced responsibilities.	Employee full-time as an ACT team member with full professional status.	1.45%

Co-Occurring Psychiatric and Substance Use Disorder (COPSD)

Thirty-eight (38) adults were diagnosed with a psychiatric and substance use disorder. Substance use diagnoses must be addressed in recovery plans as a goal, objective, or within the staff supports. Substance use must be addressed in case management notes and skills training/psychosocial rehabilitation notes.

Document	COPSD Addressed/ Total Notes (FY25)	FY 2024	FY 2025
Recovery Plan	23/38	79%	61%
Case Management Notes	45/69	72%	65%
Skills Training/ Psychosocial Rehabilitation	11/23	67%	48%

Texas Correctional Office on Offenders with Mental Impairments (TCOOMMI)

Fifteen (15) charts were reviewed for the TCOOMMI program. The TCOOMMI audit contains the following information:

- Recovery Plans
- Case Management Notes
- Skills Training Notes
- Psychosocial Rehabilitation Notes
- Texas Department of Criminal Justice requirements

(Improvements from FY 2024 are highlighted in Green. Declines are highlighted in Red)

Required Documents:	FY 2024	FY 2025
Q25 HFC: Notice of Declaration of MH Treatment: Notice is signed and filed.	NA	67%
Q26 HFC: Follow up PHQ-9 completed: Regardless of diagnosis completed at least 1x per month if seen frequently but not less than 1 time per quarter.	NA	93%
Q27 TAC: TRR Assessment: ANSA completed every 90 days.	50%	100%
Recovery Plan:		
Q29 TDCJ: Initial Recovery Plan: Completed within 10 business days after admission to TCOOMMI program.	100%	100%
Q30 TDCJ: Initial Recovery Plan: A comprehensive Initial Recovery Plan was completed within 30 business days after admission to TCOOMMI program.	100%	100%
Q31 TDCJ: Recovery Plan Reviews were completed every 90 days?	50%	90%
Q32 TAC: Current Recovery Plan: was completed prior to authorizing the needs of the individual?	100%	100%
Q33 TAC: Current Recovery Plan: Includes individual's strengths.	73%	73%
Q34 TAC: Current Recovery Plan: Includes resources for recovery supports	100%	100%
Q35 TAC: Current Recovery Plan: Specifically addresses the individual's needs, preferences, experiences and cultural background.	100%	100%
Q36 TAC: Current Recovery Plan: Presenting Problem	91%	93%
Q37 TAC: Current Recovery Plan: Expected outcomes of treatment	91%	93%
Q38 TDCJ: Current Recovery Plan: Was created in collaboration with the Supervising Officer?	91%	100%
Q39 TAC: Current Recovery Plan: Goals reflected the individual's self-direction, autonomy, and desired outcomes?	82%	67%
Q41 TAC: Current Recovery Plan: Objectives met all criteria	73%	47%
Q42 TAC: Current Recovery Plan: Documents progress on all goals and objectives.	44%	83%
Q43 TAC: Current Recovery Plan: Documents any recommendations for continuing services, any change from current services, and any discharge from services.	67%	82%
Q44 TAC: Current Recovery Plan: relates the types of services that will be provided to the individual. Describes the strategies to be implemented by staff providing the services and achieving goals.	73%	60%
Q45 TAC: Current Recovery Plan: Goals, Objectives, Staff Supports, and Interventions are congruent?	91%	67%
Q46 TAC: Current Recovery Plan: Was created in collaboration with the individual or LAR? Client input should change at each review.	64%	87%

Q47 TAC: Current Recovery Plan: If COPSD was listed as a presenting problem, is it addressed within the recovery plan?	100%	83%
Q48 TAC: Current Recovery Plan: Interventions relate to the type of services provided; Frequency, Units and Duration are appropriate and credentials of the staff member providing the service.	91%	73%
Q49 TAC: Current Recovery Plan: HFC ensures the individual crisis Recovery Plan referred to the most effective and least restrictive available treatment.	100%	87%
Q50 TAC: Current Recovery Plan: Is there evidence that the individual was provided a copy of the recovery plan?	71%	100%
Q51 TAC: Current Recovery Plan: Was signed within 24 hours of the begin date.	82%	73%
Case Management Notes:		
Q55 HFC: CM Note: Did notes meet criteria?	100%	100%
Q56 HFC: CM Note: Did note content match the goal?	78%	91%
Skills Training Notes:		
Q60 HFC: SKILLS: Did notes meet criteria?	50%	80%
Q61 HFC: SKILLS Note: Did note content match the goal?	50%	80%
Psychosocial Rehabilitation Notes:		
Q64 PSR NOTE: Did notes meet criteria?	100%	75%
Q65 PSR NOTE: Did note content match the goal?	100%	75%
Overall Compliance:		
Q69 HFC: Are the TRR, Recovery Plan, and services provided congruent with each other?	80%	73%
Q70 HFC: Were services billed according to preferences on the TRR or Recovery Plan?	50%	60%
TDCJ Requirements:		
Q73 TDCJ: Interdisciplinary Team Meeting was held within 30 days of intake?	33%	60%
Q74 TDCJ: Interdisciplinary Team Meeting was held every 90 days.	80%	44%
Q75 TDCJ: Services: Documented contact with Supervising Officer each month.	83%	100%
Q76 TDCJ: Services: Documented contact with Individual within 24 hours after a missed appointment.	73%	92%
Q77 TDCJ: Services: Documented contact with Supervising Officer after a missed appointment.	55%	77%
Q78 TDCJ: Services: Staff documented notifying Supervising Officer of rescheduled appointment in the case the individual missed an appointment.	50%	83%
Q80 The service notes indicate that at least 1 face to face contact was made each month in the community.	86%	93%

Step-Down Transition Home

Seven (7) charts were reviewed for FY 2025.

Required Documents:	FY 2024	FY 2025
Q8 HFC: Notice of Declaration of MH Treatment: Notice is signed and filed.	70%	86%
Q9 HFC: Follow up PHQ-9 completed: Regardless of diagnosis completed at least 1x per month if seen frequently but not less than 1 time per quarter.	90%	71%
Recovery Plan:		
Q12 TAC: Initial Recovery Plan: Completed within 10 business days after the LOC authorization is made.	100%	67%
Q13 TAC: Current Recovery Plan: was completed prior to authorizing the needs of the individual?	89%	75%
Q14 TAC: Current Recovery Plan: Includes individual's strengths.	40%	50%
Q15 TAC: Current Recovery Plan: Includes resources for recovery supports	100%	100%
Q16 TAC: Current Recovery Plan: Specifically addresses the individual's preference.	100%	100%
Q17 TAC: Current Recovery Plan: Specifically addresses the cultural and spiritual information.	90%	86%
Q18 TAC: Current Recovery Plan: Presenting Problem	100%	100%
Q19 TAC: Current Recovery Plan: COPSD	100%	100%
Q20 TAC: Current Recovery Plan: Physical Health	70%	86%
Q21 TAC: Current Recovery Plan: Expected outcomes of treatment	80%	86%
Q22 TAC: Current Recovery Plan: Goals reflected the individual's self-direction, autonomy, and desired outcomes?	90%	86%
Q24 Recovery Plan: Objectives met all criteria	50%	29%
Q25 TAC: Current Recovery Plan: Documents progress on all goals and objectives.	88%	100%
Q26 TAC: Current Recovery Plan: Documents any recommendations for continuing services, any change from current services, and any discharge from services.	13%	75%
Q27 TAC: Current Recovery Plan: relates the types of services that will be provided to the individual. Describes the strategies to be implemented by staff providing the services and achieving goals.	80%	86%
Q28 TAC: Current Recovery Plan: Was created in collaboration with the individual or LAR? Client input should change at each review.	50%	86%
Q29 TAC: Current Recovery Plan: If COPSD was listed as a presenting problem or in the diagnosis list, is it addressed within the recovery plan?	100%	100%
Q31 TAC: Current Recovery Plan: Interventions relate to the type of services provided; Frequency, Units and Duration are appropriate and credentials of the staff member providing the service.	70%	57%
Q32 TAC: Current Recovery Plan: HFC ensures the individual crisis Recovery Plan referred to the most effective and least restrictive available treatment.	100%	100%
Q33 TAC: Current Recovery Plan: Was signed within 24 hours of the begin date?	90%	100%
Psychosocial Rehabilitation:		
Q42 SKILLS / PSR NOTES: Did notes meet criteria?	100%	100%
Q43 SKILLS/ PSR NOTES: Did note content match the goal?	20%	71%
Curriculum Fidelity:		
Q46 IMR Fidelity: Did notes meet fidelity requirements	0%	100%
Q48 Seeking Safety Fidelity: Did notes meet fidelity requirements	NA	0%
Q50 CAT Fidelity: Did notes meet fidelity requirements	NA	67%
Overall Compliance:		
Q56 HFC: Are the TRR, Recovery Plan, and Services provided congruent with each other? Look for the "Golden Thread".	90%	57%
Q57 HFC: Were services billed monthly or according to preferences on the TRR or Recovery Plan?	33%	86%

Preadmission Screening and Resident Review (PASRR)

Thirty-eight (38) charts were reviewed for PASRR. Thirty-one (31) PASRR evaluation resulted in a Negative outcome and seven (7) resulted in a Positive outcome. Of the seven (7) Positive outcomes, none chose to start services with HFC.

PASRR Documentation	FY 2024	FY 2025
Q7 Is there an active Registration document?	75%	97%
Q8 Was the correct MHA PASRR program opened?	100%	100%
Q9 MH PASRR Evaluation (PE) Note and/or Informational Note: Includes the date when the PASRR notification or alert was received.	100%	92%
Q10 CONTACT WITH NURSING FACILITY- INITIALLY- Is there documentation that reflects contact was made with the nursing facility within three (3) calendar days / 72 hours of the alert?	89%	81%
Q11 MH PASRR Evaluation (PE) Note and/or Informational Note: Includes the DLN # from the portal entry. Portal entry needs to be within seven (7) calendar days of notification.	89%	72%
Q12 MH PASRR Evaluation (PE) Note and/or Informational Note: Includes the date when the PE was completed.	100%	97%
Q13 MH PASRR Evaluation (PE) Note and/or Informational Note: Includes the outcome of the PE- Positive-Accepted, Positive- Refused, or Negative.	90%	100%
Q14 PASRR EVALUATION- Was a copy of the PASRR Eval uploaded into the EMR?	75%	81%
Negative PASRR Result		
Q16 MH PASRR Negative: Did the clinician discharge the PASRR program?	76%	71%
Q17 MH PASRR Negative: Did the clinician close the episode?	65%	73%
Positive Result but Refused Services		
Q19 Is there documentation to reflect the initial IDT Meeting was held within 14 days after admission?	100%	86%
Q21 For positive-refused: Did the clinician complete Form # 1014- PASRR evaluation summary at the initial IDT meeting. Must be signed and in the chart.	50%	86%
Q23 For positive-refused: Form # 1041- Refusal of PASRR Services has been enter into the EMR.	50%	71%
Q24 Positive refused: At the initial IDT meeting, was the individual and/or their LAR advised of the follow up appointments required at 30-60-90 days after the initial IDT meeting?	100%	25%
Q25 Positive refused: Did the clinician discharge the PASRR program and open PASRR Follow-up program?	100%	100%
Positive Result and Accepts Services		
Q29 Positive Result Accepted: Services were started within 30 days of IDT meeting? NOTE: This includes the intake (updated Uniform Assessment/ TRR) and the 7 day appt (Recovery Plan)		--
Q30 Positive Result Accepted: Was a copy of the Uniform Assessment and Recovery provided to the Nursing Facility?		--

Peer Providers

Eighteen (18) charts were reviewed for peer providers. All but one fidelity question scored at or above the 76% compliance target.

Documentation	Score
Q10 TAC: Documentation Requirement: Date, begin and end time, location, modality (face to face), service type, individual's present in the session, and signature provided in the note? (Does the content of the note match the billing information?)	100%
Q11 HFC: Documentation Requirement: Does the note summarize the purpose and content of the service?	100%
Q14 TAC: Documentation Requirement: Date, begin and end time, location, modality (face to face), service type, individual's present in the session, and signature provided in the note? (Does the content of the note match the billing information?)	100%
Q15 HFC & TAC: Is the objective from the Recovery Plan located at the top of the note?	100%
Q16 HFC: Is the note written in the SIOP format?	100%
Q17 HFC: Does Status meet the criteria of the UM guidelines?	100%
Q18 HFC & TAC: Intervention gives a summary of activities that occurred and the method of the service provided.	83%
Q19 HFC & TAC: Does Outcome meet the criteria of the UM Manual. Any pertinent event or behavior relating to the individual's treatment which occurs during the provision of the service.	82%
Q20 HFC & TAC: The Progress meet the criteria of the UM guidelines. The progress or lack of progress in achieving recovery plan goals.	94%
IMR Fidelity	
Note identified curriculum used	100%
Note identified handout provided	100%
Note identified skills taught	86%
Note addressed natural supports	100%
Note includes personal goal	84%
Note follows up on personal goal	84%
Note includes strategies (motivational, educational, or cognitive-behavioral)	86%
Note includes homework assigned	98%
Note listed coping skills	100%
Note includes relapse prevention	65%
Q23 IMR Fidelity: Did notes meet fidelity requirements	89%

Supported Employment

Six (6) charts were review for Supported Employment Fidelity elements. Items that fell below the 76% compliance target are highlighted in red.

Documentation	Score
Q7 TAC: Current Recovery Plan: A current Recovery Plan is on file and includes the Supported Employment.	100%
Q8 TAC: Current Recovery Plan: The goal, objective, and staff support are congruent for Supported Employment?	83%
Q9 Fidelity Element: Was there an attempted or first contact made within 7 business days of the referral.	25%
Q10 Supported Employment Fidelity: Was an Intake appointment held in order to complete a vocational assessment?	100%
Q11 Fidelity Element: During the initial contact was the vocational profile completed.	100%
Q13 Fidelity Element: Was the Individual Employment Plan completed?	83%

Q15 Fidelity Element: Does the IEP contain an initial vocational goal to define their interests in services?	100%
Q17 Supported Employment Fidelity: Did the Notes reflect collaboration/information sharing between the SE staff and the Case Manager assigned?	17%
Q18 Support Employment Fidelity: Were appointments held in order to explore potential jobs via the internet or other sources to apply for?	100%
Q19 Supported Employment Fidelity: Did notes reflect that a variety of job opportunities had been discussed with the individual seeking services?	100%
Q20 Supported Employment Fidelity: Did Notes include follow up discussions on the application process, any interviews held and/or a job was received?	100%
Q21 Fidelity Element: After the completion of the VP and IEP, were appointments held which further explores opportunities to discuss jobs and interests of the individual about the type of work desired?	100%
Q22 Fidelity Element: Is an updated IEP completed which also includes the SE staff contacting employers about perspective applicants or to gain more information about opportunities?	0%
Q23 Fidelity Element: Does the documentation reflect the SE's efforts to get to know the individual's needs?	100%
Q24 Fidelity Element: Does the documentation reflect conversations about job postings?	100%
Q25 Fidelity Element: Does the documentation reflect teaching on how to locate jobs on the internet or filling out applications?	100%
Q26 Fidelity Element: Does the document reflect discussion and understanding on pay, benefits, and work hours.	100%
Q27 Fidelity Element: Does documentation reflect teach and understanding of the individual reporting earning to Social Security and housing programs, etc.	100%

Child and Adolescent Mental Health

The CAS chart audits contain the following information:

- Recovery Plans
- Case Management Notes
- Skills Training Notes

Fidelity Scales

- Nurturing Parenting Fidelity
- START Fidelity
- Seeking Safety Fidelity
- Other curriculums- PAYA

Recovery Plan

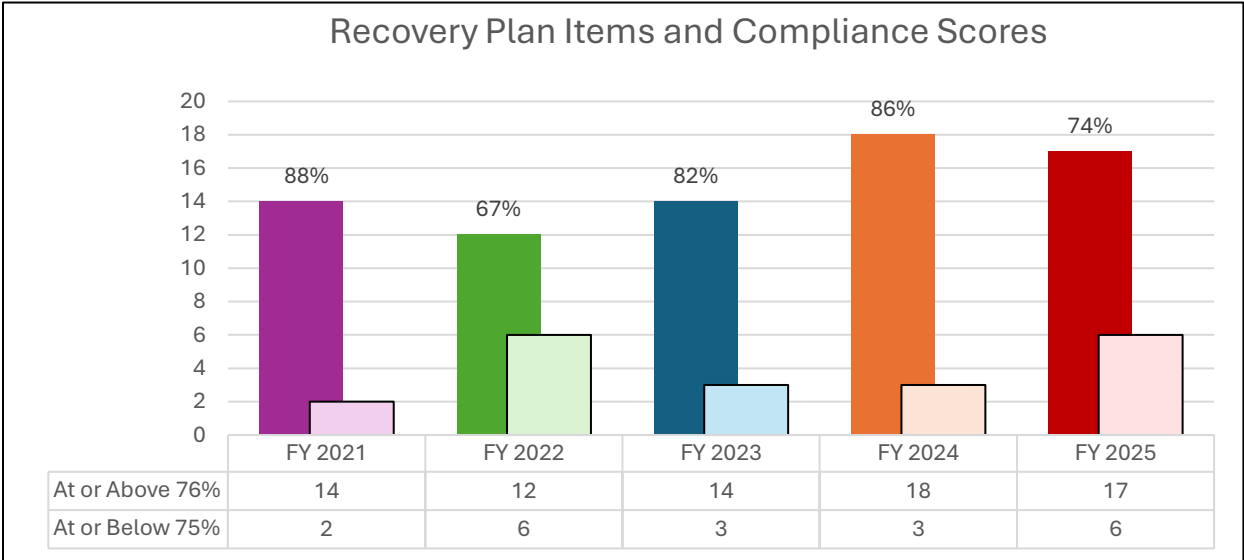
Thirty-five (35) charts were reviewed. Items highlighted in GREEN show improvement from the previous year.

RECOVERY PLAN	FY 21	FY 22	FY 23	FY 24	FY 25
The Initial Recovery Plan was completed within 10 business days after the LOC authorization is made.	60%	33%	25%	60%	67%
Current or updated recovery plan effective date and the TRR assessment date should match.	98%	85%	91%	90%	94%
Recovery Plan includes individual's strengths that match the CANS	100%	96%	96%	61%	69%
Recovery Plan includes resources for recovery supports	88%	96%	96%	97%	91%
Recovery Plan addresses the individual's preference including telephone appts, cultural and spiritual information.	94%	93%	100%	100%	71%
Recovery Plan addresses presenting problem (desc. of symptoms)				94%	97%
Recovery Plan has a description of substance use issues.	90%	93%	88%	92%	94%
Recovery Plan addresses physical health issues.				89%	91%
Recovery Plan addresses expected outcomes of treatment.	96%	100%	100%	100%	94%
Recovery Plan goals reflected the individual's self-direction, autonomy, and desired outcomes. It is person-centered and answers the What and Why questions.	100%	93%	96%	82%	97%
Recovery Plan Objectives meet SMART model	99%	96%	95%	91%	94%
Recovery Plan Objectives state who is reporting progress	NA	NA	NA	NA	91%
Recovery Plan Objectives are Person Centered	100%	96%	100%	100%	99%
Recovery Plan Objectives are modified or ended correctly	NA	67%	96%	89%	92%
Recovery Plan Objectives meet all criteria.	NA	NA	NA	NA	77%
Recovery Plan documents progress on all goals and objectives.		77%	86%	85%	79%
Recovery Plan documents recommendations for continuing services, any change from current services, and any discharge from services.	76%	65%	71%	74%	59%
Recovery Plan describes the strategies to be implemented by staff providing the services and achieving goals. Staff Supports and Interventions should match.	92%	70%	72%	77%	74%
Recovery Plan was created in collaboration with the individual or LAR? Client input should change at each review.	90%	67%	76%	92%	89%
Recovery Plan: If COPSD was listed as a presenting problem or in the diagnosis list, is it addressed within the recovery plan with a goal, objective or staff support?	50%	0%	NA	100%	67%

Recovery Plan interventions relate to the type of services provided; Frequency, Units and Duration are appropriate and credentials of the staff member providing the service.	98%	96%	100%	97%	100%
Recovery Plan ensures the crisis plan refers to the most effective and least restrictive available treatment.	90%	96%	100%	100%	100%
Recovery Plan was signed within 24 hours of the begin date?	NA	NA	NA	97%	83%

For FY 2025, eight (8) questions have improved from FY 2024. Criteria from external reviews cause some of the biggest decline in our reviews. For example on the cultural and spiritual information this was reported as needs in previous years, but in FY 25 this was changed to considerations. Asking the individual what their culture and spirituality in order is to use this in the recovery process. This was an adjustment that required training of case managers and update in criteria on the audit tool. A new criterion for recovery plan objectives was also added for FY 25, who is responsible for reporting progress. On the objective compliance question, only one “no” answer for any of the criteria would result in the objectives scoring as non-compliant. COPSD question also showed decline in 2025.

As we can see from the chart below, compliance on recovery plan items has decreased from FY 2024. The new criteria referenced above has influenced those scores as expected.



Case Management

Eighty-eight (88) case management notes were reviewed for FY 25. One (1) question showed improvement (GREEN) from last year where four (4) declined (RED) in compliance.

FY 25 Adult Case Management		
Questions	FY 2024	FY 2025
Status meets criteria of the UM manual. Must match billing information.	94%	94%
Intervention meets criteria of the UM manual. Could include follow-up, assessing of needs, medication monitored, refer or link to resources, monitoring of goals or objectives.	97%	95%
If needs are identified by the client, the need was documented and address. Could be addressed with referral or a plan to address the need.	100%	100%
Timeline for reevaluating needs was established. Look for next appointment must have medical appt and next appt with CM.	69%	88%

Outcome meets criteria of the UM manual. Look for details on how the individual responded to each intervention.	100%	100%
Progress meets criteria of the UM manual. Progress must address the overall goal. Provide evidence of progress or lack of progress.	80%	78%
COPS-D was addressed if client has substance use disorder diagnosed.	100%	22%
Content of the note matching the procedure code.	100%	100%
Content supports billing duration.	95%	93%
Content is individualized. Look for blanks in information, gender swapping, wrong name in note, etc.	100%	100%

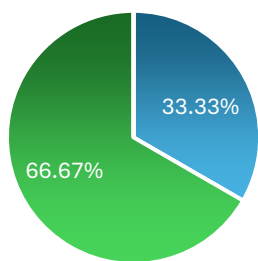
Skills Training

Thirty-nine (39) skills notes were reviewed in FY 2025. Four (4) items improved from the previous year.

Question	FY 2024	FY 2025
Status meets criteria of the UM manual. Must match billing information. If something is marked remarkable there is an explanation.	100%	100%
Intervention meets criteria of the UM manual. Look for skills language.	100%	100%
Outcome meets criteria of the UM manual. Look for details on how the individual responded to each intervention.	83%	97%
Progress meets criteria of the UM manual. Progress must address the overall goal. Provide evidence of progress or lack of progress.	80%	90%
COPS-D was addressed if client has substance use disorder diagnosed.	NA	NA
Content of the note matching the procedure code.	100%	100%
Content supports billing duration.	97%	97%
Content is individualized. Look for blanks in information, gender swapping, wrong name in note, identical outcomes, progress etc.	97%	100%

Fidelity Elements

Skills Curriculum Used



- Nurturing Parenting
- START
- Seeking Safety
- Other Curriculum

The chart to the left indicates the percentage of curriculum used in FY 2025 skills training notes. During the random pull of charts, only two curriculums were found, Nurturing Parenting (7 charts) and START (14 charts). Fidelity for Seeking Safety can not be produced.

(Note: Most used curriculum does not mean most reviewed notes.)

Skill Streaming Aggression Replacement Training (START)

Twenty-nine (29) notes were reviewed for START curriculum. All elements scored above the 76% compliance target score.

Questions	Score
Note includes a check in process prior to the intervention starting?	83%
Notes include a review of the last session and homework assigned?	96%
Notes include the use of Curriculum Topic?	97%
Notes include the provision of Handouts or Visual Aids?	100%
Notes identify the introduction of the skill?	100%
Notes identify the skill being modeled by the Case Manager in the session?	93%
Notes identify the use of role reversal by the child/adolescent within the session?	93%
Notes include identification and discussion related to the Plan's objectives?	97%
Notes include assigning homework or a home practice?	96%
Notes include the child/ adolescent behavior within the session and if present was inappropriate behavior addressed during the session?	100%

Nurturing Parenting

Sixteen (16) skills notes were reviewed containing Nurturing Parenting curriculum. All elements scored above the 76% compliance target score.

Questions	Score
Note includes a check in process prior to the intervention starting?	100%
Notes include a review of the last session and homework assigned?	79%
Notes include the use of Curriculum Topic?	100%
Notes include the provision of Handouts or Visual Aids?	100%
Notes identify the introduction of the skill?	100%
Notes include identification and discussion related to the Plan's objectives?	100%
Notes include assigning homework or a home practice?	100%
Notes include the child/ adolescent behavior within the session and if present was inappropriate behavior addressed during the session?	100%

Wraparound

During FY 25, six (6) Wraparound audits were conducted. Three (3) charts were reviewed in the second and fourth quarters. Questions scoring below compliance (76%) are highlighted in red.

Questions	Score
Q9 Initial Family Meeting: Was the initial family meeting held within 7 days from intake?	80%
Q11 Initial Family Meeting: Was the Crisis Safety Plan completed during the first session?	80%
Q13 Wraparound Facilitator Documents: Was the family story written before the Initial Family TEAM meeting?	50%
Q14 Initial Family TEAM meeting: Meeting was held within 30 days from intake? .	40%
Q15 Manual: Child and Family Team Meeting is attended by both formal and informal/natural supports and attendance is documented on the WTM sign in sheet.	100%
Q17 Initial Wraparound Plan: Was the INITIAL Wraparound Plan completed within 30 days of enrollment?	40%
Q18 Initial Wraparound Plan: Was the Wraparound Plan completed every 30 days after the initial plan?	33%
Q19 Initial Wraparound plan: D.a.3: Wraparound plan includes a team mission statement and family vision statement in the family's voice.	100%

Q20 Initial Wraparound plan: D.a.1: Wraparound Plans includes at least one needs statement for the youth and one for a family member.	100%
Q21 Initial Wraparound plan: Manual, TAC: Wraparound Plan includes outcome statements, strategies and/or tasks addressing the actionable items (score of 2 or 3) identified on the CANS/Clinical Eligibility.	33%
Q24 HFC: Follow up PHQ-9 completed: Child is 12 years or older; regardless of diagnosis completed at least 1x per month.	0%
Q25 HFC: Follow up C-SRRS: For ages 6-17 with a diagnosis of MDD or Dysthymia; completed at a minimum 1x monthly.	NA
Q26 TAC: TRR Assessment: CANS is completed every 90 days.	100%
Q27 D.c.1: Child and family teams meet at least every 30 days.	NA
Q28 Manual: Child and Family Team Meetings are routinely attended by both formal and informal/natural supports and attendance is documented on the WTM sign in sheet or attached to the Wraparound Plan.	100%
Q30 Updated Wraparound plan: D.c.1: Was the Wraparound plan reviewed and revised at every WTM?	100%
Q31 Updated Wraparound plan: D.a.2: The Crisis/safety plan is updated to address health and safety needs identified. The crisis/safety plan(s) identifies triggers or behaviors that precipitated the referral and includes specific actions, interventions and contact information for persons and resources identified.	67%
Q33 Updated Wraparound plan scoring: Plan met 75% compliance?	100%
Q35 Did Facilitator meet weekly with the family outside the Team Meeting?	33%
Q36 Did Facilitator contact team members monthly outside of Team meetings.	80%
Q39 Facilitator ICM notes: Did notes meet criteria?	100%
Q44 Nurturing Parenting Skills Notes: Did notes meet criteria?	100%
Q48 START Skills Notes: Did notes meet criteria?	100%
Q52 Seeking Safety Skills Notes: Did notes meet criteria?	NA
Q54 Skills Notes: Did notes meet criteria?	NA
Q55 Overall Tx: HFC: Are the TRR, Recovery Plan, and Service Notes provided congruent with each other?	100%
Q56 Overall Tx: HFC/ TRR: Were services scheduled or provided according to the LOC and TRR guidelines. (This can be any appointment or service)LOC 4= 7.5 hours	20%

YES Waiver

Five (5) charts were reviewed for YES Waiver. Two (2) charts were reviewed during the second quarter and three (3) during the fourth quarter. Questions scoring below compliance (76%) are highlighted in red.

Questions	Score
Q7 PCN: Individual/LAR received a return call from the LMHA within 24 hours or 1 business day from registration on the Inquiry List.	100%
Q8 PCN: Individual has a demographic eligibility assessment within 7 business	100%
Q9 PCN: Individual received a face-to-face intake assessment/Clinical Eligibility within 7 business days of the initial demographic eligibility determination contact.	100%
Q12 All enrollment forms are completed.	100%
Q14 TAC: Waiver participant and LAR has a face-to-face meeting with Facilitator within 7 days of Clinical Eligibility approval.	100%
Q15 HFC: At initial family meeting after HHSC approval for YES Waiver placement, CANS was updated for LOC-YES authorization.	75%
Q17 D.b.1: INITIAL Crisis and safety plan is developed during the Wraparound facilitator's first face to face meeting with the child and LAR.	75%
Q18 D.b.1: INITIAL Crisis and safety plan contain the following information: Triggers (warning signs)	100%
Q19 D.b.1: INITIAL Crisis and safety plan contain the following information: Potential Crisis (what happens)	100%
Q20 D.b.1: INITIAL Crisis and safety plan contain the following information: Action steps for home/school/community	100%

Q21 D.b.1: INITIAL Crisis and safety plan contain the following information: Contact information for persons responsible	100%
Q22 D.b.1: INITIAL Crisis and safety plan: Action steps include what has worked in the past, alternative strategies and addresses CANS/Clinical Eligibility (score of 2 or 3).	33%
Q23 HFC: The YES Waiver Facilitator completed the family story prior to the first Wraparound Team Meeting?	0%
Q24 Manual: First Wraparound Team Meeting (WTM) is held within the first 30 days of the youth's enrollment.	0%
Q25 Manual: Wraparound Team Meeting is attended by both formal and informal/natural supports and attendance is documented on the WTM sign in sheet.	100%
Q26 HFC: Was the Wraparound Plan completed at the first WTM?	100%
Q28 D.a.3: Wraparound plan includes a team mission statement and family vision statement in the family's voice.	100%
Q29 D.a.1: Wraparound Plans includes at least one needs statement for the youth and one for a family member.	100%
Q30 Manual, TAC: Wraparound Plan includes outcome statements, strategies and/or tasks addressing the actionable items (score of 2 or 3) identified on the CANS/Clinical Eligibility.	100%
Q34 D.c.1: CANS is completed at least every 90 days as one tool to monitor progress.	100%
Q35 Manual: Wraparound Team Meetings are routinely attended by both formal and informal/natural supports and attendance is documented on the WTM sign in sheet or in service note.	100%
Q36 D.c.1: Child and family teams meet at least every 30 days to review and revise the Wraparound plan.	100%
Q37 D.a.2: The Crisis/safety plan is updated to address health and safety needs identified. The crisis/safety plan(s) identifies triggers or behaviors that precipitated the referral and includes specific actions, interventions and contact information for persons and resources identified.	100%
Q38 D.c.2: Family vision, team mission, needs statements, outcome statements, tasks and strategies are reviewed and updated at every Wraparound Team Meeting to reflect progress or lack of progress in all areas.	100%
Q39 D.d.1: Waiver participant receives services according to the type, amount, frequency, and duration specified in their WrapAround plans.	100%
Q41 B.b.1: Annual Renewal Clinical Eligibility Assess was completed within 365 days.	NA
Q42 PCN, Manual: Wraparound facilitator did not provide or bill for any service other than Intensive Case Management without expressed authorization from HHSC.	100%
Q44 CIR: If any of the above situations are marked, is there documentation that states a Critical Incident Report was completed and uploaded to the state?	100%
Q45 CIR: If CIR was completed the facilitator met with the youth or family within 7 days to discuss the incident. If the youth is hospitalized, in detention or otherwise unavailable, face to face meeting takes place within 72 hours of discharge.	100%
Q46 CIR: Response to critical incidents are appropriate to ensure the health and safety of the participant.	100%
Q48 Waiver, TAC, Manual: There is a discharge/transition plan for youth who successfully graduate the YES program or request termination of services. If the youth is turning 19 there is a discharge/transition plan that includes a summary of community mental health services, current status, and plans to coordinate ongoing services.	NA
Q49 Manual: A Termination Clinical Eligibility document is entered for all youth discharging from YES Waiver services	NA

Licensed Practitioner of Healing Arts

Fidelity Scales

Sixteen (16) charts were reviewed for Counseling Fidelity Protocols. Seven (7) charts were Cognitive Behavioral Therapy (CBT), one (1) chart was CBT with psychosis, and three (3) charts were Trauma Focused CBT, and five (5) charts were Cognitive Processing Therapy.

Questions	Score
CBT	
Q8 Is the individual enrolled in LOC-2?	100%
Q9 Is the individual diagnosed with Major Depressive Disorder or Bipolar Disorder?	100%
Q10 Is there documentation of a Mood Check conducted at the beginning, during, and after?	100%
Q11 Is there documentation that the agenda was completed?	100%
Q12 Is there documentation of CBT skill/s taught?	100%
Q13 Is there documented Feedback from individual during the session to ensure understanding of skill taught and/or after when wrapping up session?	100%
Q14 Is there documentation that homework was reviewed from previous session?	100%
Q15 Is there documentation that homework was assigned for practice before next session?	100%
Q16 Were notes completed within 24 hours from session?	71%
CBT-p	
Q17 Does the individual have a diagnosis of psychosis?	100%
Q18 Is there documentation of a Mood Check conducted at the beginning, during, and after?	100%
Q19 Is there documentation of CBT practices used during session?	100%
Q20 Is there documentation of skill building? Look for links between thoughts, feelings, and behaviors and developing coping skills.	100%
Q21 Were notes completed within 24 hours from session?	100%
TF-CBT	
Q22 Is there clear documentation of any diagnosed trauma, trauma grief, and/or traumatic separation? This may be present with or without a documented PTSD diagnosis.	100%
Q23 Is there documentation of appropriated psychoeducation provided to child and LAR? This includes relaxation and affective modulation.	67%
Q24 Is there documentation of Cognitive coping and processing -CBT skill/s taught?	67%
Q25 Is the trauma narrative documented within the note?	0%
Q26 Is there documentation of in-vivo desensitization- practicing and teaching?	67%
Q27 Is there documentation of Enhanced Safety? (being in a safe space, teaching parents/ LAR how to provide safe spaces, age appropriate teaching of keeping oneself safe)	100%
Q28 Were notes completed within 24 hours from session?	100%
CPT	
Q29 Does the individual have a diagnosis of PTSD? Note: The individual may be in any LOC.	100%
Q30 Has the PTSD check list score been obtained?	100%
Q31 Is there documentation of follow up from previously assigned homework?	100%
Q32 Is there documentation of CPT skill/s taught?	100%
Q33 Is there documented Feedback from individual during the session to ensure understanding of skill taught and/or after when wrapping up session?	100%
Q34 Is there documentation that homework was assigned for practice before next session?	100%
Q35 Were notes completed within 24 hours from session?	100%

Medical Services

Medical services are review on four (4) separate audits or programs. The Quality Management department reviews during the third quarter; the medical providers conduct a peer review on the second and fourth quarters. Med training and support notes are reviewed during the first and third quarter. The self-administration of medication is an ongoing program monitored by the Quality Management department. Med services have a compliance target is 90%.

Medical Providers- QM

Twenty-six (26) notes were reviewed by Quality Management department.

Questions	Score
Q9 TAC: Psychiatric Evaluation/Note include Chief complaint addresses psychiatric symptoms.	92%
Q10 TAC: Psychiatric Evaluation/Note include Individual's current psychiatric information is detailed and dated. This may be found in the General History of Present Illness.	100%
Q11 TAC: Psychiatric Evaluation/ Note include Individual's current medical (physical) information is dated.	100%
Q12 TAC: Psychiatric Evaluation/Note include Current and prior Substance Abuse status indicated. If a category of use is recorded, need the further details for identified use- when, how much.	100%
Q13 TAC: Psychiatric Evaluation/Note include: If applicable, a substance abuse diagnosis was made.	100%
Q14 TAC: Psychiatric Evaluation/Note include Current Mental Status Exam	100%
Q15 TAC: If Labs were ordered, have they been entered?	100%
Q17 HFC: Are lab results available and has the medical provided reviewed the lab results. This could be an informational note, in the E&M note, the Lab Results tab, or in the medical portal.	100%
Q19 TAC: Medication Consent: HFC obtained annual informed consent for each individual medication.	92%
Q24 TAC: AIMS: An AIMS assessment was completed and documented within the record by a Prescriber or RN through the EM Note or the AIMS electronic assessment. The review is due quarterly if the individual is on antipsychotic medications.	100%

Medical Providers- Peer Audit

Forty-five (45) medical notes were reviewed by peer providers.

Questions	Score
Q8 Does the documentation support a reasonable diagnosis from the most current version of the DSM?	96%
Q9 Are substance abuse questions answered appropriately?	96%
Q10 If there is a history of substance abuse, is the diagnosis properly recorded?	96%
Q11 Did the medical provider assess and document the persons' current and historical psychiatric and medical information, mental status exam, and medication allergies?	93%
Q12 Does the medical treatment and plan of care appear reasonable for the current condition and diagnosis of the individual?	98%
Q13 Did the medical provider document the rationale for initiating, continuing or discontinuing psychoactive medication in the clinical record?	96%
Q14 Was Medication Reconciliation completed at each appointment? The Med Reconciliation checkbox must be marked.	96%
Q15 Is the frequency of medication-monitoring appropriate?	100%
Q16 Is the AIMS completed on a quarterly basis? (if medication is known to cause Tardive Dyskinesia)	100%
Q17 Are labs ordered in a timely and appropriate manner at least annually?	96%
Q18 Were labs signed off and any needed follow up documented appropriately?	98%
Q20 If Q 19 is Yes, is there proper documentation in the chart explaining what polypharmacy is being used?	98%
Q22 If Q 21 is Yes, is there proper documentation in the chart explaining what co-pharmacy is being used?	95%
Q23 Are the dosages of medications appropriate?	100%

Q24 Are the medications prescribed efficacious?	93%
Q25 Are medications ordered for PRN use appropriate?	98%
Q26 Was informed medication consent obtained for each individual medication on an annual basis?	89%
Q27 Are weight/diet issues addressed?	84%
Q28 Were vital signs taken and recorded appropriately?	96%
Q29 If there are side effects, unusual effects, contraindications, or medication interactions were they addressed appropriately?	98%
Q30 Is there indication that some type of medication education or medical related education found within the Note?	96%
Q31 Does this practitioner appear to be demonstrating competency in clinical work?	98%

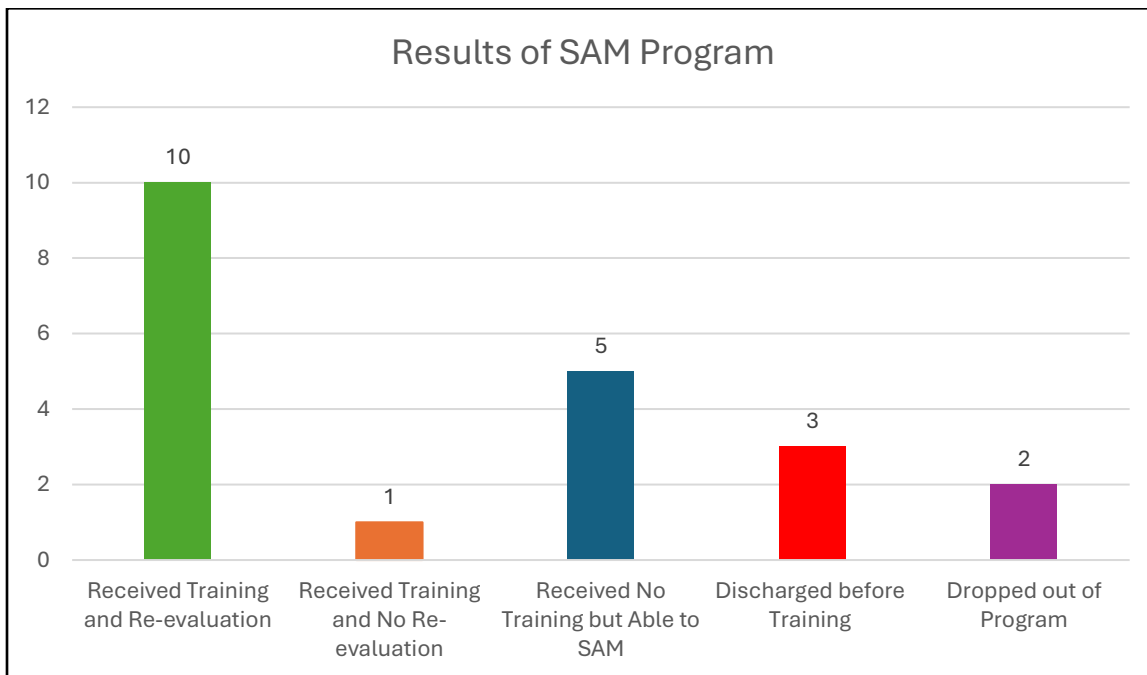
Med Training and Support

Twenty (20) Med Training and Support notes were reviewed during FY 2025.

Questions	Score
Service Provided by Case Manager	
Q12 Case Manager: Did the note include information on 1 of the 8 elements: 1) education about medications and their possible side effects; 2) understanding the nature of mental illness; 3) understanding the concepts of recovery and resilience; 4) understanding the role of medications in reducing symptoms; 5) learning the contraindications of the individual's medications; 6) identifying and managing the individual's symptoms; 7) education in understanding the overdose precautions; or 8) learning self-administration of the individual's medication.	87%
Q13 Case Manager: Was teaching/ education language used in the note?	87%
Q14 Case Manager: Does the content of the note match the procedure code?	87%
Q11 Case Manager: Was approved PFEP materials referenced in the service note?	100%
Service Provided by Nursing Staff	
Q17 Nurse: Was approved PFEP materials referenced in the service note?	100%
Q18 Nurse: Did the note include information on 1 of the 8 elements: 1) education about medications and their possible side effects; 2) understanding the nature of mental illness; 3) understanding the concepts of recovery and resilience; 4) understanding the role of medications in reducing symptoms; 5) learning the contraindications of the individual's medications; 6) identifying and managing the individual's symptoms; 7) education in understanding the overdose precautions; or 8) learning self-administration of the individual's medication.	100%
Q19 Nurse: Was teaching/ education language used in the note?	100%
Q20 Nurse: Does the content of the note match the procedure code?	100%

Self-Administration of Medication (SAM)

Twenty-one (21) individuals were referred to the SAM program. Individuals are referred by the medical provider when there are concerns that the individual does not have a good understanding of the medication they are prescribed. When an individual is referred to the program, the primary case manager is alerted and requested to provide med training and support services to educate the individual about the medication prescribed.



Crisis Assessments

Twenty (20) crisis assessment notes were reviewed.

Questions	Score
Q8 Crisis Assessment was fully completed?	55%
Q9 Crisis Assessment document was completed within 24 hours?	90%
Q11 Assigned clinician (Cara Mullenix-Artigue if not assigned) has been informed of individual having a crisis episode?	60%
Q12 Is there a safety plan scanned into the chart?	70%
Q14 Was Discharge Planning addressed on the safety planning if crisis resulted in placement?	88%

Front Desk

Twenty (20) charts were reviewed for items required by the front desk staff.

Questions	Score
Q6 TAC: Client Rights: The communication of rights was documented with the date, signatures of the individual and/or parent, guardian and the staff member who explained the rights.	100%
Q7 TAC: Initial Financial Assessment: completed within the first 30 days	100%
Q8 TAC: Financial Assessment: completed annually	86%
Q9 HFC: After Intake, was a CM appointment scheduled (not attended) within 14 days?	95%
Q10 HFC: For any client or agency cancellations a comment was added to explain reason for cancellation.	100%

House Bill 4

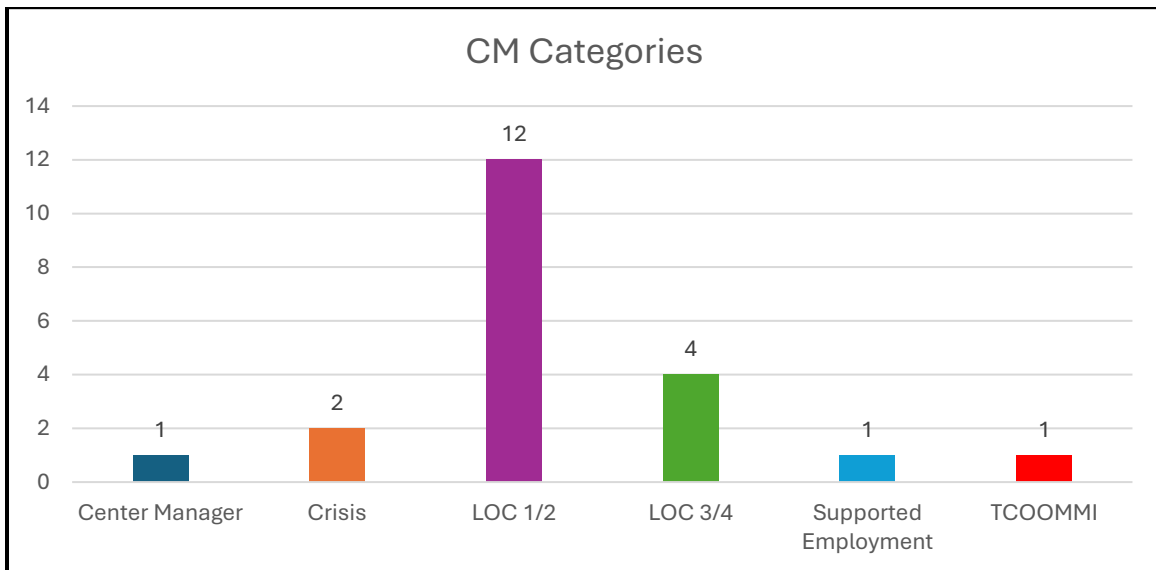
Thirty-nine (39) notes were reviewed for requirements on telephone services.

Questions	Score
Q8 In the note, is there clinical justification for a telephone session?	77%
Q10 For initial telephone service, has there been a face to face or video contact made by this provider in the last 6 months?	86%
Q11 For subsequent telephone sessions, has at least one face to face or video session occurred within the last 12 months?	100%
Q12 Are telephone services recorded on the preferences section of the recovery plan?	97%

UM Case Management Staff Training

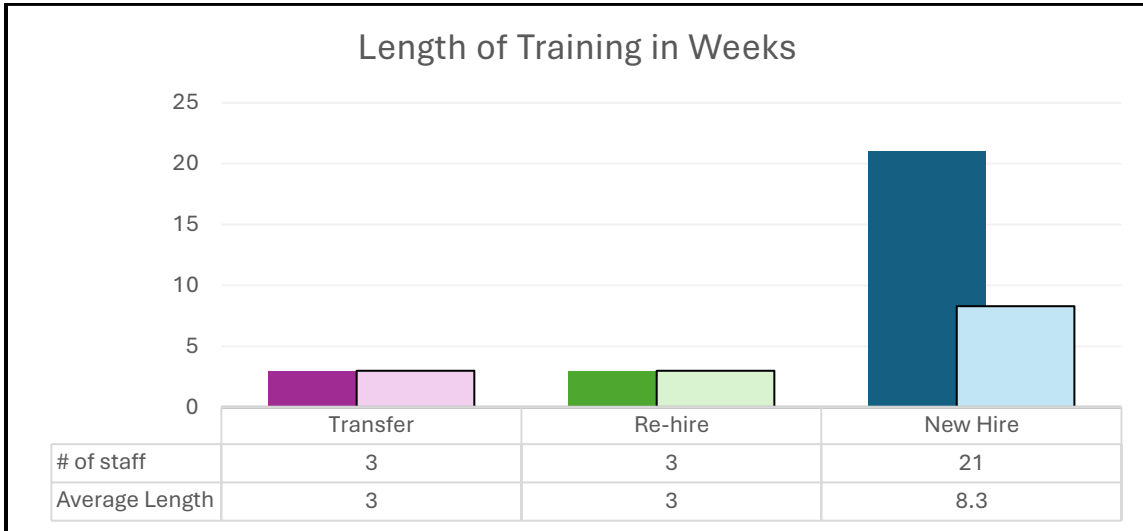
Case Management Categories

In FY 25, UM trained 27 Case Managers. Below is the breakdown of the Case Management categories. This is an increase from FY 24, where eighteen (18) case managers were trained; a 150% increase.



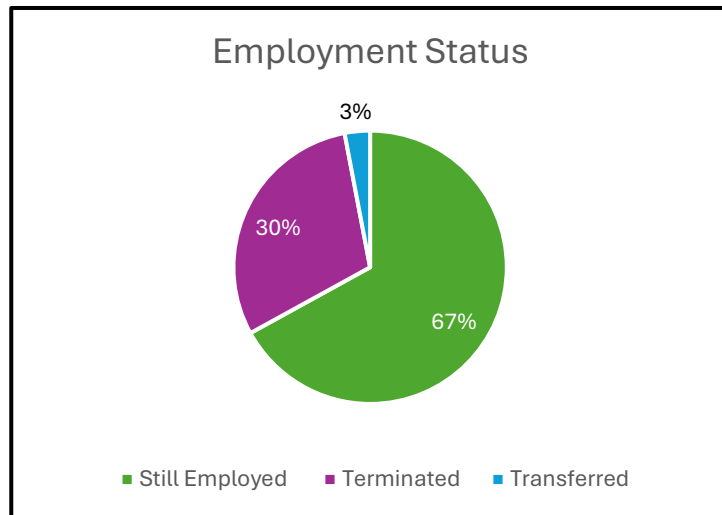
Length of Training

Training begins at New Employee Orientation to completion of the UM competency test. The training period varies between each case manager in training. Holidays, grasp of material, and scheduling can all cause the variation during the training process. This training period does not include additional mandatory trainings such as ASIST, Seeking Safety, skills curriculum training, Trauma Informed Care, crisis training, current/collaborative, and caseload management training.



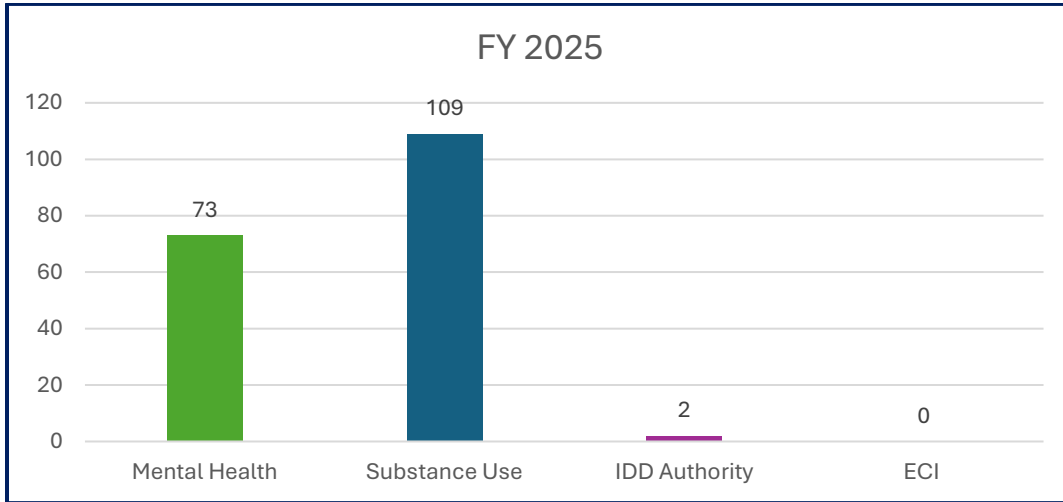
Employment Status

Based on FY 2025 data, eight (8) staff hired during the year also terminated their employment with HFC within the year. This amounts to 30% of case managers. One staff member transferred from mental health to the substance use disorder department.



Satisfaction Surveys

One hundred, eighty-four (184) satisfaction surveys were received during the year. Satisfaction surveys are submitted by paper in office and through the Helen Farabee Centers' website. Satisfaction surveys are used to address concerns an individual has or to recognize the good work a staff member provided. All satisfaction surveys are read by the Quality Management department. Below is the breakout of the surveys received by department.





QUALITY MANAGEMENT ANNUAL REPORT FOR IDD AUDIT TRENDS

FISCAL YEAR 2025
2ND- 4TH QUARTERS

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CFC- GR		2 nd Quarter		3 rd Quarter		4 th Quarter	
Question		# of correct charts/ Total # of charts	Compliance	# of correct charts/ Total # of charts	Compliance	# of correct charts/ Total # of charts	Compliance
Q2	§301.155 (c) At least annually, LIDDA provided person and LAR written notification of LIDDA's Complaint & Appeals Process. HFC #411	3/4	75%	6/6	100%	4/4	100%
Q6	§334.117 (c) Annually, give a copy of Your Rights in Local Authority Services (including Abuse, Neglect and Exploitation and HHSC Complaint Process) to person and LAR or actively involved person. HFC #411 #312	4/4	100%	6/6	100%	3/4	75%
Q13	§334.119 (d) Dated signature of staff member who explained the rights	4/4	100%	5/6	83%	4/4	100%
Q14	§263.901(e)(18) Current Letters of Guardianship	4/4	100%	5/6	83%	3/4	75%
Q39	Per 8511 Form Instruction Provided the annual oral and written explanation of Understanding Program Eligibility (Form 8511) (Required for all PDP updated after September 1, 2016) - Waiver program only / not for CFC-GR	3/4	75%	6/6	100%	4/4	100%
Q40	IDD Services Broadcast 2019-57 Oral and written presentation of Verification of Freedom of Choice (form 8601) (All PDP's updated after October 1, 2019) - Waiver program only / not for CFC-GR	3/4	75%	6/6	100%	4/4	100%
Q57	HFC: Does the service type link to the accomplishment of the outcome? The link must be evident in the narrative/justification. (Note: look in the CFC Assessment section 10 and if needed an addendum.)	4/4	100%	5/6	83%	4/4	100%
Q58	HFC: CAP 2024: Are the outcomes listed in the section 10 of the CFC Assessment/Addendum? (Note: Waiver/Non-Waiver outcomes need to justify the service.)	3/4	75%	4/6	67%	4/4	100%
Q60	HB 4000 All waiver and GR services, CFC services, non-waiver services and non-CFC services (includes all service types for all medical conditions) Starting 1/1/23 DH is converting to ISS-do not site if plan says DH or ISS-interchangeable until next renewal.	3/4	75%	6/6	100%	4/4	100%
Q64	§331.5(33)(C), §331.11(d)(2) Plan includes a service coordination plan indicating the frequency at which the Service Coordinator will meet face to face (must be at least every 90 days)	3/4	75%	1/6	17%	1/4	25%
Q67	CAP 2024: Service Coordination Monitoring Services & Minimum Contact: §331.11(b)(1)(A), §331.11 (d)(1-2)	3/4	75%	3/6	50%	3/4	75%
Q68	§331.11(b),(1),(A), TAC 40 §331.1 (d)(1-2) Evidence the SC made face-to-face contact with the individual at least once every 90 days in accordance with the SC rule or as indicated on the Service Coordination Plan.	2/4	50%	6/6	100%	2/4	50%
Q70	§331.21(a)(3) Documentation of Service Coordination: (a) The LIDDA must document the required contacts described in the person's plan of services and supports, including: (3) the progress or lack of progress in achieving goals or outcomes.	3/4	75%	4/6	67%	3/4	75%
Q72	HB 17100 Complete the IDRC Assessment for CFC (Form 8578-CFC entered in the CARE system K83)	3/4	75%	6/6	100%	4/4	100%
Q79	HB 17130 Provide a copy of "Community First Choice: Choosing a Provider".	4/4	100%	6/6	100%	3/4	75%
Q80	HB 17130 Complete form 1040 (CFC Non-Waiver Packet Information and Checklist), which includes the date, time and location of the scheduled joint meeting, and where the MCO sends a list of CFC providers.	4/4	100%	5/6	83%	3/4	75%
Q86	CAP 2024: HB 17200 The LIDDA must communicate with the MCO to determine whether the person is receiving CFC services no later than 60 days prior to the expiration of the LOC. LOC: Begin Date_____ to End Date: _____ / 60 Days Prior to: _____ / Date Contacted MCO: _____	3/4	75%	5/6	83%	4/4	100%
Q87	HB 17200 Complete the IDRC Assessment for CFC (Form 8578-CFC)	3/4	75%	5/6	83%	4/4	100%
Q88	HB 17230 Schedule SPT Meeting with Person and LAR	4/4	100%	5/6	83%	4/4	100%
Q92	CAP 2024: HB 17230 Identify with the person and LAR a date, time and location for the joint meeting with the MCO, that is approximately 3 weeks after the completion of the CFC Assessment.	1/4	25%	5/6	83%	3/4	75%
Q94	CAP 2024: No later than 45 days prior to the expiration of a person's LOC, the LIDDA must compile a packet with all applicable documentation below and submit it to the MCO via the SFPT site: Evidence the LIDDA compiled a packet with all applicable documentation and submit to MCO via the SFPT site (45 days prior to the LOC expiration) LOC: Begin Date_____ to End Date: _____ / 45 Days Prior to: _____ / Date Packet sent: _____ (If the packet was sent late, mark line 69 as Not Met and the rest as N/A. Unless there is evidence some documents were sent to the MCO within the 45 day mark.)	4/4	100%	4/6	67%	4/4	100%

Q95	CAP 2024: HB 17230 Complete form 1040 (CFC Non-Waiver Packet Information and Checklist), that includes the date, time and location of the scheduled joint meeting, and where to send provider information, if applicable;	1/4	25%	4/6	67%	2/4	50%
Q96	HB 17230 Copy of ID/RC (Form 8578-CFC)	4/4	100%	5/6	83%	2/4	50%
Q100	HB 17230 Copy of CDS Option (Form 1581)	3/4	75%	5/6	83%	1/4	25%
Q101	CAP 2024:CAP 2024: The original completed Identification of Preferences (Form 8648) is in the record (progress note or other documentation may be substituted if the original is not available) (Form examples: Identification of Preferences, Initial Preferences, Change of Preferences, Service Options) If IOP is not found, review if there is a service note requesting the IOP from an outside LIDDA? Service Note should be in SmartCare by COCC staff/intake staff. After finding the service note requesting the IOP, mark n/a. If there is no outside LIDDA then Intake staff will enter a service note stating no IOP found. Document in the QM Summary Report in the IOP section.	3/4	75%	5/6	83%	4/4	100%
Q102	CAP 2024: The date on the Identification of Preferences (Form 8648) matches the date on the interest list record in CSIL	3/4	75%	5/6	83%	4/4	100%
Q103	HFC: Is the individual receiving Respite services?	3/4	75%	6/6	100%	4/4	100%
Q104	HFC: If receiving Respite services does the CFC Assessment, Action Plan, and Implementation Plan match?	3/4	75%	5/6	83%	4/4	100%
Q106	HFC: Is there a current ICAP filed in the chart? (Every 5 years) The ICAP service level need to correspond with the LOC level on the IDRC assessment - Form 8578-CFC (Inquire K83 Care Screen)?	4/4	100%	5/6	83%	4/4	100%
Q107	HFC: Are annual consents filed in the chart? (Acknowledgment of Rights Handbook HFC #312, Process for Filing Complaints Form 411, Privacy Notice HFC #397, Exchange/Release Info HFC#4-IDD, Emergency Medical HFC #323, etc.)	4/4	100%	5/6	83%	2/4	50%
Q108	HFC: Was the individual's medical record free of any other individual's Protected Health Information? (Medical Records Only/Service Notes)	4/4	100%	6/6	100%	3/4	75%
Q109	HFC: If there is a legal change of status, were all documents CFC Assessment and consents updated during the time period of the change of legal status? (Note: This will include written and oral explanations of rights and an explanation of services and supports.)	3/4	75%	6/6	100%	4/4	100%
Q110	HFC: Did the service notes within the quarter have the correct recipient codes, mode of delivery, and location codes?	2/4	50%	4/6	67%	2/4	50%
Q111	HFC: Were the service notes and informational notes entered within the 48 hour timeframe?	3/4	75%	2/6	33%	3/4	75%
Q112	HFC: Are all signatures legible? (Medical Records policy: Illegible signatures and signatures using initials need to have full name printed next to them.)	3/4	75%	4/6	67%	3/4	75%
Q113	HFC: Do all error corrections follow the Medical Record policy? (Error corrections must have 1 line drawn through the error then initial and date when the correction was made.)	3/4	75%	5/6	83%	4/4	100%

CFC- Only		2 nd Quarter		3 rd Quarter		4 th Quarter	
		# of correct charts/ Total # of charts	Compliance	# of correct charts/ Total # of charts	Compliance	# of correct charts/ Total # of charts	Compliance
Q53	HFC: Did the Service Coordination Assessment ratings match the identified needs/outcome on the plan? (Note: measure if the SCA determine if the SC assessed all current needs and determined an adequate frequency of Service Coordination). (monthly, at least twice every 90 calendar days, at least every 90 days)	2/2	100%	3/3	100%	2/3	67%
Q64	§331.5(33)(C), §331.11(d)(2) Plan includes a service coordination plan indicating the frequency at which the Service Coordinator will meet face to face (must be at least every 90 days)	2/2	100%	0/3	0%	1/3	33%
Q67	CAP 2024: Service Coordination Monitoring Services & Minimum Contact: §331.11(b)(1)(A), §331.11(d)(1-2)	2/2	100%	2/3	67%	3/3	100%
Q68	§331.11(b),(1),(A), TAC 40 §331.1 (d)(1-2) Evidence the SC made face-to-face contact with the individual at least once every 90 days in accordance with the SC rule or as indicated on the Service Coordination Plan.	1/2	50%	2/3	67%	2/3	67%
Q70	§331.21(a)(3) Documentation of Service Coordination: (a) The LIDDA must document the required contacts described in the person's plan of services and supports, including: (3) the progress or lack of progress in achieving goals or outcomes.	2/2	100%	1/3	33%	3/3	100%
Q86	CAP 2024: HB 17200 The LIDDA must communicate with the MCO to determine whether the person is receiving CFC services no later than 60 days prior to the expiration of the LOC.	0/2	0%	2/3	67%	2/3	67%
Q87	HB 17200 Complete the IDRC Assessment for CFC (Form 8578-CFC)	2/2	100%	3/3	100%	2/3	67%
Q92	CAP 2024: HB 17230 Identify with the person and LAR a date, time and location for the joint meeting with the MCO, that is approximately 3 weeks after the completion of the CFC Assessment.	0/2	0%	1/3	33%	2/3	67%
Q94	CAP 2024: No later than 45 days prior to the expiration of a person's LOC, the LIDDA must compile a packet with all applicable documentation below and submit it to the MCO via the SFPT site: Evidence the LIDDA compiled a packet with all applicable documentation and submit to MCO via the SFPT site (45 days prior to the LOC expiration)	0/2	0%	3/3	100%	3/3	100%
Q95	CAP 2024: HB 17230 Complete form 1040 (CFC Non-Waiver Packet Information and Checklist), that includes the date, time and location of the scheduled joint meeting, and where to send provider information, if applicable;	0/2	0%	1/3	33%	0/3	0%
Q96	HB 17230 Copy of ID/RC (Form 8578-CFC)	2/2	100%	2/3	67%	2/3	67%
Q99	HB 17230 Copy of Needs Assessment Addendum (form 2060-B)	2/2	100%	3/3	100%	2/3	67%
Q100	HB 17230 Copy of CDS Option (Form 1581)	2/2	100%	2/3	67%	0/3	0%
Q108	HFC: Did the service notes within the quarter have the correct recipient codes, mode of delivery, and location codes?	1/2	50%	1/3	33%	2/3	67%
Q109	HFC: Were the service notes and informational notes entered within the 48 hour timeframe?	1/2	50%	2/3	67%	1/3	33%
Q110	HFC: Are all signatures legible? (Medical Records policy: Illegible signatures and signatures using initials need to have full name printed next to them.)	0/2	0%	1/3	33%	1/3	33%
Q111	HFC: Do all error corrections follow the Medical Record policy? (Error corrections must have 1 line drawn through the error then initial and date when the correction was made.)	2/2	100%	1/3	33%	3/3	100%

GR ONLY		2 nd Quarter		3 rd Quarter		4 th Quarter	
Question		# of correct charts/ Total # of charts	Compliance	# of correct charts/ Total # of charts	Compliance	# of correct charts/ Total # of charts	Compliance
Q10	§301.155 (c) At least annually, LIDDA provided person and LAR written notification of LIDDA's Complaint. HFC #411	4/4	100%	5/6	83%	3/3	100%
Q26	§9.190(e)(19)(B) if the service planning team determines that the individual would benefit from having a less restrictive alternative to a guardian such as a supported decision making agreement, take appropriate actions to implement such an alternative;	4/4	100%	5/6	83%	3/3	100%
Q34	§330.15(e)(2)(D) BSP was reviewed & approved by SPT prior to implementation	4/4	100%	5/6	83%	3/3	100%
Q39	§330.15 (e) (2)(E) BSP was accepted by the person or LAR as evidenced by the person's or LAR's written informed consent.	4/4	100%	5/6	83%	3/3	100%
Q43	§330.15 (b) (2) Was reviewed & approved by rights protection officer (& third party, if policy) prior to implementation (unless implemented in response to an emergency situation) and at least annually thereafter.	4/4	100%	5/6	83%	3/3	100%
Q62	HFC: Did the Service Coordination Assessment ratings match the PDP identified needs/outcome? (Note: measure if the SCA determine if the SC assessed all current needs and determined an adequate frequency of Service Coordination.(monthly, at least twice every 90 calendar days, at least every 90 days)	3/4	75%	6/6	100%	3/3	100%
Q63	PDP Guidelines: HCS HB 4000: A discovery process was used to identify the strengths, preferences, and desires of the person.	4/4	100%	5/6	83%	3/3	100%
Q72	331.5(33)(B)&(C) Plan includes a Service Coordination Plan indicating the frequency at which the Service Coordinator will meet face to face (at least every 90 calendar days)	3/4	75%	6/6	100%	3/3	100%
Q73	HFC: Is there a current Cost Estimator filed in the EMR? (Review dates and units of what's listed on the Cost Estimator.)	3/4	75%	6/6	100%	3/3	100%
Q74	HFC: Is there a current Implementation Plan and does it match the PDP? (Signature Sheet needs to be available in the EMR if the IP date has a different date from the PDP.)	3/4	75%	6/6	100%	3/3	100%
Q78	TAC 40 §331.11(b),(1),(A), TAC 40 §331.1 (d)(1-2) Evidence the SC made face-to-face contact with the Individual at least once every 90 days in accordance with the SC rule or as indicated on the service coordination plan.	4/4	100%	4/6	67%	3/3	100%
Q90	CAP 2024: General Revenue: The original completed Identification of Preferences (form 8648) is in the record. (Service note or other documentation may be substituted if the original is missing) (Form examples: Identification of Preferences, Initial Preferences, Change of Preferences, Service Options) If the IOP is not found review if there is a service note requesting the IOP from an outside LIDDA? Service Note should be in SmartCare by COCC staff/Intake staff. After finding the service note requesting the IOP, mark n/a. If there is no outside LIDDA then Intake staff will enter a service note stating there is no IOP found. Document in the QM Summary Report in the IOP section).	4/4	100%	5/6	83%	3/3	100%
Q91	CAP 2024:The date on the Identification of Preferences (Form 8648) matches the date on the interest list record in CSIL.	4/4	100%	5/6	83%	2/3	67%
Q92	HFC: Is there a DID/DMR/D&E filed in the chart and if necessary outside testing? (Signed and dated by a licensed Psychologist) (D&E must have all 4 components filed in the EMR ex: Psychological, Social, Education, Medical, and there has to be a signature page with all doctors signatures and date)	4/4	100%	5/6	83%	2/3	67%
Q96	HFC: If there is a legal change of status, were all documents, PDP Revision, and consents updated during the time period of the change of legal status? (Note: This will include written and oral explanations of rights and an explanation of services and supports.	3/4	75%	6/6	100%	3/3	100%
Q97	HFC: Did the service notes completed within the quarter have the correct recipient codes, mode of delivery, and location codes? (Data Verification)	2/4	50%	5/6	83%	3/3	100%
Q98	HFC: Were the service notes and informational notes entered within the 48 hour timeframe?	3/4	75%	5/6	83%	2/3	67%
Q99	HFC: Are all signatures legible? (Medical Records policy: Illegible signatures and signatures using initials need to have full name printed next to them.)	4/4	100%	5/6	83%	1/3	33%
Q100	HFC: Do all error corrections follow the Medical Record policy? (Error corrections must have 1 line drawn through the error then initial and date when the correction was made.)	3/4	75%	6/6	100%	3/3	100%

HCS		2 nd Quarter		3 rd Quarter		4 th Quarter	
Question		# of correct charts/ Total # of charts	Compliance	# of correct charts/ Total # of charts	Compliance	# of correct charts/ Total # of charts	Compliance
Q14	§263.901 (e)(26) Any service coordination assignment change(including the name and contact information of the service coordinator) is shared with the individual.	7/8	88%	13/13	100%	12/12	100%
Q15	§263.901 (e)(26) Any service coordination assignment change(including the name and contact information of the service coordinator) is shared with the LAR, if applicable	7/8	88%	13/13	100%	12/12	100%
Q16	§263.901 (e)(26) Any service coordination assignment change(including the name and contact information of the service coordinator) is shared with the provider	6/8	75%	13/13	100%	12/12	100%
Q17	§263.401 a1 Informed participant of the right to participate in CDS or discontinue CDS at any time	7/8	88%	13/13	100%	12/12	100%
Q20	§263.401 a3&4 Provided copy of and oral explanation of Employee Qualification Requirements (Form 1583) (Provided copy to Individual/LAR) (Mark N/A if the individual does not choose to participate in the CDS option, unless an enrollment)	8/8	100%	13/13	100%	11/12	92%
Q31	Requirement is in Rights Handbook §334.117 (E) & §263.901 (e)(4)(A) Individual was given the name, telephone number, e-mail address, and mailing address of the rights protection officer at the LIDDA to file a complaint	8/8	100%	13/13	100%	11/12	92%
Q44	IDD Services Broadcast 2024-009 Rights Addendum (Form 1681) orally and in writing (Initial/Annual)	6/8	75%	13/13	100%	12/12	100%
Q53	2160 HB Rights review indicates that both rights booklets were provided in writing	8/8	100%	12/13	92%	12/12	100%
Q54	§263.901(e)(18) Current Letters of Guardianship	8/8	100%	8/13	62%	7/12	58%
Q55	§263.901(e)(18) If individual does not have current Letters of Guardianship, a request for updated guardianship paperwork, at least annually.	8/8	100%	13/13	100%	11/12	92%
Q68	§263.302 (a)3B Participated in the development of the proposed renewal IPC	7/8	88%	11/13	85%	10/12	83%
Q70	HCS HB 6331 Completed the non-HCS Program and non-CFC program section of the IPC (Form 692 - review dates and services listed)	7/8	88%	11/13	85%	11/12	92%
Q71	HFC: The IPC is based on the PDP (Note: Ensure all data matches PDP, IPC units and Data Portal)	8/8	100%	13/13	100%	11/12	92%
Q74	§330.15(e)(2)(G)(iii) Review, with other members of the person's planning team, the behavioral support plan at least annually, or more often as indicated, to determine the effectiveness of the plan §263.901 (e)(12)(B) HCS §262.701(j)(5)	7/8	88%	13/13	100%	11/12	92%
Q79	6300, 6400 Identification of Preferences (Form 8648) was updated when the person requested a change of service support preference	8/8	100%	12/13	92%	12/12	100%
Q90	§263.901 e5A IPC and 692 Non-Waiver Services. (Research TMHP to make sure the IPC matches the entry) [Initials, Revisions and Renewals]	6/8	75%	11/13	85%	11/12	92%
Q92	§263.901 e5C ID/RC (Research TMHP to make sure the IDRC matches the entry)	5/8	63%	10/13	77%	9/12	75%
Q94	§263.901 e5D Documentation of SC activities	8/8	100%	13/13	100%	11/12	92%
Q95	§263.901 e5E Any other pertinent information	6/8	75%	13/13	100%	12/12	100%
Q100	CAP 2024: §263.104(o)(3)/ §262.103(t)(3) The proposed initial IPC	8/8	100%	13/13	100%	11/12	92%
Q102	§263.901 e(14) Provide an individual's program provider a copy of the individuals current PDP	7/8	88%	11/13	85%	11/12	92%
Q106	§331.7(c) The current Service Coordination Assessment (Form 8647) was completed (must be completed on the current HHSC form 8647 as of June 2024)	7/8	88%	13/13	100%	12/12	100%
Q107	HFC: Did the Service Coordination Assessment ratings match the PDP identified needs/outcome? (Measure if the SCA determined if the SC assessed all current needs and determined an adequate frequency of Service Coordination).	7/8	88%	11/13	85%	12/12	100%
Q108	PDP Guidelines / HCS HB 4000 A discovery process was used to identify the strengths, preferences, and desires of the person (Note: Was outcomes supported by the discovery?)	8/8	100%	12/13	92%	12/12	100%
Q118	HFC: PDP: Outcomes are listed in the summary section of the PDP. Note: Outcomes must match the non-waiver, summary section and action plans. Outcomes will need to justify the service.	8/8	100%	13/13	100%	11/12	92%

Q125	HB 4000/\$263.901 e8B Determination that a back-up plan is needed for each waiver service that is critical to the individual's health and safety. (Exception: RSS and Supervised Living do not require back-up plans & FC back-up plans are in the provider service contract.)	8/8	100%	13/13	100%	11/12	92%
Q126	\$263.901 e8B Evidence of discussion about why a service is critical (this is most appropriately evidenced in the PDP but a progress note by the SC is acceptable)	7/8	88%	13/13	100%	12/12	100%
Q128	\$263.401 (b)4 A description of each CDS service backup plan	8/8	100%	12/13	92%	12/12	100%
Q129	The case manager or service coordinator must approve a service backup plan, including a revised plan, before implementation by the employer or DR (designated representative)	8/8	100%	10/13	77%	12/12	100%
Q130	The case manager or service coordinator must review each service backup plan during monitoring and at the annual service plan meeting to determine if the plan was implemented and effective	8/8	100%	10/13	77%	12/12	100%
Q148	\$263.302 a1Bii/\$262.701(l)(1)(2)(B) If CFC PAS/HAB is included on the PDP, the SC sent a copy of the completed HHSC HCS/TxHml.CFC PAS/HAB Assessment form to the provider within 10 calendar days	6/8	75%	13/13	100%	12/12	100%
Q149	HCS HB 4000 PDP Plan Summary Section is updated each time the PDP is updated	8/8	100%	13/13	100%	12/12	100%
Q150	CAP 2024: \$263.302 a3A SC sent a copy of the updated PDP to the program provider within 10 calendar days.	7/8	88%	11/13	85%	12/12	100%
Q151	\$263.901(e)(13)(A) The need for a change to the PDP is communicated to individual or LAR, program provider, and other appropriate persons.	8/8	100%	13/13	100%	12/12	100%
Q152	CAP 2024: \$263.901(e)(13)(B) update the PDP as necessary (Waiver/Non-Waiver)	8/8	100%	13/13	100%	12/12	100%
Q153	\$263.302 (a)3B Participated in the development of the proposed renewal IPC	6/8	75%	13/13	100%	12/12	100%
Q154	HCS HB 6330 Completed the CDS portion of the proposed renewal IPC, if applicable	8/8	100%	13/13	100%	12/12	100%
Q155	HCS HB 6331 Completed the non-HCS Program and non-CFC program section of the IPC (Form 692 - review dates and services listed)	7/8	88%	12/13	92%	12/12	100%
Q167	CAP 2024: Monitoring Service Delivery/Satisfaction	8/8	100%	12/13	92%	11/12	92%
Q168		7/8	88%	12/13	92%	9/12	75%
Q169	Did the service coordinator find during monitoring that the person/LAR had an issue that needed to be followed-up by the Service Coordinator that was resolved	6/8	75%	13/13	100%	12/12	100%
Q170	CAP 2024: \$263.901 (e) (16) document whether an individual or LAR perceives that the individual is progressing toward desired outcomes identified on the individual's PDP; (Progress and lack of Progress)	8/8	100%	13/13	100%	11/12	92%
Q172	\$263.105 (c) within seven calendar days after a program provider enters information from a completed ID/RC Assessment in the HHSC data system and electronically submits the information, the service coordinator or a LIDDA representative other than the service coordinator must:(1) review the information entered in the HHSC data system and electronically submitted, to determine if the information in the HHSC data system is identical to the information on the completed ID/RC Assessment the service coordinator received from the program provider	8/8	100%	12/13	92%	12/12	100%
Q173	\$263.105(c) Evidence of the service coordinator's name and date on the ID/RC in the HHSC data system "If there is no name and date in the C83 screen/TMHP system then mark "Not Met" and put "N/A" below for line 99 and line 100"	8/8	100%	12/13	92%	12/12	100%
Q191	(e) Within 10 business days after the transfer effective date, the service coordinator must: (1) complete data entry into the HHSC data system in accordance with the HCS Handbook after the activities described in subsection (c) of this section are completed; and	8/8	100%	12/13	92%	12/12	100%
Q199	CAP 2024: The original completed Identification of Preferences (Form 8648) is in the record (progress note or other documentation may be substituted if the original is not available) (Form examples: Identification of Preferences, Initial Preferences, Change of Preferences, Service Options) If IOP is not found, review if there is a service note requesting the IOP from an outside LIDDA? Service Note should be in SmartCare by COCC staff/Intake staff. After finding the service note requesting the IOP, mark n/a. If there is no outside LIDDA then Intake staff will enter a service note stating no IOP found. Document in the QM Summary Report in the IOP section.	4/8	50%	8/13	62%	6/12	50%
Q200	CAP 2024: The date on the Identification of Preferences (Form 8648) matches the date on the interest list record in CSIL	3/8	38%	9/13	69%	8/12	67%
Q201	HFC: Is there a DID/DMR/D&E and if necessary is there outside testing filed in the chart/EMR? Look for IQ, ABL and onset (Form 365R)	6/8	75%	12/13	92%	10/12	83%

Q202	HFC: Is there a current ICAP (every 3 years) filed in the chart/EMR? Does the ICAP service level correspond with the LON and other information listed on the IDRC assessment?	6/8	75%	8/13	62%	12/12	100%
Q203	HFC: Are all annual consents filed in the chart/EMR? (Acknowledgment of Rights Handbook HFC #312, Process for Filing Complaints Form 411, Privacy Notice HFC #397, Exchange/Release Info HFC#4-IDD, Emergency Medical HFC #323, etc.)	6/8	75%	10/13	77%	10/12	83%
Q204	HFC: Was the individual's medical record free of any other individual's Protected Health Information? (Medical Records Only/Service Notes)	8/8	100%	11/13	85%	12/12	100%
Q205	HFC: There is an HCS LIDDA Residential Agreement Notification form #142 filed in the chart? (RSS/ Supervised Living/Host Home setting) Annual/Renewals - Living arrangements change or transfer in.(Beginning February 1, 2023)	8/8	100%	12/13	92%	12/12	100%
Q207	HFC: Did the service notes within the quarter have the correct recipient codes, mode of delivery, and location codes?	7/8	88%	11/13	85%	11/12	92%
Q208	HFC: Were the service notes and informational notes entered within the 48 hour timeframe?	4/8	50%	6/13	46%	6/12	50%
Q209	HFC: Are all signatures legible? (Medical Records policy: Illegible signatures and signatures using initials need to have full name printed next to them.)	3/8	38%	7/13	54%	8/12	67%
Q210	HFC: Do all error corrections follow the Medical Record policy? (Error corrections must have 1 line drawn through the error then initial and date when the correction was made.)	6/8	75%	11/13	85%	12/12	100%

TxHmL		2 nd Quarter		3 rd Quarter		4 th Quarter	
		# of correct charts/ Total # of charts	Compliance	# of correct charts/ Total # of charts	Compliance	# of correct charts/ Total # of charts	Compliance
Q3	§262.103 (k)(3)(B) If CFC PAS/HAB is included on the PDP, complete HCS/TxHmL CFC PAS/HAB Assessment form to determine the number of CFC PAS/HAB hours the applicant needs.	3/4	75%	6/6	100%	6/6	100%
Q4	§262.103 (k)(2)(A) provide names and contact information to the applicant or LAR for all program providers in the LIDDA's local service area;	4/4	100%	5/6	83%	5/6	83%
Q6	§262.103 (n) Review proposed IPC with potential provider (HHSC Form 8582).	4/4	100%	6/6	100%	5/6	83%
Q10	§262.701(r)(1) Provide names and contact information to the individual or LAR regarding all FMSAs providing services in the LIDDAs local service area. (Note: Look in service notes/PDP to see if above information was provided.)	3/4	75%	6/6	100%	6/6	100%
Q19	HFC: Acknowledgement of Information Regarding Support Consultative Services in the CDS Option (Form #1586) is complete.	4/4	100%	6/6	100%	5/6	83%
Q22	§262.701(c) A LIDDA must be objective in the process to assist an individual or LAR in the selection of a program provider or FMSA and train all LIDDA staff who may assist an individual or LAR in the process.	4/4	100%	5/6	83%	6/6	100%
Q45	§263.901(e)(18) Current Letters of Guardianship	4/4	100%	6/6	100%	5/6	83%
Q46	§263.901(e)(18) If individual does not have current Letters of Guardianship, a request for updated guardianship paperwork (Note: at least every 90 days as part of SC follow up)	4/4	100%	6/6	100%	4/6	67%
Q47	If appropriate, a referral has been made for guardianship.(Look for HFC referral letter to the court-this is a templated HFC form)	4/4	100%	5/6	83%	6/6	100%
Q88	6300, 6400 Identification of Preferences (Form 8648) was updated when the person requested a change of service support preference	4/4	100%	5/6	83%	5/6	83%
Q102	§262.701 (e)(2) If CFC PAS/HAB is included on the PDP, a completed HHSC HCS/TxHmL CFC PAS/HAB Assessment form	3/4	75%	6/6	100%	6/6	100%
Q103	§262.701 (e)(3) A current ID/RC is maintained in the individual's record	3/4	75%	6/6	100%	5/6	83%
Q106	HFC: Service information is current (check the TMHP IDRC and IPC entry to ensure the IDRC and IPC information on the hard copy matches)	2/4	50%	5/6	83%	6/6	100%
Q107	§263.104(o)/ §262.103(t) Before the applicants service begin date, a LIDDA must provide to the selected program provider and FMSA, if applicable	4/4	100%	6/6	100%	5/6	83%
Q113	§262.701(f) Program provider was given a copy of the current PDP. (SC has 10 days from PDP date/signature date to get the PDP to the provider) [PDP Signature Date - When the PDP took place.]	3/4	75%	6/6	100%	6/6	100%
Q115	CAP 2024: §262.701(f) Program provider was given a copy of the current ID/RC	2/4	50%	6/6	100%	6/6	100%
Q116	§331.7 (a) (1) (A) Service Coordination Assessment (Form 8647) was completed to determine frequency of Service Coordination.	4/4	100%	5/6	83%	6/6	100%
Q118	HFC: Did the Service Coordination Assessment ratings match the PDP identified needs/outcome? (Note: measure if the SCA determines if the SC assessed all current needs and determined an adequate frequency of Service Coordination.)	4/4	100%	5/6	83%	6/6	100%
Q126	HFC: CAP 2024: PDP Outcomes are listed in the summary section of the PDP. Note: Outcomes must match the non-waiver, summary section and action plans. Outcomes will need to justify the service.	3/4	75%	6/6	100%	6/6	100%
Q128	HB 4000 All waiver and GR services, CFC services, non-waiver services and non-CFC services (includes all service types for all medical conditions) Starting 1/1/23 DH is converting to ISS-do not site if plan says DH or ISS-interchangeable until next renewal.	4/4	100%	6/6	100%	5/6	83%
Q135	§262.202(a)(2) The setting is selected by the individual from among setting options, including non-disability specific settings.(Note-Review Page 17 of PDP Program Service Settings)	3/4	75%	6/6	100%	6/6	100%
Q136	§262.202(A)(2)The setting options are identified and documented in the PDP and are based on the individual's needs and preferences (Verify through the outcomes, Action Plans and what is checked in the Program Service Settings on the PDP)	3/4	75%	6/6	100%	6/6	100%
Q146	HFC: Do the dates listed on the PDP match up with the dates listed on the IPC and TMHP?	4/4	100%	5/6	83%	6/6	100%
Q147	CAP 2024: 9.583 (h)(4) SC must coordinate and monitor the delivery of TxHmL Program services and CFC services and non-TxHmL Program and non-CFC services. (Starting 1/1/2023, do not cite if the SC monitors delivery of and satisfaction with ISS instead of DH during conversion from DH to ISS prior to the annual renewal when ISS is fromally added to the PDP and IPC.	3/4	75%	6/6	100%	5/6	83%

Q148	§331.11(b)(1)(A) / (d)(1-2) Evidence that the SC made face to face contact with the Individual at least once every 90 days in accordance with the SC rule or as indicated on the Service Coordination Plan.	4/4	100%	4/6	67%	4/6	67%
Q150	CAP 2024: §331.21(a)(3) Documentation of Service Coordination: (a) The LIDDA must document the required contacts described in the individual's plan of services and supports, including: (3) the progress or lack of progress in achieving goals or outcomes;	4/4	100%	6/6	100%	5/6	83%
Q174	CAP 2024: The original completed Identification of Preferences (Form 8648) is in the record (progress note or other documentation may be substituted if the original is not available) (Form examples: Identification of Preferences, Initial Preferences, Change of Preferences, Service Options) If IOP is not found, review if there is a service note requesting the IOP from an outside LIDDA? Service Note should be in SmartCare by COCC staff/Intake staff. After finding the service note requesting the IOP, mark n/a. If there is no outside LIDDA then Intake staff will enter a service note stating no IOP found. Document in the QM Summary Report in the IOP section.	3/4	75%	5/6	83%	1/6	17%
Q175	CAP 2024: The date on the Identification of Preference (Form 8648) matches the date on the interest list record in CSIL	3/4	75%	6/6	100%	5/6	83%
Q176	HFC: Is there a DID/DMR/D&E and if necessary is there outside testing filed in the chart/EMR? <i>Look for IQ, ABL and onset (Form 365R)</i>	4/4	100%	5/6	83%	5/6	83%
Q178	HFC: Are all annual consents filed in the chart/EMR? (Acknowledgment of Rights Handbook HFC #312, Process for Filing Complaints Form 411, Privacy Notice HFC #397, Exchange/Release Info HFC#4-IDD, Emergency Medical HFC #323, etc.)	2/4	50%	6/6	100%	5/6	83%
Q179	HFC: Was the individual's Medical Record free from any other individual's Protected Health Information? (Medical Records Only/Service Notes)	3/4	75%	6/6	100%	5/6	83%
Q181	HFC: Did the service notes within the quarter have the correct Recipient codes, mode of delivery, and location codes?	3/4	75%	5/6	83%	5/6	83%
Q182	HFC: Were the service notes and informational notes entered within the 48 hour timeframe?	1/4	25%	1/6	17%	3/6	33%
Q183	HFC: Are all signatures legible? (Medical Record policy: Illegible signatures and signatures using initials need to have full name printed next to them.)	1/4	25%	5/6	83%	3/6	50%
Q184	HFC: Do all error corrections follow the Medical Record policy? (Error corrections must have 1 line drawn through the error then initial and date when the correction was made.)	3/4	75%	6/6	100%	5/6	83%

PASRR-HC	2 nd Quarter		3 rd Quarter		4 th Quarter	
	# of correct charts/ Total # of charts	Compliance	# of correct charts/ Total # of charts	Compliance	# of correct charts/ Total # of charts	Compliance
Q1 HFC: Is there a positive determination of disability on file with the LIDDA? (DID/DMR/D&E and if necessary Outside testing. Look for IQ, ABL and onset (Form 365R) (Intake) Q6 §303.601 (a)/4200 A Habilitation Coordinator is assigned within two business days after the positive PE is entered in the LTC online portal-TMHP.	1/2	50%	2/3	67%	3/3	100%
Q6 §303.601 (a)/4200 A Habilitation Coordinator is assigned within two business days after the positive PE is entered in the LTC online portal-TMHP.	2/2	100%	2/3	67%	2/3	67%
Q8 HC made monthly face-to-face contact with designated resident on or before: (Can be quarterly if the only service is HC)	1/2	50%	2/3	67%	3/3	100%
Q12 5320.3 PCSP Form entered into TMHP portal within 5 days of the Quarterly SPT meeting. HC will enter in the TMHP portal all required information on PCSP form	1/2	50%	3/3	100%	3/3	100%
Q13 2520 Habilitation Coordinator will confirm in the TMHP Portal, all required information on the PASRR Comprehensive Service Plan (PCSP) form, within 5 days after receiving notification from the TMHP Portal that the NF entered the PCSP. This includes initial/annual PCSP	2/2	100%	3/3	100%	2/3	67%
Q19 §303.102 (78) (D) The MCO service coordinator, if the designated resident does not object. (The staff person assigned by a resident's Medicaid managed care organization to ensure access to and coordination of needed services)	2/2	100%	2/3	67%	3/3	100%
Q24 §303.102 (78) (G) (ii) HHSC contracted relocation specialist, If the designated resident requests to move from a NF to the community.(Relocation specialist provides outreach and relocation activities to individuals in NFs who express a desire to transition to the community)	2/2	100%	3/3	100%	2/3	67%
Q29 §303.602 (a)/4/5300 Reviewed identified risk factors, such as choking, falling, and skin breakdown, including diagnoses, and ensure they are addressed	2/2	100%	2/3	67%	3/3	100%
Q37 §303.601 (b)(2) /5400 Evidence indicates that HSP (Form 1057) was developed within 10 days following initial/ annual IDT/SPT meeting.(Form 1057)	2/2	100%	3/3	100%	2/3	67%
Q38 5400 Evidence indicates that the Individual Profile was developed within 10 days following the initial/annual IDT/SPT meeting. (Form 1063)	1/2	50%	3/3	100%	2/3	67%
Q39 5470 Evidence indicates that HSP and Individual Profile were sent to/shared with the SPT members (including SPT/LAR/NF) within 10 calendar days following the first initial/annual IDT/SPT meeting when the HSP and Individual Profile are developed.	2/2	100%	2/3	67%	1/3	33%
Q44 5460.1 A descriptive narrative that includes specificity about health needs, identify risk factors and special instructions. Note: Diagnosis, risk factors, etc.	2/2	100%	3/3	100%	2/3	67%
Q63 CAP 2024: 5200/5340.2 The Hab Coordinator must complete Form 1064 Habilitative Assessment for the individual between 10 and 60 days calendar days before the scheduled annual IDT/SPT meeting? (Whether or not individual will receive or has refused Hab Coordination) (HC will document in service note)	2/2	100%	3/3	100%	2/3	67%
Q65 HFC: The HC ensured that any revisions/updates needed for the Habilitative Assessment is completed and the revised/updated form is the EMR record	2/2	100%	3/3	100%	1/3	33%
Q66 CAP 2024: 5810.1 Initial / Annual CLO presentation	2/2	100%	3/3	100%	2/3	67%
Q67 CAP 2024: 5810.1 Semi-annual CLO presentation	2/2	100%	3/3	100%	2/3	67%
Q71 §303.302(a)(2)(B)(i)(IV)/2430.5 CLO was provided at the time of the PE. (If most recent PE was conducted during the review year)	2/2	100%	2/3	67%	3/3	100%
Q76 HFC: Does the Habilitation Service Plan, Individual Profile, and the Habilitation Assessment coordinate together and match up with the NF Face Sheet and NF CARE Plan? (Look at NF Outcomes and Goals, Section 5 & 6 of the HSP and diagnosis that are included on Individual's Face Sheet)(Ensure the NF CARE plan is reflected in content of HSP)	2/2	100%	3/3	100%	2/3	67%

Q77 §303.504 (a)(4)HC has filed a copy of the most current Nursing Facility Care Plan in the resident's record.(If the LIDDA has requested a current copy then leave this as N/A)(Look for service notes requesting a current copy from the NF)	2/2	100%	3/3	100%	2/3	67%
Q98 §303.504 (a) All pertinent information related to designated resident; such as guardianship paperwork and consents are in the record. If Individual does not have current Letters of Guardianship, a request for updated guardianship paperwork, at least annually.	2/2	100%	2/3	67%	3/3	100%
Q102 HFC: CAP 2024: The original completed Identification of Preferences (Form 8648) is in the record (progress note or other documentation may be substituted if the original is not available) (Form examples: Identification of Preferences, Initial Preferences, Change of Preferences, Service Options) If IOP is not found, review if there is a service note requesting the IOP from an outside LIDDA? Service Note should be in SmartCare by COCC staff/Intake staff. After finding the service note requesting the IOP, mark n/a. If there is no outside LIDDA then Intake staff will enter a service note stating no IOP found. Document in the QM Summary Report in the IOP section.	1/2	50%	1/3	33%	2/3	67%
Q103 HFC: CAP 2024: The date on the Identification of Preferences (Form 8648) matches the date on the interest list record in CSIL	1/2	50%	1/3	33%	2/3	67%
Q107 HFC: Did the service notes completed within the quarter have the correct recipient codes, mode of delivery, and location codes? (Data Verification)	2/2	100%	1/3	33%	3/3	100%
Q108 HFC: Were the service notes and informational notes entered within the 48 hour timeframe?	2/2	100%	0/3	0%	0/3	0%

PASRR Refused		2 nd Quarter		3 rd Quarter		4 th Quarter	
Question		# of correct charts/ Total # of charts	Compliance	# of correct charts/ Total # of charts	Compliance	# of correct charts/ Total # of charts	Compliance
Q3	§303.504 (b) (1)/5340.4 / 4420 On an annual basis the Habilitation Coordinator completes form 1044 and obtains the necessary physical signatures to document refusal of Habilitation Coordination.	2/2	100%	1/2	50%	2/2	100%
Q4	§303.504 (b)/5340 / 4420 A copy of the 1044 was provided to the individual/LAR,(required after 7/7/2019), within 10 calendar days of the date on the form.	0/2	0%	0/2	0%	2/2	100%
Q6	5810.1 CLO is presented six months after the initial CLO (which was presented during the PE) and at least every six months thereafter regardless of whether the person is receiving or has refused habilitation coordination. (Presented not more than 30 days before the scheduled annual IDT meeting / Up to 30 days but no later the exact 6 month mark)	2/2	100%	1/2	50%	2/2	100%
Q7	5340.2 An HC must complete an Habilitative Assessment no earlier than 60 days before the scheduled annual IDT/SPT meeting regardless of whether the individual is receiving habilitation coordination or any other specialized service. (no later than 10 days prior). (Intake/HC will document in the EMR).	0/2	0%	1/2	50%	1/2	50%
Q8	5340.2 The HC provided a copy of the completed Habilitation Assessment to all IDT/SPT members at least 10 business days before the annual IDT/SPT meeting	0/2	0%	1/2	50%	1/2	50%
Q9	HFC: Is there an Initial/Annual IDT/SPT meeting? (Initial within 14 days if positive NF admission date. If initial PE is negative its within 14 days of the positive PE)	2/2	100%	2/2	100%	1/2	50%
Q10	HFC: Is there a Habilitation Assessment (form # 1064) within 75 days of the initial IDT meeting?	2/2	100%	1/2	50%	1/2	50%
Q11	HFC: The HC provided a copy of the initial Habilitation assessment to all IDT/SPT members following the initial IDT/SPT meeting (10 business days)?	1/2	50%	1/2	50%	1/2	50%
Q12	§303.504 (a) Current Letters of Guardianship: All pertinent information related to the designated resident, such as guardianship paperwork and consents	1/2	50%	2/2	100%	1/2	50%
Q17	HFC: Is there a Habilitation Coordination Authorization Request (Form 2358), and was it submitted to the claims department within 3 calendar days? (1 unit) / CLOs-Submit Form 2358, Habilitation Coordination Authorization Request Form, for 1 unit of CLO to cover the annual and semi-annual CLO Presentation./ Terminations-Submit Form 2358, Habilitation Coordination Authorization Request Form, for Termination, requesting number of units needed with the appropriate Termination Code.(Beginning March 1, 2023)	2/2	100%	1/2	50%	2/2	100%
Q18	HFC: FY24 CAP Is the HC Refusal CARE code (RONR) open/closed in the CARE?	1/2	50%	2/2	100%	2/2	100%
Q19	HFC: CAP 2024: The original completed Identification of Preferences (Form 8648) is in the record (progress note or other documentation may be substituted if the original is not available) (Form examples: Identification of Preferences, Initial Preferences, Change of Preferences, Service Options) If IOP is not found, review if there is a service note requesting the IOP from an outside LIDDA? Service Note should be in SmartCare by COCC staff/Intake staff. After finding the service note requesting the IOP, mark n/a. If there is no outside LIDDA then Intake staff will enter a service note stating no IOP found. Document in the QM Summary Report in the IOP section.	1/2	50%	2/2	100%	2/2	100%
Q20	HFC: CAP 2024: The date on the Identification of Preferences (Form 8648) matches the date on the interest list record in CSIL	1/2	50%	2/2	100%	2/2	100%
Q22	HFC: Did the service notes that were completed within the quarter have the correct recipient codes, mode of delivery, and location codes? (Data Verification)	2/2	100%	1/2	50%	2/2	100%
Q23	HFC: Were the service notes and informational notes entered within the 48 hour timeframe?	1/2	50%	1/2	50%	1/2	50%

Permanency Planning		2 nd Quarter		3 rd Quarter		4 th Quarter	
		# of correct charts/ Total # of charts	Compliance	# of correct charts/ Total # of charts	Compliance	# of correct charts/ Total # of charts	Compliance
Q1	If the Permanency plan is not the initial, is there evidence that the current permanency plan has been reviewed and approved by a secondary reviewer?	0/1	0%	2/3	67%	4/4	100%
Q16	P. Permanency Plan Contributors 1. Name Title or Relationship to Individual 2. Method of Participation (Enter all that apply: face-to-face in planning meeting; face-to-face other; telephone, letter, other)	1/1	100%	3/3	100%	3/4	75%

We would like to thank and recognize the **IDD** staff who provide services to meet the needs of the individuals in their care and to the **Monitoring and Compliance** staff who work to ensure the quality of those services. It takes a team of dedicated staff to better the lives of others.

Thank you!

**FY 2024 QM Plan for Mental Health Services
Adult and Child & Adolescent
Attachment A**

Mental Health Services				
Expectation # 1	<p>In accordance with the Scheduling Grid, medical record audits are completed to ensure quality care, timely services, person-centered recovery planning, and services are offered according to the authorized level of care. Additional elements of the audit include a review of assessments, medication and lab orders, service note documentation, financial assessments and required documentation such as consents, rights provided, etc.</p> <p>Target compliances are noted for each audit.</p>			
Program	1QFY25	2QFY25	3QFY25	4QFY25
Adult- Case Management (76%)	14 charts reviewed- 11 above target & 3 below	20 charts reviewed- 8 above target & 12 below	20 charts reviewed- 12 chart were above target and 8 were below	26 charts reviewed- 20 charts were above target- 6 were below.
CAS-Case Management (76%)	8 charts reviewed- 7 charts above target & 1 chart below	10 charts reviewed- 6 above target and 4 below.	8 charts reviewed- all above target.	10 charts reviewed- 7 charts were above target and 3 were below.
Med Training and Support (76%)	10 charts reviewed- 6 above target & 4 below	Deferred	10 charts reviewed- 9 above target and 1 below	Deferred
LPHA- Counseling (76%)	Deferred	4 charts were reviewed- 3 charts above target and 1 below.	Deferred	10 charts reviewed- all charts 100% compliant.
Peer Provider Review (76%)	9 charts reviewed- 7 charts above target & 2 charts below.	Deferred	9 charts reviewed- all charts above target	Deferred
Wrap Around-CAS (76%)	Deferred	3 charts reviewed- 2 charts at or above target & 1 below.	Deferred	3 charts reviewed- All 3 charts below target.
TCOOMMI (76%)	3 charts reviewed- All above target	3 charts reviewed- all charts below target.	6 chart reviewed- 4 charts above target and 2 below	3 charts reviewed- All above target

**FY 2024 QM Plan for Mental Health Services
Adult and Child & Adolescent
Attachment A**

Crisis Assessment (90%)	10 charts reviewed- 6 charts above target & 4 charts below	Deferred	10 charts reviewed – 3 charts above target and 7 below	Deferred
Program	1QFY25	2QFY25	3QFY25	4QFY25
Front Desk (90%)	Deferred	20 charts reviewed 19 above target and 1 below.	Deferred	Deferred
Medical Staff (90%)	Deferred	Deferred	24 charts reviewed – 20 charts above target and 4 below	Deferred
PASRR- MH (90%)	10 charts reviewed- 9 above target & 1 below	8 charts reviewed- 6 above target and 2 below.	12 charts reviewed- 4 charts above target and 8 below	8 charts reviewed- 6 above target and 2 below.
Medical Staff- Peer Review (completed)	Deferred	20 notes reviewed- 18 above target and 2 below target.	Deferred	26 notes reviewed- 21 above target and 5 below.
House Bill 4 (76%)	10 charts reviewed- 7 charts above target & 3 charts below.	10 charts reviewed 4 charts above target and 6 charts below.	10 charts reviewed- 7 charts above target and 3 below	10 charts reviewed- 9 above target and 1 below.
HTPP (76%)	Deferred	3 charts reviewed- All 3 above target.	Deferred	4 charts reviewed- 3 above target and 1 below.
Supportive Housing (76%)	No charts to audit	No charts to audit	No charts to audit -1 billed incorrectly	No charts to audit
Supported Employment (76%)	Deferred	3 charts reviewed all 3 above target.	Deferred	3 charts reviewed all 3 above target
Review Notes-1QFY25: Supportive housing curriculum was the only audit not able to be completed at this time. No service notes were coded for supportive housing.				
Review Notes-2QFY25: Supportive housing curriculum was the only audit not able to be completed at this time. No service notes were coded for supportive housing. There was a drop in compliance for the adult case managers in the rural centers. We are seeing a drop in House Bill 4 audits- Main cause for no scores is not putting why the session occurred over the phone.				
Review Notes-3QFY25: Supportive housing curriculum was the only audit not able to be completed at this time; one note was coded incorrectly. Crisis assessments and PASRR audits have declined in the past quarter. CAS case management and Peer Provider audits improved during the 3 rd quarter.				

Attachment A-Mental Health Services-Adult and CAS

**FY 2024 QM Plan for Mental Health Services
Adult and Child & Adolescent
Attachment A**

Review Notes-4QFY25:

Expectation # 2	In order to obtain input on services and experiences, etc., individuals served and/or their legally authorized representatives (LARs) are offered the opportunity to complete a satisfaction survey.			
	Target: Representation from all Centers with an increase from FY 24.			
Programs:	1QFY25	2QFY25	3QFY25	4QFY25
WF- Broad	3	6	1	4
WF- Denver-Medical	4	1	0	0
WF- Denver- CAS	0	0	0	0
Bowie	2	1	6	6
Decatur	0	5	3	1
Graham	1	0	1	0
Haskell	4	0	0	0
Seymour	0	0	3	1
Vernon	0	0	1	0
Quannah	0	0	0	0
Childress	0	0	0	16
Review Notes-1QFY25: Fourteen satisfaction surveys were collected during the 1 st quarter. Any concerns went to the center manager, HR, or MIS. Most surveys received were positive.				
Review Notes-2QFY25: Thirteen satisfaction surveys were collected during the 2 nd quarter. Any concerns went to the center manager, HR, or MIS. Most surveys received were positive.				
Review Notes-3QFY25: Fourteen satisfaction surveys were collected during the 3 rd quarter. Any concerns went to the center manager, HR, or MIS. Most surveys received were positive.				
Review Notes-4QFY25: Twenty-eight satisfaction surveys were collected during the 4 th quarter. Concerns were sent to the center manager. Most surveys received were positive.				

Expectation # 3	Mental Health Level of Care (LOC) Capacity: Utilization Management (UM) staff tracks level of care population by way of service authorization, minimum allowed services, and minimum time.			
	Target: At least 75% of committee meetings will occur timely			
UM Meeting	1QFY25	2QFY25	3QFY25	4QFY25
	Met	Met	Met	Met
Review Notes-1QFY25: UM committee meeting occurred on 12/9/2024.				
Review Notes-2QFY25: UM committee meeting occurred on 3/21/2025.				
Review Notes-3QFY25: UM committee meeting occurred on 6/9/2025.				
Review Notes-4QFY25: UM committee meeting occurred on 9/9/2025.				

**FY 2024 QM Plan for Mental Health Services
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Expectation # 4	Reduction in emergency department use and hospitalization. Center will review medical records for any individual receiving inpatient hospitalization that has been identified as a “30-day readmission”. (CCBHC -Reduction in emergency use & rehospitalization)			
	Target: Monitoring for baseline			
Target Report	1QFY25	2QFY25	3QFY25	4QFY25
Review Notes-1QFY25: No readmissions in Q1- Updated on 4/29/2025: 2 readmissions were reported in CARE.				
Review Notes-2QFY25: 3 adults and 1 child were re-hospitalized during the 2nd quarter. These were reported and reviewed in IOC. CARE reporting shows 9 clients that were readmitted during the 2nd quarter. Two of the nine reported were IDD.				
Review Notes-3QFY25: CARE reporting shows 18 readmissions during the 3rd quarter.				
Review Notes-4QFY25: CARE reporting shows 28 readmissions during the 4th quarter.				

Expectation # 5	The reporting and monitoring of unusual incidents are completed throughout the Helen Farabee Centers to ensure a safe and healthy environment. Center Managers and Department Heads are responsible to ensure reporting of events. The Clinical and Environmental Safety Committee will review for quality improvement activities.			
	Incidents involving any individual served by Helen Farabee Centers: These events are recorded on designated forms. Reviews are completed in accordance with local procedures. Health and Human Services Commission (HHSC) may require additional reporting for specific critical incidents.			
	<ul style="list-style-type: none"> • Incidents and Injuries of Individuals in services • Employee Incidents and Injuries • Vehicle Incidents/Accidents • Medication Discrepancies/Errors • Deaths by suicide (CCBHC requirement) • Suicide Attempts (CCBHC requirement) 			
	Target: Any increase in reported events will be evaluated.			
Identify critical incidents:	1QFY25	2QFY25	3QFY25	4QFY25
	8 deaths reported and 10 incidents	7 deaths reported and 6 incidents	9 deaths reported and 9 incidents	8 deaths reported and 6 incidents
Review Notes-1QFY25: Sept- 3 deaths and 3 incidents; Oct- 4 deaths and 3 incidents; Nov- 1 death and 4 incidents.				
Review Notes-2QFY25: Dec- 2 deaths and 1 incident; Jan- 2 deaths and 3 incidents; Feb- 3 deaths and 2 incidents.				

**FY 2024 QM Plan for Mental Health Services
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Review Notes-3QFY25: Mar- 3 deaths and 4 incidents; Apr- 4 deaths and 3 incidents; May- 2 deaths and 3 incidents

Review Notes-4QFY25: June- 0 deaths and 3 incidents; July- 3 deaths and 0 incidents; Aug- 5 deaths and 3 incidents

FY 2025 QM Plan for Child & Adolescent Services –YES Waiver

Attachment C

Youth Empowerment Services--YES Waiver				
Expectation # 1	Calls to Helen Farabee Centers dedicated YES Waiver Inquiry line will receive a timely response.			
	On a quarterly basis, an audit will be conducted to ensure that the YES Waiver Supervisor or other designated responder returned all calls to the dedicated YES Waiver Inquiry Line within 1 business day.			
Activity Description:	YES Waiver Supervisor will conduct a review of response time to calls on the dedicated YES Waiver Inquiry Line.			
Tools:	Inquiry List			
Frequency:	Quarterly, Annually on Fidelity Review			
Target:	100% of calls to the YES Waiver Inquiry line will receive a 24 hour response (business day).			
Quarter	1QFY25	2QFY25	3QFY25	4QFY25
Review	100% - 7/7 calls to the inquiry line received a response within one business day.	100% - 3 calls to the inquiry line received a response within one business day.	100% 4/4 calls to the inquiry line received a response within one business day.	100% - 3/3 calls to the inquiry line received a response within one business day.

Expectation # 2	An individual will receive timely access to YES Waiver Services.			
	On a quarterly basis, YES Waiver Supervisor will conduct an audit to ensure that all individuals who meet the demographic screening criteria for the YES Waiver receive a Clinical Eligibility Determination (CED) within 7 business days from initial phone contact.			
Activity Description:	YES Waiver Supervisor will ensure a CED is completed in CMBHS within 7 business days and an informational note is entered into the EHR.			
Tools:	Inquiry List and Clinical Eligibility			
Frequency:	Quarterly, Annually on Fidelity Review			
Target:	100% of individual will receive timely access to YES Waiver Services.			
Quarter	1QFY25	2QFY25	3QFY25	4QFY25
Review	100%- Both charts showed CED was completed or attempted within 7 days.	All clients were screened for demographic eligibility and placed on waitlist for CED.	From Audits: 100%- 1 client received CED within 7 days. 2 charts were skipped due to the waitlist.	100%
Responses		When the QM plan was created there was no need for a waitlist, however with increased interest a waitlist was	Director Response: 4 clients were screened for demographic eligibility and placed on the waitlist. 2 clients were	Director Response: 3 clients were screened for demographic eligibility and placed on the waitlist.

Attachment C-Child & Adolescent –YES Waiver Services

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FY 2025 QM Plan for Child & Adolescent Services –YES Waiver

Attachment C

		necessary and does not meet intention of this expectation.	scheduled for CED within 7 days of available slot opening. 1 client was contacted and had moved out of the catchment area	
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Expectation # 3	YES Waiver Participants will receive at least one billable service per month in the YES Waiver Service array.			
	On a quarterly basis, an audit will be conducted to ensure that billable services are reflected.			
Activity Description:	YES Waiver Supervisor will ensure at least one billable service per month. QM will complete a review of all YES Waiver Participants served each quarter and report to the YES Waiver Supervisor any findings.			
Tools:	Internal auditing tool for YES Waiver			
Frequency:	Quarterly, Annually on Fidelity Review			
Target:	90% of YES Waiver Participants will receive at least one billable service per month.			
Quarter	1QFY25	2QFY25	3QFY25	4QFY25
Review	100% - Charts show monthly services or attempts to schedule services. Clients have not been enrolled for more than 2 months at time of review.	1- Yes 2- Yes 3- Yes All 3 participants received a billable service each month of enrollment.	100%- Charts show monthly services or attempts to schedule services.	1- yes 2- yes All participants received a billable service each month of enrollment.

FY 2025 QM Plan for Child & Adolescent Services –YES Waiver

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Expectation # 4	<p>YES Waiver Participants will be provided services in accordance with the YES Waiver User Guide and YES Waiver Policy Manual.</p> <p>On a quarterly basis, an abbreviated audit will be conducted using questions from the Health and Human Services Commission (HHSC) YES Waiver Audit Tool as well as specific YES elements.</p> <p style="margin-left: 40px;">Elements of the audit will include:</p> <ul style="list-style-type: none"> • Completion of required YES Waiver forms • Wraparound Plan • Plan addressed health and safety needs • Plan addressed personal goals for the individual and/or family • Crisis Safety Plan developed • 90-day review of the Individual Care of Plan (IPC) • Revised Wraparound Plan to include any critical incidents or environmental changes • Documentation of service provided • Transition and discharge planning 			
Activity Description:	<p>a) YES Waiver Supervisor will contact QM staff with names of YES Waiver Participants for completion of a medical record review.</p> <p>b) QM staff will complete an internal audit of the medical record for 100% of YES Waiver Participants per the elements listed herein. YES Waiver Supervisor will follow up with all needed corrective actions (Quality Management Action Plan-QMAP).</p>			
Tools:	Internal auditing tool for YES Waiver			
Frequency:	6 month intervals; Reviewed on 1 st and 3 rd quarter			
Target:	At least 76% compliance on medical record review			
Quarter	1QFY25	2QFY25	3QFY25	4QFY25
Review	2 charts had medical record audits conducted. Scores were 91% and 93%.	Deferred did not conduct YES Waiver audits. See frequency.	3 charts had a medical record audit conducted. Scores were: 100%, 88%, and 83%.	Deferred did not conduct YES Waiver audits. See frequency.

Expectation # 5	<p>Wraparound Services will be provided to YES Waiver Participants according to the Wraparound Model endorsed by the National Wraparound Implementation Center (NWIC) by UCONN (University of Connecticut) coaches.</p>			
Activity Description:	YES Waiver Supervisor will ensure each participant enrolled in YES waiver will received Wraparound services.			
Tools:	Chart Review			
Frequency:	Annually			
Target:	100% of YES Waiver Participants will receive Wraparound Services.			
Quarter	1QFY25	2QFY25	3QFY25	4QFY25

Attachment C-Child & Adolescent –YES Waiver Services

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Review	67% - 2/3 enrolled participants received Wraparound services. One individual was admitted to a psychiatric hospital after enrollment and has not yet begun Wraparound.	1- Yes 2- Yes 3- Yes Each participant received Wraparound services each month of enrollment.	100%- 3/3 enrolled participants received Wraparound services.	1- yes 2- yes All participants received Wraparound services each month of enrollment.
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Expectation # 6	All risk or safety incidents occurring during the provision of YES Waiver Services will be reported and reviewed in a timely and appropriate manner.			
	On a quarterly basis, the Clinical and Environmental Safety Committee will review data related to the YES Waiver Program including abuse-neglect-exploitation allegations/confirmations, medical injuries, elopements, hospitalizations, behavioral or psychiatric emergencies, allegations of rights violations, criminal activity, property loss or damage (including vehicles), medication errors, unauthorized departure/elopement, legal or juvenile justice involvement, and/or death. Review will be focused on any patterns/trends as well as corrective actions needed on reporting. YES Waiver Form 2803 “Critical Incident Report” must be completed and submitted to the YESWaiver@hhsc.state.tx.us within 72 hours of being notified of the incident. Program Manager will ensure that a copy of the critical incident (Form 2803) is available for any auditor request and a copy will be provided to @ HR for filing with other incident reports.			
Activity Description:	Reporting of critical incidents. All reports will be distributed to the Director of Risk Management. The Clinical and Safety Committee will review on a quarterly basis for any patterns or trends as well as any corrective actions needed.			
Tools:	Designated Incident Reports HHSC Critical Incident Report, # 2803			
Frequency:	Quarterly			
Target:	No incidents or injuries which were attributed to the staff’s neglect.			
Quarter	1QFY25	2QFY25	3QFY25	4QFY25
Review	100% Both charts had CIRs found in chart.	100% One participant had a CIR submitted and uploaded to the chart.	100%-CIRs were found with in the medical records for RTC placement. No incidents were related to staff neglect.	100% CIRs were submitted and uploaded to the chart. No incidents were related to staff neglect.

Expectation # 7	YES Waiver Services will be reviewed for appropriate utilization.			
	On a quarterly basis, the Utilization Management Committee will review utilization data related to the YES Waiver Program.			
Activity Description:	YES Waiver Supervisor will provide monthly reports to IOC regarding outcome measures including Inquiry Line activity and response time, and timely and appropriate service provision.			
Tools:	Report			

Attachment C-Child & Adolescent –YES Waiver Services

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Frequency:	Monthly- YES Waiver Supervisor & Quarterly- Director of Utilization and Quality Management			
Target:	Reports will be provided 100% to executive meetings.			
Quarter	1QFY25	2QFY25	3QFY25	4QFY25
Review	Committee met on 12/9/2024- Met	Committee meeting on 3/21/2025- Met	Committee meeting on 6/9/2025	Committee meeting on 9/9/2025

Expectation # 8	<p>Trainings Required for Wraparound/YES Waiver Fidelity.</p> <p>YES Waiver Supervisor and designated QM staff will ensure that YES Waiver providers are delivering services in accordance with the Texas Administrative Code (TAC), Health and Human Services Commission (HHSC), and the Local Mental Health Authority (LMHA). Required trainings, which are available face-to-face, virtual, and online, are as follows:</p> <ol style="list-style-type: none"> 1) Wraparound Training Series <ol style="list-style-type: none"> a) Phase I: Introduction to Wraparound (one-time training) b) Phase II: Engagement in Wraparound (one-time training) c) Phase III: Implementation in Wraparound (one-time training) 2) NWIC Intro to Systems of Care—Training Series: <ol style="list-style-type: none"> a) Wraparound Overview (Video-one-time training) b) Team Roles in Wraparound (Video-one-time training) c) YES Waiver 101 (In-person or Video-one-time training) 3) Identifying and Reporting of abuse, neglect, and exploitation (Annually)- HHSC 4) Confidentiality and Encryption Capability (Annually) - HHSC 5) Critical Incident Reporting (Annually)- HHSC 6) Service Documentation requirements (one-time training) 7) Crisis and Safety planning (one-time training)- HHSC 8) PMAB (Annually) 9) First Aid/CPR (certification is valid for 2 years) 10) Training on Trauma Informed Care (certification is valid for 2 years)- HHSC 			
Activity Description:	YES Waiver Supervisor will ensure certificates of completion for all required trainings are submitted to @ HR to be filed within the employee’s personnel files.			
Tools:	Training Records			
Frequency:	Annually			
Target:	At least 90% of training is current within 30 days of the due date.			
Quarter	1QFY25	2QFY25	3QFY25	4QFY25
Review	100% - 6/6 providers are in compliance with all training requirements.	98.5% - 6/7 providers are in compliance with all training requirements. 1 provider missing CPR training due to limitations related to a physical injury. Will be completed in Q3.	100%- 6/6 providers in compliance with all training requirements.	100% - 10/10 providers in compliance with all training requirements.

Attachment C-Child & Adolescent –YES Waiver Services

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FY 2025 QM Plan for Child & Adolescent Services –YES Waiver

Attachment C

FY 2025 QM Plan-Intellectual and Developmentally Disabled Services- IDD

Attachment D-Local IDD Authority Services (LIDDA)

Involving Stakeholders in the Quality Management Program

Expectation # 1	Individuals receiving services, their legally authorized representatives (LARs) or any interested community member are afforded the opportunity to complete a satisfaction survey using the Helen Farabee Centers website. “Community Voice for IDD-Authority” services can be accessed at any time.			
Activity Description:	IDD staff will ensure that individual and their LAR’s have knowledge of the available satisfaction surveys through the HFC website.			
Activity Description:	QM staff ensures reviewing any surveys entered into the Community Voice location. Concerning results are shared with Supervisor and their Department Head, and Director of UM/QM for review and recommendations for improvement to services. Any surveys that deserve further recognition will be sent to the Chair of the Trauma-Informed Care Team for “Caught in the Act” in our HFC Newsletter.			
Tools:	Community Voice Satisfaction Survey through HFC Website			
Frequency:	Ongoing			
Target:	Increase in number of surveys is desired from FY 24			
Program	1QFY25	2QFY25	3QFY25	4QFY2
IDD- A- Individual	4 GR satisfaction letters mailed out.	Completed annually per UM/QM Director.	0 satisfaction surveys were completed	0 satisfaction surveys were completed
IDD- A- LAR	5 GR satisfaction letters mailed out.	1 satisfaction survey completed	0 satisfaction surveys were completed	0 satisfaction surveys were completed
Review Notes-1QFY25: Our satisfaction letter numbers changed since we are no longer provider. 1 satisfaction survey was completed in person using the online survey.				
Review Notes-2QFY25: One satisfaction survey was completed online and provided to IDD Director.				
Review Notes-3QFY25: No surveys were completed online or by paper				
Review Notes-4QFY25: No surveys were completed online or by paper				

Measuring, assessing, and improving the LIDDA’s authority functions

Expectation # 2	Comprehensive medical record audits completed for the purpose of assessing the documentation compliance. Results of the audits provide an opportunity to review our deficiencies and ensure understanding of the requirements and future improvement of our services.			
	Target: Average for the quarter 90% compliance per program			
Programs:	1QFY25	2QFY25	3QFY25	4QFY25
Texas Home Living (TxHmL)	6 completed. 5 were above target. (91.72%, 95.31%, 98.43%, 99%,	6 completed. 5 were above target and 1 below (95.19; 94;	6 completed. All above target. (97.95%, 95.96%;	6 completed – 5 above target and 1 below (97%, 98.8%, 94.4%,

Attachment D-IDD Authority Services

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FY 2025 QM Plan-Intellectual and Developmentally Disabled Services- IDD

Attachment D-Local IDD Authority Services (LIDDA)

	98.18%) and 1 below target (47.76%) .	44.37 ; 91.23; 95.12; 98.77)	99%, 99.01%, 95.88%, 90.54%)	96.7%, 95.12%, 59.48%)
Community First Choice (CFC)	3 charts complete. 2 were above target (95.29%) 2 below target. (87.8%, 81.25%)	3 completed- All above target. (95.03; 92.73; 90.79)	3 completed- 1 above target & 2 below. (57.27% , 94.05%, 87.50%)	3 completed- 2 above target and 1 below (90.41%, 92.06%, 88.24%)
Home and Community Based Services-Authority (HCS)	12 charts reviewed. (93.14%, 96.79%, 95.12%, 90.10%, 96.25%, 96.95%, 94.94%, 96.81%, 91.76%) 3 chart below target. (89.58%, 57.45%, 81.35%)	12 completed- 11 were above target and 1 below (95.56; 91.36; 91.36; 83.93 ; 99.32; 93.6; 9.43; 92.81; 94.81; 95.57; 96.43; 90.91)	12 completed- 11 were above target and 1 below (97.60%, 96.09%, 96.77%, 68.90% , 93.94%, 98.41%, 95.19%, 94.52%, 96.64%, 97.67%, 91.53%, 93.62%)	10 completed - 9 above target and 1 below (97.50%, 95.65%, 77.91% , 93.25%, 97.30%, 97.46%, 96.83%, 98.93%, 93.53%, 96.06%)
General Revenue (GR)	5 charts reviewed (93.20%, 95.58%, 91.03%, 96.10%) 1 below target. (87.25%)	6 completed. 5 were above target and 1 below. (97.48; 83.87 ; 96.34; 96.04; 100; 97.62)	6 completed. All above target. (100%, 97.56%, 98.82%, 95.59%, 95.71%, 90.91%)	3 completed – All above target (96.55%. 97.40% , 100%)
General Revenue/Community First Choice (GR/CFC)	5 charts reviewed. (96.20%, 97.85%, 97.28%, 90.18%) 1 chart below target (88.64%)	6 completed- 4 were above target and 2 below. (86.75 ; 96.43; 85.71 ; 96.35; 90.48; 94.79)	6 completed- 4 were above target and 2 below. (86.99% , 88.37% , 94.38%, 92.41%, 94.92%, 97.78%)	4 completed – All above target (91%, 96.62%, 92.22%, 94.92%)
PASRR- Hab. Coordination-Active	3 charts reviewed. All below target. (85.58%, 77.06%, 83.33%)	4 completed. 3 were above and 1 below. (94.47; 88.89 ; 90.63; 90.51)	3 completed all above target (92.05%, 92.09%, 94.55%)	3 completed All above target (99.44%, 90.77%, 97.52%)
PASRR-Hab. Coordination-Refusals	3 charts reviewed. 1 chart above target at (90.50%) 2 charts below target (50%, 75%)	2 completed, both did not meet target (70.69 ; 70)	2 completed: 1 above target and 1 below (95%, 52.38%)	2 completed- 1 above and 1 below (70% , 100%)
HCS- ECC	3 charts reviewed. All above target at (91.55%, 90.18%. 93.55%)	2 completed. 1 above and 1 below. (81.48 ; 100)	1 completed (96.36%)	1 completed above target (97.62%)
Enhanced Community Coordination (ECC)	0	0	0	1 completed Below target (80%)
Perm Planning		2 completed. Both above target (93; 93.75)	3 completed: 2 above and 1 below target (100%, 100%, 81%)	4 completed – All above target (100%, 93.33%, 100%, 100%)
Review Notes-1QFY25: A total of 42 charts were reviewed during the first quarter. All QMAPs have been submitted and returned.				
Review Notes-2QFY25: A total of 43 charts were reviewed during the second quarter. All QMAPs have been submitted and returned.				

Attachment D-IDD Authority Services

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FY 2025 QM Plan-Intellectual and Developmentally Disabled Services- IDD

Attachment D-Local IDD Authority Services (LIDDA)

Review Notes-3QFY25: A total of 44 charts were reviewed during the third quarter. Two PASRR ECC were reviewed: 1 scored above target (93.33%) and 1 below (11.25%)
Review Notes-4QFY25: A total of 37 charts were reviewed during the fourth quarter. All QMAPs have been submitted and returned.

Measuring, Assessing, and Improving Services Provided by or through the Local Authority

Expectation # 3	Ensuring the Center is appropriately addressing waiver enrollments. Target: 95% per quarter			
Programs:	1QFY25	2QFY25	3QFY25	4QFY25
HCS	100%	100%	95%	100%
TxHmL	100%	100%	86%	100%
Review Notes-1QFY25: As far as director is aware the scores for both programs in Q1 was 100%.				
Review Notes-2QFY25: As far as director is aware the scores for both programs in Q2 was 100%.				
Review Notes-3QFY25: Director provide percentages; one was above target and other below. Director stated that the target was missed by one day.				
Review Notes-4QFY25: As far as director is aware the scores for both programs in Q4 was 100%.				

Measuring, Analyzing, and Improving Service Capacity and Access

Expectation # 4	Ensuring the Center is appropriately maintaining individuals placed on the Interest List. Target: At least 50% by end of FY 24 and 100% by FY 25			
Interest List:	1QFY25	2QFY25	3QFY25	4QFY25
	60.22%	68.36%	88%	100%
Review Notes-1QFY25: Internal goal at the end of Q1 was 63.62%. We did not meet our goal but have a plan to meet our 100% by end of FY25.				
Review Notes-2QFY25: Internal goal at the end of Q2 was 81.78%. We did not meet our goal, though this division is just getting fully staffed and a plan is established to meet the state goal by the deadline.				
Review Notes-3QFY25: We expect to hit the goal by the end of the fiscal year.				
Review Notes-4QFY25: We met target!				

Expectation # 5	Ensuring CARE service codes, associated with Permanency Planning, are entered timely to reflect initial contact and six-month contacts. (Erin) Medical record audit completed to ensure elements are found within the record. Target: Average for the quarter 95% compliance.			
Perm Plan Audits:	1QFY25	2QFY25	3QFY25	4QFY25

Attachment D-IDD Authority Services

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FY 2025 QM Plan-Intellectual and Developmentally Disabled Services- IDD

Attachment D-Local IDD Authority Services (LIDDA)

	100%	100%	100%	
Review Notes-1QFY25: As far as director is aware the scores in Q1 were 100%.				
Review Notes-2QFY25: As far as director is aware the scores in Q2 were 100%.				
Review Notes-3QFY25: As far as director is aware the scores in Q3 were 100%.				
Review Notes-4QFY25: As far as director is aware the scores in Q4 were 100%.				

Measuring, assessing, and reducing critical incidents and incidents of individual abuse, neglect and exploitation and improving the individual rights protection process:

Expectation # 6	Incidents at Helen Farabee locations or involving individuals engaged in a LIDDA activity is recorded on designated forms and submitted for review in accordance with local procedures.			
	Target: Any increase in reported events will be evaluated.			
Identify critical incidents:	1QFY25	2QFY25	3QFY25	4QFY25
	6	5	3	4
Review Notes-1QFY25: Sept- 2 deaths and 1 incident Oct- 2 deaths Nov- 1 incident 0 deaths				
Review Notes-2QFY25: Dec- 2 deaths Jan- 0 incident and 2 deaths Feb- 1 death				
Review Notes-3QFY25: Mar- 0 incidents and 0 deaths Apr- 0 incidents and 2 deaths May- 0 incidents and 1 death				
Review Notes-4QFY25: June-1 death and 0 incidents July-0 incidents and 0 deaths Aug- 2 deaths and 1 incident				

Assessing and improving the process for reviewing rights restrictions

Attachment D-IDD Authority Services

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FY 2025 QM Plan-Intellectual and Developmentally Disabled Services- IDD

Attachment D-Local IDD Authority Services (LIDDA)

Expectation # 7	When Rights Restrictions are received, the individual’s case will be reviewed to ensure that clinical justification is present as well as the restriction being in the best interest of the individual in services.			
	Target: No more than 1 error per quarter.			
Reports:	1QFY25	2QFY25	3QFY25	4QFY25
	0	3	5	3
Review Notes-1QFY25: There were no rights restrictions, or any rights issues reported within the 1Q.				
Review Notes-2QFY25: There were 3 rights restrictions within the 2Q. They were reviewed by the SPT and approved. There were no rights issues reported for 2Q.				
Review Notes-3QFY25: There were 5 rights restrictions within the Q3. There were all reviewed by the team and no client’s rights were violated or issues reported.				
Review Notes-4QFY25: There were 3 rights restrictions within the 4 th Quarter. They were all reviewed by the team and there were no client’s rights issues or violations reported.				

Measuring, Assessing, and Improving the Accuracy of Data Reported by the LIDDA:

Expectation # 8	Staff compare and update data as needed for data integrity.			
Activity Description:	<p>QM staff review the information from the CARE/TMHP suspense file to make sure that information from the electronic medical record (Smart care) and CARE match. Includes all demographic information: Individual’s Name, Date of Birth, Social Security Number, Address, Primary Correspondent, if applicable, and County of Residence.</p> <p>If their County of Residence is outside of the Helen Farabee Centers catchment area, this information is identified, and a request made to change the County of Residence from another LIDDA.</p> <p>Target: Any increase in the number of errors will be reviewed</p>			
Data Errors	1QFY25	2QFY25	3QFY25	4QFY25
	All errors were reviewed.	All errors were reviewed.	All errors were reviewed.	All errors were reviewed and corrected
Review Notes-1QFY25: There were a few instances of wrong name, SS Number or DOB within Q1 were researched and corrections were made. When we received requests for County of Residence changes those are researched and are updated as requested. There were some PHI found but were corrected.				
Review Notes-2QFY25: There was 5 PHI cases found in Q2, but all have been corrected at the time of review.				
Review Notes-3QFY25: There were 3 issues of PHI found during the reviews in Q3, but all were corrected at the time they were found. There have been name misspellings, SS# errors, address				

Attachment D-IDD Authority Services

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FY 2025 QM Plan-Intellectual and Developmentally Disabled Services- IDD

Attachment D-Local IDD Authority Services (LIDDA)

changes and county of residence requests for change. All were corrected during working on corrections and county changes are addressed as soon as they are requested.

Review Notes-4QFY25: There was 1 instance of PHI found during a review in the 4th Quarter, and it was corrected at the time it was reported. There have been name misspellings or additions, SS# errors, DOB errors, address changes and county of residence requests for change. All were corrected during working on corrections and county changes are addressed as soon as they are requested.

Performance Measures: See Addendums

**FY 2025 QM Plan for Substance Abuse Services
Attachment F**

Goal # 1	Ensuring Competence and Due Care, Accuracy, Confidentiality, Client Bill of Rights, and Process for any Grievances			
Objective # 1.1	Ensuring Competence and Due Care - TAC Rule §564.6: Providers shall plan, supervise adequately, and evaluate any activity for which they are responsible. Providers shall render services carefully and promptly. Providers shall follow the technical and ethical standards related to the provision of services, strive continually to improve personal competence and quality of service delivery, and discharge their professional responsibility to the best of their abilities. Providers are responsible for assessing the adequacy of their own competence for the responsibility to be assumed. Services shall be designed and administered as to do no harm to recipients. The provider shall always act in the best interest of the individual being served. The provider shall terminate any professional relationship that is not beneficial, or is in any way detrimental, to the individual being served.			
Competence and Due Care	1QFY25	2QFY25	3QFY25	4QFY25
	Target met.	Target met.	Target met.	Target met.
<p>Review Notes-1QFY25: The Substance Abuse Services (SAS) department offers outpatient substance abuse treatment services in Wichita Falls and eight rural centers utilizing nine licensed Counselors, four Counselor Interns, two Recovery Coaches, and one fulltime and one parttime clerk. Weekly staff meetings are held with the SAS staff for the purpose of maintaining open communication, comradery, and moral; dispense information related to changes in any process; ensuring all that seek services are taken care of and assigned and scheduled for intake with a counselor; coverage for any upcoming staff absences; reviewing the census/waitlist for any needed action; and provided feedback/consultation for any counselor seeking to staff a client.</p> <p>During this first quarter, Perry Green, Clinical Manager, audited 16 open charts with an average score of 90%, 7 closed charts with an average score of 95%, for a total of 23 charts audited with an overall average score of 91%.</p>				
<p>Review Notes-2QFY25: The SAS department continued to offer outpatient substance abuse treatment services in Wichita Falls and eight rural centers with nine licensed Counselors, three Counselor Interns, two Recovery Coaches, and one fulltime and one parttime clerk. Currently, the department is operating with two unfilled vacancies for substance abuse counselors.</p> <p>During this second quarter, internal QM audits were completed on 16 open charts with an average score of 91%, 10 closed charts with an average score of 92%, for a total of 26 charts audited with an overall average score of 92%.</p>				
<p>Review Notes-3QFY25: The SAS department continued to offer outpatient substance abuse treatment services in Wichita Falls and eight rural centers with eight licensed Counselors, four Counselor Interns, two Recovery Coaches, and one fulltime and one parttime clerk. Currently, the department is operating with two unfilled vacancies for substance abuse counselors.</p>				

Attachment F-Substance Abuse Services

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During this third quarter, internal QM audits were completed on 12 open charts with an average score of 93%, 16 closed charts with an average score of 93%, for a total of 28 charts audited with an overall average score of 93%.

Review Notes-4QFY25: The SAS department continued to offer outpatient substance abuse treatment services in Wichita Falls and eight rural centers with nine licensed Counselors, two Counselor Interns, two Recovery Coaches, and one fulltime and one parttime clerk. Currently, the department is operating with two unfilled vacancies for substance abuse counselors. During this fourth quarter, internal QM audits were completed on 14 open charts with an average score of 89%, 10 closed charts with an average score of 93%, for a total of 24 charts audited with an overall average score of 91%.

Review Notes- Overview FY25: The SAS department finished FY25 with nine licensed counselors (one out on FMLA), two Counselor Interns, two Recovery Coaches, and one parttime clerk. We are currently two counselors short in WF and our fulltime Clerk is in the process of being filled. Internal QM audits totaled 101 charts with an overall average of 92% consisting of 58 open charts averaging 91% and 43 closed charts averaging 93%.

Objective # 1.2	Ensuring Accuracy - TAC Rule §564.8: The provider shall report information fairly, professionally, and accurately when providing services and when communicating with other professionals, the Commission, and the general public. Each provider shall document and assign credit to all contributing sources used in published materials or public statements. Providers shall not misrepresent either directly or by implication professional qualifications or affiliations.			
Audits	1QFY25	2QFY25	3QFY25	4QFY25
	Target met.	Target met.	Target met.	Target met.
	Review Notes-1QFY25: No reported issues.			
	Review Notes-2QFY25: No reported issues.			
	Review Notes-3QFY25: No reported issues.			
	Review Notes-4QFY25: No reported issues.			

Objective # 1.3	Ensuring Confidentiality - TAC Rule §564.13: The provider shall protect the privacy of individuals served and shall not disclose confidential information without express written consent, except as permitted by law. The provider shall remain knowledgeable of, and obey, all State and Federal laws and regulations relating to confidentiality of records relating to the provision of services. The provider shall not discuss or divulge information obtained in clinical or consulting relationships except in appropriate settings and for professional purposes that demonstrably relate to the case. Confidential information acquired during the delivery of services shall be safeguarded from illegal or inappropriate use, access, and disclosure from loss, destruction or tampering. These safeguards shall protect against verbal disclosure, prevent unsecured maintenance of records, or recording of an activity or presentation without appropriate releases.
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Attachment E-Substance Abuse Services

Revised: November 2023: Meeting minutes of Board of Trustees approval will be on file.

	Target <ul style="list-style-type: none"> When referrals were needed, this form was completed, signed, and uploaded to EMR. No reports of loss of client record or documentation -100% compliance. 			
Confidentiality	1QFY25	2QFY25	3QFY25	4QFY25
	Target met.	Target met.	Target met.	Target met.
Review Notes-1QFY25:				
<ul style="list-style-type: none"> 100% compliance on forms completed, signed, and uploaded to EMR when referrals were needed. 100% compliance related to no reports of loss of client record or documentation. 				
Review Notes-2QFY25: 100% compliance.				
Review Notes-3QFY25: 100% compliance.				
Review Notes-4QFY25: 100% compliance.				

Objective # 1.4	Ensuring the Client Bill of Rights - TAC Rule §564.701: All elements noted within the cited TAC Rule will be provided to all individuals and their legally authorized representatives upon admission into the Helen Farabee Centers Substance Abuse out-patient services. (HFC # 481- Client Bill of Rights). Target: At least 85% compliance on audit question SAS # 13, and RTC - Olney # 16 Any correctable documentation will be completed no later than 14 days following discovery. No substantiated rights violations in a quarter.			
Bill of Rights	1QFY25	2QFY25	3QFY25	4QFY25
	Target met.	Target met.	Target met.	Target met.
Review Notes-1QFY25: Client Bill of Rights (HFC form #481) were completed on the EMRs audited during the first quarter of FY25.				
Review Notes-2QFY25: 100% compliance.				
Review Notes-3QFY25: 100% compliance.				
Review Notes-4QFY25: 100% compliance.				

Objective # 1.5	Ensuring the Process for Grievances - TAC Rule §564.702: All elements noted within the cited TAC Rule will be provided to all individuals and their legally authorized representatives upon admission into the Helen Farabee Centers Substance Abuse out-patient services. (HFC # 489- Grievance Procedure). Target: At least 85% compliance on audits. Any correctable documentation will be completed no later than 14 days following discovery. No substantiated grievances in a quarter.			
Grievances	1QFY25	2QFY25	3QFY25	4QFY25
	Target met.	Target met.	Target met.	Target met.
Review Notes-1QFY25: There were no grievances received this quarter.				
Review Notes-2QFY25: 100% compliance - no grievances received.				

Attachment E-Substance Abuse Services

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Review Notes-3QFY25: 100% compliance - no grievances received.
Review Notes-4QFY25: 100% compliance - no grievances received.

Goal # 2	Managing the Wait List Utilization Management			
Objective # 1	Substance Use Disorders Utilization Management Guidelines: The provider will ensure timely and accurate reporting of individuals who are placed on a treatment wait list. Target: All individuals will be tracked on Wait List and interim services provided as required.			
Wait List	1QFY25	2QFY25	3QFY25	4QFY25
	Target met.	Target met.	Target met.	Target met.
Review Notes-1QFY25: Individuals seeking SUD outpatient treatment services that could not be seen on contact were placed on the CMBHS waitlist according to HFC establish priority list. Interim services or weekly contact was completed or attempted until such time as intake screening, assessment, admission paperwork, and the initial treatment plan/discharge plan and/or space in the outpatient substance abuse services treatment programs became available.				
Review Notes-2QFY25: 100% compliance.				
Review Notes-3QFY25: 100% compliance.				
Review Notes-4QFY25: 100% compliance.				

Goal # 3	Ensuring opportunities for feedback.			
Objective # 1	Individuals served will be offered the opportunity to complete a satisfaction survey in order to obtain input from them on services and experiences: A satisfaction survey is provided to individuals to complete after 45 days of service but no later than discharge. Within the HFC website, a satisfaction survey is available; known as Community Voice- Substance Abuse Services. Target: No more than one substantiated complaint per quarter via satisfaction surveys that were attributed to the staff's actions in services.			
Satisfaction Surveys	1QFY25	2QFY25	3QFY25	4QFY25
	Target met.	Target met.	Target met.	Target met.
Review Notes-1QFY25: There were no substantial complaints on the thirty-four (34) paper copies of the satisfaction surveys returned and uploaded to the Network file. There were no satisfaction surveys completed on the electronic platform.				
Review Notes-2QFY25: No substantial complaints on the thirty-six (36) paper copies of the satisfaction surveys returned and uploaded to the QM-SAS Network folder.				
Review Notes-3QFY25: No substantial complaints on the ten (10) paper copies of the satisfaction surveys returned and uploaded to the QM-SAS Network folder.				
Review Notes-4QFY25: No substantial complaints on the twenty-nine (29) paper copies of the satisfaction surveys returned and uploaded to the QM-SAS Network folder.				

Attachment E-Substance Abuse Services

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Goal # 4	Incidents involving any individual served by Helen Farabee Centers will be recorded on designated forms; and submitted for review in accordance with local procedures. Health and Human Services Committee (HHSC) may require additional reporting for specific critical incidents.			
Activity Description	Reporting all incidents, injuries, or death of individuals in services. TAC Rule §564.509: All Staff with direct knowledge will record and report any incidents/injuries in accordance with Safety, Death Reporting or Department procedures; and completion of the HHSC # 6108- HHSC Substance Abuse Treatment Facility Incident report. Target: No incidents or injuries which were attributed to the staff's neglect			
Incidents	1QFY25	2QFY25	3QFY25	4QFY25
	0 incidents or injuries reported	0 incidents or injuries reported	0 incidents or injuries reported	0 incidents or injuries reported
Review Notes-1QFY24: 0 – Sept, 0- Oct, 0-Nov				
Review Notes-2QFY24: 0 – December, 0 - January, February - 0				
Review Notes-3QFY24: 0 – March, 0 – April, and 0 – May.				
Review Notes-4QFY24: 0 – June, 0 – July, and 0 – August				

Goal # 5	Sub-Contracting Monitoring will occur as it relates to the utilization and service issues on the Psychiatric Emergency Service Center (PESC) and Senate Bill (SB-292) funding for in-patient bed days and as it relates to the Outreach Screening, Assessment, and Referral (OSAR) process.			
Objective # 5.1	Psychiatric Emergency Service Center (PESC) and Senate Bill (SB-292) funding Performance Contract. Require that any subcontracted provider provide rapid crisis stabilization, inpatient substance use disorders, and detoxification beds. Furnish notification of any change in the licensure status or accreditation status of the subcontractor's facility where these are provided. Target: No unapproved spending over the allotment without approval.			
PSEC/ SB 292	1QFY25	2QFY25	3QFY25	4QFY25
Review Notes-1QFY25: No unauthorized funds were spent.				
Review Notes-2QFY25: No unauthorized funds were spent.				
Review Notes-3QFY25: No unauthorized funds were spent.				
Review Notes-4QFY25: No unauthorized funds were spent.				

Attachment E-Substance Abuse Services

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Objective # 5.2:	<p>Outreach Screening, Assessment, and Referral (OSAR) process. Performance Contract: Program Administrator and/or Clinical Manager will ensure ongoing review and monitoring of performance contract items to ensure requirements are met and any likelihood of financial withholdings will be mitigated.</p> <p>The OSAR will complete clinical record reviews and will provide to the Program Administrator as a method to monitor OSAR services.</p> <p>Target: At least 85% compliance with clinical record reviews or audit.</p>			
OSAR Audits	1QFY25	2QFY25	3QFY25	4QFY25
Review Notes-1QFY25: OSAR clinical record reviews were 100%				
Review Notes-2QFY25: OSAR clinical record reviews were 100%				
Review Notes-3QFY25: OSAR clinical record reviews were 100%				
Review Notes-4QFY25: OSAR clinical record reviews were 100%				

Attachment E-Substance Abuse Services

Revised: November 2023: Meeting minutes of Board of Trustees approval will be on file.

FY 2025 QM Plan for Continuous Quality Improvement (CQI)

Annual Projects Attachment H

Project # 1	Literacy
Activity Description:	<p>The Quality Management department will identify community literacy level and HFC forms, documents, or signage related to accessing services.</p> <p>Perform SMOG literacy test on forms, documents, and signs identified.</p> <p>Rewrite documents that score above the community literacy level.</p>
Tools:	SMOG literacy tool
Staff Responsible	Utilization and Quality Management Departments
Frequency:	Annual
Target:	Forms, documents, or signs related to accessing services will undergo the SMOG literacy test. At the end of the year, 50% of identified forms, documents, or signage will meet the community literacy level.
1st Quarter	LOC Verification form was asked to be translated into Spanish and reduced literacy level. Reduced literacy level forms were distributed to staff.
2nd Quarter	Two folders within the Policy and Procedure Shared Folder were added for reduced literacy forms called “Alternate Reading Level Forms & Alternate Reading Level Letters”. Sub folders were also added for Spanish versions.
3rd Quarter	<p>Group participation forms were added to the forms folder with lower literacy levels:</p> <p>Form # 14 – CAS Services Group Participant Agreement</p> <p>Form # 14 – 8th grade CAS Services Group Participant Agreement</p> <p>Form # 152 – Adult Services Group Participation Agreement</p> <p>Form # 152 – 8th grade Adult Services Group Participation Agreement</p> <p>Form # 153 – TCOOMMI Services Group Participation Agreement</p> <p>Form # 153 – 9th grade TCOOMMI Services Group Participation Agreement</p>

Attachment H- CQI Annual Projects

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4th Quarter	Form # 157 – Supported Employment Closure Letter – Spanish Form # 704 – Adult & Client Information Forms – Spanish
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Project # 2	Increase Skills Training Services
Activity Description:	The Quality Management and Utilization Management team will train, mentor, and encourage case managers to provide quality skills training. Provide a Skills Training Refresher Training to case managers. Provide ongoing skills training. Monitor skills training hours compared to direct time for HFC case managers and center managers carrying a case load. Peers and Wood Group employees are not counted in the total. (Note: this will not match MBOW reporting)
Tools:	Approved curriculum – A3 framework (attached)
Staff Responsible	Quality and Utilization Management team.
Frequency:	Large training provided in October, monthly training for trainers.
Target:	Increase skills training to 30% of HFC case manager direct time.
1st Quarter	Sept- 268.95 skills hrs./ 1124.26 total hrs.= 23.92%- Not Met Oct- 337.72 skills hrs./ 1208.97 total hrs.= 27.93%- Not Met Nov- 345.83 skills hrs./ 1111.99 total hrs.=31.10%- MET
2nd Quarter	Dec- 375.48 skills hrs./ 1168.22 total hrs.=32.14% - MET Jan- 357.46 skills hrs./ 1229.57 total hrs. = 29.07%- Not Met Feb- 318.75 skills hrs./ 1205.14 total hrs.= 26.45%- Not Met
3rd Quarter	Mar- 331.00 skills hrs./ 1403.10 total hrs.= 23.59%- Not Met Apr- 376.02 skills hrs./ 1537.30 total hrs.= 24.45%- Not Met May- 353 skills hrs./ 1318.91 total hrs.= 26.76%- Not Met
4th Quarter	June-384.33 skills hrs./ 1380.54 total hrs. = 27.83%- Not Met July- 373.73 skills hrs. /1313.84 total hrs. = 28.44%- Not Met Aug- 354.85 skills hrs./ 1365.56 total hrs.= 26%- Not Met

Attachment H- CQI Annual Projects

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Project # 3	Quality Measures
Activity Description:	<p>Helen Farabee Centers will participate in HHSC data and evaluation activities as outlined in the T-CCBHC Quality Measure Workbook.</p> <ul style="list-style-type: none"> • Time to Services (I-Serv) • Depression Remission at six months (DEP-REM-6) • Preventive Care Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC). • Screening for Social Drivers of Health (SDOH) • Controlling High Blood Pressure (CBP-AD) • Follow-Up after Hospitalization for Mental Illness (FUH). <p>Helen Farabee will review outcomes for trends and patterns to ensure the center is meeting quality goals and objectives.</p>
Tools:	T-CCBHC criterion and Quality Measure Workbook
Staff Responsible:	Quality Management Team
Frequency:	Annual
Target:	100% of above data points are able to be produced for reporting.
1st Quarter	All reports are able to be completed in SQL.
2nd Quarter	<p>Received and reviewed calendar 2023 box plot quality measures from CCHBHC initiative.</p> <p>Summary of results:</p> <ol style="list-style-type: none"> 1. We're really good at getting people in quickly. 2. We need to get our NMDOH Screening Tool built- Built and started in FY 2024. 3. Other screenings <ol style="list-style-type: none"> a. Adult alcohol and counseling – needs work b. 30d hospitalization follow-up needs work c. ED Visit follow-up is all 0s because we don't have data d. Controlling Hypertension looks good

Attachment H- CQI Annual Projects

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3rd Quarter	Attending webinars to understand measures and improve. Attended the Depression Remission series.
4th Quarter	Finalizing numbers from submission. All reports listed above were able to be gathered.

Project # 4	Death Review
Activity Description:	The Director of Utilization and Quality Management will review significant events such as deaths in accordance with Procedure 800.2.2- Reporting a Death of a Mental Health Person Served and 800.2.2.1- Death Review Process-All Services Significant events can be defined as: Suicide or suicide attempts Fatal or non-fatal overdose Any Death of a person receiving services
Tools:	HFC Form #25-Report of Death of a Person Served, 8490 HHSC - Report of Death, 8492-Preliminary Review
Staff Responsible:	Director of Utilization and Quality Management, Medical Director, other appointed members of Death Review Committee.
Target:	100% of known deaths will be reviewed in accordance with Procedure.
1st Quarter	1 death was reviewed by committee. 100% of deaths were reviewed.
2nd Quarter	No deaths were required to be reviewed by committee. 100% of deaths were reviewed per procedure.
3rd Quarter	No deaths were required to be reviewed by committee. 100% of deaths were reviewed per procedure.
4th Quarter	3 deaths were required to be reviewed by committee. 100% of deaths were reviewed per procedure.

Attachment H- CQI Annual Projects

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Project # 5	30-Day hospital re-admission
Activity Description:	The Director of Utilization and Quality Management will review significant events such as 30-day hospital readmissions for psychiatric or substance use reason. Monitor and track individuals returning to the community after hospital discharge. Share information in Improvement and Oversight Committee
Tools:	CARE database, 292-Report, Target Report
Staff Responsible:	Director of Utilization and Quality Management will report to the Improvement and Oversight Committee.
Target:	100% of rehospitalizations within 30 days will be reviewed and reported.
1st Quarter	3 clients hospitalized in the 1 st quarter and were reviewed and reported to IOC.
2nd Quarter	3 adults and 1 child were re-hospitalized during the 2 nd quarter. These were reported and reviewed in IOC.
3rd Quarter	CARE states 18 readmissions for the 3 rd quarter. See email from Darla 6/9. From Cara 3 additional clients were re- hospitalized on 292 (2) and on PESC (1).
4th Quarter	CARE states there were 28 readmissions for the 4 th quarter. Additional 7: (3) PESC, 0 PPB, (3) 292, (1) Wise

Attachment H- CQI Annual Projects

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**FY 2025 QM Plan of Early Childhood Intervention (ECI) Services
Attachment I**

Early Childhood Intervention Services				
Expectation # 1	The ECI Program will serve 202 children per month per the Performance Contract. Target: Average monthly enrollment is 190 children or more.			
Activity Description:	The ECI Program Director will monitor enrollment to ensure the program is adequately identifying, enrolling, and maintaining services for contracted number of children.			
Tools:	T-Kids Data Base (TRAD) State Enrollment Report / Provider Soft Active Child Report			
Frequency:	Monthly			
Target:	Performance Target: Average monthly enrollment is 190 children or more.			
# of children monthly	1QFY25	2QFY25	3QFY25	4QFY25
	186	180	182	192
Review Notes-1QFY25: September – 186, October 186, November – 185. Average monthly enrollment for the 1st Quarter was 186, which is 16 less than the Performance Contract number and 4 less than the Performance Target number. Referrals and Enrollments have remained steady; however, discharges have increased. Further analysis of discharges and implementation of an action plan to include supervisory review before discharge is in initial implementation stage.				
Review Notes-2QFY25: December – 182, January – 179, February – 180. Average monthly enrollment for the 2nd Quarter was 180, which is 22 less than the Performance Contract number and 10 less than the Performance Target number. Efforts are underway to carefully analyze admission and discharge data, as well as increase Child Find efforts.				
Review Notes-3QFY25: March – 177, April – 181, May – 187. Average monthly enrollment for the 3rd Quarter was 182, which indicates improvement but remains below the Performance Contract number and Performance Target number.				
Review Notes-4QFY25: June – 189, July – 193, August – 195. Average monthly enrollment for the 4th Quarter was 192, which is above the performance target but remains below the contract number.				

Expectation # 2	Timely Service Delivery New ECI services will be provided to a child served within 28 days of the parent’s signature on the Initial Individual Family Service Plan (IFSP).			
Activity Description:	The ECI Clinical Supervisors and ECI Data Manager will review reports for timely delivery of new/ initial services.			
Tools:	HHSC-ECI 28-day timeline report (Extranet) / Provider Soft 28-day Report			
Frequency:	Monthly/Quarterly/Annually			

Attachment I-Early Childhood Intervention Services
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FY 2025 QM Plan of Early Childhood Intervention (ECI) Services Attachment I

Target:	Performance Target: 100% timely services delivered			
Service Delivery	1QFY25	2QFY25	3QFY25	4QFY25
	97.53%	100%	100%	97%
Review Notes-1QFY25: September – 100% compliant, October – 92.59% compliant, November – 100% compliant. 2 SST services missed the 28-Day Timeline in October. 1 SST service was not timely due to the EIS/SC transposing the family’s phone number. The second SST service was not timely due to the EIS/SC not offering a service date/time within the 28-Day Timeline.				
Review Notes-2QFY25: December – 100% compliant, January – 100% compliant, February – 100% compliant				
Review Notes-3QFY25: March – 100% complaint, April – 100% complaint, May – 100% compliant				
Review Notes-4QFY25: June – 100% compliant, July – 96% compliant, August – 94% compliant. (3 total services were delayed: July-1 (OT), Aug-2 (PT, SST). OT was assigned late; PT’s limited scheduling capacity and EIS illness/inability to reschedule timely resulted in delays.)				

Expectation # 3	The Individual Family Service Plan (IFSP) will be completed in a timely manner as indicated per the Performance Contract. The ECI staff will ensure the IFSP is completed within 45 days of the referral date.			
Activity Description:	The ECI Program Director will review reports for timely completion of the IFSP.			
Tools:	TRAD Enrollment Report / Provider Soft 45 Day Deadline Report			
Frequency:	Monthly/Quarterly/Annually			
Target:	Performance Target: 100%			
IFSP timely	1QFY25	2QFY25	3QFY25	4QFY25
	100%	100%	100%	100%
Review Notes-1QFY25: 100% compliant; 5 out of the 55 Initial IFSPs were a “Family” reason.				
Review Notes-2QFY25: 100% compliant; 3 out of the 55 Initial IFSPs were a “Family” reason.				
Review Notes-3QFY25: 100% compliant; 10 out of the 61 Initial IFSPs were a “Family” reason.				
Review Notes-4QFY25: 100% compliant; 7 out of the 59 Initial IFSPs were a “Family” reason.				

Attachment I-Early Childhood Intervention Services
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**FY 2025 QM Plan of Early Childhood Intervention (ECI) Services
Attachment I**

Expectation # 4	<p>The Transition Process is completed timely based on identified timeframes as evidenced by the child’s birthdate, ECI referral date, IFSP date, IFSP Transition Steps and Services and updates.</p> <ol style="list-style-type: none"> 90-days before a child’s 3rd birthday, the IFSP will include transition steps and services. 90-days before a child’s 3rd birthday, notification is made by ECI staff to the local school district if the child is determined potentially eligible for special education services. 90-days before a child’s 3rd birthday, a transition conference is held between ECI staff and the local school district staff if the child is determined potentially eligible for special education services or if the parent requests. 			
Activity Description	The ECI Data Manager and ECI Program Director will review reports for timely transition steps.			
Tools:	HHSC-ECI Quarterly Report for Indicator 8a, 8b, 8c (Extranet) / Provider Soft Transition Report			
Frequency:	Quarterly			
Target:	Performance Target: 100%			
Transition Process	1QFY25 98.04%	2QFY25 100%	3QFY25 100%	4QFY25 100%
Review Notes-1QFY25:				
<ol style="list-style-type: none"> 8A – 100% compliant 8B – 94.12% compliant; 1 out of the 17 LEA Notifications was not sent timely due to the family not signing the consent to release information in time for the LEA Notification to be sent in a timely manner. We learned in November 2024 that “Family” reasons for 8B (Notification to Part B) not being sent timely will be considered non-compliant. We have since implemented strategies to ensure compliance. 8C – 100% compliant 				
Review Notes-2QFY25:				
<ol style="list-style-type: none"> 8A – 100% compliant 8B – 100% compliant 8C – 100% compliant 				
Review Notes-3QFY25:				
<ol style="list-style-type: none"> 8A – 100% compliant 8B – 100% compliant 8C – 100% compliant 				
Review Notes-4QFY25:				
<ol style="list-style-type: none"> 8A – 100% complaint 8B – 100 % compliant 8C – 100% compliant 				

Attachment I-Early Childhood Intervention Services
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**FY 2025 QM Plan of Early Childhood Intervention (ECI) Services
Attachment I**

Expectation # 5	The ECI program will deliver a total of 2.74 hours/ per child/per month.			
Activity Description:	1. The ECI Clinical Supervisor and ECI Data Manager will track service hours to ensure the delivery of services with the child/family. 2. ECI Data Manager runs the delivered services reports by the 20 th of each month.			
Tools:	HHSC-ECI Monthly Services Reports (Extranet) / Provider Soft Activity Summary Report by Provider			
Frequency:	Monthly			
Target:	Performance Target: Average 2.74 hours/ per child/per month.			
Service Hours	1QFY25	2QFY25	3QFY25	4QFY25
	1.67 hours	1.69 hours	1.88 hours	1.84 hours
Review Notes-1QFY25: September – 1.60 hours, October – 1.92 hours, November – 1.50 hours; more intensive efforts are underway to examine ways in which to increase delivered service hours, including weekly feedback to staff regarding productivity and percent delivered verses planned.				
Review Notes-2QFY25: December – 1.66 hours, January – 1.83 hours, February – 1.59 hours; individual meetings are in process with staff to address service planning and delivery, including a written plan of improvement if needed.				
Review Notes-3QFY25: March – 1.86 hours, April – 1.85 hours, May – 1.93 hours – evidence of a steady increase in average delivered hours/month! I do expect this to continue to increase as we hired a full-time PT in July.				
Review Notes- 4QFY25: 4QFY25: June – 1.95 hours, July – 1.87 hours, August – 1.70 hours				

Attachment I-Early Childhood Intervention Services

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FY 2025 QM Plan of Early Childhood Intervention (ECI) Services Attachment I

Expectation # 6	<p>Outcomes of the Child demonstrate improvement in the following domains:</p> <ol style="list-style-type: none"> 1. Positive social-emotional skills (including social relationships). <ul style="list-style-type: none"> • Performance Target: 69.51% (children who substantially increased their rate of growth upon exit). • Performance Target: 46.30% (children functioning within age expectations upon exit). 2. Acquisition and use of knowledge and skills (including early language/ communication). <ul style="list-style-type: none"> • Performance Target: 77.11% (children who substantially increased their rate of growth upon exit). • Performance Target: 35.31% (children functioning within age expectations upon exit). 3. Use of appropriate behaviors to meet their needs. <ul style="list-style-type: none"> • Performance Target: 77.47% (children who substantially increased their rate of growth upon exit). • Performance Target: 44.14% (children functioning within age expectations upon exit). 			
Activity Description:	<ol style="list-style-type: none"> 1. ECI team members rate each newly enrolled child who is 30 months of age or younger upon development of the child’s initial IFSP, annual IFSP, and at exit. 2. ECI Data Manager will ensure reporting occurs for all applicable children on a monthly basis. 3. ECI Clinical Supervisors and Program Director will review results on a quarterly basis to improve outcomes for children and families. 			
Tools:	T-Kids Data Base (TRAD) Entry, Annual and Exit COSF report / Provider Soft Enrolled, Annual IFSP and Exit Reports			
Frequency:	Quarterly / Annually			
Targets:	Noted above.			
Domains	1QFY25	2QFY25	3QFY25	4QFY25
Positive social-emotional skills (including social relationships):	A. 64.5% B. 40.0%	A. 54.5% B. 36.8%	A. 64.3% B. 41.2%	A. 55.2% B. 44.1%
Acquisition and use of knowledge and skills (including early language/ communication).	A. 72.7% B. 31.4%	A. 65.8% B. 28.9%	A. 71.0% B. 35.3%	A. 72.7% B. 35.3%

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Use of appropriate behaviors to meet their needs.	A. 74.3% B. 31.4%	A. 76.3% B. 39.5%	A. 79.4% B. 38.2%	A. 69.7% B. 44.1%
Review Notes-1QFY25: Further analysis of COSF ratings at initial evaluation and discharge is warranted to identify areas for targeted training.				
Review Notes-2QFY25: Additional training initiated in March 2025 will continue on a periodic basis. COSF review/feedback to staff is now incorporated in greater detail with monthly eligibility reviews in an effort to improve achievement of goals.				
Review Notes-3QFY25: Some improvement(s) noted; however, ratings do not accurately reflect the improvements children have made while receiving services in ECI. This continues to be a training need. Due to the time-consuming nature of the rating system, lack of consistency in application of the ratings persists.				
Review Notes-4QFY25: Training has proven a challenge in impacting ratings and reflecting improvement in children's outcomes. A peer review of COSF ratings will be implemented by 2nd quarter FY2026 in an effort to achieve targets.				

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Expectation # 7	<p>a) Family outcomes and indicators of family capacity are measured annually using a comprehensive family survey of the following areas:</p> <ol style="list-style-type: none"> 1. Family Perceptions of ECI Services -Extent to which early intervention services helped families know their rights. Performance Target: 87% 2. Family Perceptions of ECI Services-- Extent to which early intervention services helped families communicate their child’s needs. Performance Target: 88%. 3. Family Perceptions of ECI Services- Extent to which early intervention services helped families help their children develop and learn. Performance Target: 88% <p>b) Family satisfaction with ECI services is measured for enrolled children upon discharge.</p>			
Activity Description:	<p>a) Local ECI staff administer the delivery of the family survey to a statistically valid sampling of families as directed by HHSC-ECI. ECI Program Director utilizes survey results to improve family outcomes.</p> <p>b) Upon discharge from ECI services, all families are mailed a letter requesting completion of the 10-question HFC-ECI survey located on the HFC website.</p>			
Tools:	<p>a) HHSC-ECI Family Outcomes Survey b) HFC-ECI Survey / Survey Monkey</p>			
Frequency:	<p>a) Annually b) Monthly / Quarterly / Annually</p>			
Target:	Noted above.			
Family Surveys	1QFY25	2QFY25	3QFY25	4QFY25
Review Notes-1QFY25:				
<p>a) N/A – annual HHS-ECI surveys will be delivered sometime between May – July 2025. b) N/A – no surveys received this quarter.</p>				
Review Notes-2QFY25:				
<p>a) Results of the FY24 Family Outcomes Surveys show significant improvement from FY23! With a 37% return rate, only one area was below 90% in terms of positive responses. Three areas achieved above 95%. The area below 90% represents questions related to the family’s ability to access services after they leave ECI, including talking with families who have a child with similar needs. Overall, very positive survey outcomes! Survey results have been discussed with staff with plans for continued discussion and development of a plan to better address family needs.</p> <p>b) N/A – no surveys received this quarter.</p>				
Review Notes-3QFY25:				
<p>a) 2025 Surveys were distributed by staff in June/July of this year. Return rates were 30%. b) N/A – no surveys received this quarter.</p>				

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Review Notes-4QFY25:

- a) 2025 Surveys return rate increased to 69.57%; results were received in Q1FY26 and will be reported within the FY26 QM report.
- b) N/A – no surveys received this quarter.

Expectation # 8	Incidents involving any individual served, employed or contracted by Helen Farabee Centers are recorded on designated forms, and submitted for review in accordance with local procedures.			
	<ul style="list-style-type: none"> ➤ Consumer Incident and Injuries (HFC # 27) ➤ Employee Incidents and Injuries. (HFC # 317) ➤ Vehicle Incidents/Accidents. (HFC # 120) 			
Activity Description	All Staff with direct knowledge will record and report any incidents/injuries in accordance with Safety and Department procedures.			
Activity Description:	<ul style="list-style-type: none"> • Designated Human Resource/ Risk Management staff will review all consumer and employee incidents and injuries reports. • Designated Business Office staff will review all vehicle incidents or accidents. 			
Activity Description:	The Clinical and Environmental Committee reviews all incidents for the purpose of mitigating risks, identifying patterns or trends, and identifying performance improvement opportunities.			
Tools:	Designated Forms and Report formats.			
Frequency:	Monthly			
Target:	No incidents or injuries which were attributed to the staff's neglect			
Incidents	1QFY25	2QFY25	3QFY25	4QFY25
	0	2	0	0
Review Notes-1QFY25: September – No accidents or injuries reported. October – No accidents or injuries reported. November – No accidents or injuries reported.				
Review Notes-2QFY25: December- No accidents or injuries reported. January- One incident and one death reported. February – No accidents or injuries reported.				
Review Notes-3QFY25: March – No accidents or injuries reported. April – No accidents or injuries reported. May – No accidents or injuries reported.				
Review Notes-4QFY25: June – No accidents or injuries reported. July – No accidents or injuries reported. August – No accidents or injuries reported.				

Attachment I-Early Childhood Intervention Services

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FY 2025 QM Plan

Subcontracting – Person-centered Care Attachment J

Expectation # 1	<p>The reporting and monitoring of subcontracts which are person-centered care services will be conducted using required elements of the services.</p> <ul style="list-style-type: none"> • The Wood Group (Crisis Respite Unit, Extended Living Center, Hospital Transition Home) • Wise Behavioral Health Services • Red River Hospital <p>The elements specifically reviewed in accordance with Texas Administrative Code</p> <ul style="list-style-type: none"> • Competency of the Contractor to provide care. • Consumer’s access to services. • Safety of the environment in which services are provided. • Continuity of care. • Compliance with performance expectations. • Training and Technical Assistance. <p>Target: All required elements will be monitored, and any deficiencies will be addressed.</p>			
Subcontractors	1QFY25	2QFY25	3QFY25	4QFY25
The Wood Group	Received	Received	Received	Not received
Medical City	Received	NA	NA	Not received
Red River Hospital	Received	Received	Not received.	Not received
The Pavilion	Received	Different Quarters	Not received.	Not received
Millwood Hospital	Received	Received	Not received. Different quarters	Received
Perimeter	Received	Received	Not received.	Not received.
Review Notes-1QFY25: All received				
Review Notes-2QFY25: Added Oceans - Received				
Review Notes-3QFY25: No longer contracting with Medical City, effective 1/31/2025. Have not received information from Red River, multiple reminders have been sent to. Oceans- not received. Reminders have been sent to all subcontractors.				
Review Notes-4QFY25: Oceans sent 4 th quarter information. We received RRH 3 rd quarter information late. Emails have been sent for information and have not been received.				

Attachment J-Subcontracting

Approved September 2024: Meeting minutes of the Board of Trustees approval will be on file.

Page 1 of 1

AGENDA ITEM: 030526-5E1

MEETING DATE: MARCH 5, 2026

5 RECOMMENDATIONS
E. POLICIES AND PROCEDURES
1) POLICY STATEMENTS

Page 1 of 1

RECOMMENDED ACTION: The Board of Trustees approves the attached Policy Statement.

- 800.2 General Services for Individuals Policy Statement – No changes

HELEN FARABEE CENTERS	
CLINICAL ACCOUNTABILITY POLICY 800.2	
SECTION: GENERAL SERVICES FOR INDIVIDUALS	
SUBJECT: POLICY STATEMENT	Page 1 of 1

EFFECTIVE: 3/5/2026	ORIGINAL: 03/03/2016
APPROVED BY: Cara Mullenix	APPROVED BY: Andrew Martin
Cara Mullenix-Artigue Director of Utilization and Quality Management	Andrew Martin Associate Executive Director of Operations
CONCURRED: Gianna Harris	APPROVED BY:
Gianna Harris Executive Director	J. Brian Eby Vice-Chair, Board of Trustees

POLICY:

1. It is the policy of the Board of Trustees to have established procedures that are utilized across the services of all individuals served by Helen Farabee Centers. Procedures covered in this section include:
 - The review/reporting of any deaths of individuals served.
 - The use of Interpreter Services for individuals served.
 - To use plain language for individuals served, considering Limited English Proficiency (LEP).
 - Orientation material provided to individuals served during Intake processes.
 - Procedures established for center-wide appointment attendance standard.
 - Use of Telehealth Services.
 - Procedure established for the self-administration of medication assessment.

Signature: *Cara Mullenix*

Email: mullenixc@helenfarabee.org

Signature: *Andrew Martin*
Andrew Martin (Feb 6, 2026 13:42:45 CST)

Email: martina@helenfarabee.org

Signature: *Gianna Harris*
Gianna Harris (Feb 6, 2026 14:42:19 CST)

Email: harrisg@helenfarabee.org

800.2 General Services for Individuals Policy Statement

Final Audit Report

2026-02-06

Created:	2026-02-06
By:	Cara Mullenix (mullenixc@helenfarabee.org)
Status:	Signed
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"800.2 General Services for Individuals Policy Statement" History

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✔ Agreement completed.

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- 6 QUARTERLY REPORTS
 - C. EXTERNAL AUDITS
 - 1) FIRST QUARTER REPORT
-

RECOMMENDED ACTION: Information Item Only

BACKGROUND INFORMATION: On a quarterly basis, Superior, a Medicaid Managed Care Organization (MCO), reviews selected charts for purposes of compliance. This review was held November 14, 2025, and the review period was 7/1/2025 – 9/30/2025.

SUPPORTING INFORMATION: For this review, three (3) Child & Adolescent Services (CAS) charts and one (1) Adult Mental Health (AMH) charts were reviewed. Our chart compliance averaged **86.59%** and our claims compliance averaged **54.43%**. I rebutted the findings and our final average for chart compliance was **87.63%** and our final average for claims compliance was **77.31%**

SPECIFIC REASONS WHY THESE ACTIONS ARE NECESSARY FOR THE CENTER:

As an organization who contracts with MCO's Program Provider, we must be in continuous compliance with Superior as it is our largest MCO. They schedule quarterly reviews with Helen Farabee Centers and have for the past ten (10) + years. Our most recent review was held on February 26, 2026, and that review period was from 10/1/2025 – 12/31/2025.