Agenda

HELEN FARABEE CENTERS BOARD OF TRUSTEES

September 3, 2026
11:00 AM
Sue Nunn Conference Room, 1000 Brook Ave., Wichita Falls, TX

Agenda Topics

MEETING STARTS AT 11:00 A.M.	
090326-1 CALL TO ORDER	**J. Brian Eby**
A. INTRODUCTION OF GUESTS	
090326-2 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."*	
090326-3 APPROVAL OF MINUTES	**J. Brian Eby**
Recommended Action: That the Board of Trustees approves the minutes of the July 2026 Board of Trustee meetings. **Citizen Comment:**	**Page 4**
090326-4 TRAINING	
No Agenda Items	
090326-5 RECOMMENDATIONS	
A. BOARD OF TRUSTEES	
1) Ad-Hoc Committee to Recommend Slate Of Officers	**Melissa Collins**
Recommended Action: That the ad-hoc committee recommends a slate of officers for fiscal year 2027. **Citizen Comment:**	**Page 8**
B. BUDGET AND FINANCE	
1) *Financial Statements June and July*	**Linda Poenitzsch**
Recommended Action: That the Board of Trustees approves the financial statements for June and July 2026. **Citizen Comment:**	**Page 9 June** **Page 18 July**
2) *Budget FY27*	**Linda Poenitzsch**
Recommended Action: That the Board of Trustees approve the FY 2027 Center Budget. **Citizen Comment:**	**Page 27**

3) Line of credit	**Linda Poenitzsch**
Recommended Action: That the Board of Trustees approve and authorize the Board Chair and/or Secretary to sign a Borrowing Resolution to renew the line of credit with Investar Bank. **Citizen Comment:**	**Page 32**
4) Texas Council Dues	**Linda Poenitzsch**
Recommended Action: That the Board of Trustees approve the Fiscal Year 2027 Dues Commitment with the Texas Council of Community Centers and authorize the Chair and Executive Director to sign the commitment form. **Citizen Comment:**	**Page 34**
C. CONTRACTS AND PLANS	
1) Quality Management Plan	**Sandra Rapson**
Recommended Action: That the Board of Trustees review and approve the FY 2027 Quality Management Plan and joint FY 2027 Continuous Quality Improvement Plan. **Citizen Comment:**	**Page 41**
D. FACILITIES AND EQUIPMENT	
1) Plumbing Repairs at 516 Denver St.	**Bruce Sperry**
Recommended Action: That the Board of Trustees ratify the additional expenditure of $40,000.00 for sewer repairs at 516 Denver St. **Citizen Comment:**	**Page 123**
2) New Maintenance Van Replacement	**Bruce Sperry**
Recommended Action: That the Board of Trustees ratify the expenditure of $42,279.53 for the purchase of one new maintenance vehicle. **Citizen Comment:**	**Page 132**
E. POLICIES AND PROCEDURES	
1) Policy Statement Summary	**Cara Mullenix-Artigue**
Recommended Action: That the Board of Trustees review and approve the Policy Statements. • 300.1.1 Charity Care Policy Statement – No changes **Citizen Comment:**	**Page 142**
F. PROGRAM AND PERSONNEL	
1) Public Information Officer Appointment	**Connie Johnston**
Recommended Action: That the Board of Trustees delegates the responsibility of responding to Public Information Act request to a Public Information Officer and appoint Connie Johnston. **Citizen Comment:**	**Page 151**

090326-6 QUARTERLY REPORTS	
A. ESSENTIAL SERVICES AND CLINICAL ACCOUNTABILITY	
No Agenda Items	
B. PLANNING AND NETWORK ADVISORY COMMITTEE	
No Agenda Items	
C. EXTERNAL AUDITS	
1) SUD External Audits	**Cara Mullenix-Artigue**
Recommended Action: Information Only Item **Citizen Comment:**	**Page 152**
D. TEXAS COUNCIL BOARD OF DIRECTORS MEETING	
No Agenda Items	
090326-7 EXECUTIVE DIRECTOR'S REPORT	**Gianna Harris**
A. ADMINISTRATION AND BOARD OF TRUSTEES	
B. BUDGET	
C. LEGISLATIVE ISSUES	
D. SERVICES	
E. HUMAN RESOURCES	
090326-8 CLOSED SESSION	
In accordance with Chapter 551.074 of the Government Code, the Board of Trustees will now meet in closed session for the purpose of discussion of personnel matters. Continued Review and Discussion of Executive Director Evaluation	
090326-9 OPEN SESSION	
Results of Closed Session	
090326-10 ANNOUNCEMENTS	**J. Brian Eby**
A. NEXT MEETING	
11 a.m., Thursday, ***November 5, 2026*** at the Administration Building, Sue Nunn Conference Room, 1000 Brook Ave., Wichita Falls, TX.	
090326-11 OTHER BUSINESS	
090326-12 ADJOURN	**J. Brian Eby**

Minutes

HELEN FARABEE CENTERS
BOARD OF TRUSTEES

July 2, 2026
11:00 AM
TELEVIDEO &
1000 Brook Ave., Sue Nunn Conference, Wichita Falls, TX

Board of Trustee Members Present:	**J. Brian Eby,** Chairman**; David Cook, Cynthia Kessler, Jessica Traw; Kathy Thorp, Jan Driver Ward, Sheriff Darcy White, Ashley Davin**
Board of Trustee Members Absent:	**Cindy Barksdale, Tom Johnson, Dana Tilton, Sheriff Babcock**
Staff Present:	**Gianna Harris,** Executive Director; **Andy Martin**, Associate Executive Director; **Linda Poenitzsch**, Financial Operations Director; **Connie Johnston,** Director of Community, Consumer Support & Client Rights, **Cara Mullenix-Artigue**, Director of Utilization and Quality Management; **Sandra Rapson,** Quality Assurance Coordinator; **Bruce Sperry** Facilities Manager; **Kelly Wooldridge,** Director of Human Resources
Other Staff and Guests Present:	**Tom Taylor,** City Councilman and Liaison **Melissa Collins**, Board of Trustee Liaison, Recorder

AGENDA TOPICS

070226-1 CALL TO ORDER

J. Brian Eby, Board Chair, called meeting to order at 11:00 A.M. with seven (7) Board Members in attendance.

070226-2 PRESENTATIONS

A. Open Citizen Comment to The Board

No comments were presented to the Board.

070226-3 APPROVAL OF MINUTES

Recommended Action: That the Board of Trustees approves the minutes of the May 2026 Board of Trustee meeting.

The Board of Trustees reviewed and approved the minutes of the May 2026 Board of Trustee meeting.

Motion: **Jessica Traw**	Affirmative: 7
Second: **Cynthia Kesler**	Negative: 0

Citizen Comment: None

070226-4 TRAINING

Cara Mullenix-Artigue, UM/QM Services Director provided training on the Utilization and Quality Management Services. Presentations were distributed to all members in the board packet, available for review upon request.

Kelly Wooldridge, Human Resources Director provided training on the center staff and Risk Management Services. Presentations were distributed to all members in the board packet, available for review upon request.

Tom Johnson joined the meeting at 11:20 am.

Connie Johnston, Community and Consumer Support Director provided training on the social media presence, and community activities. Presentations were distributed to all members, available for review upon request.

080226 - 5 RECOMMENDATIONS

A. BOARD OF TRUSTEES

1) Committee To Review Slate Of Officers and make recommendation

Recommended Action: That the committee to review the functions of the officers and recommend a slate of officers for fiscal year 2027.

The chair appointed Jan Driver Ward, Ashley Davin, and Kathy Thorp to review the functions of the officers and recommend a slate of officers for FY2027.

Motion: **Jessica Traw**	Affirmative: 7
Second: **Cynthia Kesler**	Negative: 0

Citizen Comment: None

2) Veteran on the Board

Recommended Action: That the Board of Trustees welcomed Ashley Davin to the board.

The Board of Trustees welcomed of Ashley Davin to the board position.

Citizen Comment: None

B. BUDGET AND FINANCE

1) Financial Statements April and May

Recommended Action: That the Board of Trustees approves the financial statements for April and May 2026.

The Board of Trustees approved the financial statements for April and May 2026.

Motion: **Jessica Traw**	Affirmative: 7
Second: **Ashley Davin**	Negative: 0

Citizen Comment: None

2) 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: 7
Second: **Jan Driver Ward**	Negative: 0

Citizen Comment: None

C. CONTRACTS AND PLANS

No Agenda Items

D. FACILITIES AND EQUIPMENT

1) Plumbing Repairs at 516 Denver St.

Recommended Action: That the Board of Trustees approves the expenditure of $14,000 for sewer repairs at 516 Denver St.

The Board approved the expenditure of $14,000 for sewer repairs at 516 Denver St.

Motion: **David Cook**	Affirmative: 7
Second: **Tom Johnson**	Negative: 0

Citizen Comment: None

E. POLICY AND PROCEDURE

1) Policy Statement Summary

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

- 100.1.2 Board of Trustees Organizational Structure (Procedure),
- 100.1.11 Board of Trustees Veteran Board Members (Procedure)
- 200.1.14 Tobacco Free Policy Statement – No changes
- 300.1 Financial Services Policy Statement
- 300.5 Lease Policy Statement
- 500.1 Clients Rights Policy Statement – No changes
- 900.1.11 Jail Based Competency Restoration (JBCR) Policy Statement
- 900.12 Veterans Services – Policy Statement – No changes

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

Motion: **Jan Driver Ward**	Affirmative: 7
Second: **Ashley Davin**	Negative: 0

Citizen Comment: None

F. PROGRAM AND PERSONNEL

No Agenda Items

070226-6 QUARTERLY REPORTS

A. ESSENTIAL SERVICES AND CLINICAL ACCOUNTABILITY

1) Essential Services Report

Recommended Action: Information Only Item

Cara Mullenix-Artigue reported.

B. PLANNING AND NETWORK ADVISORY COMMITTEE

1) PNAC 3rd Quarter Report

Recommended Action: Information Only Item

Connie Johnston reported.

C. EXTERNAL AUDITS

1) SUD External Audit Report

Recommended Action: Information Only Item

Cara Mullenix-Artigue reported.

2) Superior MCO External Audit 2nd Quarter

Recommended Action: Information Only Item

Cara Mullenix-Artigue reported.

D. TEXAS COUNCIL BOARD OF DIRECTORS MEETING
No Agenda Items
070226 - 7 EXECUTIVE DIRECTOR'S REPORT
Nothing to Report.
070226-8 CLOSED SESSION
In accordance with Chapter 551.074 of the Government Code, the Board of Trustees will now meet in closed session for the purpose of deliberating the appointment, employment, evaluation, reassignment, duties, discipline, or dismissal of a public officer or employee. Review and Discussion of Executive Director Evaluation. Closed Session began at 12:21 pm. Open Session was reconvened at 12:31 pm.
070226-9 OPEN SESSION
Reconvene at 12:32 pm. No action was taken in Closed Session. Will revisit in September.
070226-10 ANNOUNCEMENTS
A. Next Meeting - The next meeting will be held at 11 A.M., Thursday, **September 3**, **2026** at the **Sue Nunn Conference Room,** Administration Bldg, 1000 Brook Ave. Wichita Falls, TX.
070226-11 OTHER BUSINESS
No other business
070226-12 ADJOURN
The Board of Trustees meeting was adjourned by **Board Chairman, J. Brian Eby** at 12:33 pm.

Approved as presented:		Approved as corrected:
September 3, 2026		September 3, 2026

5 RECOMMENDATIONS
A. BOARD OF TRUSTEES
1) AD-HOC COMMITTEE TO RECOMMEND SLATE OF OFFICERS FOR FY 2027

RECOMMENDED ACTION: That the Board of Trustees ad-hoc committee recommend a slate of officers for fiscal year 2027.

BACKGROUND INFORMATION:

A. Board of Trustee Officer appointments are for one-year terms.

B. Current Board of Trustee officers:

Chair: ***J. Brian Eby***
Current Office Term Began: April 6, 2023
Current Board Term Expires: August 31, 2026

Vice-Chair: ***Kathy Thorp***
Current Office Term Began: April 6, 2023
Current Board Term Expires: August 31, 2027

Secretary: ***Jessica Traw***
Current Office Term Began: September 1, 2025
Current Board Term Expires: resigned July 2026

SPECIFIC REASONS WHY THESE ACTIONS ARE NECESSARY FOR THE CENTER:
To allow the Board of Trustees to vote for officers prior to the new fiscal year in September 2026.

RECOMMENDED ACTION: That the Board of Trustees approves the financial statements for June 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 is 158.
- Accounts Receivable decreased by $931,102, going from $1,999,895 to $1,068,793. This was due to the Center receiving the SB292 amount for April and May of $685,447 in June. The Center also received a portion of the USDA grant money from FY2025 in the amount of $174,143.
- Accounts Payable *decreased by* $92,334, going from $1,038,298 to $945,964.
- FINANCIAL STATUS: The Center had a loss of $283,322 for June and a cumulative gain of $786,307 for the year**.**
- **REVENUE**: Overall Revenue received in June 2026 was $430,226 less than budgeted.
  - **Patient Fees** were $10,210 more than budgeted.
    - This is based on actual cash received in June for services.
  - **Miscellaneous** was $133,547 less than budgeted.
    - In-kind Match was $146,865 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 uses bed days from various contracted hospitals where we are receiving in-kind.

- USDA Grant was $12,949 more than budgeted. This grant is for the new technology equipment that MIS is buying for the company, just like cameras and TVs for Telemedicine.

➢ **Other State Funding** was $369,083 less than budgeted.
- Justice Involved Grant Program (SB292) Revenue was $361,258 less than budgeted. We were given notice from the state that we had money from FY2025 to expend in FY2026 and so the budget was increased accordingly. This is all based on need for psychiatric beds which will vary greatly from month to month.

➢ **Other Federal Funding** was $21,023 less than budgeted.
- State Hospital Step-Down program is $7,902 less than budgeted. At this time, we only have two clients in the program.
- DPP-BHS revenue is $5,624 less than budgeted. This will vary due to fewer encounters during this time last year.
- Medicaid Services are $7,869 less than budgeted.

➢ **General Revenue** was $75,218 more than budgeted.
- PESC revenue was $71,117 more than budgeted. PESC revenue fluctuates based on client need for psychiatric beds.
- Private Psychiatric Beds MH/PPB Revenue was $4,101 more than budgeted. This revenue also fluctuates based on client need for psychiatric beds.

➢ **Allocated Federal Funds** were right on budget.

❖ **EXPENSES:** Overall expense for June 2026 was $351,880 less than budgeted.

➢ **Personnel** cost was $5,172 more than budgeted.
- Salaries were $2,965 more than budgeted.
- Benefits were $2,207 more than budgeted.

➢ **Contract** cost was $249,796 less than budgeted.
- SB292 Bed Day Expense was $329,473 less than budgeted, PPB Bed Day expense was $4,208 more than budgeted, and PESC Bed Day expense was $67,232 more than budgeted. All these expenses fluctuate based on client need for the psychiatric beds.

➢ **Travel and Training** expenses were $3,786 more than budgeted. There was a Mass Violence Readiness workshop in early June that was not budgeted in advance as it was a workshop that just came up in April of 2026.

There was also some training for a doctor that we paid out that was not budgeted.

- **Capital Outlay** expense was $5,031 more than budgeted. When the adjusted budget was completed, it was without knowing that we would receive the new cars for ECI almost immediately. Our last endeavor to acquire cars took 8 months.

- **Non-Capitalized Equipment** expense was $17,416 more than budgeted. This is due to the MIS department using the funds from the USDA grant to purchase the technology equipment.

- **Pharmaceutical** expense was $3,368 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 $132,452 less than budgeted.
    - In-Kind Expense was $146,865 less 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.
    - Building Repair & Maintenance was $10,848 more than budgeted. The Center had to repair a bathroom in the CRU building, putting in a new bathtub lift installation. The Center also had some foundation repair done that was needed at the Turtle Creek property.

Helen Farabee Centers

Balance Sheet - As Of June 2026

Assets	**Actual**	
CASH GENERAL OPERATING FUND	$	7,353,857.24
CASH INTERNAL SERVICE FUND	$	2,193,498.71
CASH SELF FUNDED INSURANCE	$	475,736.00
SAVINGS	$	21,319.97
PETTY CASH FUNDS-CENTERWIDE	$	798.17
INVESTMENTS GENERAL OPERATING FUND	$	8,859,963.11
INVESTMENTS INTERNAL SERVICE FUND	$	717,281.99
ACCOUNTS RECEIVABLE	$	1,068,792.86
PREPAID	$	417,783.83
PREPAID MISCELLANEOUS-SELF INSURED FUNDS	$	458.30
DEPOSITS	$	347,628.33
DEPOSITS-SELF INSURED FUNDS	$	25,000.00
AMTS PROVIDED-PERSONAL LEAVE	$	947,522.78
LAND	$	1,057,659.65
BUILDINGS & IMPROVEMENTS	$	2,476,885.44
LEASEHOLD IMPROVEMENTS	$	132,631.17
EQUIP/FURN/FIX	$	422,095.46
COMPUTERS & PERIPHERALS	$	757,459.77
VEHICLES & CONTRACTORS EQ	$	1,924,780.72
COMPUTER SOFTWARE	$	368,100.66
ACCUMULATED DEPRECIATION	$	(4,961,205.99)
CLINICAL SOFTWARE PROJECT	$	-
WICHITA FALLS BUILDING PROJECT	$	386,012.69
ISF-MAJOR PROJECTS WORK-IN-PROGRESS	$	(1,228.23)
Total Assets	**$**	**24,992,832.63**
Liabilities and Net Assets		
Liabilities		
ACCOUNTS PAYABLE GENERAL OPERATING FUND	$	743,508.13
ACCOUNTS PAYABLE INTERNAL SERVICE FUND	$	-
ACCOUNTS PAYABLE-SELF INSURED FUND	$	72,706.90
ACCOUNTS PAYABLE-PAYABLE TO STATE	$	129,748.80
PAYROLL PAYABLE	$	509,787.26
UMR PAYABLE	$	87,233.61
EMPLOYEE DEDUCTION PAYBLE	$	10,256.35
DEFERRED REVENUE	$	2,275,535.39
ACCUM PERSONAL LEAVE-CURRENT	$	19,117.92
ACCUM PERSONAL LEAVE-LONGTERM	$	947,522.78
UMR CLAIMS PAYABLE - IBNR	$	140,000.00
Total Liabilities	**$**	**4,935,417.14**
Net Assets		
UNRESERVED-FUND BALANCE	$	13,767,404.69
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	$	(238,730.32)
RETAINED EARNINGS	$	151,301.06
Total Net Assets	**$**	**20,057,415.49**
Total Liabilities and Net Assets	**$**	**24,992,832.63**

Helen Farabee Centers
JUNE 2026 Income Statement

		JUNE 2026					YEAR TO DATE				
		JUN FY26 Actual	JUN FY26 Budget	JUNE 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	$8,333.34	$0.00	($0.01)	$83,333.33	$83,333.33	$83,333.34	$0.00	($0.01)
2-7001	CITY OF CHILLICOTHE	$27.50	$27.50	$27.50	$0.00	$0.00	$275.00	$275.00	$275.00	$0.00	$0.00
2-7002	CITY OF QUANAH	$55.00	$55.00	$55.00	$0.00	$0.00	$550.00	$550.00	$550.00	$0.00	$0.00
2-7004	CITY OF BURKBURNETT	$417.66	$417.66	$417.66	$0.00	$0.00	$4,176.66	$4,176.66	$4,176.66	$0.00	$0.00
2-7005	CITY OF GRAHAM	$1,250.00	$1,250.00	$1,250.00	$0.00	$0.00	$12,500.00	$12,500.00	$12,500.00	$0.00	$0.00
2-7006	CITY OF NOCONA	$125.00	$125.00	$125.00	$0.00	$0.00	$1,250.00	$1,250.00	$1,250.00	$0.00	$0.00
2-7007	CITY OF BOWIE	$666.67	$666.67	$666.66	$0.00	$0.01	$6,666.67	$6,666.67	$6,666.66	$0.00	$0.01
Total City Revenue		**$10,875.16**	**$10,875.16**	**$10,875.16**	**$0.00**	**($0.00)**	**$108,751.66**	**$108,751.66**	**$108,751.66**	**$0.00**	**$0.00**
County Revenue - Deferred Revenue											
2-7020	WICHITA COUNTY	$18,333.33	$18,333.33	$13,333.33	$0.00	$5,000.00	$163,333.33	$163,333.33	$119,999.98	$0.00	$43,333.35
2-7021	HASKEL COUNTY	$1,387.69	$1,387.67	$1,387.67	$0.02	$0.02	$13,876.70	$13,876.70	$13,498.20	$0.00	$378.50
2-7022	STONEWALL COUNTY	$211.89	$211.89	$176.84	$0.00	$35.05	$2,118.90	$2,118.90	$1,768.34	$0.00	$350.56
2-7023	KNOX COUNTY	$554.17	$554.17	$551.40	$0.00	$2.77	$5,541.67	$5,541.67	$5,514.00	$0.00	$27.67
2-7024	DICKENS COUNTY	$0.00	$0.00	$149.81	$0.00	($149.81)	$0.00	$0.00	$1,498.10	$0.00	($1,498.10)
2-7025	YOUNG COUNTY	$3,958.34	$3,958.34	($21,758.00)	$0.00	$25,716.34	$39,583.34	$39,583.34	$4,000.00	$0.00	$35,583.34
2-7026	THROCKMORTON COUNTY	$273.27	$273.27	$156.06	$0.00	$117.21	$2,732.67	$2,732.67	$1,560.54	$0.00	$1,172.13
2-7027	HARDEMAN COUNTY	$353.45	$353.45	$0.00	$0.00	$353.45	$3,534.43	$3,534.43	$0.00	$0.00	$3,534.43
2-7028	WISE COUNTY	$4,616.67	$4,616.67	$4,616.66	$0.00	$0.01	$46,166.66	$46,166.66	$46,166.66	$0.00	$0.00
2-7029	BAYLOR COUNTY	$433.34	$433.34	$433.34	$0.00	$0.00	$4,333.32	$4,333.32	$4,333.34	$0.00	($0.02)
2-7030	FOARD COUNTY	$110.00	$110.00	$205.99	$0.00	($95.99)	$1,100.00	$1,100.00	$2,059.90	$0.00	($959.90)
2-7031	MONTAGUE COUNTY	$8,388.03	$8,388.03	$8,107.84	$0.00	$280.19	$83,880.37	$83,880.37	$81,078.40	$0.00	$2,801.97
2-7032	JACK COUNTY	$2,956.19	$2,956.19	$1,250.00	$0.00	$1,706.19	$29,561.87	$29,561.87	$12,500.00	$0.00	$17,061.87
2-7033	CLAY COUNTY	$333.34	$333.34	$1,158.32	$0.00	($824.98)	$3,333.32	$3,333.32	$3,333.33	$0.00	($0.01)
2-7034	COTTLE COUNTY	$199.75	$199.75	$199.75	$0.00	$0.00	$1,997.50	$1,997.50	$1,997.50	$0.00	$0.00
2-7035	CHILDRESS COUNTY	$347.92	$347.92	$347.92	$0.00	$0.00	$3,479.17	$3,479.17	$3,479.18	$0.00	($0.01)
2-7036	ARCHER COUNTY SUPPORT	$964.59	$964.59	($1,874.98)	$0.00	$2,839.57	$9,645.82	$9,645.82	$0.02	$0.00	$9,645.80
Total County Revenue		**$43,421.97**	**$43,421.95**	**$8,441.95**	**$0.02**	**$34,980.02**	**$414,219.07**	**$414,219.07**	**$302,787.49**	**$0.00**	**$111,431.58**
Other Taxing Authority Funds - Deferred Revenue											
2-7038	INDEPENDENT SCHOOL DISTRICT	$265.00	$265.00	$265.00	$0.00	$0.00	$2,650.00	$2,650.00	$2,650.00	$0.00	$0.00
Total Other Taxing Authority Funds		**$265.00**	**$265.00**	**$265.00**	**$0.00**	**$0.00**	**$2,650.00**	**$2,650.00**	**$2,650.00**	**$0.00**	**$0.00**
Patient Fees - Cash Basis Only											
2-7050	CONSUMER FEES	$47,120.77	$37,924.03	$22,986.46	$9,196.74	$24,134.31	$241,961.69	$201,829.30	$178,362.30	$40,132.39	$63,599.39
2-7060	PRIVATE INSURANCE MCO CARD SERVICES	$39,754.62	$39,604.74	$32,104.74	$149.88	$7,649.88	$323,676.77	$317,047.72	$298,697.49	$6,629.05	$24,979.28
2-7070	PRIVATE INSURANCE MCO CASE MANAGEMENT	$20,590.13	$20,280.79	$18,629.38	$309.34	$1,960.75	$155,151.19	$132,968.60	$131,520.25	$22,182.59	$23,630.94
2-7080	PRIVATE INSURANCE MCO REHAB	$15,945.65	$15,391.80	$14,491.80	$553.85	$1,453.85	$126,298.00	$123,606.42	$121,263.78	$2,691.58	$5,034.22
Total Patient Fees		**$123,411.17**	**$113,201.36**	**$88,212.38**	**$10,209.81**	**$35,198.79**	**$847,087.65**	**$775,452.04**	**$729,843.82**	**$71,635.61**	**$117,243.83**
Miscellaneous - Cash Basis											
2-7037	IN-KIND MATCH	$649,298.30	$796,163.41	$1,011,628.25	($146,865.11)	($362,329.95)	$6,645,868.04	$6,981,390.14	$7,871,826.76	($335,522.10)	($1,225,958.72)
2-7100	MEDICARE - TITLE XVII	$5,250.01	$3,651.99	$3,651.99	$1,598.02	$1,598.02	$37,161.14	$30,366.11	$30,366.11	$6,795.03	$6,795.03
2-7260	RENT	$1,225.00	$1,137.50	$2,868.25	$87.50	($1,643.25)	$11,462.50	$11,375.00	$47,182.50	$87.50	($35,720.00)
2-7270	DONATIONS/CONTRIBUTIONS	$106.01	$50.00	$283.33	$56.01	($177.32)	$11,089.47	$7,730.89	$9,430.88	$3,358.58	$1,658.59
2-7272	CART EARNED REVENUE	$22,592.00	$20,864.74	$68,846.90	$1,727.26	($46,254.90)	$176,877.35	$178,587.37	$369,727.79	($1,710.02)	($192,850.44)
2-7273	OPIOID GRANT	$12,959.45	$13,226.33	$1,000.00	($266.88)	$11,959.45	$77,144.50	$68,651.86	$3,996.00	$8,492.64	$73,148.50
2-7274	USDA GRANT REVENUE- IT TECHNOLOGY	$12,949.00	$0.00	$161,194.00	$12,949.00	($148,245.00)	$12,949.00	$0.00	$161,194.00	$12,949.00	($148,245.00)
2-7275	INTEREST INCOME	$23,456.50	$23,427.57	$29,427.57	$28.93	($5,971.07)	$228,855.16	$213,040.70	$244,742.35	$15,814.46	($15,887.19)
2-7280	MISCELLANEOUS	$799.00	$3,660.92	$1,660.92	($2,861.92)	($861.92)	$34,399.70	$38,045.87	$113,250.93	($3,646.17)	($78,851.23)
Total Miscellaneous		**$728,635.27**	**$862,182.46**	**$1,280,561.21**	**($133,547.19)**	**($551,925.94)**	**$7,235,806.86**	**$7,529,187.94**	**$8,851,717.32**	**($293,381.08)**	**($1,615,910.46)**

		JUNE 2026					YEAR TO DATE				
		JUN FY26 Actual	JUN FY26 Budget	JUNE 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
Other State Funding - Accrued Basis Only											
2-7120	MH FIRST AID	$0.00	$0.00	$0.00	$0.00	$0.00	$55,000.00	$55,000.00	$47,000.00	$0.00	$8,000.00
2-7122	TCOOMMI EARNED INCOME	$30,970.46	$31,558.67	$30,081.49	($588.21)	$888.97	$310,030.14	$304,573.41	$300,144.91	$5,456.73	$9,885.23
2-7124	SUBSTANCE ABUSE SERVICES	$36,337.49	$28,530.10	$26,364.55	$7,807.39	$9,972.94	$325,481.10	$318,364.40	$224,057.01	$7,116.70	$101,424.09
2-7125	SUD COMMUNITY MH GRANT PROGRAM	$4,424.13	$3,521.67	$2,310.73	$902.46	$2,113.40	$38,675.09	$35,216.66	$18,907.51	$3,458.43	$19,767.58
2-7127	OSAR - OUTREACH, SCREENING ASSESSMENT, REFFERAL	$40,805.22	$44,063.40	$50,687.41	($3,258.18)	($9,882.19)	$286,771.01	$324,097.88	$374,340.60	($37,326.87)	($87,569.59)
2-7128	RSS - RECOVERY SUPPORT SERVICES	$11,046.24	$13,398.78	$6,393.95	($2,352.54)	$4,652.29	$95,060.28	$102,457.77	$61,122.98	($7,397.49)	$33,937.30
2-7150	MFP/ECC REVENUE	$0.00	$2,707.50	$2,593.10	($2,707.50)	($2,593.10)	$36,061.91	$27,074.98	$26,542.47	$8,986.93	$9,519.44
2-7152	PASSR IDD SPECIALIZED SERVICES	$341.75	$654.77	$504.77	($313.02)	($163.02)	$8,541.29	$10,172.06	$6,216.59	($1,630.77)	$2,324.70
2-7153	PASRR IDD SPECIALIZED SERVICES - OBRA - LIDDA	$0.00	$350.00	$0.00	($350.00)	$0.00	$1,050.00	$1,050.00	$4,200.00	$0.00	($3,150.00)
2-7132	CMHG LPHA EXPANSION	$5,999.71	$6,250.66	$4,873.77	($250.95)	$1,125.94	$52,971.42	$54,245.26	$41,427.06	($1,273.84)	$11,544.36
2-7216	MHGJII NCA - JBCR	$20,429.23	$20,209.43	$11,179.01	$219.80	$9,250.22	$192,709.02	$189,291.72	$11,179.01	$3,417.30	$181,530.01
2-7218	JUSTICE INVOLVED GRANT PROGRAM	$137,204.53	$498,462.50	$287,757.12	($361,257.97)	($150,552.59)	$1,964,033.95	$2,636,767.41	$2,067,718.81	($672,733.46)	($103,684.86)
2-7245	DARS-ECI REVENUE	$6,184.87	$13,119.65	$130,035.56	($6,934.78)	($123,850.69)	$1,076,202.32	$1,067,596.69	$1,040,695.28	$8,605.63	$35,507.04
Total Other State Funding		**$293,743.63**	**$662,827.13**	**$552,781.46**	**($369,083.50)**	**($259,037.83)**	**$4,442,587.53**	**$5,125,908.24**	**$4,223,552.23**	**($683,320.71)**	**$219,035.30**
Other Federal Funding											
2-7102	MEDICAID-CARD SERVICES	$1,415.05	$2,009.64	$2,153.23	($594.59)	($738.18)	$18,560.24	$8,928.36	$9,664.89	$9,631.88	$8,895.35
2-7104	MEDICAID-CASE MANAGEMENT	$2,830.83	$6,934.15	$5,934.15	($4,103.32)	($3,103.32)	$32,567.54	$44,678.41	$47,873.84	($12,110.87)	($15,306.30)
2-7106	MEDICAID-IDD SERV COORDINATION	$54,581.50	$57,602.60	$49,602.60	($3,021.10)	$4,978.90	$553,214.30	$562,550.83	$578,269.38	($9,336.53)	($25,055.08)
2-7108	MEDICAID REHAB	$19,323.70	$19,474.13	$17,658.58	($150.43)	$1,665.12	$176,921.99	$179,472.13	$176,298.75	($2,550.14)	$623.24
2-7110	MEDICAID PASRR	$623.77	$585.58	$585.58	$38.19	$38.19	$5,305.77	$5,575.54	$6,670.52	($269.77)	($1,364.75)
2-7112	MEDICAID-ADMIN CLAIMING	$40,000.00	$40,000.00	$40,000.00	$0.00	$0.00	$518,373.67	$451,556.46	$429,452.30	$66,817.21	$88,921.37
2-7114	MEDICAID-HABILITATION COORDINATION	$12,077.34	$11,290.23	$7,862.76	$787.11	$4,214.58	$90,001.28	$79,593.84	$76,166.37	$10,407.44	$13,834.91
2-7120	MH FIRST AID	$10,500.28	$10,895.22	$13,294.01	($394.94)	($2,793.73)	$76,542.38	$77,241.82	$75,033.51	($699.44)	$1,508.87
2-7126	STATE HOSPITAL STEP-DOWN PROGRAM	$47,114.60	$55,016.51	$52,445.84	($7,901.91)	($5,331.24)	$523,185.59	$542,996.22	$543,725.55	($19,810.63)	($20,539.96)
2-7130	MH OUTPATIENT CAPACITY EXPANSION	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$117,260.83	$0.00	($117,260.83)
2-7252	DIRECTED PAYMENT PROGRAM - BEHAVIORAL HEALTH SERVICES	$30,691.30	$36,315.40	$41,824.80	($5,624.10)	($11,133.50)	$368,921.99	$355,282.82	$357,050.13	$13,639.17	$11,871.86
2-7254	PUBLIC HEALTH PROVIDER - CHARITY CARE PROGRAM	$0.00	$0.00	$0.00	$0.00	$0.00	$2,569,055.57	$2,569,055.57	$2,197,789.03	$0.00	$371,266.54
2-7258	TRANSITION SUPPORT LIAISON	$5,202.41	$5,260.34	$5,414.74	($57.93)	($212.33)	$53,341.15	$52,603.32	$12,668.17	$737.83	$40,672.98
Total Other Federal Funding		**$224,360.78**	**$245,383.80**	**$236,776.29**	**($21,023.02)**	**($12,415.51)**	**$4,985,991.47**	**$4,929,535.32**	**$4,627,923.27**	**$56,456.15**	**$358,068.20**
General Revenue - Deferred Revenue											
2-7215	PESC	$239,453.96	$168,336.73	$386,062.14	$71,117.23	($146,608.18)	$1,813,388.72	$1,841,154.52	$1,962,468.67	($27,765.80)	($149,079.95)
2-7217	Private Psychiatric Beds MH/PPB	$64,390.90	$60,290.31	$5,390.00	$4,100.59	$59,000.90	$763,543.66	$817,019.38	$908,594.03	($53,475.72)	($145,050.37)
2-7220	GENERAL REVENUE - MH	$600,876.26	$600,876.26	$600,876.25	$0.00	$0.01	$6,008,762.51	$6,008,762.51	$6,008,762.50	$0.00	$0.01
2-7222	GENERAL REVENUE - VETERANS SERVICES	$5,833.34	$5,833.34	$5,833.34	$0.00	$0.00	$58,333.34	$58,333.34	$58,333.34	$0.00	$0.00
2-7224	GENERAL REVENUE - BH SVCS IN EDUC SVC CTR	$9,583.34	$9,583.34	$9,583.34	$0.00	$0.00	$95,833.34	$95,833.34	$95,833.34	$0.00	$0.00
2-7230	GENERAL REVENUE - IDD	$93,036.53	$93,036.53	$93,036.53	$0.00	$0.00	$930,365.31	$930,365.31	$930,365.30	$0.00	$0.01
2-7232	GENERAL REVENUE-CRISIS REDESIG	$39,884.50	$39,884.50	$39,884.50	$0.00	$0.00	$398,845.00	$398,845.00	$398,845.00	$0.00	$0.00
2-7235	GENERAL REVENUE - IDD ARPA	$0.00	$0.00	$0.00	$0.00	$0.00	$2,795.39	$2,795.39	$17,061.96	$0.00	($14,266.57)
2-7236	IDD GR-CRISIS RESPITE-CIS	$17,980.66	$17,980.66	$17,980.66	$0.00	$0.00	$179,806.66	$179,806.66	$179,806.66	$0.00	$0.00
2-7238	PERMANENCY PLANNING	$1,854.75	$1,854.75	$1,854.75	$0.00	$0.00	$18,547.50	$18,547.50	$18,547.50	$0.00	$0.00
Total General Revenue		**$1,072,894.24**	**$997,676.42**	**$1,160,501.51**	**$75,217.82**	**($87,607.27)**	**$10,270,221.43**	**$10,351,462.95**	**$10,578,618.30**	**($81,241.52)**	**($308,396.87)**
Medicaid Waiver											
2-7137	ICF-QAF	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($105.20)	$0.00	$105.20
Total Medicaid Waiver		**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$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	$145,657.50	$145,657.50	$145,657.50	$0.00	$0.00
2-7201	TANF-ADULT	$3,207.59	$3,207.59	$3,207.59	$0.00	$0.00	$32,075.84	$32,075.84	$32,075.84	$0.00	$0.00
2-7202	TANF-TITLE XX-ADULT	$3,663.66	$3,663.66	$3,663.66	$0.00	$0.00	$36,636.66	$36,636.66	$36,636.66	$0.00	$0.00
2-7203	TRANSITION-TITLE XX-CRISIS	$5,992.25	$5,992.25	$5,992.25	$0.00	$0.00	$59,922.50	$59,922.50	$59,922.50	$0.00	$0.00
2-7210	MENTAL HEALTH BLOCK GRANT	$36,511.91	$36,511.91	$36,511.87	$0.00	$0.04	$365,119.15	$365,119.15	$365,119.12	$0.00	$0.03
Total Allocated Federal Funds		**$63,941.16**	**$63,941.16**	**$63,941.12**	**$0.00**	**$0.04**	**$639,411.65**	**$639,411.65**	**$639,411.62**	**$0.00**	**$0.03**
Total Revenue		**$2,561,548.38**	**$2,999,774.44**	**$3,402,356.08**	**($438,226.06)**	**($840,807.70)**	**$28,946,727.32**	**$29,876,578.87**	**$30,065,150.51**	**($929,851.55)**	**($1,118,423.19)**

		JUNE 2026					YEAR TO DATE				
		JUN FY26 Actual	JUN FY26 Budget	JUNE 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
Expense											
Salaries											
2-8000	SALARIES	$964,238.07	$962,571.80	$942,098.19	$1,666.27	$22,139.88	$9,735,809.73	$9,757,199.09	$9,550,894.26	($21,389.36)	$184,915.47
2-8001	OVERTIME	$8,885.74	$7,586.73	$8,756.61	$1,299.01	$129.13	$90,729.11	$72,802.17	$93,299.40	$17,926.94	($2,570.29)
Total Salaries		**$1,009,310.77**	**$1,012,295.37**	**$954,461.49**	**$2,965.28**	**$22,269.01**	**$1,974,172.10**	**$1,966,350.34**	**$1,891,678.48**	**($3,462.42)**	**$182,345.18**
Benefits											
2-8002	EMPLOYER'S FICA/MEDICARE	$71,877.11	$71,309.85	$70,284.54	$567.26	$1,592.57	$718,929.26	$730,824.52	$705,725.79	($11,895.26)	$13,203.47
2-8003	TEC UNEMPLOYMENT TAX	$1,101.84	$1,048.48	$389.97	$53.36	$711.87	$45,140.43	$45,644.51	$19,918.41	($504.08)	$25,222.02
2-8004	WORKER'S COMPENSATION	$1,896.00	$1,983.49	$1,824.00	($87.49)	$72.00	$28,559.00	$30,419.08	$18,655.00	($1,860.08)	$9,904.00
2-8005	RETIREMENT EMPLOYER CONTRIBUTION 401A	$51,763.88	$51,561.09	$50,067.23	$202.79	$1,696.65	$522,807.16	$523,897.34	$482,626.32	($1,090.18)	$40,180.84
2-8006	HEALTH INSURANCE	$171,083.29	$169,612.72	$156,401.45	$1,470.57	$14,681.84	$1,654,229.83	$1,652,836.69	$1,467,155.79	$1,393.14	$187,074.04
2-8008	EMPLOYER FUNDED BASIC LIFE	$962.77	$962.66	$958.91	$0.11	$3.86	$9,609.86	$9,542.32	$5,759.15	$67.54	$3,850.71
Total Benefits		**$284,233.15**	**$285,526.89**	**$256,608.09**	**$2,206.60**	**$18,758.79**	**$564,672.54**	**$565,309.08**	**$509,788.70**	**($13,888.92)**	**$279,435.08**
Contracts											
2-8300	PSYCHIATRIST	$25,800.00	$22,400.00	$22,800.00	$3,400.00	$3,000.00	$238,275.00	$234,000.00	$233,475.00	$4,275.00	$4,800.00
2-8302	MEDICAL DIRECTOR	$0.00	$0.00	$7,300.00	$0.00	($7,300.00)	$0.00	$0.00	$21,900.00	$0.00	($21,900.00)
2-8304	PSYCHOLOGIST	$250.00	$750.00	$750.00	($500.00)	($500.00)	$2,250.00	$4,750.00	$4,750.00	($2,500.00)	($2,500.00)
2-8306	RN NURSES	$0.00	$0.00	$0.00	$0.00	$0.00	$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	$124,620.00	$125,118.44	$124,620.00	($498.44)	$0.00
2-8320	PESC BED DAYS	$196,640.00	$129,408.00	$339,810.00	$67,232.00	($143,170.00)	$1,462,445.00	$1,469,184.00	$1,645,150.00	($6,739.00)	($182,705.00)
2-8321	PPB BED DAYS	$55,865.00	$51,657.00	$4,900.00	$4,208.00	$50,965.00	$662,390.00	$707,281.00	$824,680.00	($44,891.00)	($162,290.00)
2-8322	OSAR-SUBSTANCE ABUSE	$40,083.27	$40,163.97	$50,163.97	($80.70)	($10,080.70)	$297,647.67	$332,802.14	$341,802.14	($35,154.47)	($44,154.47)
2-8326	LABORATORY CONTRACTS	$1,872.09	$2,327.62	$1,280.80	($455.53)	$591.29	$21,371.52	$24,808.50	$19,180.57	($3,436.98)	$2,190.95
2-8336	RESPITE-CONTRACTED	$5,685.50	$5,670.00	$3,670.00	$15.50	$2,015.50	$45,607.75	$42,588.00	$39,588.00	$3,019.75	$6,019.75
2-8338	SOFTWARE WEB-BASED	$22,372.33	$21,454.42	$21,544.58	$917.91	$827.75	$227,572.28	$225,920.03	$224,930.31	$1,652.25	$2,641.97
2-8344	JUSTICE INVOLVED BED DAYS (SB292)	$123,675.00	$453,147.53	$260,475.00	($329,472.53)	($136,800.00)	$1,774,390.00	$2,390,182.59	$1,868,400.00	($615,792.59)	($94,010.00)
2-8346	STATE HOSPITAL STEP-DOWN PROGRAM CONTRACTED	$45,500.00	$45,500.00	$45,500.00	$0.00	$0.00	$455,000.00	$455,000.00	$455,000.00	$0.00	$0.00
2-8348	BH SVCS IN ESC-REGION 9	$799.07	$703.00	$703.00	$96.07	$96.07	$5,309.11	$6,610.52	$6,610.52	($1,301.41)	($1,301.41)
2-8350	OTHER CONTRACTED CONSULTANTS	$2,896.15	$3,118.28	$7,275.56	($222.13)	($4,379.41)	$37,489.44	$45,335.60	$51,088.35	($7,846.16)	($13,598.91)
2-8352	WFPD - CART	$10,369.05	$8,320.30	$6,554.98	$2,048.75	$3,814.07	$58,688.14	$52,266.04	$91,696.08	$6,422.10	($33,007.94)
2-8353	TECHNICAL ASSISTANCE - CART	$0.00	$0.00	$52,490.00	$0.00	($52,490.00)	$12,490.00	$32,895.00	$98,980.00	($20,405.00)	($86,490.00)
2-8354	WFFD - CART	$5,703.44	$5,166.57	$5,000.00	$536.87	$703.44	$52,219.62	$50,999.42	$90,000.00	$1,220.20	($37,780.38)
2-8355	Other Contracted/Non-Contracted Consultants-G & A Services	$12,129.84	$9,595.58	$9,261.70	$2,534.26	$2,868.14	$95,686.93	$86,974.24	$96,990.31	$8,712.69	($1,303.38)
Total Contracts		**$562,102.74**	**$811,898.69**	**$851,941.59**	**($249,795.95)**	**($289,838.85)**	**$5,573,647.46**	**$6,286,715.52**	**$6,238,906.28**	**($713,068.06)**	**($665,258.82)**
Travel and Training											
2-8021	EMPLOYEE MILEAGE	$1,495.27	$1,952.91	$1,952.91	($457.64)	($457.64)	$13,614.79	$17,316.15	$17,968.30	($3,701.36)	($4,353.51)
2-8022	EMPLOYEE PER DIEM (MEALS AND HOTEL)	$9,202.83	$8,498.15	$8,498.15	$704.68	$704.68	$39,396.89	$30,694.33	$31,111.71	$8,702.56	$8,285.18
2-8023	EMPLOYEE TRAVEL-AIRFARE & CAR RENTAL	$1,677.62	$699.40	$765.65	$978.22	$911.97	$10,377.60	$7,798.88	$8,503.12	$2,578.72	$1,874.48
2-8024	EMPLOYEE TRAVEL OVER STATE RATE	$2,450.31	$986.00	$986.00	$1,464.31	$1,464.31	$4,190.18	$1,198.87	$1,198.87	$2,991.31	$2,991.31
2-8025	EMPLOYEE DEVELOPMENT & TRAINING	$6,832.58	$5,736.05	$6,627.83	$1,096.53	$204.75	$29,857.37	$30,572.36	$30,807.28	($714.99)	($949.91)
Total Travel and Training		**$21,658.61**	**$17,872.51**	**$18,830.54**	**$3,786.10**	**$2,828.07**	**$97,436.83**	**$87,580.59**	**$89,589.28**	**$9,856.24**	**$7,847.55**
Capital Outlay											
2-8106	BUILDING USE FEE	$6,185.14	$6,232.24	$7,428.99	($47.10)	($1,243.85)	$74,139.23	$72,666.51	$78,432.05	$1,472.72	($4,292.82)
2-8126	EQUIP/FURN/FIX USE FEE	$2,135.39	$2,278.06	$2,186.63	($142.67)	($51.24)	$20,691.91	$23,123.43	$23,167.05	($2,431.52)	($2,475.14)
2-8146	VEHICLE USE FEE	$14,962.21	$9,581.82	$5,434.71	$5,380.39	$9,527.50	$86,391.51	$73,722.37	$57,134.03	$12,669.14	$29,257.48
2-8156	SOFTWARE USE FEE	$0.00	$0.00	$208.33	$0.00	($208.33)	$208.33	$208.33	$2,083.33	$0.00	($1,875.00)
2-8166	COMPUTER & PRINTER USE FEE	$3,143.85	$3,303.73	$5,215.08	($159.88)	($2,071.23)	$38,924.09	$43,412.43	$49,763.70	($4,488.34)	($10,839.61)
2-8170	CAPITAL OUTLAY	$0.00	$0.00	$92,203.96	$0.00	($92,203.96)	$5,506.04	$5,506.04	$114,462.01	$0.00	($108,955.97)
Total Capital Outlay		**$26,426.59**	**$21,395.85**	**$112,677.70**	**$5,030.74**	**($86,251.11)**	**$225,861.11**	**$218,639.11**	**$325,042.17**	**$7,222.00**	**($99,181.06)**
Non-Capitalized Equipment											
2-8190	MINOR EQUIPMENT PURCHASES	$28,713.22	$11,297.24	$513.83	$17,415.98	$28,199.39	$53,372.47	$24,295.23	$30,635.49	$29,077.24	$22,736.98
Total Non-Capitalized Equipment		**$28,713.22**	**$11,297.24**	**$513.83**	**$17,415.98**	**$28,199.39**	**$53,372.47**	**$24,295.23**	**$30,635.49**	**$29,077.24**	**$22,736.98**

		JUNE 2026					YEAR TO DATE				
		JUN FY26 Actual	JUN FY26 Budget	JUNE 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
Pharmaceutical											
2-8316	PHARMACIST	$64,562.38	$61,194.40	$58,805.25	$3,367.98	$5,757.13	$586,354.60	$574,289.68	$553,015.78	$12,064.92	$33,338.82
Total Pharmaceutical		**$64,562.38**	**$61,194.40**	**$58,805.25**	**$3,367.98**	**$5,757.13**	**$586,354.60**	**$574,289.68**	**$553,015.78**	**$12,064.92**	**$33,338.82**
Other Operating											
2-8007	EAP EXPENSE	$403.20	$406.40	$406.40	($3.20)	($3.20)	$4,052.80	$4,064.00	$3,943.18	($11.20)	$109.62
2-8020	HIRING RELATED EXPENSES	$3,401.24	$4,790.44	$3,241.15	($1,389.20)	$160.09	$39,253.39	$36,382.89	$32,866.67	$2,870.50	$6,386.72
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	$1,567.89	$1,567.89	($1,011.33)	($1,011.33)
2-8040	PROFESSIONAL/ERROR&OMMISSIONS	$2,174.49	$2,174.49	$2,410.61	$0.00	($236.12)	$21,744.90	$21,744.90	$24,106.10	$0.00	($2,361.20)
2-8041	LIABILITY COVERAGE	$103.67	$103.67	$107.25	$0.00	($3.58)	$1,136.70	$1,036.70	$1,260.47	$100.00	($123.77)
2-8042	OTHER INSURANCE COVERAGE	$1,777.85	$1,777.85	$1,713.36	$0.00	$64.49	$17,778.50	$17,778.50	$17,133.60	$0.00	$644.90
2-8050	ADVERTISING EXPENSE	$930.30	$1,595.05	$1,594.77	($664.75)	($664.47)	$15,858.79	$19,736.38	$12,736.38	($3,877.59)	$3,122.41
2-8055	DUES AND MEMBERSHIPS	$5,401.42	$5,720.53	$20,674.09	($319.11)	($15,272.67)	$55,897.58	$53,796.12	$58,586.03	$2,101.46	($2,688.45)
2-8057	LICENSES	$4,326.69	$2,044.64	$15,835.91	$2,282.05	($11,509.22)	$22,635.07	$13,845.36	$23,806.31	$8,789.71	($1,171.24)
2-8060	BOARD ACTIVITY EXPENSE	$2,666.09	$1,617.52	$1,617.52	$1,048.57	$1,048.57	$4,961.80	$3,381.20	$4,436.46	$1,580.60	$525.34
2-8065	DPP-BHS RISK AND ADMIN EXPENSE	$2,044.17	$2,044.17	$2,044.17	$0.00	$0.00	$20,441.70	$20,441.70	$20,441.63	$0.00	$0.07
2-8070	UTILITIES	$19,625.24	$16,988.61	$17,977.95	$2,636.63	$1,647.29	$183,571.07	$177,799.66	$178,059.73	$5,771.41	$5,511.34
2-8072	TELECOMMUNICATIONS	$23,780.01	$23,731.26	$25,011.63	$48.75	($1,231.62)	$266,678.34	$265,964.09	$265,763.32	$714.25	$915.02
2-8076	TELEPHONE-BASIC SERVICE EXPENSE	$2,019.39	$2,429.00	$2,426.33	($409.61)	($406.94)	$20,264.83	$24,211.75	$24,219.86	($3,946.92)	($3,955.03)
2-8078	CELL PHONE SERVICE EXPENSE	$3,246.32	$1,926.99	$1,952.07	$1,319.33	$1,294.25	$20,746.05	$20,927.19	$21,077.64	($181.14)	($331.59)
2-8080	LONG DISTANCE TELEPHONE SERVICE EXPENSE	$356.47	$262.50	$262.51	$93.97	$93.96	$3,939.07	$2,559.19	$2,559.21	$1,379.88	$1,379.86
2-8100	BUILDING RENT	$57,099.53	$57,099.53	$56,826.97	$0.00	$272.56	$570,128.49	$567,734.49	$634,479.61	$2,394.00	($64,351.12)
2-8101	P.O. BOX/STORAGE RENTAL/LEASE	$86.83	$82.19	$82.20	$4.64	$4.63	$835.02	$805.43	$805.70	$29.59	$29.32
2-8102	PROPERTY DAMAGE COVERAGE	$10,935.10	$11,732.53	$10,163.60	($797.43)	$771.50	$114,226.29	$117,325.30	$101,497.00	($3,099.01)	$12,729.29
2-8104	BUILDING REPAIR & MAINTENANCE	$25,172.90	$14,224.65	$13,875.59	$10,948.25	$11,297.31	$164,906.30	$155,479.99	$157,014.50	$9,426.31	$7,891.80
2-8120	EQUIPMENT RENTAL/LEASE	$7,267.56	$7,120.75	$7,155.12	$146.81	$112.44	$71,797.46	$71,295.78	$71,598.08	$501.68	$199.38
2-8124	EQUIPMENT REPAIR & MAINTENANCE	$2,514.86	$1,428.99	$1,428.99	$1,085.87	$1,085.87	$21,827.51	$21,421.76	$25,590.77	$405.75	($3,763.26)
2-8140	VEHICLE LEASE	$2,278.46	$2,611.11	$2,611.11	($332.65)	($332.65)	$23,665.61	$26,111.10	$26,111.10	($2,445.49)	($2,445.49)
2-8142	AUTO LIABILITY/PHYS DAMAGE INS	$8,921.67	$9,331.45	$7,886.17	($409.78)	$1,035.50	$86,896.32	$87,715.78	$81,516.94	($819.46)	$5,379.38
2-8143	INSURANCE EXP-DEDUCTIBLES PAID	$0.00	$0.00	$1,000.00	$0.00	($1,000.00)	$0.00	$0.00	$1,400.00	$0.00	($1,400.00)
2-8144	VEHICLE REPAIR & MAINTENANCE	$1,710.57	$3,836.05	$3,910.62	($2,125.48)	($2,200.05)	$31,405.86	$30,788.38	$31,005.15	$617.48	$400.71
2-8145	GAS-VEHICLE & EQUIPMENT	$8,722.81	$8,687.49	$5,884.31	$35.32	$2,838.50	$73,619.24	$70,516.22	$60,609.66	$3,103.02	$13,009.58
2-8200	OFFICE SUPPLIES	$9,069.37	$9,060.76	$9,360.48	$8.61	($291.11)	$116,489.60	$117,446.66	$89,028.74	($957.06)	$27,460.86
2-8202	BOOKS & SUBSCRIPTIONS	$1,969.22	$2,183.30	$3,741.25	($214.08)	($1,772.03)	$37,086.82	$37,111.94	$38,094.39	($25.12)	($1,007.57)
2-8204	JANITORIAL/CLEANING SUPPLIES	$1,770.57	$1,213.23	$1,214.07	$557.34	$556.50	$9,205.68	$7,260.74	$7,384.69	$1,944.94	$1,820.99
2-8206	OTHER CONSUMABLE SUPPLIES	$945.93	$1,259.71	$1,665.72	($313.78)	($719.79)	$12,999.43	$12,687.35	$12,723.71	$312.08	$275.72
2-8208	MEDICAL SUPPLIES	$1,132.22	$455.59	$4,100.30	$676.63	($2,968.08)	$11,922.20	$10,925.49	$11,039.94	$996.71	$882.26
2-8210	FOOD	$369.64	$394.44	$403.50	($24.80)	($33.86)	$3,495.60	$2,680.00	$3,815.87	$815.60	($320.27)
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	$415.97	$0.00	$0.00	$415.97	$415.97	$1,281.63	$0.00	$0.00	$1,281.63	$1,281.63
2-8218	CONSUMER ASSISTANCE	$559.86	$1,080.05	$1,004.05	($520.19)	($444.19)	$7,796.64	$8,280.91	$20,183.11	($484.27)	($12,386.47)
2-8220	PRINTING SERVICES	$2,286.19	$2,041.38	$2,050.00	$244.81	$236.19	$28,053.42	$25,490.53	$23,009.83	$2,562.89	$5,043.59
2-8221	COURIER DELIVERY SERVICES	$0.00	$0.00	$0.00	$0.00	$0.00	$370.64	$386.37	$386.37	($15.73)	($15.73)
2-8222	POSTAGE & DELIVERY CHARGES	$1,442.96	$1,675.03	$1,675.03	($232.07)	($232.07)	$15,686.32	$16,371.77	$16,376.60	($685.45)	($690.28)
2-8226	SANCTIONS	$287.00	$0.00	$0.00	$287.00	$287.00	$3,560.06	$0.00	$3,138.70	$3,560.06	$421.36
2-8228	BNK CHRGES & CREDIT CRD FEES	$955.07	$964.32	$964.32	($9.25)	($9.25)	$8,965.99	$10,279.53	$10,287.96	($1,313.54)	($1,321.97)
2-8232	MISCELLANEOUS CHARGE & EXPENSE	$939.03	$902.27	$902.27	$36.76	$36.76	$2,816.69	$4,124.76	$10,835.13	($1,308.07)	($8,018.44)
2-8237	IN-KIND EXPENSES	$649,298.30	$796,163.42	$1,011,628.25	($146,865.12)	($362,329.95)	$6,645,868.04	$6,981,390.16	$7,871,826.76	($335,522.12)	($1,225,958.72)
2-8340	CPA FIRM	$0.00	$0.00	$0.00	$0.00	$0.00	$25,708.20	$25,000.00	$32,500.00	$708.20	($6,791.80)
2-8342	ATTORNEY-CONTRACTED/NON-CONTR	$209.91	$0.00	$0.00	$209.91	$209.91	$966.16	$756.25	$0.00	$209.91	$966.16
2-8359	NON-CONTRACTED RESPITE	$168.00	$84.00	$84.00	$84.00	$84.00	$168.00	$613.00	$252.00	($445.00)	($84.00)
2-8360	NON-CONTRACTED CONSULTANTS	$506.85	$500.00	$0.00	$6.85	$506.85	$11,532.05	$10,018.51	$1,519.61	$1,513.54	$10,012.44
Total Other Operating		**$869,292.93**	**$1,001,745.36**	**$1,246,893.64**	**($132,452.43)**	**($377,600.71)**	**$8,817,626.00**	**$9,122,255.72**	**$10,051,353.55**	**($304,629.72)**	**($1,233,727.55)**
Total Expense		$2,844,565.17	$3,192,040.87	$3,520,443.45	($347,475.70)	($675,878.28)	$28,160,112.85	$29,136,941.57	$29,632,576.67	($976,828.72)	($1,472,463.82)

	JUNE 2026					YEAR TO DATE				
	JUN FY26 Actual	JUN FY26 Budget	JUNE 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
BEGINNING NET ASSETS	$14,585,448.46	$14,585,448.46	$13,902,156.54	$0.00	$683,291.92	$13,515,817.20	$13,515,817.20	$13,351,495.33	$0.00	$164,321.87
NET SURPLUS/(DEFICIT)	($283,016.79)	($192,266.43)	($118,087.37)	($90,750.36)	($164,929.42)	$786,614.47	$739,637.30	$432,573.84	$46,977.17	$354,040.63
ENDING NET ASSETS	$14,302,431.67	$14,393,182.03	$13,784,069.17	($90,750.36)	$518,362.50	$14,302,431.67	$14,255,454.50	$13,784,069.17	$46,977.17	$518,362.50

RECOMMENDED ACTION: That the Board of Trustees approves the financial statements for July 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 is *156*.
- Accounts Receivable *increased by $42,510,* going from $1,068,793 to $1,111,303.
- Accounts Payable *increased by* $145,403, going from $945,964 to $1,091,367.
- FINANCIAL STATUS: The Center had a loss of $172,047 for July and a cumulative gain of $614,567 for the year**.**
- **REVENUE**: Overall Revenue received in July 2026 was $232,288 less than budgeted.
  - **Patient Fees** were $7,542 more than budgeted.
    - This is based on actual cash received in June for services.
  - **Miscellaneous** was $73,232 less than budgeted.
    - In-kind Match was $84,700 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.
    - Interest was $10,321 more than budgeted.

- **Other State Funding** was $299,492 less than budgeted.
  - Justice Involved Grant Program (SB292) Revenue was $281,212 less than budgeted. We were given notice from the state that we had money from FY2025 to expend in FY2026 and so the budget was increased accordingly. It is all based on need for psychiatric beds which will vary greatly from month to month.

- **Other Federal Funding** was $72,018 more than budgeted.
  - Medicaid Admin Claiming program is $86,349 less than budgeted. The state found an error in their calculations, and we had to reverse our 1st Quarter recording we did in May.
  - DPP-BHS revenue is $156,133 more than budgeted. We received a total of $164,600 from past reconciliation years.
  - Medicaid Services are $13,828 less than budgeted.
  - Medicaid-Habilitation Coordination is $27,536 more than Budgeted. Our IDD Director talked to TMHP about some billing they missed, and they have paid up.

- **General Revenue** was $40,876 more than budgeted.
  - PESC revenue was $44,959 more than budgeted. PESC revenue fluctuates based on client need for psychiatric beds.
  - Private Psychiatric Beds MH/PPB Revenue was $4,083 more than budgeted. This revenue also fluctuates based on client need for psychiatric beds.
- **Allocated Federal Funds** were right on budget.

❖ **EXPENSES:** Overall expense for July 2026 was $320,166 less than budgeted.

- **Personnel** cost was $25,935 less than budgeted.
  - Salaries were $23,919 less than budgeted.
  - Benefits were $2,016 less than budgeted.

- **Contract** cost was $217,026 less than budgeted.
  - SB292 Bed Day Expense was $256,723 less than budgeted, PPB Bed Day expense was $2,982 less than budgeted, and PESC Bed Day expense was $44,802 more than budgeted. All these expenses fluctuate based on client need for the psychiatric beds.

- **Travel and Training** expenses were $428 less than budgeted.

- **Capital Outlay** expense was $1,679 more than budgeted. When the adjusted budget was completed, it was without knowing that we would receive the new cars for ECI almost immediately. Our last endeavor to acquire cars took 8 months.

- **Non-Capitalized Equipment** expense was $1,049 less than budgeted.

- **Pharmaceutical** expense was $2,243 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 $79,646 less than budgeted.
  - In-Kind Expense was $84,700 less 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. This 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 July 2026

Assets	**Actual**	
CASH GENERAL OPERATING FUND	$	6,134,550.28
CASH INTERNAL SERVICE FUND	$	2,146,021.14
CASH SELF FUNDED INSURANCE	$	582,947.76
SAVINGS	$	21,629.65
PETTY CASH FUNDS-CENTERWIDE	$	797.93
INVESTMENTS GENERAL OPERATING FUND	$	8,898,112.68
INVESTMENTS INTERNAL SERVICE FUND	$	720,153.49
ACCOUNTS RECEIVABLE	$	1,111,303.38
PREPAID	$	390,881.37
PREPAID MISCELLANEOUS-SELF INSURED FUNDS	$	229.13
DEPOSITS	$	318,405.65
DEPOSITS-SELF INSURED FUNDS	$	25,000.00
AMTS PROVIDED-PERSONAL LEAVE	$	947,522.78
LAND	$	1,057,659.65
BUILDINGS & IMPROVEMENTS	$	2,529,784.16
LEASEHOLD IMPROVEMENTS	$	132,631.17
EQUIP/FURN/FIX	$	430,402.71
COMPUTERS & PERIPHERALS	$	747,319.77
VEHICLES & CONTRACTORS EQ	$	1,924,780.72
COMPUTER SOFTWARE	$	368,100.66
ACCUMULATED DEPRECIATION	$	(4,965,241.36)
CLINICAL SOFTWARE PROJECT	$	-
WICHITA FALLS BUILDING PROJECT	$	386,012.69
ISF-MAJOR PROJECTS WORK-IN-PROGRESS	$	-
Total Assets	**$**	**23,909,005.41**
Liabilities and Net Assets		
Liabilities		
ACCOUNTS PAYABLE GENERAL OPERATING FUND	$	773,916.85
ACCOUNTS PAYABLE INTERNAL SERVICE FUND	$	674.96
ACCOUNTS PAYABLE-SELF INSURED FUND	$	183,511.89
ACCOUNTS PAYABLE-PAYABLE TO STATE	$	133,263.30
PAYROLL PAYABLE	$	509,787.26
UMR PAYABLE	$	87,235.86
EMPLOYEE DEDUCTION PAYBLE	$	10,014.97
DEFERRED REVENUE	$	1,219,436.11
ACCUM PERSONAL LEAVE-CURRENT	$	19,117.92
ACCUM PERSONAL LEAVE-LONGTERM	$	947,522.78
UMR CLAIMS PAYABLE - IBNR	$	140,000.00
Total Liabilities	**$**	**4,024,481.90**
Net Assets		
UNRESERVED-FUND BALANCE	$	13,591,534.91
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	$	(235,752.52)
RETAINED EARNINGS	$	151,301.06
Total Net Assets	**$**	**19,884,523.51**
Total Liabilities and Net Assets	**$**	**23,909,005.41**

Helen Farabee Centers
JULY 2026 Income Statement

		JULY 2026					YEAR TO DATE				
		JUL FY26 Actual	JUL FY26 Budget	JUL FY25 Actual	Variance Budget	Variance FY 2025	FY2026 Y-T-D Actual	FY2026 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	$8,333.34	$0.00	($0.01)	$91,666.66	$91,666.66	$91,666.68	$0.00	($0.02)
2-7001	CITY OF CHILLICOTHE	$27.50	$27.50	$27.50	$0.00	$0.00	$302.50	$302.50	$302.50	$0.00	$0.00
2-7002	CITY OF QUANAH	$55.00	$55.00	$55.00	$0.00	$0.00	$605.00	$605.00	$605.00	$0.00	$0.00
2-7004	CITY OF BURKBURNETT	$417.66	$417.66	$417.66	$0.00	$0.00	$4,594.32	$4,594.32	$4,594.32	$0.00	$0.00
2-7005	CITY OF GRAHAM	$1,250.00	$1,250.00	$1,250.00	$0.00	$0.00	$13,750.00	$13,750.00	$13,750.00	$0.00	$0.00
2-7006	CITY OF NOCONA	$125.00	$125.00	$125.00	$0.00	$0.00	$1,375.00	$1,375.00	$1,375.00	$0.00	$0.00
2-7007	CITY OF BOWIE	$666.67	$666.67	$666.66	$0.00	$0.01	$7,333.34	$7,333.34	$7,333.32	$0.00	$0.02
Total City Revenue		**$10,875.16**	**$10,875.16**	**$10,875.16**	**$0.00**	**($0.00)**	**$119,626.82**	**$119,626.82**	**$119,626.82**	**$0.00**	**$0.00**
County Revenue - Deferred Revenue											
2-7020	WICHITA COUNTY	$18,333.33	$18,333.33	$13,333.33	$0.00	$5,000.00	$181,666.66	$181,666.66	$133,333.31	$0.00	$48,333.35
2-7021	HASKEL COUNTY	$1,387.69	$1,387.69	$1,387.67	$0.00	$0.02	$15,264.39	$15,264.39	$14,885.87	$0.00	$378.52
2-7022	STONEWALL COUNTY	$211.89	$211.89	$176.84	$0.00	$35.05	$2,330.79	$2,330.79	$1,945.18	$0.00	$385.61
2-7023	KNOX COUNTY	$554.17	$554.17	$551.40	$0.00	$2.77	$6,095.84	$6,095.84	$6,065.40	$0.00	$30.44
2-7024	DICKENS COUNTY	$0.00	$0.00	$149.81	$0.00	($149.81)	$0.00	$0.00	$1,647.91	$0.00	($1,647.91)
2-7025	YOUNG COUNTY	$3,958.34	$3,958.34	$400.00	$0.00	$3,558.34	$43,541.68	$43,541.68	$4,400.00	$0.00	$39,141.68
2-7026	THROCKMORTON COUNTY	$273.27	$273.27	$156.06	$0.00	$117.21	$3,005.94	$3,005.94	$1,716.60	$0.00	$1,289.34
2-7027	HARDEMAN COUNTY	$353.45	$353.45	$0.00	$0.00	$353.45	$3,887.88	$3,887.88	$0.00	$0.00	$3,887.88
2-7028	WISE COUNTY	$4,616.67	$4,616.67	$4,616.66	$0.00	$0.01	$50,783.33	$50,783.33	$50,783.32	$0.00	$0.01
2-7029	BAYLOR COUNTY	$433.34	$433.34	$433.34	$0.00	$0.00	$4,766.66	$4,766.66	$4,766.68	$0.00	($0.02)
2-7030	FOARD COUNTY	$110.00	$110.00	$205.99	$0.00	($95.99)	$1,210.00	$1,210.00	$2,265.89	$0.00	($1,055.89)
2-7031	MONTAGUE COUNTY	$8,388.03	$8,388.03	$8,107.84	$0.00	$280.19	$92,268.40	$92,268.40	$89,186.24	$0.00	$3,082.16
2-7032	JACK COUNTY	$2,956.19	$2,956.19	$1,250.00	$0.00	$1,706.19	$32,518.06	$32,518.06	$13,750.00	$0.00	$18,768.06
2-7033	CLAY COUNTY	$333.34	$333.34	$333.32	$0.00	$0.02	$3,666.66	$3,666.66	$3,666.65	$0.00	$0.01
2-7034	COTTLE COUNTY	$199.75	$199.75	$199.75	$0.00	$0.00	$2,197.25	$2,197.25	$2,197.25	$0.00	$0.00
2-7035	CHILDRESS COUNTY	$347.92	$347.92	$347.92	$0.00	$0.00	$3,827.09	$3,827.09	$3,827.10	$0.00	($0.01)
2-7036	ARCHER COUNTY SUPPORT	$964.59	$964.59	$0.00	$0.00	$964.59	$10,610.41	$10,610.41	$0.02	$0.00	$10,610.39
Total County Revenue		**$43,421.97**	**$43,421.97**	**$31,649.93**	**$0.00**	**$11,772.04**	**$457,641.04**	**$457,641.04**	**$334,437.42**	**$0.00**	**$123,203.62**
Other Taxing Authority Funds - Deferred Revenue											
2-7038	INDEPENDENT SCHOOL DISTRICT	$265.00	$265.00	$265.00	$0.00	$0.00	$2,915.00	$2,915.00	$2,915.00	$0.00	$0.00
Total Other Taxing Authority Funds		**$265.00**	**$265.00**	**$265.00**	**$0.00**	**$0.00**	**$2,915.00**	**$2,915.00**	**$2,915.00**	**$0.00**	**$0.00**
Patient Fees - Cash Basis Only											
2-7050	CONSUMER FEES	$31,423.30	$24,328.54	$27,328.54	$7,094.76	$4,094.76	$273,384.99	$226,157.84	$205,690.84	$47,227.15	$67,694.15
2-7060	PRIVATE INSURANCE MCO CARD SERVICES	$31,712.85	$35,128.40	$34,270.68	($3,415.55)	($2,557.83)	$355,389.62	$352,176.12	$332,968.17	$3,213.50	$22,421.45
2-7070	PRIVATE INSURANCE MCO CASE MANAGEMENT	$15,788.41	$16,094.12	$16,627.65	($305.71)	($839.24)	$170,939.60	$149,062.72	$148,147.90	$21,876.88	$22,791.70
2-7080	PRIVATE INSURANCE MCO REHAB	$16,965.53	$12,797.35	$12,997.35	$4,168.18	$3,968.18	$143,263.53	$136,403.77	$134,261.13	$6,859.76	$9,002.40
Total Patient Fees		**$95,890.09**	**$88,348.41**	**$91,224.22**	**$7,541.68**	**$4,665.87**	**$942,977.74**	**$863,800.45**	**$821,068.04**	**$79,177.29**	**$121,909.70**
Miscellaneous - Cash Basis											
2-7037	IN-KIND MATCH	$711,463.49	$796,163.41	$939,565.39	($84,699.92)	($228,101.90)	$7,357,331.53	$7,777,553.55	$8,811,392.15	($420,222.02)	($1,454,060.62)
2-7100	MEDICARE - TITLE XVII	$5,978.31	$5,782.00	$5,782.00	$196.31	$196.31	$43,139.45	$36,148.11	$36,148.11	$6,991.34	$6,991.34
2-7260	RENT	$87.50	$1,137.50	$4,968.25	($1,050.00)	($4,880.75)	$11,550.00	$12,512.50	$52,150.75	($962.50)	($40,600.75)
2-7270	DONATIONS/CONTRIBUTIONS	$0.00	$0.00	$233.33	$0.00	($233.33)	$11,089.47	$7,730.89	$9,664.21	$3,358.58	$1,425.26
2-7272	CART EARNED REVENUE	$12,618.27	$13,582.13	$32,983.13	($963.86)	($20,364.86)	$189,495.62	$192,169.50	$402,710.92	($2,673.88)	($213,215.30)
2-7273	OPIOID GRANT	$13,476.24	$10,097.33	$1,000.00	$3,378.91	$12,476.24	$90,620.74	$78,749.19	$4,996.00	$11,871.55	$85,624.74
2-7274	USDA GRANT REVENUE- IT TECHNOLOGY	$0.00	$0.00	$0.00	$0.00	$0.00	$12,949.00	$0.00	$161,194.00	$12,949.00	($148,245.00)
2-7275	INTEREST INCOME	$45,399.23	$35,077.86	$35,090.13	$10,321.37	$10,309.10	$274,254.39	$248,118.56	$279,832.48	$26,135.83	($5,578.09)
2-7280	MISCELLANEOUS	$3,981.96	$4,396.50	$2,396.50	($414.54)	$1,585.46	$38,381.66	$42,442.37	$115,647.43	($4,060.71)	($77,265.77)
Total Miscellaneous		**$793,005.00**	**$866,236.73**	**$1,022,018.73**	**($73,231.73)**	**($229,013.73)**	**$8,028,811.86**	**$8,395,424.67**	**$9,873,736.05**	**($366,612.81)**	**($1,844,924.19)**

		JULY 2026					YEAR TO DATE				
		JUL FY26 Actual	JUL FY26 Budget	JUL FY25 Actual	Variance Budget	Variance FY 2025	FY2026 Y-T-D Actual	FY2026 Y-T-D Budget	FY2025 Y-T-D Actual	Variance Y-T-D Budget	Variance 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	$55,000.00	$55,000.00	$47,000.00	$0.00	$8,000.00
2-7122	TCOOMMI EARNED INCOME	$31,092.72	$31,688.98	$31,604.60	($596.26)	($511.88)	$341,122.86	$336,262.39	$331,749.51	$4,860.47	$9,373.35
2-7124	SUBSTANCE ABUSE SERVICES	$30,397.77	$31,530.10	$23,336.80	($1,132.33)	$7,060.97	$355,878.87	$349,894.50	$247,393.81	$5,984.37	$108,485.06
2-7125	SUD COMMUNITY MH GRANT PROGRAM	$3,584.91	$3,521.67	$2,688.77	$63.24	$896.14	$42,260.00	$38,738.33	$21,596.28	$3,521.67	$20,663.72
2-7127	OSAR - OUTREACH, SCREENING ASSESSMENT, REFFERAL	$37,474.81	$44,063.40	$33,045.15	($6,588.59)	$4,429.66	$324,245.82	$368,161.28	$407,385.75	($43,915.46)	($83,139.93)
2-7128	RSS - RECOVERY SUPPORT SERVICES	$11,198.75	$13,398.78	$6,584.88	($2,200.03)	$4,613.87	$106,259.03	$115,856.55	$67,707.86	($9,597.52)	$38,551.17
2-7150	MFP/ECC REVENUE	$0.00	$2,707.51	$0.00	($2,707.51)	$0.00	$36,061.91	$29,782.49	$26,542.47	$6,279.42	$9,519.44
2-7152	PASSR IDD SPECIALIZED SERVICES	$252.12	$710.97	$560.79	($458.85)	($308.67)	$8,793.41	$10,883.03	$6,777.38	($2,089.62)	$2,016.03
2-7153	PASRR IDD SPECIALIZED SERVICES - OBRA - LIDDA	$350.00	$0.00	$0.00	$350.00	$350.00	$1,400.00	$1,050.00	$4,200.00	$350.00	($2,800.00)
2-7132	CMHG LPHA EXPANSION	$3,773.81	$6,250.66	$4,873.77	($2,476.85)	($1,099.96)	$56,745.23	$60,495.92	$46,300.83	($3,750.69)	$10,444.40
2-7216	MHGJII NCA - JBCR	$19,473.09	$21,387.10	$30,030.89	($1,914.01)	($10,557.80)	$212,182.11	$210,678.82	$41,209.90	$1,503.29	$170,972.21
2-7218	JUSTICE INVOLVED GRANT PROGRAM	$217,250.93	$498,462.50	$436,397.02	($281,211.57)	($219,146.09)	$2,181,284.88	$3,135,229.91	$2,504,115.83	($953,945.03)	($322,830.95)
2-7245	DARS-ECI REVENUE	$0.00	$619.65	$32,546.79	($619.65)	($32,546.79)	$1,076,202.32	$1,068,216.34	$1,073,242.07	$7,985.98	$2,960.25
Total Other State Funding		**$354,848.91**	**$654,341.32**	**$601,669.46**	**($299,492.41)**	**($246,820.55)**	**$4,797,436.44**	**$5,780,249.56**	**$4,825,221.69**	**($982,813.12)**	**($27,785.25)**
Other Federal Funding											
2-7102	MEDICAID-CARD SERVICES	$1,099.62	$1,623.21	$1,692.67	($523.59)	($593.05)	$19,659.86	$10,551.57	$11,357.56	$9,108.29	$8,302.30
2-7104	MEDICAID-CASE MANAGEMENT	$3,184.61	$7,212.93	$4,212.93	($4,028.32)	($1,028.32)	$35,752.15	$51,891.34	$52,086.77	($16,139.19)	($16,334.62)
2-7106	MEDICAID-IDD SERV COORDINATION	$54,500.70	$58,189.92	$64,189.92	($3,689.22)	($9,689.22)	$607,715.00	$620,740.75	$642,459.30	($13,025.75)	($34,744.30)
2-7108	MEDICAID REHAB	$15,342.03	$20,928.57	$22,928.57	($5,586.54)	($7,586.54)	$192,264.02	$200,400.70	$199,227.32	($8,136.68)	($6,963.30)
2-7110	MEDICAID PASRR	$305.52	$1,171.36	$471.01	($865.84)	($165.49)	$5,611.29	$6,746.90	$7,141.53	($1,135.61)	($1,530.24)
2-7112	MEDICAID-ADMIN CLAIMING	($46,348.47)	$40,000.00	$61,836.15	($86,348.47)	($108,184.62)	$472,025.20	$491,556.46	$491,288.45	($19,531.26)	($19,263.25)
2-7114	MEDICAID-HABILITATION COORDINATION	$35,399.10	$7,862.76	$11,290.23	$27,536.34	$24,108.87	$125,400.38	$87,456.60	$87,456.60	$37,943.78	$37,943.78
2-7120	MH FIRST AID	$6,998.25	$10,220.70	$7,678.26	($3,222.45)	($680.01)	$83,540.63	$87,462.52	$82,711.77	($3,921.89)	$828.86
2-7126	STATE HOSPITAL STEP-DOWN PROGRAM	$47,525.31	$55,016.51	$53,874.39	($7,491.20)	($6,349.08)	$570,710.90	$598,012.73	$597,599.94	($27,301.83)	($26,889.04)
2-7130	MH OUTPATIENT CAPACITY EXPANSION	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$117,260.83	$0.00	($117,260.83)
2-7252	DIRECTED PAYMENT PROGRAM - BEHAVIORAL HEALTH SERVICES	$192,448.08	$36,315.40	$41,958.44	$156,132.68	$150,489.64	$561,370.07	$391,598.22	$399,008.57	$169,771.85	$162,361.50
2-7254	PUBLIC HEALTH PROVIDER - CHARITY CARE PROGRAM	$0.00	$0.00	$0.00	$0.00	$0.00	$2,569,055.57	$2,569,055.57	$2,197,789.03	$0.00	$371,266.54
2-7258	TRANSITION SUPPORT LIAISON	$5,364.87	$5,260.34	$6,047.57	$104.53	($682.70)	$58,706.02	$57,863.66	$18,715.74	$842.36	$39,990.28
Total Other Federal Funding		**$315,819.62**	**$243,801.70**	**$276,180.14**	**$72,017.92**	**$39,639.48**	**$5,301,811.09**	**$5,173,337.02**	**$4,904,103.41**	**$128,474.07**	**$397,707.68**
General Revenue - Deferred Revenue											
2-7215	PESC	$213,295.46	$168,336.73	$129,726.64	$44,958.73	$83,568.82	$2,026,684.18	$2,009,491.25	$2,092,195.31	$17,192.93	($65,511.13)
2-7217	Private Psychiatric Beds MH/PPB	$56,207.65	$60,290.31	$13,387.00	($4,082.66)	$42,820.65	$819,751.31	$877,309.69	$921,981.03	($57,558.38)	($102,229.72)
2-7220	GENERAL REVENUE - MH	$600,876.26	$600,876.26	$600,876.25	$0.00	$0.01	$6,609,638.77	$6,609,638.77	$6,609,638.75	$0.00	$0.02
2-7222	GENERAL REVENUE - VETERANS SERVICES	$5,833.34	$5,833.34	$5,833.34	$0.00	$0.00	$64,166.68	$64,166.68	$64,166.68	$0.00	$0.00
2-7224	GENERAL REVENUE - BH SVCS IN EDUC SVC CTR	$9,583.34	$9,583.34	$9,583.34	$0.00	$0.00	$105,416.68	$105,416.68	$105,416.68	$0.00	$0.00
2-7230	GENERAL REVENUE - IDD	$93,036.53	$93,036.53	$93,036.53	$0.00	$0.00	$1,023,401.84	$1,023,401.84	$1,023,401.83	$0.00	$0.01
2-7232	GENERAL REVENUE-CRISIS REDESIG	$39,884.50	$39,884.50	$39,884.50	$0.00	$0.00	$438,729.50	$438,729.50	$438,729.50	$0.00	$0.00
2-7235	GENERAL REVENUE - IDD ARPA	$0.00	$0.00	$0.00	$0.00	$0.00	$2,795.39	$2,795.39	$17,061.96	$0.00	($14,266.57)
2-7236	IDD GR-CRISIS RESPITE-CIS	$17,980.66	$17,980.66	$17,980.66	$0.00	$0.00	$197,787.32	$197,787.32	$197,787.32	$0.00	$0.00
2-7238	PERMANENCY PLANNING	$1,854.75	$1,854.75	$1,854.75	$0.00	$0.00	$20,402.25	$20,402.25	$20,402.25	$0.00	$0.00
Total General Revenue		**$1,038,552.49**	**$997,676.42**	**$912,163.01**	**$40,876.07**	**$126,389.48**	**$11,308,773.92**	**$11,349,139.37**	**$11,490,781.31**	**($40,365.45)**	**($182,007.39)**
Medicaid Waiver											
2-7137	ICF-QAF	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	($105.20)	$0.00	$105.20
Total Medicaid Waiver		**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$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	$160,223.25	$160,223.25	$160,223.25	$0.00	$0.00
2-7201	TANF-ADULT	$3,207.59	$3,207.59	$3,207.59	$0.00	$0.00	$35,283.43	$35,283.43	$35,283.43	$0.00	$0.00
2-7202	TANF-TITLE XX-ADULT	$3,663.66	$3,663.66	$3,663.66	$0.00	$0.00	$40,300.32	$40,300.32	$40,300.32	$0.00	$0.00
2-7203	TRANSITION-TITLE XX-CRISIS	$5,992.25	$5,992.25	$5,992.25	$0.00	$0.00	$65,914.75	$65,914.75	$65,914.75	$0.00	$0.00
2-7210	MENTAL HEALTH BLOCK GRANT	$36,511.91	$36,511.91	$36,511.87	$0.00	$0.04	$401,631.06	$401,631.06	$401,630.99	$0.00	$0.07
Total Allocated Federal Funds		**$63,941.16**	**$63,941.16**	**$63,941.12**	**$0.00**	**$0.04**	**$703,352.81**	**$703,352.81**	**$703,352.74**	**$0.00**	**$0.07**
Total Revenue		**$2,716,619.40**	**$2,968,907.87**	**$3,009,986.77**	**($252,288.47)**	**($293,367.37)**	**$31,663,346.72**	**$32,845,486.74**	**$33,075,137.28**	**($1,182,140.02)**	**($1,411,790.56)**

		JULY 2026					YEAR TO DATE				
		JUL FY26 Actual	JUL FY26 Budget	JUL FY25 Actual	Variance Budget	Variance FY 2025	FY2026 Y-T-D Actual	FY2026 Y-T-D Budget	FY2025 Y-T-D Actual	Variance Y-T-D Budget	Variance Y-T-D FY 2025
Expense											
Salaries											
2-8000	SALARIES	$964,087.03	$988,099.05	$997,642.74	($24,012.02)	($33,555.71)	$10,699,896.76	$10,745,298.14	$10,548,537.00	($45,401.38)	$151,359.76
2-8001	OVERTIME	$8,041.02	$7,948.02	$5,167.92	$93.00	$2,873.10	$98,770.13	$80,750.19	$98,467.32	$18,019.94	$302.81
Total Salaries		**$1,009,310.77**	**$1,012,295.37**	**$954,461.49**	**($23,919.02)**	**($30,682.61)**	**$1,974,172.10**	**$1,966,350.34**	**$1,891,678.48**	**($27,381.44)**	**$151,662.57**
Benefits											
2-8002	EMPLOYER'S FICA/MEDICARE	$73,212.71	$73,397.49	$74,265.54	($184.78)	($1,052.83)	$792,141.97	$804,222.01	$779,991.33	($12,080.04)	$12,150.64
2-8003	TEC UNEMPLOYMENT TAX	$976.57	$1,076.96	$391.68	($100.39)	$584.89	$46,117.00	$46,721.47	$20,310.09	($604.47)	$25,806.91
2-8004	WORKER'S COMPENSATION	$1,947.00	$2,041.46	$1,992.00	($94.46)	($45.00)	$30,506.00	$32,460.54	$20,647.00	($1,954.54)	$9,859.00
2-8005	RETIREMENT EMPLOYER CONTRIBUTION 401A	$52,883.93	$53,036.55	$52,510.42	($152.62)	$373.51	$575,691.09	$576,933.89	$535,136.74	($1,242.80)	$40,554.35
2-8006	HEALTH INSURANCE	$168,142.03	$169,612.72	$155,000.84	($1,470.69)	$13,141.19	$1,822,371.86	$1,822,449.41	$1,622,156.63	($77.55)	$200,215.23
2-8008	EMPLOYER FUNDED BASIC LIFE	$949.27	$962.66	$940.70	($13.39)	$8.57	$10,559.13	$10,504.98	$6,699.85	$54.15	$3,859.28
Total Benefits		**$284,233.15**	**$285,526.89**	**$256,608.09**	**($2,016.33)**	**$13,010.33**	**$564,672.54**	**$565,309.08**	**$509,788.70**	**($15,905.25)**	**$292,445.41**
Contracts											
2-8300	PSYCHIATRIST	$23,465.00	$22,000.00	$25,200.00	$1,465.00	($1,735.00)	$261,740.00	$256,000.00	$258,675.00	$5,740.00	$3,065.00
2-8302	MEDICAL DIRECTOR	$0.00	$0.00	$7,300.00	$0.00	($7,300.00)	$0.00	$0.00	$29,200.00	$0.00	($29,200.00)
2-8304	PSYCHOLOGIST	$1,750.00	$1,050.00	$1,050.00	$700.00	$700.00	$4,000.00	$5,800.00	$5,800.00	($1,800.00)	($1,800.00)
2-8306	RN NURSES	$0.00	$0.00	$0.00	$0.00	$0.00	$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	$137,082.00	$137,634.86	$137,082.00	($552.86)	$0.00
2-8320	PESC BED DAYS	$174,210.00	$129,408.00	$107,110.00	$44,802.00	$67,100.00	$1,636,655.00	$1,598,592.00	$1,752,260.00	$38,063.00	($115,605.00)
2-8321	PPB BED DAYS	$48,675.00	$51,657.00	$12,170.00	($2,982.00)	$36,505.00	$711,065.00	$758,938.00	$836,850.00	($47,873.00)	($125,785.00)
2-8322	OSAR-SUBSTANCE ABUSE	$36,752.52	$40,529.95	$32,529.95	($3,777.43)	$4,222.57	$334,400.19	$373,332.09	$374,332.09	($38,931.90)	($39,931.90)
2-8326	LABORATORY CONTRACTS	$1,448.13	$2,167.50	$2,111.20	($719.37)	($663.07)	$22,819.65	$26,976.00	$21,291.77	($4,156.35)	$1,527.88
2-8336	RESPITE-CONTRACTED	$6,670.00	$4,233.50	$6,233.50	$2,436.50	$436.50	$52,277.75	$46,821.50	$45,821.50	$5,456.25	$6,456.25
2-8338	SOFTWARE WEB-BASED	$22,474.25	$21,460.98	$21,346.33	$1,013.27	$1,127.92	$250,046.53	$247,381.01	$246,276.64	$2,665.52	$3,769.89
2-8344	JUSTICE INVOLVED BED DAYS (SB292)	$196,425.00	$453,147.53	$395,225.00	($256,722.53)	($198,800.00)	$1,970,815.00	$2,843,330.12	$2,263,625.00	($872,515.12)	($292,810.00)
2-8346	STATE HOSPITAL STEP-DOWN PROGRAM CONTRACTED	$45,500.00	$45,500.00	$45,500.00	$0.00	$0.00	$500,500.00	$500,500.00	$500,500.00	$0.00	$0.00
2-8348	BH SVCS IN ESC-REGION 9	$799.07	$913.37	$913.37	($114.30)	($114.30)	$6,108.18	$7,523.89	$7,523.89	($1,415.71)	($1,415.71)
2-8350	OTHER CONTRACTED CONSULTANTS	$2,825.53	$2,295.24	$6,689.38	$530.29	($3,863.85)	$40,314.97	$47,630.84	$57,777.73	($7,315.87)	($17,462.76)
2-8352	WFPD - CART	$9,769.14	$8,320.30	$757.59	$1,448.84	$9,011.55	$68,457.28	$60,586.34	$92,453.67	$7,870.94	($23,996.39)
2-8353	TECHNICAL ASSISTANCE - CART	$0.00	$0.00	$20,000.00	$0.00	($20,000.00)	$12,490.00	$32,895.00	$118,980.00	($20,405.00)	($106,490.00)
2-8354	WFFD - CART	$94.25	$5,166.57	$5,000.00	($5,072.32)	($4,905.75)	$52,313.87	$56,165.99	$95,000.00	($3,852.12)	($42,686.13)
2-8355	Other Contracted/Non-Contracted Consultants-G & A Services	$9,616.01	$9,595.58	$13,365.20	$20.43	($3,749.19)	$105,302.94	$96,569.82	$110,355.51	$8,733.12	($5,052.57)
Total Contracts		**$592,935.90**	**$809,961.94**	**$714,963.52**	**($217,026.04)**	**($122,027.62)**	**$6,166,583.36**	**$7,096,677.46**	**$6,953,869.80**	**($930,094.10)**	**($787,286.44)**
Travel and Training											
2-8021	EMPLOYEE MILEAGE	$686.09	$739.81	$900.49	($53.72)	($214.40)	$14,300.88	$18,055.96	$18,868.79	($3,755.08)	($4,567.91)
2-8022	EMPLOYEE PER DIEM (MEALS AND HOTEL)	$1,067.16	$1,344.87	$1,344.87	($277.71)	($277.71)	$40,464.05	$32,039.20	$32,456.58	$8,424.85	$8,007.47
2-8023	EMPLOYEE TRAVEL-AIRFARE & CAR RENTAL	$151.60	$610.23	$619.12	($458.63)	($467.52)	$10,529.20	$8,409.11	$9,122.24	$2,120.09	$1,406.96
2-8024	EMPLOYEE TRAVEL OVER STATE RATE	$0.00	$0.00	$0.00	$0.00	$0.00	$4,190.18	$1,198.87	$1,198.87	$2,991.31	$2,991.31
2-8025	EMPLOYEE DEVELOPMENT & TRAINING	$719.00	$357.00	$507.00	$362.00	$212.00	$30,576.37	$30,929.36	$31,314.28	($352.99)	($737.91)
Total Travel and Training		**$2,623.85**	**$3,051.91**	**$3,371.48**	**($428.06)**	**($747.63)**	**$100,060.68**	**$90,632.50**	**$92,960.76**	**$9,428.18**	**$7,099.92**
Capital Outlay											
2-8106	BUILDING USE FEE	$6,408.20	$6,232.24	$7,429.56	$175.96	($1,021.36)	$80,547.43	$78,898.75	$85,861.61	$1,648.68	($5,314.18)
2-8126	EQUIP/FURN/FIX USE FEE	$2,273.97	$2,278.06	$2,093.65	($4.09)	$180.32	$22,965.88	$25,401.49	$25,260.70	($2,435.61)	($2,294.82)
2-8146	VEHICLE USE FEE	$14,962.48	$9,581.84	$5,434.79	$5,380.64	$9,527.69	$101,353.99	$83,304.21	$62,568.82	$18,049.78	$38,785.17
2-8156	SOFTWARE USE FEE	$0.00	$0.00	$208.34	$0.00	($208.34)	$208.33	$208.33	$2,291.67	$0.00	($2,083.34)
2-8166	COMPUTER & PRINTER USE FEE	$3,112.03	$3,303.73	$5,174.61	($191.70)	($2,062.58)	$42,036.12	$46,716.16	$54,938.31	($4,680.04)	($12,902.19)
2-8170	CAPITAL OUTLAY	$7,151.37	$10,833.41	$1,220.74	($3,682.04)	$5,930.63	$12,657.41	$16,339.45	$115,682.75	($3,682.04)	($103,025.34)
Total Capital Outlay		**$33,908.05**	**$32,229.28**	**$21,561.69**	**$1,678.77**	**$12,346.36**	**$259,769.16**	**$250,868.39**	**$346,603.86**	**$8,900.77**	**($86,834.70)**
Non-Capitalized Equipment											
2-8190	MINOR EQUIPMENT PURCHASES	$377.03	$1,426.00	($1,713.62)	($1,048.97)	$2,090.65	$53,749.50	$25,721.23	$28,921.87	$28,028.27	$24,827.63
Total Non-Capitalized Equipment		**$377.03**	**$1,426.00**	**($1,713.62)**	**($1,048.97)**	**$2,090.65**	**$53,749.50**	**$25,721.23**	**$28,921.87**	**$28,028.27**	**$24,827.63**

		JULY 2026					YEAR TO DATE				
		JUL FY26 Actual	JUL FY26 Budget	JUL FY25 Actual	Variance Budget	Variance FY 2025	FY2026 Y-T-D Actual	FY2026 Y-T-D Budget	FY2025 Y-T-D Actual	Variance Y-T-D Budget	Variance Y-T-D FY 2025
Pharmaceutical											
2-8316	PHARMACIST	$57,269.77	$55,026.79	$58,196.50	$2,242.98	($926.73)	$643,624.37	$629,316.47	$611,212.28	$14,307.90	$32,412.09
Total Pharmaceutical		**$57,269.77**	**$55,026.79**	**$58,196.50**	**$2,242.98**	**($926.73)**	**$643,624.37**	**$629,316.47**	**$611,212.28**	**$14,307.90**	**$32,412.09**
Other Operating											
2-8007	EAP EXPENSE	$396.80	$406.40	$406.40	($9.60)	($9.60)	$4,449.60	$4,470.40	$4,349.58	($20.80)	$100.02
2-8020	HIRING RELATED EXPENSES	$3,506.28	$5,014.86	$3,696.00	($1,508.58)	($189.72)	$42,759.67	$41,397.75	$36,562.67	$1,361.92	$6,197.00
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	$1,567.89	$1,567.89	($1,011.33)	($1,011.33)
2-8040	PROFESSIONAL/ERROR&OMMISSIONS	$2,174.49	$2,174.49	$2,410.61	$0.00	($236.12)	$23,919.39	$23,919.39	$26,516.71	$0.00	($2,597.32)
2-8041	LIABILITY COVERAGE	$103.67	$103.67	$107.25	$0.00	($3.58)	$1,240.37	$1,140.37	$1,367.72	$100.00	($127.35)
2-8042	OTHER INSURANCE COVERAGE	$1,777.85	$1,777.85	$1,713.36	$0.00	$64.49	$19,556.35	$19,556.35	$18,846.96	$0.00	$709.39
2-8050	ADVERTISING EXPENSE	$4,323.11	$2,594.77	$1,813.47	$1,728.34	$2,509.64	$20,181.90	$22,331.15	$14,549.85	($2,149.25)	$5,632.05
2-8055	DUES AND MEMBERSHIPS	$5,401.42	$5,720.53	$5,326.13	($319.11)	$75.29	$61,299.00	$59,516.65	$63,912.16	$1,782.35	($2,613.16)
2-8057	LICENSES	$3,278.44	$2,384.64	$1,911.27	$893.80	$1,367.17	$25,913.51	$16,230.00	$25,717.58	$9,683.51	$195.93
2-8060	BOARD ACTIVITY EXPENSE	($717.00)	$0.00	$0.00	($717.00)	($717.00)	$4,244.80	$3,381.20	$4,436.46	$863.60	($191.66)
2-8065	DPP-BHS RISK AND ADMIN EXPENSE	$2,044.17	$2,044.17	$2,044.17	$0.00	$0.00	$22,485.87	$22,485.87	$22,485.80	$0.00	$0.07
2-8070	UTILITIES	$21,780.77	$18,078.97	$20,342.28	$3,701.80	$1,438.49	$205,351.84	$195,878.63	$198,402.01	$9,473.21	$6,949.83
2-8072	TELECOMMUNICATIONS	$23,981.98	$22,558.12	$22,451.49	$1,423.86	$1,530.49	$290,660.32	$288,522.21	$288,214.81	$2,138.11	$2,445.51
2-8076	TELEPHONE-BASIC SERVICE EXPENSE	$1,767.02	$1,804.11	$1,922.65	($37.09)	($155.63)	$22,031.85	$26,015.86	$26,142.51	($3,984.01)	($4,110.66)
2-8078	CELL PHONE SERVICE EXPENSE	($516.49)	$1,963.86	$2,008.91	($2,480.35)	($2,525.40)	$20,229.56	$22,891.05	$23,086.55	($2,661.49)	($2,856.99)
2-8080	LONG DISTANCE TELEPHONE SERVICE EXPENSE	$74.54	$305.23	$305.23	($230.69)	($230.69)	$4,013.61	$2,864.42	$2,864.44	$1,149.19	$1,149.17
2-8100	BUILDING RENT	$57,099.53	$57,099.53	$56,826.57	$0.00	$272.96	$627,228.02	$624,834.02	$691,306.18	$2,394.00	($64,078.16)
2-8101	P.O. BOX/STORAGE RENTAL/LEASE	$86.83	$82.19	$82.20	$4.64	$4.63	$921.85	$887.62	$887.90	$34.23	$33.95
2-8102	PROPERTY DAMAGE COVERAGE	$10,935.10	$11,732.53	$10,163.60	($797.43)	$771.50	$125,161.39	$129,057.83	$111,660.60	($3,896.44)	$13,500.79
2-8104	BUILDING REPAIR & MAINTENANCE	$19,504.49	$13,067.67	$12,827.61	$6,436.82	$6,676.88	$184,410.79	$168,547.66	$169,842.11	$15,863.13	$14,568.68
2-8120	EQUIPMENT RENTAL/LEASE	$7,141.35	$7,142.04	$7,173.12	($0.69)	($31.77)	$78,938.81	$78,437.82	$78,771.20	$500.99	$167.61
2-8124	EQUIPMENT REPAIR & MAINTENANCE	$2,568.51	$5,814.62	$1,814.62	($3,246.11)	$753.89	$24,396.02	$27,236.38	$27,405.39	($2,840.36)	($3,009.37)
2-8140	VEHICLE LEASE	$332.65	$2,611.11	$2,611.11	($2,278.46)	($2,278.46)	$23,998.26	$28,722.21	$28,722.21	($4,723.95)	($4,723.95)
2-8142	AUTO LIABILITY/PHYS DAMAGE INS	$8,639.69	$9,331.45	$7,886.15	($691.76)	$753.54	$95,536.01	$97,047.23	$89,403.09	($1,511.22)	$6,132.92
2-8143	INSURANCE EXP-DEDUCTIBLES PAID	$0.00	$1,000.00	$0.00	($1,000.00)	$0.00	$0.00	$1,000.00	$1,400.00	($1,000.00)	($1,400.00)
2-8144	VEHICLE REPAIR & MAINTENANCE	$2,194.73	$3,020.78	$3,051.72	($826.05)	($856.99)	$33,600.59	$33,809.16	$34,056.87	($208.57)	($456.28)
2-8145	GAS-VEHICLE & EQUIPMENT	$9,762.47	$8,665.92	$6,101.11	$1,096.55	$3,661.36	$83,381.71	$79,182.14	$66,710.77	$4,199.57	$16,670.94
2-8200	OFFICE SUPPLIES	$9,168.64	$4,834.21	$11,138.07	$4,334.43	($1,969.43)	$125,658.24	$122,280.87	$100,166.81	$3,377.37	$25,491.43
2-8202	BOOKS & SUBSCRIPTIONS	$1,969.22	$11,292.60	$742.71	($9,323.38)	$1,226.51	$39,056.04	$48,404.54	$38,837.10	($9,348.50)	$218.94
2-8204	JANITORIAL/CLEANING SUPPLIES	($6,956.63)	$723.31	$728.60	($7,679.94)	($7,685.23)	$2,249.05	$7,984.05	$8,113.29	($5,735.00)	($5,864.24)
2-8206	OTHER CONSUMABLE SUPPLIES	$1,827.57	$1,084.95	$1,101.56	$742.62	$726.01	$14,827.00	$13,772.30	$13,825.27	$1,054.70	$1,001.73
2-8208	MEDICAL SUPPLIES	$384.58	$299.18	$319.17	$85.40	$65.41	$12,306.78	$11,224.67	$11,359.11	$1,082.11	$947.67
2-8210	FOOD	$0.00	$393.75	$403.13	($393.75)	($403.13)	$3,495.60	$3,073.75	$4,219.00	$421.85	($723.40)
2-8214	PERSONAL CARE/HYGENE SUPPLIES	$0.00	$0.00	$128.32	$0.00	($128.32)	$0.00	$0.00	$128.32	$0.00	($128.32)
2-8216	TRAINING/BEHAVIOR MODIFICATION	$21.49	$0.00	$0.00	$21.49	$21.49	$1,303.12	$0.00	$0.00	$1,303.12	$1,303.12
2-8218	CONSUMER ASSISTANCE	$247.63	$750.72	$1,150.72	($503.09)	($903.09)	$8,044.27	$9,031.63	$21,333.83	($987.36)	($13,289.56)
2-8220	PRINTING SERVICES	$3,017.89	$3,415.36	$3,430.45	($397.47)	($412.56)	$31,071.31	$28,905.89	$26,440.28	$2,165.42	$4,631.03
2-8221	COURIER DELIVERY SERVICES	$0.00	$0.00	$0.00	$0.00	$0.00	$370.64	$386.37	$386.37	($15.73)	($15.73)
2-8222	POSTAGE & DELIVERY CHARGES	$2,749.37	$1,551.74	$1,551.74	$1,197.63	$1,197.63	$18,435.69	$17,923.51	$17,928.34	$512.18	$507.35
2-8226	SANCTIONS	$0.00	$0.00	$0.00	$0.00	$0.00	$3,560.06	$0.00	$3,138.70	$3,560.06	$421.36
2-8228	BNK CHRGES & CREDIT CRD FEES	$1,801.88	$1,027.94	$1,221.91	$773.94	$579.97	$10,767.87	$11,307.47	$11,509.87	($539.60)	($742.00)
2-8232	MISCELLANEOUS CHARGE & EXPENSE	$17,667.09	$16.54	$904.28	$17,650.55	$16,762.81	$20,483.78	$4,141.30	$11,739.41	$16,342.48	$8,744.37
2-8237	IN-KIND EXPENSES	$711,463.49	$796,163.42	$939,565.39	($84,699.93)	($228,101.90)	$7,357,331.53	$7,777,553.58	$8,811,392.15	($420,222.05)	($1,454,060.62)
2-8340	CPA FIRM	$0.00	$1,600.00	$0.00	($1,600.00)	$0.00	$25,708.20	$26,600.00	$32,500.00	($891.80)	($6,791.80)
2-8342	ATTORNEY-CONTRACTED/NON-CONTR	$0.00	$0.00	$0.00	$0.00	$0.00	$966.16	$756.25	$0.00	$209.91	$966.16
2-8359	NON-CONTRACTED RESPITE	$308.00	$576.00	$576.00	($268.00)	($268.00)	$476.00	$1,189.00	$828.00	($713.00)	($352.00)
2-8360	NON-CONTRACTED CONSULTANTS	$0.00	$732.50	$0.00	($732.50)	$0.00	$11,532.05	$10,751.01	$1,519.61	$781.04	$10,012.44
Total Other Operating		**$931,312.62**	**$1,010,961.73**	**$1,137,959.08**	**($79,649.11)**	**($206,646.46)**	**$9,748,938.62**	**$10,133,217.45**	**$11,189,312.63**	**($384,278.83)**	**($1,440,374.01)**
Total Expense		$2,888,666.78	$3,208,832.56	$3,222,250.49	($320,165.78)	($333,583.71)	$31,048,779.63	$32,345,774.13	$32,854,827.16	($1,296,994.50)	($1,806,047.53)

	JULY 2026					YEAR TO DATE				
	JUL FY26 Actual	JUL FY26 Budget	JUL FY25 Actual	Variance Budget	Variance FY 2025	FY2026 Y-T-D Actual	FY2026 Y-T-D Budget	FY2025 Y-T-D Actual	Variance Y-T-D Budget	Variance Y-T-D FY 2025
BEGINNING NET ASSETS	$14,302,431.67	$14,302,431.67	$13,784,069.17	$0.00	$518,362.50	$13,515,817.20	$13,515,817.20	$13,351,495.33	$0.00	$164,321.87
NET SURPLUS/(DEFICIT)	($172,047.38)	($239,924.69)	($212,263.72)	$67,877.31	$40,216.34	$614,567.09	$499,712.61	$220,310.12	$114,854.48	$394,256.97
ENDING NET ASSETS	$14,130,384.29	$14,062,506.98	$13,571,805.45	$67,877.31	$558,578.84	$14,130,384.29	$14,015,529.81	$13,571,805.45	$114,854.48	$558,578.84

RECOMMENDED ACTION: That the Board of Trustees approve the FY 2027 Center Budget.

BACKGROUND INFORMATION: The FY 2027 State budget must be prepared and submitted to the Health and Human Service Commission Behavioral Health and Intellectual Developmental Disabilities Divisions in September. Those budgets are consolidated into large categories that do not correspond to our general ledger or financial statements. Therefore, we do not ask the Board to approve those budgets.

SUPPORTING INFORMATION:

A. Attached is the FY 2027 Center budget with explanations.

B. The budget is based on historical data and known changes.

C. Helen Farabee Centers has no taxing authority and therefore no taxpayer impact statement is applicable.

	Helen Farabee Centers FY27 BUDGET			
	REVENUE			
Account Number	Description	Category	Total	
2-7000	CITY OF WICHITA FALLS	Revenue	$100,000.00	No Change to contribution
2-7001	CITY OF CHILLICOTHE	Revenue	$330.00	No Change to contribution
2-7002	CITY OF QUANAH	Revenue	$660.00	No Change to contribution
2-7003	CITY OF HASKELL	Revenue	$0.00	no support since FY23
2-7004	CITY OF BURKBURNETT	Revenue	$5,012.00	No Change to contribution
2-7005	CITY OF GRAHAM	Revenue	$15,000.00	No Change to contribution
2-7006	CITY OF NOCONA	Revenue	$1,500.00	No Change to contribution
2-7007	CITY OF BOWIE	Revenue	$8,000.00	No Change to contribution
2-7020	WICHITA COUNTY	Revenue	$220,000.00	INCREASE OF $60,000
2-7021	HASKEL COUNTY	Revenue	$16,652.00	No Change to contribution
2-7022	STONEWALL COUNTY	Revenue	$2,543.00	No Change to contribution
2-7023	KNOX COUNTY	Revenue	$6,650.00	No Change to contribution
2-7024	DICKENS COUNTY	Revenue	$0.00	ONLY IN-KIND
2-7025	YOUNG COUNTY	Revenue	$47,500.00	No Change to contribution
2-7026	THROCKMORTON COUNTY	Revenue	$1,803.41	DECREASE OF $1476
2-7027	HARDEMAN COUNTY	Revenue	$4,241.33	No Change to contribution
2-7028	WISE COUNTY	Revenue	$55,400.00	No Change to contribution
2-7029	BAYLOR COUNTY	Revenue	$5,200.00	No Change to contribution
2-7030	FOARD COUNTY	Revenue	$1,320.00	No Change to contribution
2-7031	MONTAGUE COUNTY	Revenue	$114,256.45	INCREASE OF $13600
2-7032	JACK COUNTY	Revenue	$35,474.25	No Change to contribution
2-7033	CLAY COUNTY	Revenue	$0.00	DECREASE OF $4000
2-7034	COTTLE COUNTY	Revenue	$1,803.41	DECREASE OF $594
2-7035	CHILDRESS COUNTY	Revenue	$4,175.00	No Change to contribution
2-7036	ARCHER COUNTY SUPPORT	Revenue	$11,575.00	No Change to contribution
2-7037	IN-KIND MATCH	Revenue	$7,755,377.00	This is the daily rate that we receive for Bed Days with Red River Hospital and other hospitals we have contracts with over the amount that we pay. We get the difference in the form of in-kind. This fluctuates based on the number of bed days actually used.
2-7038	INDEPENDENT SCHOOL DISTRICT	Revenue	$3,180.00	No Change to contribution
2-7050	CONSUMER FEES	Revenue	$257,342.54	
2-7060	PRIVATE INSURANCE MCO CARD SERVICES	Revenue	$387,698.00	
2-7070	PRIVATE INSURANCE MCO CASE MANAGEMENT	Revenue	$186,480.00	
2-7080	PRIVATE INSURANCE MCO REHAB	Revenue	$156,288.00	
2-7100	MEDICARE - TITLE XVII	Revenue	$47,061.00	
2-7102	MEDICAID-CARD SERVICES	Revenue	$21,447.00	
2-7104	MEDICAID-CASE MANAGEMENT	Revenue	$39,002.00	
2-7106	MEDICAID-IDD SERV COORDINATION	Revenue	$662,862.00	

2-7108	MEDICAID REHAB	Revenue	$209,743.00	
2-7110	MEDICAID PASRR	Revenue	$6,121.00	
2-7112	MEDICAID-ADMIN CLAIMING	Revenue	$514,937.00	
2-7114	MEDICAID-HABILITATION COORDINATION	Revenue	$136,800.00	
2-7120	MH FIRST AID	Revenue	$150,000.00	SAME AS LAST YEAR
2-7122	TCOOMMI EARNED INCOME	Revenue	$366,842.61	SAME AS LAST YEAR
2-7124	SUBSTANCE ABUSE SERVICES	Revenue	$378,424.60	This only includes our Fee-For-Service Substance abuse services.
2-7125	SUD COMMUNITY MH GRANT PROGRAM	Revenue	$42,260.00	SAME AS LAST YEAR
2-7126	HOSPITAL TRANSITION PILOT PROGRAM	Revenue	$622,594.00	
2-7127	OSAR - OUTREACH, SCREENING ASSESSMENT, REFFERAL	Revenue	$412,224.74	SAME AS LAST YEAR
2-7128	RSS - RECOVERY SUPPORT SERVICES	Revenue	$115,918.00	SAME AS LAST YEAR
2-7132	CMHG LPHA EXPANSION	Revenue	$66,746.58	SAME AS LAST YEAR
2-7150	MFP/ECC REVENUE	Revenue	$32,490.00	SAME AS LAST YEAR
2-7152	PASSR IDD SPECIALIZED SERVICES	Revenue	$9,593.00	SAME AS LAST YEAR
2-7153	PASRR IDD SPECIALIZED SERVICES - OBRA - LIDDA	Revenue	$1,400.00	SAME AS LAST YEAR
2-7200	TANF-CAS	Revenue	$174,789.00	Remained the same as last year
2-7201	TANF-ADULT	Revenue	$38,491.00	Remained the same as last year
2-7202	TANF-TITLE XX-ADULT	Revenue	$43,964.00	Remained the same as last year
2-7203	TRANSITION-TITLE XX-CRISIS	Revenue	$71,907.00	Remained the same as last year
2-7210	MENTAL HEALTH BLOCK GRANT	Revenue	$438,143.00	Remained the same as last year
2-7215	GENERAL REVENUE - PESC	Revenue	$2,177,828.00	Remained the same as last year
2-7216	JUSTICE INVOLVED GRANT PROGRAM - JCBR	Revenue	$228,863.38	Remained the same as last year
2-7217	GENERAL REVENUE - PPB	Revenue	$937,600.00	Remained the same as last year
2-7218	JUSTICE INVOLVED GRANT PROGRAM - SB292	Revenue	$2,355,826.00	Remained the same as last year
2-7220	GENERAL REVENUE - MH	Revenue	$7,210,515.00	Remained the same as last year
2-7222	GENERAL REVENUE - VETERANS SERVICES	Revenue	$70,000.00	Remained the same as last year
2-7224	GENERAL REVENUE - BH SVCS IN EDUC SVC CTR	Revenue	$115,000.00	Remained the same as last year
2-7230	GENERAL REVENUE - IDD	Revenue	$1,116,438.37	Remained the same as last year
2-7232	GENERAL REVENUE-CRISIS REDESIG	Revenue	$478,614.00	Remained the same as last year
2-7236	IDD GR-CRISIS RESPITE-CIS	Revenue	$215,768.00	Remained the same as last year
2-7238	PERMANENCY PLANNING	Revenue	$22,257.00	Remained the same as last year
2-7245	DARS-ECI REVENUE	Revenue	$1,057,324.00	Slight decrease over last year
2-7252	DIRECTED PAYMENT PROGRAM-BEHAVIORAL HEALTH PROGRAM	Revenue	$364,020.00	
2-7254	PUBLIC HEALTH PROVIDER-CHARITY CARE PROGRAM	Revenue	$2,197,789.03	Decrease over last year – $371267
2-7258	TRANSITION SUPPORT LIAISON	Revenue	$60,366.00	Remained the same as last year
2-7260	RENT	Revenue	$13,650.00	
2-7270	DONATIONS/CONTRIBUTIONS	Revenue	$8,000.00	
2-7275	INTEREST INCOME	Revenue	$248,118.00	
2-7280	MISCELLANEOUS	Revenue	$41,871.00	
			$32,929,069.70	

	EXPENSES			
2-8000	SALARIES	Expense	$11,733,398.16	
2-8001	OVERTIME	Expense	$88,698.21	
2-8002	EMPLOYER'S FICA/MEDICARE	Expense	$877,619.42	
2-8003	TEC UNEMPLOYMENT TAX	Expense	$47,717.50	
2-8004	WORKER'S COMPENSATION	Expense	$34,502.00	
2-8005	RETIREMENT EMPLOYER CONTRIBUTION 401A	Expense	$629,970.44	
2-8006	HEALTH INSURANCE	Expense	$2,000,057.00	Center amount will change from $933.73 to $980.42
2-8007	EAP EXPENSE	Expense	$4,854.00	
2-8008	EMPLOYER BASIC LIFE INSURANCE	Expense	$11,519.00	
2-8020	HIRING RELATED EXPENSES	Expense	$46,647.00	
2-8021	EMPLOYEE MILEAGE	Expense	$15,601.00	
2-8022	EMPLOYEE PER DIEM (MEALS AND HOTEL)	Expense	$44,143.00	
2-8023	EMPLOYEE TRAVEL-AIRFARE & CAR RENTAL	Expense	$9,771.15	
2-8024	EMPLOYEE TRAVEL OVER STATE RATE	Expense	$4,571.00	
2-8025	EMPLOYEE DEVELOPMENT & TRAINING	Expense	$33,356.00	
2-8026	EMPLOYEE AWARDS & BANQUETS	Expense	$14,500.00	Employee appreciation day in September
2-8027	EMPLOYEE FLU SHOTS AND TB	Expense	$607.71	
2-8040	PROFESSIONAL/ERROR&OMMISSIONS	Expense	$31,211.70	
2-8041	LIABILITY COVERAGE	Expense	$1,448.85	
2-8042	OTHER INSURANCE COVERAGE	Expense	$21,701.00	
2-8050	ADVERTISING EXPENSE	Expense	$22,017.00	
2-8055	DUES, MEMBERSHIP, LICENSES	Expense	$66,872.00	
2-8057	LICENSES	Expense	$28,269.00	
2-8060	BOARD ACTIVITY EXPENSE	Expense	$4,630.00	
2-8065	DPP-BHS RISK & ADMIN EXPENSE	Expense	$24,530.00	
2-8070	UTILITIES	Expense	$224,020.00	
2-8072	TELECOMMUNICATIONS	Expense	$317,084.00	
2-8076	TELEPHONE-BASIC SERVICE EXPENSE	Expense	$24,035.00	
2-8078	CELL PHONE SERVICE EXPENSE	Expense	$22,067.00	
2-8080	LONG DISTANCE TELEPHONE SERVICE EXPENSE	Expense	$4,378.00	
2-8100	BUILDING RENT	Expense	$687,161.16	SLIGHT INCREASE OVER LAST YEAR
2-8101	P.O. BOX/STORAGE RENTAL/LEASE	Expense	$1,006.00	
2-8102	PROPERTY DAMAGE COVERAGE	Expense	$66,077.00	One time discount – $44,977
2-8104	BUILDING REPAIR & MAINTENANCE	Expense	$201,175.00	
2-8106	BUILDING USE FEE	Expense	$76,898.00	
2-8120	EQUIPMENT RENTAL/LEASE	Expense	$86,115.00	
2-8124	EQUIPMENT REPAIR & MAINTENANCE	Expense	$26,614.00	
2-8126	EQUIP/FURN/FIX USE FEE	Expense	$27,679.55	
2-8142	AUTO LIABILITY/PHYS DAMAGE INS	Expense	$102,462.75	Slight decrease from last year
2-8143	INSURANCE EXP-DEDUCTIBLES PAID	Expense	$1,000.00	

2-8144	VEHICLE REPAIR & MAINTENANCE	Expense	$36,655.00	
2-8145	GAS-VEHICLE & EQUIPMENT	Expense	$90,962.00	
2-8146	VEHICLE USE FEE	Expense	$179,549.76	
2-8166	COMPUTER & PRINTER USE FEE	Expense	$37,344.00	
2-8170	CAPITAL OUTLAY	Expense	$13,808.00	
2-8190	MINOR EQUIPMENT PURCHASES	Expense	$26,273.34	
2-8200	OFFICE SUPPLIES	Expense	$137,082.00	
2-8202	BOOKS & SUBSCRIPTIONS	Expense	$42,606.00	
2-8204	JANITORIAL/CLEANING SUPPLIES	Expense	$2,454.00	
2-8206	OTHER CONSUMABLE SUPPLIES	Expense	$16,175.00	
2-8208	MEDICAL SUPPLIES	Expense	$13,426.00	
2-8210	FOOD	Expense	$3,813.00	
2-8218	CONSUMER ASSISTANCE	Expense	$8,775.00	
2-8220	PRINTING SERVICES	Expense	$33,896.00	
2-8221	COURIER DELIVERY SERVICES	Expense	$404.00	
2-8222	POSTAGE & DELIVERY CHARGES	Expense	$20,112.00	
2-8228	BNK CHRGES & CREDIT CRD FEES	Expense	$11,747.00	
2-8232	MISCELLANEOUS CHARGE & EXPENSE	Expense	$22,346.00	
2-8237	IN-KIND EXPENSES	Expense	$7,755,377.00	
2-8300	PSYCHIATRIST	Expense	$285,535.00	
2-8304	PSYCHOLOGIST	Expense	$4,400.00	
2-8316	PHARMACIST	Expense	$702,135.00	
2-8318	CRISIS-CONTRACTED	Expense	$149,544.00	
2-8320	PESC BED DAYS	Expense	$1,728,000.00	Based on estimate number of bed days used
2-8321	PPB	Expense	$810,596.00	Based on estimate number of bed days used
2-8322	OSAR-SUBSTANCE ABUSE	Expense	$412,436.00	
2-8326	LABORATORY CONTRACTS	Expense	$24,894.00	
2-8336	RESPITE-CONTRACTED	Expense	$57,030.00	
2-8338	SOFTWARE WEB-BASED	Expense	$272,778.00	
2-8340	CPA FIRM	Expense	$42,000.00	
2-8342	ATTORNEY-CONTRACTED/NON-CONTR	Expense	$500.00	
2-8344	JUSTICE INVOLVED BED DAYS (SB292)	Expense	$2,155,500.00	Based on estimate number of bed days used
2-8346	HOSPITAL TRANSITION CONTRACTED	Expense	$546,000.00	
2-8348	BH SVCS IN ESC-REGION 9	Expense	$6,663.00	
2-8350	OTHER CONTRACTED CONSULTANTS	Expense	$43,980.00	
2-8355	Other Contracted/Non-Contracted Consultants-G & A Services	Expense	$114,875.00	
2-8359	NON-CONTRACTED RESPITE	Expense	$659.00	
2-8360	NON-CONTRACTED CONSULTANTS	Expense	$12,580.00	
			$33,488,894.70	
	NET INCOME		**($559,825.00)**	

5 RECOMMENDATIONS
B. BUDGET AND FINANCE
3) LINE OF CREDIT RENEWAL

RECOMMENDED ACTION: That the Board of Trustees approve and authorize the Board Chair and/or Secretary to sign a Borrowing Resolution to renew the line of credit with Investar Bank.

BACKGROUND INFORMATION:

A. Board must approve bank resolutions for the purpose of conducting Center business.

B. Current signers include Linda Poenitzsch-CFO and Melinda Wilson-Budget Analyst. Both are designated Investment Officers.

C. In January of 2018, the Center established a line of credit with First National Bank. This was Board approved.

D. The Center established the line of credit for processing January 2018, 1115 Waiver IGT.

E. The credit line has not been used yet.

F. The line of credit matures on 09/28/2026.

G. First National Bank was bought out by Investar as of 2026.

SUPPORTING INFORMATION:

A. The Center is seeking to keep this line of credit in the amount of $1,600,000.

B. Interest rate will fluctuate based on the prime rate.

C. Interest is only generated on current use of credit. If the Center uses $500,000, interest is generated on the $500,000 not the $1,600,000.

D. The Center is using current investments as collateral.

E. The Center has the option of increasing or decreasing the line of credit at any time.

F. Renewing the line of credit will open other options, if needed, in the future.

HELEN FARABEE CENTERS

A RESOLUTION AUTHORIZING CENTER TO RENEW THE LINE OF CREDIT WTH INVESTAR BANK FOR $1,600,000

NOW, THEREFORE, BE IT RESOLVED

That the Board approves the Center to renew the line of credit with Investar Bank in the amount of $1,600,000. The Certificate of Deposits established with Investar Bank will act as collateral. The designated investment officers are authorized to make decisions and sign required documents as stated;

Linda Poenitzsch, Chief Financial Officer

Melinda Wilson, Budget Analyst

PASSED, ADOPTED, AND APPROVED by the Board of Trustees of Helen Farabee Centers this 3rd day of September 2026.

APPROVED

_____

J. Brian Eby
Chair, Board of Trustees

5 RECOMMENDATIONS
B. BUDGET
4) TEXAS COUNCIL DUES 2027

RECOMMENDED ACTION: That the Board of Trustees approve the Fiscal Year 2027 Dues Commitment with the Texas Council of Community Centers and authorize the Chair and Executive Director to sign the commitment form.

BACKGROUND INFORMATION:

A. The Texas Council is the trade organization for all of the community centers in the state of Texas. They have provided a forum for all community centers in dealing with State agencies including the Legislature, Health and Human Service Commission, Department State Health Services and Department of Aging and Disability Services. They have also been active in supporting the Public Health Provider - Charity Care Program, Directed Payment Program for Behavioral Health Services, and associated reporting requirements.

B. The Texas Council is the sponsoring entity for our insurance through the Risk Management Fund.

C. They provide valuable training and resources at little or no extra cost.

D. Annually, each community center is assessed membership dues by the Texas Council. Our Fiscal Year 2026 assessment was $39,662.00 ($41,745.00 - $2,083.00 credit for our membership in the Risk Management Fund).

SUPPORTING INFORMATION:

A. Our total Fiscal Year 2027 dues are $41,100.00, but we are receiving credit in the amount of $2,083 for our membership in the Risk Management Fund for a total due of $39,016.00.

B. Attached are the FY 2027 Commitment of Dues Payment for Texas Council of Community Centers;
the Texas Council of Community Centers FY 2027 Budget Overview;
and a TCCC, Inc. Dues Comparison Year Ended August 31, 2026.

Texas Council
of Community Centers

MEMO
August 24, 2026

TO: Gianna Harris
Executive Director, Helen Farabee Centers

FROM: Lee Johnson
Chief Executive Officer

SUBJECT: FY 2027 Commitment of Dues for
Texas Council of Community Centers

Please find attached the FY 2027 (September 1, 2026 – August 31, 2027) Commitment of Dues Payment Form. This form establishes the basis for payment of your dues. Please note on the form that you can choose a payment schedule that meets your needs.

The dues assessment reflects the budget as approved by the Texas Council Board of Directors at the August 14, 2026 annual board meeting. To assist with local discussions, we include the following information:

- Budget Overview
- FY 2027 Budget (with side-by-side comparison to FY 2026)
- FY 2027 Dues Comparison to FY 2026 Dues
- FY 2027 Commitment of Dues Payment Form

If you have any questions, please contact Rae Horne at rhorne@txcouncil.com or Tara Brown at tbrown@txcouncil.com.

cc: Texas Council Board Delegate

8140 North Mopac Expressway, Westpark Building 3, Suite 225, Austin, Texas 78759
Tel. 512.794.9268 Fax: 512.794.8280 Web: www.txcouncil.com

Texas Council of Community Centers

Proposed FY27 Budget Highlights

REVENUE ASSUMPTIONS

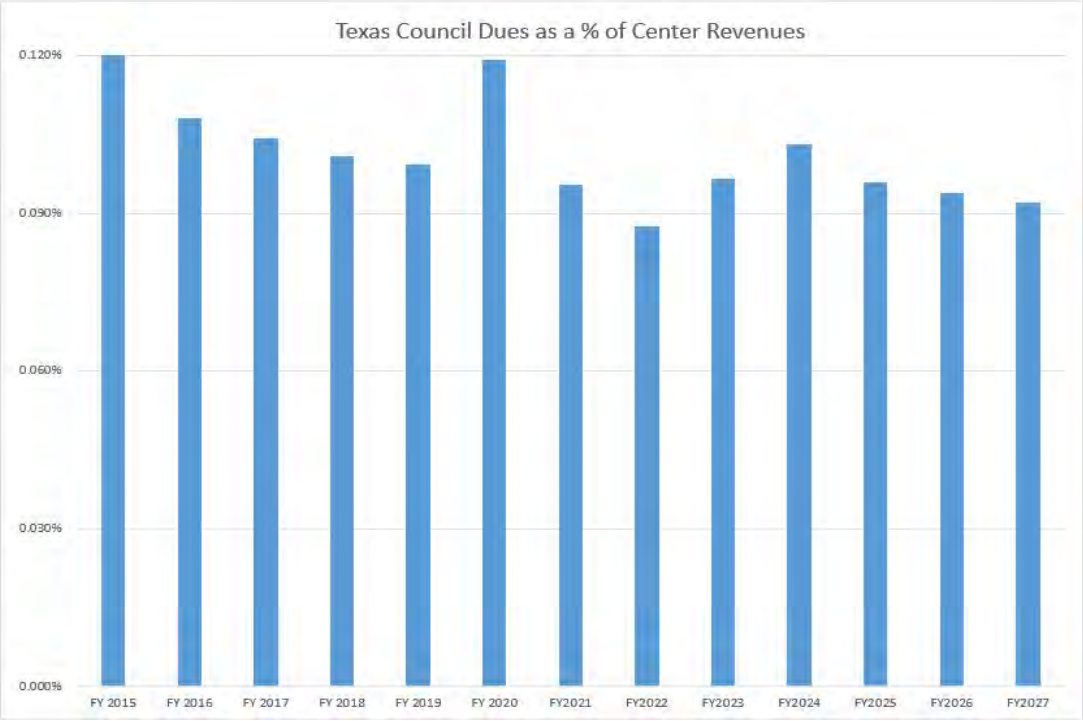
- No increase in total member dues from FY26 level
- $156,575 (-4.9%) decrease in overall revenues and expenses compared to revised FY26 budget
- $224,300 in bond admin commission funds (Municipal Markets sponsored bond program)
- $150,000 TCRMF (sponsored risk management program) contribution (same as FY26)
- $78,500 in ISC (sponsored retirement program) contribution
- $186,000 in consortia meeting fees in TXC meeting space
- $100,000 Conference Salary Reimbursement (same as FY26)

EXPENSE ASSUMPTIONS

- $18,333 (-1.0%) decrease in Personnel expenses for staffing changes
- $14,550 (11.2%) increase in employee health insurance stipend
- $6,000 (-20%) decrease in CEO travel expenses for legislative session year
- $36,000 (-28.6%) decrease in Meeting Space Expenses from more efficient catering budgeting
- $14,200 (-54.2%) decrease in Advocacy Associations (planned adjustment due to FY26 one-time bond revenue)
- $47,869 (-37.5%) decrease in Purchased Services expenses (planned adjustment due to FY26 one-time bond revenue)

FY26 DUES HIGHLIGHTS

- Dues are calculated using a board approved formula as follows: a base assessment is applied to each Center ($18,500) and the remaining amount needed to fund total dues for the year is assessed to each member by determining the net revenue of each Center in proportion to the total net revenues of all members. Using the most current independent audit (FY25), the net revenue for each Center equals its gross revenues less local funds, 1115 Transformation Waiver (DPP and CCP) funds and community hospital funds. Total dues assessed equals the base assessment plus the proportionate share.
- Per agreement between Texas Council and TCRMF, $75,000 of the TCRMF contribution is used to offset dues for its members and $75,000 to cover administrative support provided by the Texas Council. Renewal of the agreement for FY27-29 was approved at these terms by the TCRMF Board on August 7, 2026.



Texas Council of Community Centers, Inc.
Proposed Budget Overview
September 2026 through August 2027

	FY2026	FY2027	Change
Revenue			
40100 · DUES REVENUE			
40110 · Dues - Member Centers	2,258,850.00	2,258,850.00	-
40120 · Dues from Associate Members	27,000.00	27,000.00	-
Total 40100 · DUES REVENUE	2,285,850.00	2,285,850.00	-
41000 · PRODUCT LINE FEES			
41110 - Bond Program - Admin.	382,875.00	224,300.00	(158,575.00)
41130 · Risk Management Program (TCRMF)	150,000.00	150,000.00	-
41140 · Retirement Program (ISC Group)	78,500.00	78,500.00	-
Total 41000 · PRODUCT LINE FEES	611,375.00	452,800.00	(158,575.00)
42000 · OTHER REVENUE			
42140 - Meeting Income	184,000.00	186,000.00	2,000.00
42150 · Annual Conf. Salary Reimb.	100,000.00	100,000.00	-
42160 · Miscellaneous	0.00	0.00	-
42300 - Virtual Learning Seminars	2,000.00	2,000.00	-
Total 42000 · OTHER REVENUE	286,000.00	288,000.00	2,000.00
Total Revenue	3,183,225.00	3,026,650.00	(156,575.00)
Expense			
61100 · PERSONNEL			
61110 · Salaries	1,764,166.67	1,745,833.33	(18,333.34)
62210 · Retirement Prog. Contributions	176,412.67	174,588.00	(1,824.67)
62220 · Employee Life/Health Insurance	129,550.00	144,100.00	14,550.00
62310 · FICA (Social Security/Medicare)	131,630.00	129,048.00	(2,582.00)
62320 · State Unemployment	565.00	720.00	155.00
62330 · Federal Unemployment	633.00	625.00	(8.00)
62340 · Workers Comp	5,253.33	5,880.00	626.67
62380 · Payroll Fees	2,640.00	2,760.00	120.00
Total 61100 · PERSONNEL	2,260,842.67	2,203,553.00	(57,289.67)
64000 · INSURANCE (Other than Payroll)			
64110 · Commercial Package	936.00	936.00	-
64130 · Directors & Officers Liability	1,872.00	1,872.00	-
64170 · Office Contents	276.00	276.00	-
Total 64000 · INSURANCE (Other than Payroll)	3,084.00	3,084.00	-
65100 · OCCUPANCY			
65130 · Base Office Lease	109,530.00	112,815.92	3,285.92
65135 · Assessment from Office Lease	66,369.00	70,100.00	3,731.00
Total 65100 · OCCUPANCY	175,899.00	182,915.92	7,016.92
65200 · OFFICE EQUIPMENT (LEASE, ETC.)			
65240 · Lease - Office Equipment	6,000.00	6,120.00	120.00
65250 · Maintenance - Office Equipment	22,800.00	20,400.00	(2,400.00)
Total 65200 · OFFICE EQUIPMENT (LEASE, ETC.)	28,800.00	26,520.00	(2,280.00)
65300 · OFFICE EXPENSES (OTHER)			

Texas Council of Community Centers, Inc.
Proposed Budget Overview
September 2026 through August 2027

	FY2026	FY2027	Change
65325 · Office Supplies	14,400.00	14,400.00	-
65330 · Postage and Delivery	1,200.00	1,560.00	360.00
65335 · Printing	4,800.00	1,440.00	(3,360.00)
65340 · Telephone & Internet	7,800.00	8,400.00	600.00
65345 · Subscriptions - Publications	24,000.00	30,600.00	6,600.00
65380 · Depreciation - Office Equipment	13,860.00	13,860.00	-
65390 · Depreciation - Office Furniture	4,800.00	4,800.00	-
Total 65300 · OFFICE EXPENSES (OTHER)	70,860.00	75,060.00	4,200.00
66000 · TRAVEL			
66110 · CEO - Auto Allowance	12,000.00	12,000.00	-
66112 · CEO - Travel/Meetings	30,000.00	24,000.00	(6,000.00)
66140 · TX Council Staff (except CEO)	36,000.00	36,000.00	-
66150 · Registration Fees/Conferences	2,400.00	4,800.00	2,400.00
66160 · Oversight Committees	1,200.00	1,500.00	300.00
Total 66000 · TRAVEL	81,600.00	78,300.00	(3,300.00)
67000 · MEETINGS			
67110 · TX Council Board of Directors	0.00	0.00	-
67120 · Executive Directors' Consortium	0.00	0.00	-
67130 · Other Sponsored Consortia	0.00	0.00	-
67150 · Other Meeting Costs	126,000.00	90,000.00	(36,000.00)
Total 67000 · MEETINGS	126,000.00	90,000.00	(36,000.00)
68000 · OTHER OPERATING			
68110 · Memberships - Associations, etc	65,000.00	60,000.00	(5,000.00)
68120 · Advocacy Associations	26,200.00	12,000.00	(14,200.00)
68130 · Public Info. - Contracted	6,000.00	2,400.00	(3,600.00)
68160 · National Council Dues	127,210.00	129,157.00	1,947.00
Total 68000 · OTHER OPERATING	224,410.00	203,557.00	(15,853.00)
69000 · CONTRACTED & PURCHASED SERVICES			
69120 · Governmental Relations- State	48,000.00	48,000.00	-
69210 · Audit/Tax Services	20,000.00	21,000.00	1,000.00
69220 · Legal Services	13,200.00	12,000.00	(1,200.00)
69250 - FinancialServices	3,000.00	3,000.00	-
69260 · Purchased Services/Consultation	127,529.33	79,660.08	(47,869.25)
Total 69000 · CONTRACTED & PURCHASED SERVICES	211,729.33	163,660.08	(48,069.25)
Total Expense	3,183,225.00	3,026,650.00	(156,575.00)
Net Income	-	-	-

Texas Council of Community Centers, Inc.
Proposed Dues Calculation
Fiscal Year Ended August 31, 2027

Note: Calculations are based on Centers' FY 2025 financial audit reports

Center	FY 2026 Dues	FY 2025 Gross Revenues	FY 2025 Net Revenues (B)	FY 2027 Dues Base	FY 2027 Proportional Assessment	FY 2027 Total Dues Assessment	TCRMF Member?	LESS: Dues Offset for TCRMF Members	FY 2027 Dues	FY 2027 Dues Increase (Decrease)	FY 2027 Dues as a % of FY25 Gross Revenues	FY 2027 Dues as a % of FY27 Total Dues	% Increase (Decrease) In Dues
ACCESS	$ 25,399	$ 15,703,498	$ 8,038,663	$ 18,500	$ 8,746.69	$ 27,247	Yes	$ (2,083)	$ 25,163	(236)	0.16%	1.11%	(0.93%)
Andrews	$ 36,408	$ 30,157,321	$ 20,233,002	$ 18,500	$ 22,015.09	$ 40,515	Yes	$ (2,083)	$ 38,432	2,024	0.13%	1.70%	5.56%
Integral Care	$ 84,151	$ 158,929,044	$ 70,460,453	$ 18,500	$ 76,666.48	$ 95,166	Yes	$ (2,083)	$ 93,083	8,932	0.06%	4.12%	10.61%
Betty Hardwick	$ 30,651	$ 21,261,179	$ 13,866,217	$ 18,500	$ 15,087.53	$ 33,588	Yes	$ (2,083)	$ 31,504	853	0.15%	1.39%	2.78%
Bluebonnet Trails	$ 73,901	$ 83,376,057	$ 56,716,268	$ 18,500	$ 61,711.73	$ 80,212	Yes	$ (2,083)	$ 78,128	4,227	0.09%	3.46%	5.72%
Border Region	$ 37,448	$ 34,675,664	$ 20,671,477	$ 18,500	$ 22,492.18	$ 40,992	Yes	$ (2,083)	$ 38,909	1,461	0.11%	1.72%	3.90%
Brazos Valley	$ 29,349	$ 18,834,831	$ 12,964,209	$ 18,500	$ 14,106.07	$ 32,606	Yes	$ (2,083)	$ 30,523	1,174	0.16%	1.35%	4.00%
Burke	$ 43,606	$ 43,778,537	$ 26,792,524	$ 18,500	$ 29,152.36	$ 47,652	Yes	$ (2,083)	$ 45,569	1,963	0.10%	2.02%	4.50%
Camino Real	$ 50,357	$ 48,373,744	$ 31,866,789	$ 18,500	$ 34,673.56	$ 53,174	Yes	$ (2,083)	$ 51,090	733	0.11%	2.26%	1.46%
CHCS	$ 93,718	$ 141,755,826	$ 70,430,667	$ 18,500	$ 76,634.07	$ 95,134	Yes	$ (2,083)	$ 93,051	(668)	0.07%	4.12%	(0.71%)
Center for Life Resources	$ 25,515	$ 14,246,497	$ 9,624,030	$ 18,500	$ 10,471.70	$ 28,972	Yes	$ (2,083)	$ 26,888	1,373	0.19%	1.19%	5.38%
Central Counties	$ 39,834	$ 32,372,746	$ 22,724,688	$ 18,500	$ 24,726.24	$ 43,226	Yes	$ (2,083)	$ 41,143	1,309	0.13%	1.82%	3.28%
Central Plains	$ 26,060	$ 10,770,464	$ 8,395,904	$ 18,500	$ 9,135.40	$ 27,635	Yes	$ (2,083)	$ 25,552	(507)	0.24%	1.13%	(1.95%)
Coastal Plains	$ 37,873	$ 24,949,290	$ 16,632,860	$ 18,500	$ 18,097.85	$ 36,598	No	$ -	$ 36,598	(1,276)	0.15%	1.62%	(3.37%)
Community Healthcore	$ 50,968	$ 42,412,105	$ 33,131,765	$ 18,500	$ 36,049.95	$ 54,550	Yes	$ (2,083)	$ 52,467	1,498	0.12%	2.32%	2.94%
Concho Valley	$ 28,961	$ 15,056,848	$ 11,817,413	$ 18,500	$ 12,858.27	$ 31,358	Yes	$ (2,083)	$ 29,275	314	0.19%	1.30%	1.08%
Metrocare (Dallas)	$ 126,224	$ 161,781,057	$ 100,730,090	$ 18,500	$ 109,602.21	$ 128,102	Yes	$ (2,083)	$ 126,019	(205)	0.08%	5.58%	(0.16%)
Denton County	$ 42,649	$ 39,347,481	$ 22,521,254	$ 18,500	$ 24,504.88	$ 43,005	Yes	$ (2,083)	$ 40,922	(1,727)	0.10%	1.81%	(4.05%)
Emergence Health Network	$ 60,856	$ 75,537,856	$ 42,248,628	$ 18,500	$ 45,969.81	$ 64,470	No	$ -	$ 64,470	3,614	0.09%	2.85%	5.94%
Gulf Bend	$ 26,736	$ 15,415,937	$ 9,762,652	$ 18,500	$ 10,622.53	$ 29,123	Yes	$ (2,083)	$ 27,039	303	0.18%	1.20%	1.13%
Gulf Coast	$ 45,039	$ 45,384,757	$ 30,162,538	$ 18,500	$ 32,819.20	$ 51,319	Yes	$ (2,083)	$ 49,236	4,196	0.11%	2.18%	9.32%
Harris Center	$ 215,663	$ 376,403,670	$ 166,167,544	$ 18,500	$ 180,803.27	$ 199,303	Yes	$ (2,083)	$ 197,220	(18,443)	0.05%	8.73%	(8.55%)
Heart of Texas	$ 51,969	$ 48,834,463	$ 35,848,291	$ 18,500	$ 39,005.74	$ 57,506	Yes	$ (2,083)	$ 55,422	3,453	0.11%	2.45%	6.64%
Helen Farabee	$ 38,883	$ 36,104,507	$ 20,770,150	$ 18,500	$ 22,599.55	$ 41,100	Yes	$ (2,083)	$ 39,016	133	0.11%	1.73%	0.34%
Hill Country	$ 47,429	$ 46,918,324	$ 30,189,541	$ 18,500	$ 32,848.58	$ 51,349	Yes	$ (2,083)	$ 49,265	1,836	0.11%	2.18%	3.87%
Lakes Regional	$ 52,725	$ 44,522,630	$ 33,747,613	$ 18,500	$ 36,720.04	$ 55,220	Yes	$ (2,083)	$ 53,137	412	0.12%	2.35%	0.78%
LifePath Systems	$ 57,266	$ 55,521,647	$ 36,482,370	$ 18,500	$ 39,695.67	$ 58,196	Yes	$ (2,083)	$ 56,112	(1,153)	0.10%	2.48%	(2.01%)
StarCare/Lubbock	$ 69,675	$ 96,699,659	$ 63,740,425	$ 18,500	$ 69,354.56	$ 87,855	Yes	$ (2,083)	$ 85,771	16,096	0.09%	3.80%	23.10%
Nueces Center for MHID	$ 33,370	$ 31,261,665	$ 16,243,137	$ 18,500	$ 17,673.80	$ 36,174	Yes	$ (2,083)	$ 34,090	721	0.11%	1.51%	2.16%
Pecan Valley	$ 38,306	$ 30,323,071	$ 19,203,655	$ 18,500	$ 20,895.08	$ 39,395	Yes	$ (2,083)	$ 37,312	(994)	0.12%	1.65%	(2.59%)
PermiaCare	$ 46,722	$ 42,019,612	$ 29,481,354	$ 18,500	$ 32,078.02	$ 50,578	Yes	$ (2,083)	$ 48,495	1,773	0.12%	2.15%	3.79%
Spindletop	$ 55,798	$ 50,031,727	$ 37,390,391	$ 18,500	$ 40,683.67	$ 59,184	Yes	$ (2,083)	$ 57,100	1,302	0.11%	2.53%	2.33%
MHMR Tarrant	$ 172,874	$ 216,676,924	$ 149,991,592	$ 18,500	$ 163,202.57	$ 181,703	Yes	$ (2,083)	$ 179,619	6,746	0.08%	7.95%	3.90%
Texana	$ 73,944	$ 75,473,038	$ 50,564,999	$ 18,500	$ 55,018.67	$ 73,519	Yes	$ (2,083)	$ 71,435	(2,508)	0.09%	3.16%	(3.39%)
Texas Panhandle	$ 46,623	$ 31,533,398	$ 24,623,009	$ 18,500	$ 26,791.76	$ 45,292	No	$ -	$ 45,292	(1,331)	0.14%	2.01%	(2.86%)
Texoma	$ 26,823	$ 14,720,689	$ 10,306,420	$ 18,500	$ 11,214.19	$ 29,714	Yes	$ (2,083)	$ 27,631	808	0.19%	1.22%	3.01%
Tri-County	$ 48,173	$ 43,187,461	$ 28,574,796	$ 18,500	$ 31,091.61	$ 49,592	Yes	$ (2,083)	$ 47,508	(664)	0.11%	2.10%	(1.38%)
Tropical Texas	$ 88,661	$ 113,098,220	$ 67,709,162	$ 18,500	$ 73,672.86	$ 92,173	Yes	$ (2,083)	$ 90,090	1,428	0.08%	3.99%	1.61%
West Texas	$ 39,393	$ 28,454,243	$ 21,006,366	$ 18,500	$ 22,856.57	$ 41,357	Yes	$ (2,083)	$ 39,273	(120)	0.14%	1.74%	(0.30%)
Totals	$ 2,220,000	$ 2,455,905,687	$ 1,481,832,906	$ 721,500	$ 1,612,350	$ 2,333,850	36	$ (75,000)	$ 2,258,850	38,850	0.09%	100.00%	1.75%

FY 2027 Commitment of Dues Payment for
Texas Council of Community Centers

CENTER: Helen Farabee Centers

The dues for FY 2027 have been calculated as follows:

Total Dues … ……$41,100.00
LESS: Credit for Texas Council Risk Management Fund Members… ($2,083.00)

Net Dues ……$39,016.00

The dues payment may be paid in one payment or in monthly or quarterly installments. Please identify the dues payment methodology you plan to use:

	Monthly	Quarterly	Lump Sum
September 2026	**__3251.33_**	_____	$_____
October	**__3251.33_**		
November	**__3251.33_**		
December	**__3251.33_**	_____	
January 2027	**__3251.33_**		
February	**__3251.33_**		
March	**__3251.33_**	_	
April	**__3251.33_**	_____	
May	**__3251.33_**		
June	**__3251.33_**	_____	
July	**_3251.33_**		
August	**__3251.37_**		
	____		
TOTALS	**39,016.00__**	**$_____**	**$_____**
	_____		

Invoice for each payment required? __X___Yes _____No

We appreciate your prompt and timely payment!

APPROVED: _____

_____Date: _____
(Authorized Signature)

5 RECOMMENDATIONS
C. CONTRACTS AND PLANS
1) QUALITY MANAGEMENT PLAN

RECOMMENDED ACTION: That the Board of Trustees review and approve the FY 2027 Quality Management Plan and joint FY 2027 Continuous Quality Improvement Plan.

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. The Continuous Quality Improvement (CQI) plan is required by CCBHC. It defines a list of activities and projects that Helen Farabee Centers are conducting based on data provided to the State for the Center's improvement.

SUPPORTING INFORMATION: Several changes were made to the attachments to align with state, federal, and external audit requirements. Sandra Rapson, Quality Assurance Coordinator, will briefly address the changes.

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

HELEN FARABEE CENTERS

Quality Management Plan

Fiscal 2027

Helen Farabee Centers Quality Management Plan including Attachments:

Approved by Gianna Harris, Executive Director **Date**

Approved by J. Brian Eby, Chair, Board of Trustees **Date**

Table of Contents

Introduction

Helen Farabee Centers (HFC) maintains an annual Quality Management (QM) Plan, which identifies the internal and external processes of our quality management program per Texas Administrative Code Title 26, Part 1, Chapter 301, Subchapter G, Division 2, Rule § 301.333- Quality Management.

HFC's Quality Management Plan addresses services provided by internal providers and contractors serving those individuals with Behavioral Health disorders (Mental Health and Substance Abuse disorders), Intellectual and Developmental Disabilities (IDD), and Early Childhood Intervention (ECI) services.

Helen Farabee Centers is a Certified Community Behavioral Health Clinic (CCBHC). This ensures that there is no "wrong door" approach to providing accessible, high-quality, recovery-oriented services. HFC provides quality behavioral health services for individuals regardless of their ability to pay, place of residence, and/or homelessness.

Mission Statement

To provide supports, resources, and opportunities to enable people with behavioral health issues and intellectual and developmental disabilities to live satisfying, responsible, and productive lives to the fullest of their abilities.

Values:

The Center promotes these values to individuals, families, and other stakeholders in the provision of our services:

- **Person-centered** – the individual's needs will be at the core of all plans and services.
- **Respect** – the presence of respect for individuals, families, providers, and staff.
- **Independence** –promoting the individual's personal and economic independence.
- **Choice** – individuals will have options for services and supports.
- **Self-determination** – individuals will direct their own lives.
- **Living well** – the individual's services and supports will promote health and well-being.
- **Trauma-informed care-** the treatment environment and communications will reflect an understanding, recognition, and response to all types of traumas.
- **Contributing to the community** – individuals are able to work, volunteer, and participate in local communities.
- **Cultural awareness**– individuals can interact effectively with people of different cultures.
- **Flexibility** – individual strengths and needs will guide our actions.
- **Effective and efficient** – individuals' needs will be met in a timely and cost-effective way.
- **Collaboration** – partnerships with families, communities, providers, and other federal, state, and local organizations result in better services.

Purpose

The purpose of the Quality Management Plan is to:

- Guide the activities of the organizational quality management (QM) program and services provided by the Quality Management staff.
- Identify the standards against which performance is measured.
- Establish a cohesive and focused work plan that directs time, effort, and resources.
- Communicate and coordinate significant changes in monitoring procedures with other departments.
- Establish a process to review outcomes and implement changes to staffing, services, and availability that will improve the quality and timeliness of services.

- Improve patterns of care delivery in the reduction of emergency department use, rehospitalization, and repeated crisis episodes.
- Integration of mental health, substance use, and physical health services to adhere to a whole health model.

QM activities are initiated in the following ways:

- Ongoing performance review activities to include the completion of fidelity reviews on identified evidence-based practices by qualified staff.
- Monitoring standards identified within relevant contracts.
- Locally selected performance improvement initiatives.
- Participating in audits conducted by external sources, including any required corrective action plans.

To ensure the improvement of service delivery and Center practices, the Quality Management staff should offer or employ the following strategies to the employees of Helen Farabee Centers:

- Consultation as it relates to compliance standards, performance measures on contracts, and policy/procedures.
- Oversight of policy and procedures within the organization to ensure that they are clear and relevant and direct processes and systems across the organization.
- Completion of monitoring and evaluation activities as identified related to our processes to ensure appropriate services, competent staff, a safe environment, and that corrective action plans are established. The monitoring and evaluation activities are internally directed reviews for purposes of performance improvement. Closing the Loop: Therefore, corrective actions/responses for these activities are requested through the Quality Action Management Plan process (QMAP) or as governed by a requested corrective action plan.
- Seeking stakeholder input/ satisfaction as it relates to providing opportunities for individuals to provide feedback. This information is provided in a manner for which discussion and follow-up can occur.
- Data entry/ Integrity as it relates to identified data/measures being entered or tracked by the Quality Management staff.
- Ongoing assessment or review of systems and processes of the organization as identified.

Annual Evaluation

On an annual basis, an evaluation/review of the Helen Farabee Center's Quality Management Plan will be completed to identify any additions, deletions, or changes needed to the plan.

Quality Management Infrastructure

Committees

The structure of the HFC's various committees, including the Board of Trustees, assists the leadership in effectively administering the primary functions/services of the organization. The structure of the committee includes representatives who speak on behalf of their assigned area for the purpose of information sharing, identification of issues/ concerns, and assisting in any corrective actions that are required within the organization. Established committees at this time include:

- Board of Trustees (BOT)
- Central Leadership
    - Improvement and Oversight Committee (IOC)
    - Expanded Improvement and Oversight Committee (Ex-IOC)

    - Trauma-Informed Care Team
- Corporate Compliance Committee
- Utilization Review Committee
- Credentialing Committee
- Safety and Risk Management Committee
- Planning and Network Advisory Committee
- Death Review Committee
- Quality Management/ Continuous Quality Improvement Committee

A variety of staff meetings also occur, and QM staff may attend at the request of the Department Head/ Program Manager for consultation. Each committee engages in activities that promote positive outcomes for HFC and the community. Each committee and department has defined responsibilities that ensure quality standards are met.

Board of Trustees

• Board members receive formal training on
  o Roles and responsibilities
  o Services delivered
  o Populations served
• Board members are responsible for conducting performance evaluation(s) of the Executive Director
• Board members approve HFC policy statements
• Board members receive regular reports about the operations and community involvement of the center provided to them by the Executive Team- Improvement and Oversight Committee (IOC)

Central Leadership

• The Executive Team meets regularly with the Board of Trustees to apprise them of the Center's budget, operations, external audits, etc.
• The Executive Team is responsible for maintaining a safe and healthy environment, financially
• The Executive Team is responsible for maintaining financially sound business practices.
• The Executive Team is responsible for the development of and maintaining organizational plans such as Emergency Management Plan, Accessibility Plan, Cultural Plan, Strategic Plan, Staffing Plan, Training Plan, Quality Management Plan, and Utilization Management Plan.
• The Executive Team is responsible for ensuring all aspects of performance contracts and statements of work.
• The Executive Team is responsible for the development of and maintaining center-specific procedures.
• The Executive Team is responsible for ensuring monitoring and corrective actions as appropriate in relation to their quality management activities.
• The Executive Team is responsible for ensuring the use and adherence to the governing documents for service provision and compliance requirements in the State of Texas and Helen Farabee Centers:
  o Code of Federal Regulations (CFR) including Health Insurance Portability and Accountability Act
  o Texas Administrative Code (TAC)
  o Texas Health and Safety Code
  o Performance Contracts and Statements of Work
  o Criteria of the Certified Community Behavioral Health Clinic (CCBHC)
  o Memoranda of Understanding
  o Memoranda of Agreement
  o Care Coordination Agreements
  o Policy and Procedures
• The Executive Team is responsible for ensuring data integrity processes. Such as Mental Retardation and Behavioral Health Outpatient Data Warehouse (MBOW); Clinical Management Behavioral Health System (CMBHS); electronic medical record; human resource/payroll system Pay Com; CARE; Texas Medicaid and Healthcare Partnership (TMHP); and any required data portals used at the Center.

- The Executive Team is responsible for ensuring appointed committees in accordance with established requirements.
    - Improvement and Oversight Committee (IOC)
    - Expanded Improvement and Oversight Committee (Ex-IOC)
    - Utilization Management Review Committee
    - Planning and Network Advisory Committee
    - Client Rights Committee
    - Safety and Risk Management Committee
    - Trauma Informed Care Team

Corporate Compliance Committee
• The committee investigates any grievances or complaints made against HFC. • The committee reviews any appeal to the grievance decision and informs appropriate executive leadership.

Utilization Management (UM) Committee
• UM committee reviews for appropriate utilization of services. • UM committee reviews for quality of services, along with timeliness of documentation. • UM committee ensures clinical staff are appropriately trained in clinical practices and credentialed for the provision of services. • UM committee ensures staff training and development is conducted according to service delivery rules or contract requirements.

Credentialing Committee
• The committee reviews applicants for education required for credentialing • The committee approves newly hired staff for privileging to solo duty • The committee reviews recredentialing applications for staff

Safety and Risk Management Committee
• HFC maintains facilities as required by local, state, and federal requirements regarding individual health and safety. • Safety committee maintains appropriate licenses for facilities. • Safety committee maintains compliance with applicable Health and Safety rules and standards. • Safety committee maintains policies and procedures related to emergency management, safety practices, safe environment, and the safe disposal of bio-hazardous waste as applicable.

Planning and Network Advisory Committee (PNAC)
• HFC will actively involve individuals served and family members in planning activities (Consolidated Local Service Plan and Local Network Development Plan). • PNAC identifies community needs and goals. • PNAC provides input on service development, quality improvement, fiscal and budget priorities. • PNAC provides meaningful guidance to the Board of Trustees.

Death Review Committee
• Death Review Committee conducts an Administrative Review on any reported death of an HFC client • Death Review Committee will determine if a Clinical Death Review is required dependent on the circumstances of the death. • Death Review Committee will make determinations and guide staff based on findings.

Quality Management/ Continuous Quality Improvement Committee
• The QM/CQI committee monitors, assesses, and improves the accuracy of data from across HFC's departments

- The QM/CQI committee conducts continual analysis of internal processes, outcomes, and external forces to provide HFC with valuable information that guides the development and redevelopment of quality management, service delivery systems, and business practices.
- The QM/CQI committee updates the Continuous Quality Improvement (CQI) Plan continually.
- The QM/CQI committee ensures staff training and development is conducted according to service delivery rules or contract requirements.

Departments

Quality Management activities are conducted within each department of Helen Farabee Centers. Reviews and monitoring may be conducted by the Quality Management department or the department's director. Each director reports any quality management concerns within one or multiple committees. Each department has defined responsibilities and quality compliance monitoring.

Client Rights/ Community Services
• HFC offers all individuals served the rights provided to them through the Texas Administrative Code and local policy and procedure. • Client Rights will follow up on any complaints related to one's rights being violated or associated concerns and any reports of abuse, neglect, and/or exploitation in accordance with the Texas Administrative Code and the Department of Family and Protective Services (DFPS). • Client Rights department will participate in community coalitions and collaborate with legislative resources. • Client Rights will seek input on satisfaction with services provided and will develop and maintain formal agreements between service providers, as needed.
Director of Client Rights performs internal QM reviews on: • A mechanism to improve individual's rights protection processes. • A mechanism to measure, assess, and reduce incidents of abuse, neglect, and exploitation. • A mechanism to track and address grievances reported. **Director of Client Rights will monitor and track:** • Documentation of community activities through social media. • Individuals served involvement in community planning activities. • Compliance with requirements for formal agreements between service providers (e.g., volunteers, interns). • Scheduling and coordinating activities for the Planning and Network Advisory Committee (PNAC).
Human Resources
• HFC ensures legal and appropriate hiring practices. • Human Resources ensures proper background screening is conducted prior to hiring. • Human Resources ensures proper licenses/ certifications are verified by way of the Primary Source for this information-initially and prior to expiration. • Human Resources maintains policies and procedures on personnel requirements. • Human Resources ensures that staff training is completed in accordance with credentialing and privileging criteria. • Human Resources maintains appropriate documentation of new employee orientation- training, annual refresher training, and "as needed" training such as evidence-based practices, along with competency testing.
Director of Human Resources performs internal QM reviews on: • Credentials/Licensure • Position Descriptions • Performance Evaluations

- Staff Training
- Employee Injuries and associated costs

Financial Office

- HFC ensures fiscal accounting and business processes within local policy and procedures.
- Financial Office ensures accurate billing practices that ensure department funds are used as a last resort.
- Financial Office ensures HFC follows the instructions/ guidelines of the Uniform Grant Management Standards, Office of Management and Budget, circulars, local and state requirements as appropriate.
- Financial Office ensures routine financial reports to the Board of Trustees.
- Financial Office ensures that any financial activities conducted on behalf of individuals served will be monitored routinely.
- Financial Office ensures compliance with the Texas Administrative Code on financial requirements.

Chief Financial Officer ensures a variety of checks and balances through:

- Reconciliations
- Reporting
- External Audits
- Other internal processes

Information Services

- Information Services ensures upkeep of center technology/ equipment.
- Information Services ensures security guidelines as it relates to electronic equipment: phone system, cell phones, projectors, printers, faxes, Xerox machines, desktop and laptop computers.
- Information Services provides education and guidance to staff related to responsibilities of assigned equipment.
- Information Services provides "helpdesk" services by way of email contact @Helpdesk or phone contact.
- Information Services ensures the electronic medical record is designed to meet the collection of required measures and standards of practice and is functional for the clinical staff's use.

Director of Information Services performs internal QM activities on:

- Issues surrounding the center technology/ equipment.
- Issues surrounding the electronic medical record.
- Issues surrounding virus protection or scams.

Program Specific Quality Management Plan Attachments

A. Mental Health Services-Adults
B. Archived- Home and Community based services-Adult Mental Health
C. Child/ Adolescent –Youth Empowerment Services (YES)
D. Intellectual and Developmentally Disabled Authority Services
E. Archived- Intellectual and Developmentally Disabled Provider Services
F. Substance Abuse Services
G. Evidence-Based Practices and Fidelity Elements
H. Continuous Quality Improvement (CQI)
I. Early Childhood Intervention Services (ECI)
J. Subcontracting

K. Mental Health Services- Child and Adolescent (CAS)
L. Medical Services
M. Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI)
N. Crisis Services
O. Care Coordination

Continuous Quality Improvement

The Continuous Quality Improvement (CQI) Plan is a separate plan that falls under the umbrella of Quality Management. The CQI plan can be operated independently from the QM plan to allow for adjustments, new projects, and removal of completed projects. The CQI plan is monitored quarterly by the QM and CQI committee.

FY 2027 QM Plan for Mental Health Services
Adult Services
Attachment A

Mental Health Services	
Expectation # 1	**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.**
Activity Description:	**Step 1:** Designated Quality Management (QM) staff will select medical records to monitor mental health services provided. A sample is taken from each Case Manager, LPHA, Peer Provider, and Center Front Desk staff as indicated on the Scheduling Grid. Any specialty programs such as Hospital Transition Pilot Program (HTPP) and Supported Employment will be audited according to the Scheduling Grid. Each staff member will be audited during the year. Only exception at this time, will be if they are still in training. **Step 2:** Medical record cases will be selected randomly and will be audited on an approved audit tool. For any scores not meeting set guidelines, a Quality Management Action Plan (QMAP) will be completed for needed actions/ response. If refresher training has been identified, this will be set up between the auditor and the staff member. **Step 3**: Audit results will be sent to audited staff member or supervisor along with the QMAP, if applicable. **Step 4:** For any low compliance scores, the Supervisor will be consulted to discuss QM actions. **Step 5:** A two-week response time is assigned for the QMAP Request to be returned to the QM auditor. Extensions may be granted if a justified reason. **Step 6**: All completed QMAP responses with the staff and the QM auditor's signature will be maintained on file with the audit. A copy of the audit/ QMAP/ and Training record will be provided to the Supervisor for their files. An email to @HR will also be sent with any training records completed. **Step 7**: Any organizational trends found in the audits, will be brought to the attention of supervisors and staff through the Adult Staffing Meetings. On a quarterly basis, a Summary Report will be provided on each audited category to leadership.
Activity Guidelines:	• For any audit that scores **90% or greater on average:** No formal Quality Management Plan (QMAP) will be issued but the results of the audits will be shared for ongoing communication on the No scores. Staff are required to complete corrective actions or learn from error for future activities. • Any audit that receives **89% or below on average:** A formal QMAP will be completed and sent to the staff member which identifies the actions needed from them. The staff have two-weeks to respond. They are to indicate their understanding of the audit; any

	corrective actions taken and sign the QMAP response. They are to return the completed QMAP to the QM auditor who will review the actions and only follow up if needed. After acceptance, the QM auditor will sign the QMAP as well and file. **NOTE**: The QM auditor will have the discretion to forego the initiation of a QMAP based on the following considerations: a) the number of audit questions were minimal and therefore the % was not representative of their work, or b) the improvement identified on the audit as compared to early audits was significant, therefore the staff may not receive a formal QMAP but will be advised of any pending areas to work on. • Any audit that receives **below <u>76% on average</u>**: A formal QMAP will be required. The staff have two-weeks to respond. They are to indicate their understanding of the audit; any corrective actions taken and sign the QMAP. They are to return the completed QMAP to the QM auditor who will review the actions and only follow up if needed. After acceptance, the QM auditor will sign the QMAP, may schedule the refresher training and document on HFC # 535 with copies being provided to Human Resources (#HR) and filed within our files. • If two medical records pulled score an average of 90% or above no formal QMAP will be issued. The audit results will be shared for ongoing communication on the No scores. • For audits that score below the 76%, additional auditing will be completed as time allows by the QM auditor with a goal of them reaching compliance.
Tools:	Based on the Health and Human Services Commission (HHSC) Monitoring Tool, all audits are completed using locally approved formats within Survey Monkey; a QMAP and a Training Record as applicable.
Frequency:	Time frames in accordance with Scheduling Grid. (On file)
Target:	76% compliance on average. 90% compliance for those identified (Front Desk, Intake, LPHA- Counseling, Peer Providers)

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.**
Activity Description:	Helen Farabee Centers (HFC) staff will assist in distribution and/or collection of the satisfaction surveys in a variety of ways: • Suggestion Boxes are available in each Service location for comment cards and tele video services. • Satisfaction Surveys are available on the HFC Website. Designated QM staff will review and provide a composite report for review. Concerning results are shared with Supervisor and their Department Head 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:	Approved Satisfaction Surveys (Satisfaction survey comment cards including tele-video services, and a link on the HFC Website will direct surveys through Survey Monkey platform). English and Spanish versions available.
Frequency:	Monthly
Target:	Representation from all Centers

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.
Activity Description:	Designated QM staff will participate in the UM Committee for review of performance measures noted above and will consult on capacity decisions based on this data.
Tools:	UM Report.
Frequency:	Monthly through Target Report at IOC and Quarterly through UM meetings.
Target:	100% of committee meetings will occur timely.

Expectation # 4	**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. • 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)
Activity Description	All Staff with direct knowledge will record and report any incidents/injuries in accordance with Safety, Death Reporting or Department procedures.
Activity Description:	• Designated Human Resource/ Risk Management staff will review reports submitted for improvement opportunities. • Designated Business Office staff will review any vehicle incidents or accidents for improvement opportunities. • Designated Medical Records staff and Quality Management will receive and process any deaths reported to include identified causes such as medical condition, suicide, accident, other, unknown as possible. (Suicide- CCBHC requirement) • Nursing staff will review any Medication Discrepancies/Errors. • Quality Management will track suicide attempts. (CCBHC requirement)
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. QM staff will ensure the creation and distribution of summary reports on a need-to-know basis.
Tools:	Designated Forms and Report formats.
Frequency:	Ongoing, Review at Scheduled Safety meetings
Target:	Any increase in reported events will be evaluated.

FY 2027 QM Plan for Child & Adolescent Services –YES Waiver

Attachment C

Expectation # 1	**An individual will receive timely access to YES Waiver Services.** On a quarterly basis, YES Waiver Supervisor will 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 when no waitlist is present.
Activity Description:	YES Waiver Supervisor will ensure a CED is completed in CMBHS within 7 business days. CED will be scanned into the chart or an informational note detailing when the CED occurred.
Tools:	Monthly or Quarterly YES Waiver report
Frequency:	Quarterly
Target:	100% of individuals will receive timely access to YES Waiver Services.

Expectation # 2	**An individual will receive timely access to YES Waiver Services when a waitlist is present.** YES Waiver participants will receive services within 7 business days from intake.
Activity Description:	QM will conduct an audit to ensure that YES participants receive services within 7 days from intake.
Tools:	Internal YES Waiver audit tool.
Frequency:	Biannual audit
Target:	100% of individuals will receive timely access to YES Waiver Services.

Expectation # 3	**YES Waiver Participants will receive at least one billable service per month in the YES Waiver Service array.** On a biannual basis, an audit will be conducted to ensure that billable services are reflected.
Activity Description:	QM will complete a bi-annual audit of YES Waiver Participants served and report to the YES Waiver Supervisor any findings.
Tools:	Internal auditing tool for YES Waiver
Frequency:	Biannual audit
Target:	90% of YES Waiver Participants will receive at least one billable service per month.

FY 2027 QM Plan for Child & Adolescent Services –YES Waiver

Attachment C

Expectation # 4	**YES Waiver Participants will be provided services in accordance with the YES Waiver User Guide and YES Waiver Policy Manual.** Elements of the audit will include: • 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:	QM staff will complete an internal audit of the medical record for YES Waiver Participants. YES Waiver Supervisor will follow up with all needed corrective actions (Quality Management Action Plan-QMAP).
Tools:	Internal auditing tool for YES Waiver
Frequency:	Charts are reviewed in the 1st and 3rd quarter with a minimum of two charts per clinician (when able).
Target:	At least 76% compliance on medical record review

Expectation # 5	**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 Critical Incidents data involving any individual served by Helen Farabee Centers. Incidents include: • Incidents and Injuries of Individuals in services on HFC property • Employee Incidents and Injuries • Vehicle Incidents/Accidents • Medication Discrepancies/Errors • Deaths by suicide • Suicide Attempts Additionally, the YES Waiver Program will report the following incidents to HHSC: • 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 • Death The YES Waiver Form 2803 "Critical Incident Report" will 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.
Activity Description:	Reporting of critical incidents to appropriate entity. All HFC critical incident reports will be distributed to the Director of Risk Management for review by the Clinical and Safety Committee on a quarterly basis to determine 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 were attributed to the staff's neglect.

Expectation # 6	**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 quarterly reports to Utilization Committee if issues arise related to utilization of YES Waiver.
Tools:	Report
Frequency:	Quarterly- YES Waiver Supervisor & Quarterly- Director of Utilization and Quality Management
Target:	Reports will be provided and reviewed quarterly at 100%.

Expectation # 7	**Trainings Required for Wraparound/YES Waiver Fidelity.** YES Waiver Supervisor and designated QM staff will ensure that HFC 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: 1) Wraparound Training Series a) NWIC Systems of Care Module 1 (one-time training) b) Phase I: Introduction to Wraparound (one-time training) c) Phase II: Engagement in Wraparound (one-time training) d) Phase III: Implementation in Wraparound (one-time training) 2) NWIC Training Series: 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) Health Insurance Portability and Accountability Act (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.

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. IDD M&C staff will mail letters to 10% of the GR population to invite them to complete a satisfaction survey.
Activity Description:	QM staff reviews any surveys entered in the Survey Monkey website. 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:	Satisfaction Survey through HFC Website collected by Survey Monkey
Frequency:	Monthly
Target:	10% of GR population will be invited to participate in a satisfaction survey.

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.**
Activity Description:	**Step 1**: QM staff will select medical record case numbers based on a recent time frame, service provided and the staff member. Each staff member as well as each program is reviewed quarterly. Only exception at this time will be if they are still in training as they will be picked up for auding after they receive a caseload. • Texas Home Living (TxHmL) • Community First Choice (CFC) • Home and Community Based Services-Authority (HCS) • General Revenue (GR) • General Revenue/ Community First Choice (GR/CFC) • PASRR-Hab. Coordination, including refusals • Enhanced Community Coordination (ECC) as applicable to programs • Combinations of programs A sample is recorded on the Excel Report. Each staff member will be audited during the year. Only exception at this time will be if they are still in training.

	Step 2: Medical record cases will be selected randomly and will be audited on an approved audit tool. For any scores not meeting set guidelines, a Quality Management Action Plan (QMAP) Request will be completed for needed actions/ response. If refresher training has been identified, this will be set up between the Team Lead or Trainers and the staff member. **Step 3**: Audit results will be sent to audited staff member and their designated supervisor along with the QMAP request. **Step 4:** A two-week response time is assigned for the QMAP Request to be returned to the QM auditor. Extensions may be granted on a needed basis or justified reason. **Step 5**: All completed QMAP Responses with the staff and the designated supervisor's signature will be maintained on file with the audit. A copy of the audit/ QMAP/ and Training record will be maintained on file. An email to @HR will also be sent with any training records completed. **Step 6**: Any organizational trends found in the audits, will be brought to the attention of IDD Director on a quarterly basis through a Summary Report. **Monitoring:** The Quality Management- Monitoring and Compliance (M& C) staff will select charts by the staff's name who have at least 90 days of service training time and who provided identified services**. There will be two (2)charts per staff per program and per quarter selected for auditing.** If after the first chart audited receives a score of 90% or more the second chart may be skipped. All staff will be audited twice a year either (1^{st} and 3^{rd} quarters or 2^{nd} and 4^{th} quarters- 4^{th} quarter is the CAP review). Review includes but is not limited to the following: person-centered planning, progress note documentation, monitoring and reporting needs/services of the individual, evaluations, assessments, CARE/TMHP assignment codes, interest lists, authorizations for unit billing, rights review for legal status changes, consents; and in addition, Service Coordination/ Habilitation Coordination/ Enhanced Community Coordination contacts are made at the required frequency and those services are justified. **Pre-admission Screening and Resident Review (PASRR**): Monitoring includes a review of active and inactive cases with a review of the appropriate R0 codes in CARE that reflect the assigned Habilitation Coordinator and/or ECC Coordinator. This will include a review of the Authorization for Habilitation Coordination to ensure billing units match the plan, SPT addresses identified risk factors, evaluating the effectiveness and adequacy of all specialized services, reviewed and discussed all outcomes, diagnoses and risk factors identified in the Nursing Facility Care Plan were reflected in the content of the Individual Profile, Diversion Coordinator submits all Targeted HCS Transition Slot Requests when an individual has requested to transition to the community with transition planning, and the completed CLO including barriers to transition.

Activity Description:	• For any audit that scores **90% or greater** no formal Quality Plan (QMAP) will be issued but the results of the audits will be shared for ongoing communication on the No scores. Staff are required to complete corrective actions or note error for future activities. • Any audit that receives **89% or below** the staff will need complete a formal QMAP in order to reflect corrective actions have been taken or noted for future audits. • Any audit that receives **Below 75%** required leadership action and formal retraining by IDD Team Leads or Trainers. The training is documented on HFC # 535 with copies being provided to Quality Management (QM) and Human Resources (HR). • Continue auditing will be completed as time allows by QM but supervisory staff are asked to follow up closely again until successfully reaching the target.
Tools:	Auditing tools and QMAP form
Frequency:	On a scheduled quarterly basis, medical records are selected for review by staff and program to include the last 90-days of service or a period as appropriate for the document compliance. Schedule grid- on file.
Target:	Average for the quarter 90% compliance per program

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

Expectation # 3	**Ensuring the Center is appropriately addressing waiver enrollments.**
Activity Description:	Monitor enrollments into the HCS and TxHmL programs, ensuring that individuals are enrolled at the frequencies designated in the IDD Performance Contract and within slot timeframes.
Tools:	Board of Trustees- Essential Services and Clinical Accountability- Quarterly report. Item 1.2- HCS Enrollments-Percent of all enrollments into HCS (Home and Community Services) that meet timelines in the LIDDA Handbook. Item 1.3-Percent of all enrollments into TxHmL (Texas Home Living Services) that meet timelines in the LIDDA Handbook.
Frequency:	Quarterly
Target:	➢ 95% per quarter

Measuring, Analyzing, and Improving Service Capacity and Access

Expectation # 4	**Ensuring the Center is appropriately maintaining individuals placed on the Interest List.**
Activity Description:	Confirm list status monthly through ongoing monitoring.
Tools:	Board of Trustees- Essential Services and Clinical Accountability Quarterly Report. Item: 1.13-Percent of HCS and TxHmL interest list population contacted for biennial review as described in Section 7500 of the LIDDA Handbook
Frequency:	Quarterly
Target:	At least 50% by end of FY 2026 100% by end of FY 2027

Expectation # 5	**Ensuring CARE service codes, associated with Permanency Planning, are entered timely to reflect initial contact and six-month contacts.** Medical record audit completed to ensure elements are found within the record**.**
Activity Description:	QM staff monitors CARE data entry in screens 309 and 249 for permanency planning to ensure individuals are contacted initially and at least every six (6) months under the age of 22. CARE reports that indicate this contact are also referenced to confirm that required contacts are being made. Any "late" contacts are to be noted on the monitoring tool in Excel and the date that HHSC was contacted also noted in this report. Variances identified during the service code review through contact with the IDD Authority Director, Team Leader and Trainer.
Tools:	COC Spreadsheet Excel Tracking-Permanency Planning and CARE
Frequency:	1 time quarterly by way of performance measure; 1 time annually through M/C audits
Target:	Average for the quarter 95% compliance

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.**

	In addition, reporting is required by Health and Human Services Commission for specific critical incidents. The LIDDA staff reports deaths, abuse/neglect/exploitation (ANE), non-ANE allegations involving law enforcement, emergency room visits, medication errors, vehicle incidents and safety risk issues of staff. Incidents that occur while attending day habilitation is the Provider staff's responsibility. The Providers are responsible to notify the LIDDA of any critical incidents to enter this information into the state Critical Incident Management System (CIMS). The LIDDA is only responsible if the individual is in the CDS services only without any Provider services on the Individual Plan of Care (IPC) and for LIDDA General Revenue (GR) services. Reports are provided to the Clinical and Environmental Committee reviews on a quarterly or as scheduled basis for the purposes of mitigating risks and performance improvement opportunities. Review focused on any patterns/ trends as well as corrective actions needed on reporting.
Activity Description:	Program Manager ensures reporting and review of incidents and injuries with any reports being sent to @HR for purposes of review by the Clinical and Environmental Safety Committee; as well as Deaths reported to @Medical Records and abuse, neglect or exploitation reported through Client Rights Officer. **Health and Human Services Committee (HHSC) require additional reporting for specific critical events/injuries/incidents. These events are flagged with an asterisk (*) for entry into the state Critical Incident Management System (CIMS) database.** • Serious injuries- head trauma/ concussion, laceration requiring stiches, broken/ fractured bones, contusion larger than 2 ½ inches in diameter, second- or third-degree burn, dislocation of any joint, internal injury, injury determined "serious" by a physician, physician assistant, registered nurse or a vocational nurse (*) • Restraint or Seclusion Use-several details required for data entry- type of restraint, time of restraint, was it in response of a behavioral emergency, was it authorized for this individual (*) • Elopements, lost, missing person-several details required for data entry- was it observed, willingness of leave, leave with someone else, how long, any prior history of elopement (*) • Medical Hospitalization Admission for Medical or Behavioral/ Psychiatric reasons (*) • Emergency Room (ER) Visits for Medical or Behavioral/ Psychiatric reasons (*) • Law enforcement interventions – Why were they involved such as 911 Calls, Arrests, etc. (*) • Medication Errors – will need to know if harm or risk of harm was present; for no harm- details are required regarding what occurred for data entry (*) • Deaths (*)

	• Abuse, Neglect, Exploitation Allegations and Confirmations-need defined type to be reported for data entry- Abuse-verbal/ emotional/ physical/ sexual. Neglect or Exploitation. Will need HHSC Intake ID and DFPS Call ID for data entry (*) • Other Incident/ Events (*) o Choking- food or object o Physical assault/ altercation o Property damage o Self- injurious behavior- cutting o Suicidal threat
Tools:	Forms identified for purposes of data collection-Monthly Reportable Incident/Injury Report. Entry into CIMS once all system training is completed.
Frequency:	Monthly
Target:	Any increase in reported events will be evaluated.

Assessing and improving the process for reviewing rights restrictions

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.**
Activity Description:	• For any Rights Restrictions received by the LIDDA, the assigned Service Coordinator will review. If any concerns identified, the Service Coordinator will staff with the Program Manager in order to ensure clinical justification is present and to advocate on behalf of the individual in services. • If during a Quality Management medical record audit, the reviewer will report any concerns related to a Rights Restriction to the Service Coordinator, Trainer, Team Lead and Program Manager. Rights Restrictions are to be documented with a clinical justified need by the Service Planning Team (SPT) and found on the Person-Directed-Plan (PDP). • Any unjustified Rights Restrictions will be discussed with the Client Rights Officer and the Program Manager for any improvement opportunities with the IDD Provider.
Tools:	Verbal referrals from IDD Providers, QM medical record audits.
Frequency:	Ongoing
Target:	No more than 1 error per quarter.

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:	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. 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. All non-corrected errors will be reported and tracked.
Tools:	Smart care, CARE database, TMHP, and CSIL
Frequency:	Daily, as needed, tracked quarterly
Target:	90% of errors will be corrected

FY 2027 QM Plan for Substance Abuse Services
Attachment F

In accordance with Title 26 Part 1 Chapter 564, HHSC SUD/MH Contracts, and HFC Policy and Procedures, the Quality Management (QM) for the Helen Farabee Centers Substance Abuse Services include:

1. The QM Plan has been developed and will be implemented in accordance with said guidelines and conforms with Texas Administrative Code (TAC), Chapter 564, Rule §564.504. This QM Plan will be made available to the Human and Health Services Commission (HHSC) upon request.

2. The QM Plan will be developed and submitted to our Board of Trustees by the end of the first quarter or sooner if available. The QM Plans at Helen Farabee Centers are reviewed on an annual basis.

3. The QM Plan will describe the methods to measure, assess and improve the following TAC elements:

   a. TAC Rule §564.6 Competence and Due Care
   b. TAC Rule §564.8 Accuracy
   c. TAC Rule §564.13 Confidentiality
   d. TAC Rule §564.701 Client Bill of Rights
   e. TAC Rule §564.702 Grievances

4. This QM Plan reflects our participation in the continuous quality improvement process (CQI) and is not limited to data verification, performing self-reviews, submitting self-review results, and supporting documentation for an HHSC desk review and participating with the HHSC onsite or desk review when scheduled.

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.

Goal # 1- continued

Activity Description	The Program Administrator and Clinical Manager, as applicable, will ensure the day-to-day operations of the substance abuse services are operationalized according to approved policy and procedures of Helen Farabee Centers and the Substance Abuse Services. All SAS staff will complete training in a timely manner and will provide updated licensure information for files.
Tools:	Human Resource Delinquent Training Report Credentialing files Medical record audits Quality Management Action Plan (QMAP)
Frequency:	Daily, Weekly, Monthly, Ongoing
Target:	• Clinical supervision includes signing off on clinical documentation, as needed, use of the Knowledge, Skills, and Attitude process. 90% or more training/ licensure documentation is timely and on file. • Use of medical record audit for purposes of ensure competence documentation practices. Quarterly, an average of 75% compliance on audits. • Any correctable documentation will be completed no later than 14 days following discovery.

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. Provides shall not misrepresent either directly or by implication professional qualifications or affiliations.
Activity Description	The Program Administrator and Clinical Manager, as applicable requested, will review clinical record documentation to ensure that it provides an accurate recording of the services and will provide use of evidenced-based practices in a manner where credit is given to use of these clinical resources within the appointments.
Activity Description	Clinical record reviews will be conducted monthly on three (3) active charts if time allows. Each Counselor receives a review on a quarterly basis. On a quarterly basis, chart reviews will also be completed on discharged/closed cases with a minimal of nine reviewed if time allows. Areas to be reviewed will include: ➢ timeliness of documentation ➢ receipt of required consents and informational handouts ➢ appropriateness of the treatment plan goals, objectives and strategies based on the results of the bio-psychosocial assessment. ➢ identification of the length of stay ➢ identification of the stage of change and ➢ continuity of care outlined in the individual's discharge plan when finalized.

Activity Description	Clinical record reviews will include evidence-based practices including, but not limited to: Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Motivational Enhanced Therapy, Co-Occurring Psychiatric and Substance Use Disorders (COPSD), and Screening, Brief Intervention, Seeking Safety, Cannabis Youth Treatment Curriculum, Living in Balance, Substance Abuse and Mental Health Services Administration (SAMSHA).
Tools:	Medical record audits Quality Management Action Plan (QMAP) Training Attendance Record, HFC # 535
Frequency:	Monthly
Target:	• At least 75% compliance on audits • Any correctable documentation will be completed no later than 14 days following discovery. Refresher training will be provided and documented if indicated.

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.
Activity Description	The Program Administrator and Clinical Manager, as applicable requested, will review clinical record documentation to ensure that it includes the use of appropriate release or exchange of information consents as provided by the individual or their legally authorized representative. The clinical record is also to include providing a copy of the Statement of Confidentiality, HFC # 493 for signature and filing in the clinical record.; as well as the appropriate consent to Release/ Exchange Information, HFC # 4. In addition, any receipt of any concerns/complaints/grievances related to the mishandling of any confidential information will be addressed in an expediated manner with the Privacy Officer at Helen Farabee Centers. Centers will ensure medical records (paper or electronic) will be property stored and handled to ensure no breach of confidentiality.
Tools:	Clinical record review audit tool QMAP Training Attendance Record, HFC # 535 Authorization to Release or Exchange of Information, HFC # 4 Statement of Confidentiality, HFC # 493
Frequency:	Daily

Target:	• When referrals were needed, this form was completed, signed, and uploaded to EMR. 85% compliance on question. Q # 13 & # 14 (Q # 14 & # 15- Olney) • No reports of loss of client record or documentation -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).
Activity Description	The Program Administrator and Clinical Manager, as applicable requested, will review clinical record documentation to ensure that it includes the provision of the Client Bill of Rights, HFC # 481 or in their preferred language. In addition, any receipt of any concerns/complaints/grievances related to a rights issue will be addressed in an expediated manner with the Client Rights Officer at Helen Farabee Centers.
Tools:	Medical record audits Quality Management Action Plan (QMAP) HFC Bill of Rights, # 481
Frequency:	Monthly
Target:	• At least 85% compliance on audit question # 22. • Any correctable documentation will be completed no later than 14 days following discovery. No substantiated rights violations in a quarter.

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).
Activity Description	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).
Tools:	Medical record audits Quality Management Action Plan (QMAP) Incoming reports
Frequency:	Daily, Weekly, Monthly, Ongoing
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.

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.

Activity Description	The Program Administrator and Clinical Manager, as applicable requested, will ensure the ongoing maintenance and documentation of the wait list in CMBHS. If the individual is unable to be admitted into treatment services within seven calendar days of the request, they will be entered into the Wait List. If unable to be admitted within 14 days, they will be provided interim services. A review of individuals on the Wait List will be addressed at the weekly staff meeting.
Tools:	1) CMBHS, 2) Daily Census, 3) Waitlist, 4) Capacity Report
Frequency:	Daily
Target:	• All individuals will be tracked on Wait List and interim services provided as required.

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. SAS staff provide the individuals the HHSC SUD approved survey link:https://forms.office.com/r/EbmMEuNPXn or Spanish version: https://forms.office.com/r/dchRAHMrrq. Satisfaction Survey's are also available on HFC's website under the "Surveys" tab. Satisfaction surveys are collected by HHSC and results are distributed to HFC annually.
Activity Description:	Program Administrator and/or Clinical Manager will ensure substance abuse staff provides surveys. Ensure that they are reviewed and recorded to identify patterns/trends/ performance improvement.
Tools:	HHSC Satisfaction Survey
Frequency:	Annually or as needed.
Target:	• No more than 1 substantiated complaint via satisfaction surveys that were attributed to the staff's actions in services.

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**: ➢ Violation of a client rights, including but not limited to, allegations of abuse, neglect, and exploitation. ➢ Accidents and injuries ➢ Medical emergencies ➢ Psychiatric emergencies ➢ Medication errors (NA) ➢ Illegal or violent behavior ➢ Loss of a client record ➢ Personal or mechanical restraint or seclusion (NA) ➢ Release of confidential information without client consent ➢ Fire ➢ Death of an active outpatient or residential client (on or off program site) ➢ Clients absent without permission from a residential program (NA) ➢ Suicide attempt by an active client (on or off program site) ➢ Medical and psychiatric emergencies that result in admission to an input unit of a medical or psychiatric facility. ➢ Any other significant disruptions. 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
Activity Description:	• Designated Human Resource/ Risk Management staff will review HFC incidents and injuries reports (HFC # 27) • Designated Medical Records staff will receive and process any deaths reported to include identified causes such as medical condition, suicide, accident, other, unknown as possible. (HFC # 25) • Client Rights Director will review process any Abuse, Neglect, Exploitation Allegations and Confirmations identified. • The Program Administrator will report any knowledge of any other category listed and will ensure the completion of the HHSC # 6108 form.
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-listed above HHSC # 6108- HHSC Substance Abuse Treatment Facility Incident report
Frequency:	Monthly
Target:	No incidents or injuries which were attributed to the staff's neglect

Goal # 5	Sub-Contracting Monitoring on the Outreach Screening, Assessment, and Referral (OSAR) process.
Objective # 5.1	**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 not and any likelihood of financial withholdings will be mitigated. The OSAR will complete clinical record reviews and will provide to the Program Administrator as a method to monitor OSAR services.
Activity Description:	Chart reviews will be conducted monthly on five (5) charts. Each Outreach Screening, Assessment and Referral (OSAR) counselor receives a review on a quarterly basis. On a quarterly basis, chart reviews will also be conducted on discharged/ closed cases with a minimum of five (5) charts for review if available. NOTE: Preferably, "all" if time allows. Areas under review will include a) timeliness of documentation, b) identification on stage of change, c) results of outreach screening, assessment and referrals clearly documented.
Tools:	Internal Program Processes On-site audit annually with OSAR
Frequency:	Quarterly
Target:	• At least 85% compliance with clinical record reviews or audit.

FY 2027 QM Plan

Attachment G: Evidenced Based Practices (EBP) and Fidelity Reviews

Evidence Based Practices (EBPs) are interventions determined to be effective for certain populations when performed according to fidelity standards. Some practices may be effective for various population types while others are more effective with population types. This document describes which EBPs are considered most effective for various Helen Farabee Centers (HFC) populations and the training required providing them. Some of the Fidelity Review activities will be completed through the ongoing medical record reviews and some will be addressed on an annual basis. All staff completing EBP interventions will be reviewed by Quality Management or their respective Department head.

Expectation # 1	Center will ensure staff are trained and are using evidence-based practices derived from Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health and Human Services Commission (HHSC) to deliver services.
Activity Description:	Some elements of the fidelity reviews captured within the medical record audits on Expectation # 1. Other elements are the fidelity review captured based on a review of training on file or in a separate review form.
Activity Description:	Case Manager/ Provider/Center Manager and/or Program Manager will ensure follow-up to the audits and ensure corrective actions taken via the Quality Management Action Plan (QMAP).
Activity Description:	All training records are to be provided to @ HR email group for filing in the employee's credentialing /training file.
Tools:	Survey Monkey Audit Tools and Fidelity Evaluation tools
Frequency:	Annually
Target:	76% program compliance
Requirement Criteria	CCBHC Evidence Based Services are listed on 4.f.2 of Provider Manual (9/2025)

Evidenced Based Practices and Population Served	**Fidelity Process:** **Chart Review and Training**	**Key Components of Curriculum**	**Key Outcomes of Service**	**Required by:**
1 IMR-Illness Management and Recovery	**Chart Review: Yes** **Training verified: Yes**	Psychoeducation. Behavior tailoring. Relapse prevention. Coping skills training.	More knowledge about mental illnesses. Fewer relapses. Fewer re-hospitalizations. Reduced distress from symptoms. More consistent uses of medications.	CCBHC HHSC Performance Contract

Population: Adult Mental Health (MH)				
2 CBT-Cognitive Behavioral Therapy Population: Adult and Child/ Adolescent MH	**Chart Review: Yes** **Training verified: Yes**	Targets individuals diagnosed with depression and/or anxiety. Psycho-social intervention that aims to improve mental health. CBT focuses on challenging and changing cognitive distortions and behaviors, improving emotional regulation, and the development of personal coping strategies that target solving current problems.	Decrease in symptoms of depression and/or anxiety. Improved social functioning in work and relationships. Improved mood and outlook.	CCBHC HHSC Performance Contract
3 CBTp-Cognitive Behavioral Therapy with Psychosis Population: Adult MH	**Chart Review: Yes** **Training verified: Yes**	A specific type of cognitive behavioral therapy developed to reduce the distress associated with the symptoms of psychosis and improve functioning. CBTp is generally delivered over 16 sessions.	Designed to help the individual understand psychotic symptoms and make sense of those experiences. Normalize the psychotic experience to address the stigma often associated with psychosis. Acceptance of psychotic symptoms by reducing stress related to the symptoms.	N/A
4 CPT-Cognitive Processing Therapy Population: Adult MH	**Chart Review: Yes** **Training verified: Yes**	A specific type of cognitive behavioral therapy that has been effective in reducing symptoms of PTSD that have developed after experiencing a variety of traumatic events. CPT is generally delivered over 12 sessions and helps individuals learn how to challenge and modify unhelpful beliefs related to their trauma.	Decrease in arousal response and intrusive thoughts related to the memories of the trauma. Reduce feelings of anxiety, anger, guilt, and shame. Improved day-to-day living, including improved social functioning.	CCBHC
5 Trauma Focused CBT	**Chart Review: Yes** **Training verified: Yes**	Conjoint child and parent psychotherapy approach for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events.	Works for children who have experienced any trauma, including multiple traumas. Effective with children from diverse backgrounds. Works in as few as 12 treatment sessions.	CCBHC HHSC Performance Contract

Population: Child/ Adolescent MH		Components-based treatment model that incorporates trauma-sensitive interventions with cognitive behavioral, family, and humanistic principles and techniques. Children and parents learn new skills to help process thoughts and feelings related to traumatic life events; manage and resolve distressing thoughts, feelings and behaviors related to traumatic life events; and enhance safety, growth, parenting skills, and family communication.	Has been used successfully in clinics, schools, homes, residential treatment facilities and inpatient settings. Works even if there is no parent or caregiver to participate in treatment. Works for children in foster care. Has been used effectively in a variety of languages and countries.	
6 IPS Employment Center Supported Employment Population: Adult MH	**Chart Review: Yes** **Training verified: Yes**	Caseload Assistance for employees/ vocational services Collaboration of team. Job options provided. Eligibility requirements. Search for competitive jobs. Employer contacts based on preferences. Individualized follow-along supports provided. Assertive engagement and outreach.	Higher rates of competitive employment. More work hours. Higher wages. Improved symptoms. Improved self-esteem. More responsibility. More self-sufficiency. More independence. Increased consumer satisfaction with finances.	CCBHC HHSC Performance Contract
7 Nurturing Parenting Population: Child/ Adolescent MH	**Chart Review: Yes** **Training verified: Yes**	Designed to build nurturing parenting skills as an alternative to abusive and neglecting parenting and child-rearing practices. Addresses the following patterns and behaviors: Inappropriate developmental expectations of children. Lack of empathy in children's needs. Strong belief in the use of corporal punishment as the means of discipline. Demanding strict adherence to parental demands.	Increased sense of self-worth, personal empowerment, empathy, bonding, and attachment of the parent. Increased use of alternative strategies to harsh and abusive disciplinary practices. Increase parents' knowledge of age-appropriate developmental expectations.	CCBHC HHSC Performance Contract
8 Intensive Case Management using Wraparound Model	**Chart Review: Yes** **Training verified: Yes**	A person-centered service delivery model for children with severe emotional or behavioral needs. Based on an ecological model, the process engages the youth's family and social support system in addition to professionals and draws upon the strengths and	Builds problem solving skills, coping skills, and self-efficacy of the youth and family members. Youth and family will have the community support they may need when more formal supports and services end.	CCBHC HHSC Performance Contract

Population: Child/ Adolescent MH		resources of this group to develop an individualized plan for care for the youth and their caregivers. Youth and family voice and choice are prioritized. Informal support is valued equally with professional supports.	Reduction in the need for residential and hospital care. Improved youth functioning. Reduction in emotional and behavioral problems. Greater community adjustment.	
9 Seeking Safety Population: Adult MH, Child/ Adolescent MH, and SUD	**Chart Review: Yes** **Training verified: Yes**	Evidence-based, present-focused counseling model to help people grow in their coping skills to attain safety from trauma and/or substance abuse. Directly addresses both trauma and addiction, but without requiring individuals to delve into the trauma narrative. Appropriate for youth and adults, any length of treatment, any level of care, and any type of trauma or substance used. Highly flexible across a broad range of individuals; can be conducted in a group or individual setting.	Improvement in trauma-related symptoms, suicide risk, social adjustment, family functioning, problem solving, depression, and cognitions about substance use.	CCBHC HHSC Performance Contract
10 Assertive Community Treatment Team (ACT) Population: Adult MH	**Chart Review: Yes** **Training verified: Yes**	Service-delivery model, not a case management program. Primary goal of recovery through community treatment and habilitation. Characterized by 1) team approach, 2) in vivo services, 3) a small caseload, 4) time unlimited services, 5) a shared caseload, 6) a flexible service delivery, 7) a fixed point of responsibility, and 8) 24/7 crisis availability. ACT is for consumers with the most challenging and persistent problems. Programs that adhere most closely to the ACT model are more likely to get the best outcomes.	Greatly reduces psychiatric hospitalization and leads to a higher level of housing stability. Improved quality of life, symptoms, and social functioning.	CCBHC HHSC Performance Contract NOTE: HFC completes the “rural” version of ACT services.

11 Aggression Replacement Techniques (Skill streaming, Aggression Replacement, Moral Reasoning) Population: Child/ Adolescent MH	**Chart Review: Yes** **Training verified: Yes**	Aggression Replacement Training features three coordinated and integrated components: Social Skills Training—Teaches participants what to do, helping them replace antisocial behaviors with positive alternatives. Anger Control—Teaches participants what not to do, helping them respond to anger in a nonaggressive manner and rethink anger-provoking situations. Moral Reasoning—Helps raise participants' level of fairness, justice, and concern for the needs and rights of others.	Improved relationships with peers/family. Fewer outbursts of anger/frustration. Increased ability to work well with others. Improvement in school behaviors (less referrals, office visits, ISS, etc.). Ability to identify and be able to employ anger techniques prior to outburst.	HHSC Performance Contract
12 SAMHSA COPSD Integrated Treatment for Co-occurring Disorders (COPSD- Co-occurring Psychiatric and Substance Abuse Disorders Population: Adult MH, Child/ Adolescent MH,	**Chart Review: Yes** **Training verified: Yes**	Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders. Integrated treatment specialists are trained to treat substance use disorders and serious mental illnesses. Co-occurring disorders are treated in a stage-wise fashion with different services provided at different stages. Services may include Case Management, Skills Training, Psycho-social Rehabilitation (PSR), Medication Training and Support, and Crisis Intervention Services. Stages of intervention- are engagement, persuasion, active treatment, and relapse prevention. Motivational interventions (e.g., expressing empathy, developing discrepancy, avoiding argumentation, rolling with resistance, and instilling self-efficacy and hope) are used to treat consumers in all stages, but especially in the persuasion stage.	Reduced substance use. Improvement in psychiatric symptoms and functioning. Decreased hospitalization. Increased housing stability. Fewer arrests and Improved quality of life.	CCBHC HHSC Performance Contract

		Substance abuse counseling, using a cognitive-behavioral approach, is used to treat consumers in the active treatment and relapse prevention stages. Using educational materials for recovery and/or relapse prevention. Multiple formats for service are available, including individual, group, self-help, and family. Individuals should have access to other comprehensive services including Residential Services, Supported Employment, Family interventions, Illness Management and Recovery (IMR), and Assertive Community Treatment (ACT). Medication services are integrated and coordinated with psychosocial services. Self-help resources will be provided with encouragement to attend. Health interventions are discussed and promoted for well-being (e.g., avoiding high risk behaviors and situations that could lead to infectious diseases, find safe housing, practice proper diet and exercise).		
14 Person-Centered Recovery Planning/Safety Planning Population: Adult MH and Child/ Adolescent MH	**Chart Review: Yes** **Training is provided through Utilization Management as part of the privileging process.**	Collaborative process resulting in a recovery-oriented treatment plan. Is directed by consumers and produced in partnership with care providers and natural supporters for treatment and recovery. Supports consumer preferences and a recovery orientation.	Better quality care as evidenced by 1) decrease in emergency room visits 2) reduction in days spent in a hospital 3) ability of consumers to deal more effectively with problems. Better social outcomes as evidenced by 1) increase in gainful activity 2) decrease in self-harm 3) reduction in harm to others	CCBHC

			Lower costs for 1) inpatient services 2) outpatient services 3) community supports	
15 Permanent Supportive Housing Population: Adult MH	**Chart Review: Yes** **Training- Yes**	Through a collaborative process, it is very important to know the individual's needs, abilities, goals, and preferences for housing choices. Development of social support opportunities within a community	Better quality of life through having the security of a place to go that is safe and comfortable. Having reasonable accommodation for housing. Housing choice must be person-centered. Program assists individuals 18 years and up who are at risk of becoming homeless find safe, affordable housing. Individuals will learn skills to maintain housing and live independently.	CCBHC
16 Cognitive Adaptation Training (CAT) Population: Adult MH	**Chart Review: Yes** **Training: Yes**	Addresses the impact of serious mental illness on behavior and executive functioning. Designed to improve daily function and quality of life for individuals.	To compensate for cognitive impairments and improve daily functioning To enhance organizational skills, time management, and problem-solving abilities To promote independence and reduce reliance on support systems To improve social and occupational outcomes	N/A

In addition to the evidence-based practices listed above, Helen Farabee Centers also uses:

ASIST-Applied Suicide Intervention Skills Training
Mental Health First Aid
ANSA-Adults Needs and Strengths Assessment…. HHSC Performance Contract
CANS-Child Adolescent Needs and Strengths Scale… HHSC Performance Contract
Treatment Improvement Protocols
Trauma informed care principles

Use of PHQ-9
Use of C-SSRS

Within Substance Abuse Services: Cognitive Behavioral Therapy (CBT), Motivational Interviewing, Motivational Enhanced Therapy, Co-Occurring Psychiatric and Substance Abuse Disorders (COPSD), and Screening, Brief Intervention, Referral to Treatment Model (SBIRT), Seeking Safety, Cannabis Youth Treatment Curriculum, Twelve Step Program and Living in Balance, Substance Abuse Mental Health Association (SAMHA) materials such as TIP-42 .

Brief Description of Child and Adolescent EBPs: All Training Certificates are to be filed in the Employee's Credentialing File in Human Resources.

Nurturing Parenting/Program

Designed for children and adolescents in all Levels of Care in which skills training services are available.
Parental training curriculum designed to increase parent's knowledge of age-appropriate developmental expectations and the use of alternative strategies to harsh/abusive discipline.

> **Training Requirements**: Completion of a 3-day training on Nurturing Parenting by a trainer who has been certified as an Organizational Trainer or National Trainer by Nurturing Parenting Programs®.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Designed for children and adolescents in Levels of Care 2, 3, or 4 with or without a diagnosis of PTSD.
A 12-session conjoint child and parent psychotherapy approach for children and adolescents who are experiencing significant emotional and behavioral difficulties related to traumatic life events.

> **Training Requirements**: Unless applicants complete training with Dr. Susana Rivera directly, they must complete basic online training, online Complex Traumatic Grief training, and two days of face-to-face training by a nationally approved TF-CBT trainer. Additionally, applicants complete twelve (12) consultation calls in which they will present at least one case. For additional information, refer to Information Item A on the Mental Health Performance Contract.

Cognitive Behavioral Therapy (CBT)

Designed for adolescents and children in Levels of Care 2, 3, or 4.
This is a 12-16-week counseling protocol designed to reduce symptoms of depression by integrating rational thoughts to reduce negative symptoms.
Contraindicated for individuals with active psychosis, borderline intellectual functioning, or who are otherwise verbally impaired.

Training Requirements: Prior to providing CBT services, staff must complete a CBT training that has the following core CBT Training Elements that are consistent with *Cognitive Therapy of Depression* (Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. 1979) and the *Cognitive Therapy Scale Rating Manual* (Young, J.E. & Beck, A.T. August 1980). Providers may develop an in-house clinical training that contains the core CBT Training elements. Providers are responsible for the training, competency and supervision of staff providing CBT. For additional information, refer to Information Item A on the Mental Health Performance Contract.

To align programming with evidence-based and best practices, HHSC is engaged in efforts to ensure that services are reflective of national standards. Although other evidence-based practices have accompanying fidelity instruments, there is no nationally recognized fidelity instrument for CBT. However, the *Cognitive Therapy Rating Scale (CTRS)* (Young, J.E. & Beck, A.T. August 1980) is a nationally recognized instrument in determining clinician competence and adherence to the CBT model. It is recommended, but not required, that the CTRS be used to guide supervision and adherence to CBT.

Intensive Case Management/ Wraparound Services

Designed for children and adolescents in Level of Care 4.
A person-centered service delivery model for children with severe emotional or behavioral needs.
Contraindicated for families preferring infrequent contact.

Training Requirements: Complete Wraparound training with a Department of State Health Services (DSHS) approved facilitator, complete three core training modules and receives monthly supervision from a Wraparound Supervisor certified as a training entity by the National Wraparound Initiative.

Seeking Safety

Designed for adolescents (age 13 and older) in all Level of Care where skills training services are available.
Seeking Safety is a present-focused therapy to help individuals attain safety from trauma/Post traumatic stress disorder (PTSD) and substance abuse. Considered an evidence-based practice, this is a present-focused counseling model to help people grow in their coping skills to attain safety from trauma and/or substance abuse.

Training Requirements: Attendance at a 1-day live training on Seeking Safety by a licensed professional and a one-time observation of within a year of training.

Aggression Replacement Techniques (ART)

Designed for children and adolescents in all Levels of Care in which skills training services are available.
Improving relationships with peers and family through social skills training, anger control, and moral reasoning.

Training Requirements: Complete one day of live training by an approved trainer or documented completion of required DVD course plus completing required observation forms within one year of training.

Brief Description of Adult EBPs

Illness Management and Recovery (IMR)

State requires for all Levels of Care.
Provides intensive psychoeducation, behavior modification, relapse prevention strategies, and coping skills training using a standard curriculum.

Training Requirements: IMR training through Relias is completed. Utilization Review staff provides initial and ongoing training.

Cognitive Adaptation Training (CAT)

Designed for adults in all Levels of Care in which skills training services are available.
Provides one on one training to improve daily functioning and quality of life for individuals with severe mental illness such as schizophrenia. Components include environmental supports, task- specific training, problem-solving skills, goal setting, and motivation.

Training Requirements: 2.5-hour training through Centralized Training Infrastructure and Utilization Management staff provide training.

Assertive Community Treatment (ACT), Rural Model

Designed for adults in Level of Care 4.
A service delivery model with the goal of recovery through community treatment and habilitation for consumers with the most challenging and persistent problems including multiple psychiatric hospitalizations, generally low functioning, and unstable housing situations.

Training Requirements: Utilization Management staff provide training.

Cognitive Behavioral Therapy (CBT)

Designed for adults in Level of Care 2.
This is a 12-16-week counseling course designed to reduce symptoms of depression by integrating rational thoughts to reduce negative symptoms.

Contraindicated for individuals with borderline intellectual functioning, or who are otherwise verbally impaired.

Training Requirements: Prior to providing CBT services, staff must complete a CBT training that has the following core CBT Training Elements that are consistent with *Cognitive Therapy of Depression* (Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. 1979) and the *Cognitive Therapy Scale Rating Manual* (Young, J.E. & Beck, A.T. August 1980). Providers may develop an in-house clinical training that contains the core CBT Training elements. Providers are responsible for the training, competency and supervision of staff providing CBT.

To align programming with evidence-based and best practices, HHSC is engaged in efforts to ensure that services are reflective of national standards. Although other evidence-based practices have accompanying fidelity instruments, there is no nationally recognized fidelity instrument for CBT. However, the *Cognitive Therapy Rating Scale (CTRS)* (Young, J.E. & Beck, A.T. August 1980) is a nationally recognized instrument in determining clinician competence and adherence to the CBT model. It is recommended, but not required, that the CTRS be used to guide supervision and adherence to CBT. For additional information, refer to Information Item A on the Mental Health Performance Contract.

Cognitive Behavioral Therapy with Psychosis (CBTp)

Designed for adults in Level of Care 2.
This is a 16-week counseling course designed to reduce the distress associated with the symptoms of psychosis and improve functioning.
Contraindicated for individuals with borderline intellectual functioning, or who are otherwise verbally impaired.

Training Requirements: Prior to providing CBTp services, staff must complete a CBT training that has the following core CBT Training Elements that are consistent with *Cognitive Therapy of Depression* (Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. 1979) and the *Cognitive Therapy Scale Rating Manual* (Young, J.E. & Beck, A.T. August, 1980). Providers must also complete CBTp facilitated by Dr. Sally Riggs and complete phone supervision for 10 weeks. Providers are responsible for the training, competency and supervision of staff providing CBTp.

To align programming with evidence-based and best practices, HHSC is engaged in efforts to ensure that services are reflective of national standards. Although other evidence-based practices have accompanying fidelity instruments, there is no nationally recognized fidelity instrument for CBTp. For additional information, refer to Information Item A on the Mental Health Performance Contract.

Cognitive Processing Therapy (CPT)

Designed for adults in Levels of Care 1-5.
A 12-session course adapted from cognitive behavioral therapy to help individuals explore recovery from PTSD or other trauma-related conditions.
Contraindicated for individuals with borderline intellectual functioning, or who are otherwise verbally impaired.

Training Requirements: Training Phase: Practitioners will complete the HHSC approved 2-Day classroom training on CPT or an equivalent training, such as Veteran's Administration training on CPT. Consultation Phase: Practitioners will participate in the consultation phase of the training process by attending the scheduled consultation calls with qualified trainers/consultants and concurrently conducting CPT with clients. To complete this phase, the clinician must document attendance of at least 19.5 hours of consultation calls during the consultation period within one year of the classroom training. Counseling Phase: The counseling phase requires practitioners complete two 12-session cases of CPT during the consultation phase within one year of the training. Once added to the CPT Registry, the clinician in now in approved status. Being added to the registry creates a permanent record of those practitioners approved to provide CPT in Texas. For additional information, refer to Information Item A on the Mental Health Performance Contract.

Supported Employment

Designed for adults in Levels of Care 1-5.
Based on the model supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), this intervention assists individuals throughout the entire process of job preparation, search, and maintenance.
Contraindicated for individuals who express a clear desire not to work.

Training Requirements: Initial HHSC training. Supported Employment Supervisor provides training. We have eight specific Supported Employment Trainings through Relias:

1) Evidenced Based Practices in Supported Employment Part 1
2) Evidenced Based Practices in Supported Employment Part 2
3) Employment Support Focused Learning
4) Customized Community Careers: Part 1- Overview of Customized Employment
5) Customized Community Careers: Part 2-Understanding the Discovery of Personal Genius
6) Customized Community Careers: Part 3-Employment Opportunities through Customized Job Development
7) Customized Community Careers: Part 4-Customized Employment Using Interest Based Negotiations
8) Customized Community Careers: Part 5- Systemic Instruction and Job Training

There is also training available through University of North Texas that one must have to work with TWS-VRS

1) Job Coach/Job Skills Training- Designated staff will receive training
2) Job Placement Specialist- Designated staff will receive training
3) Supported Employment-Designated staff will receive training
4) Directors- Designated Coordinator will receive training

The above four are from University of North Texas and are maintained by getting 30 Continuing Education credits through webinars from UNT and HFC training through Relias.

Seeking Safety

Designed for children and adults in all Levels of Care. This is a present-focused counseling model to help people grow in their coping skills to attain safety from trauma and/or substance abuse.

Training Requirements: Attendance at a 1-day live training on Seeking Safety by a licensed professional and a one-time observation of within a year of training.

Permanent Supportive Housing:
Designed for adults in Levels of Care 1-5. This evidence-based practice is for individuals in services who are 18 or older and who are at risk of becoming homeless and need to find safe, affordable housing.

Training Requirements: Utilization Management staff provides training.

Special Population EBPs:

Older Adults

The Adult EBPs for the general adult population may be used with any age adult unless contraindicated as noted. As with all therapeutic interventions, the individual's developmental stage, learning style, and individual preferences should guide treatment in a person-centered approach.

Developmentally/Cognitively Disabled

Some adults or children with developmental/cognitive issues may struggle with a particular intervention depending on the nature of their issues. For example, an adult with an intellectual disability or communication disorder may not benefit from highly cognitive/verbal forms of therapy like CBT. A behavior-focused skills training intervention may be more suitable.

Substance Abuse:

Co-Occurring Psychiatric and Substance Abuse Disorder (COPSD) Treatment

Designed for adults or adolescents in any Level of Care who have co-occurring psychiatric, and substance use diagnosis.
Mental health and substance abuse treatment are integrated to meet the needs of people with co-occurring disorders. Integrated treatment specialists are trained to treat substance use disorders and serious mental illnesses.

Training Requirements: State Central Training and Relias training is scheduled through Human Resources Department.

Screening, Brief Intervention, Referral to Treatment (SBIRT) Model

A model designed for adults or adolescents in any Level of Care who have or may be at risk of developing substance use disorders. This is a comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance abuse use disorders, as well as those who are at risk of developing these disorders.

Training Requirements: Relias training is scheduled through Human Resources Department

General Techniques for All Populations

Motivational Interviewing

A specific approach to interacting with individuals designed to inspire motivation to change and engage in treatment while expressing empathy, avoiding arguments, and supporting self-efficacy.

Training Requirements: Relias training is scheduled through Human Resources Department

Person-Centered Recovery Planning

A collaborative process resulting in a recovery-oriented treatment plan. The process is directed by consumers in partnership with care providers and natural supports such as family members.

Training Requirements: Utilization Management staff provides training.

Applied Suicide Intervention Skills Training

A nationally implemented model that trains professional and non-professional staff in techniques used to intervene with people who express suicidal thoughts/plans.

Training Requirements: All employees will attend a mandatory two-day course and become certified. Course leaders are certified to train others.

FY 2027 QM Plan for Continuous Quality Improvement (CQI)

Annual Projects & Activities Attachment H

Project # 1	**Increase Skills Training Services**
Activity Description:	• UM/ QM will address skills training with staff on how to improve client buy-in and expectations. • Quarterly skills training refreshers for staff members. • Study indirect benefits of skills to improve buy-in from staff and clients. • Encourage clients to engage in skills training before participating in CPT counseling. • Monitor skills training hours compared to direct time.
Tools:	EBP and Approved curricula; Client Billed Services reporting; Counseling tracking spreadsheet; PDSA worksheet
Staff Responsible	Quality and Utilization Management team; MH trainers; Associate Executive Director; management team
Frequency:	Monthly, quarterly, and annual tracking
Target:	Increase skills training to 30% of case manager direct time.

Project # 2	**Food Insecurity/ SDOH**
Activity Description:	• Update the SDOH form to better measure food insecurity and follow up efforts to address • Collect baseline data of HFC's population experiencing food insecurity • Report food insecurity numbers and follow up efforts for the DPP-BHS measure • Implement updated SDOH assessment in SmartCare. Begin collecting data and forming a sample of individuals to study for successful referrals and utilization of treatment. • Track progress.
Tools:	SDOH Assessment in SmartCare
Staff Responsible:	Quality Management Team; Associate Executive Director; Director of MIS
Frequency:	Quarterly Monitoring
Target:	HFC would like to see a reduction of food insecurity by 50% of participants in the sample.

Project # 3	**Preventive Care Screening: Unhealthy Alcohol Use: Screening and Brief Counseling**
Activity Description:	• Determine where the information for the measure is being reported • Train staff to enter the information needed for reporting • Monitor for improvements
Tools:	SmartCare Flowsheet/ MBOW reporting
Staff Responsible:	Quality Management Team; Associate Executive Director; Director of MIS; Chief Medical Director
Frequency:	Quarterly Monitoring
Target:	HFC would like to see an increase of the number of clients screened for alcohol by 20%

Project # 4	CCBHC Quality Measures
Activity Description:	Helen Farabee Centers will participate in HHSC data and evaluation activities as outlined in the T-CCBHC Quality Measure Workbook. • 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). The CQI committee will review outcomes for trends and patterns to ensure the center is meeting quality goals and objectives. The Chief Medical Officer will review measures and outcomes for primary care issues.
Tools:	T-CCBHC criterion and Quality Measure Workbook
Staff Responsible:	Quality Management Team; Associate Executive Director; Chief Medical Director; Director of MIS
Frequency:	Annual
Target:	100% of above data points can be produced for reporting.

Activity # 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. Process: The Director of UM/QM tracks 30 day re-admissions. Each quarter, the CQI Committee discusses the information provided by the CARE database and other reports. If there are patterns or clients identified, those individuals are discussed to create a plan with the Continuity of Care Liaison. The Director of UM/ QM also reports to the Improvement and Oversight Committee if there are issues noted on hospital readmission.
Tools:	CARE database, 292-Report, Target Report
Staff Responsible:	Director of Utilization and Quality Management will report to the Improvement and Oversight Committee, Continuity of Care Liaison, and CQI Committee
Frequency	Review Quarterly
Target:	100% of rehospitalizations within 30 days will be reviewed and reported.

Activity # 6	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 Process: The UM Reviewer is a member of HFC's Safety Committee. During quarterly committee meeting the UM Reviewer reports any incidents or events that occurred during the quarter. The Safety Committee reviews the incident reports and will make recommendations if needed. The UM Reviewer then informs the CQI Committee of the recommendations. The CQI Committee will revise procedures and update training based off the recommendations. The CQI Committee members will train staff during weekly staffing. If the death requires a review from the Death Review Committee, then a similar process occurs. The Director of UM/QM is a member of the Death Review Committee. Deaths requiring review are assessed with the Chief Medical Officer and other appointed members to determine . If there is a recommendation by the Chief Medical Office or other committee members to revise procedures or update training, that information is relayed to the CQI Committee by the Director of UM/ QM who then revises the procedures and the CQI Committee will train staff during weekly staffing. Significant events can be defined as: • Suicide or suicide attempts • Fatal or non-fatal overdose • Any Death of a person receiving services
Tools:	Incident Reports (HFC Form #25-Report of Death of a Person Served) 8490 HHSC -Report of Death, 8492-Preliminary Review.
Staff Responsible:	Members of the Safety Committee, Members of the CQI Committee, Members of the Death Review Committee, Director of Utilization and Quality Management, and Chief Medical Officer.
Frequency	Review Quarterly
Target:	100% of known deaths will be reviewed in accordance with Procedure.

Early Childhood Intervention Services	
Expectation # 1	**The ECI Program will serve 200 children per month per the Performance Contract.**
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: Defined by HHS to include the annual average number of enrolled children who receive a program provided ECI service during each month. The year-to-date average number of children served monthly is no more than 10% below contract target (180).

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 Clerk 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
Target:	Performance Target: 90% timely services delivered.

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: 90%

Expectation # 4	**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.** 1. 90-days before a child's 3rd birthday, the IFSP will include transition steps and services. 2. 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. 3. 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 Clerk and 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: 90% for each Indicator.

Expectation # 5	**The ECI program will deliver a total of 2.35 hours/ per child/per month.**
Activity Description:	1. The ECI Clinical Supervisor and ECI Data Clerk will track service hours to ensure the delivery of services with the child/family. 2. ECI Data Clerk runs the delivered services reports by the 20th of each month.
Tools:	HHSC-ECI Monthly Services Reports (Extranet) / Provider Soft Activity Summary Report by Provider
Frequency:	Monthly
Target:	Performance Target: Average 2.35 hours/ per child/ per month.

Expectation # 6	**Outcomes of the Child demonstrate improvement in the following domains:** 1. Positive social-emotional skills (including social relationships). • Performance Target: 69.5% (children who substantially increased their rate of growth upon exit). • Performance Target: 46.3% (children functioning within age expectations upon exit). 2. Acquisition and use of knowledge and skills (including early language/ communication). • Performance Target: 77.1% (children who substantially increased their rate of growth upon exit). • Performance Target: 35.3% (children functioning within age expectations upon exit). 3. Use of appropriate behaviors to meet their needs. • Performance Target: 77.5% (children who substantially increased their rate of growth upon exit). • Performance Target: 44.2% (children functioning within age expectations upon exit).
Activity Description:	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 Clerk 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.

Expectation # 7	**a) Family outcomes and indicators of family capacity are measured annually using a comprehensive family survey of the following areas:** 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% **b) Family satisfaction with ECI services is measured for enrolled children upon discharge.**
Activity Description:	a) Local ECI staff facilitate the electronic 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. 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.
Tools:	a) HHSC-ECI Family Outcomes Survey performance target is at least 45% of families sampled shall complete the family outcomes survey annually. b) HFC-ECI Survey / Survey Monkey
Frequency:	a) Annually b) Monthly / Quarterly / Annually
Target:	In addition to performance targets noted above, HHS-ECI Family Outcomes Survey response submissions are expected to be at least 45% of families sampled annually.

Expectation # 8	**Therapy Utilization**
Activity Description	Therapy service hours delivered by ECI program employees and contractors (OT, PT and SLP) are based upon the needs of children served and in alignment with HHSC-ECI contract requirements.
Activity Description:	➢ Individual family service plans are monitored by ECI Clinical Supervisors and Program Director to ensure rationale for planned services ➢ Delivered services are monitored monthly by discipline and proportion.
Tools:	TRAD Planned and Delivered Service Reports / ProviderSoft Caseload and Activity Summary Reports
Frequency:	Monthly
Target:	At least 40% of the total delivered Program Provided service hours are therapy hours.

Expectation	**Timely Submission of TKIDS Data**

# 9	
Activity Description	Data is submitted in accordance with data standards and reporting requirements established by HHSC.
Activity Description:	Complete and accurate data is entered into the Texas Kids Intervention Data System (TKIDS) by established due dates.
Activity Description:	ECI staff submit data within the Provider Soft Electronic Medical Record within established timeframes and/or due dates.
Tools:	TKIDS User Manual, Provider Soft Activity Summary and Documents, TKIDS Report Form
Frequency:	Monthly
Target:	90% of data is entered into TKIDS by due date(s).

Expectation # 10	**Collection of local funds (LCF), which when combined with HHS-ECI contract funds, are sufficient to successfully perform the requirements of the Contract. Local funds include revenue generated from public, federal, and private insurance for ECI services rendered in addition to state, local, in-kind contributions, cash donations and private funds allocated for ECI program costs.**
Activity Description:	ECI employees or contractors licensed, certified, or otherwise granted authority within the agency or program to evaluate the child's need for developmental services or deliver the medically necessary services per the Individual Family Service Plan developed for each eligible child, submit required reports in a timely fashion to bill for these services.
Activity Description:	Delivered/documented evaluations and ongoing services are verified by appointed supervisory and clerical staff to ensure content and billing accuracy prior to submission for payment.
Activity Description:	Services are billed via a clearinghouse. Families determined to have the ability to pay for a portion of the services are billed directly via monthly statements. Payments received are posted to individual child records, as well as summarized and reported to the HFC financial office. Payment denials are investigated for resubmission and/or appeal as applicable. Secondary insurance is also billed when applicable.
Activity Description:	Locally collected funds are tallied each month and utilized to pay approved program expenses. Analysis is completed on/around the 15th of the following month to monitor income in relationship to use of HHSC-ECI funds to achieve a balanced budget.
Tools:	HHS-ECI Financial System Items: Contract Budget, Fiscal Year Funding, Monthly Invoices, Expenditures to Date, and Quarterly Reports 269a (Financial Status Report) and Expenditure Summary by Funding Source.
Frequency:	During the third and fourth quarter of each fiscal year.
Target:	LCF year-to-date must be no less than 40% of projected income.

Expectation # 11	**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.** ➢ 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:	• 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

FY 2027 QM Plan

Subcontracting –Attachment J

Expectation # 1	**The reporting and monitoring of hospitals which provide person-centered care services will be conducted using required elements of service.** • Red River Hospital • The Pavilion • Millwood Hospital • Perimeter • Oceans The elements specifically reviewed in accordance with Texas Administrative Code: • 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. • Satisfaction of consumers and family members. • Utilization of resources. • Training and Technical Assistance.
Activity Description	Each Sub-Contractor will complete an annual attestation form.
Tools:	Annual Sub-Contractor Attestation form provided by the subcontractor.
Frequency:	Occurring 1 time per fiscal year.
Target:	100% of sub-contractors will complete the annual attestation form.

Expectation # 2	**The reporting and monitoring of YES Waiver subcontracts which person-centered care services will be conducted using required elements of the services.** • Camp Summit • Thinking Above Average • Heart and Harmony The elements specifically reviewed in accordance with Texas Administrative Code • 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. • Satisfaction of consumers and family members. • Utilization of resources. • Training and Technical Assistance.

FY 2027 QM Plan

Subcontracting –Attachment J

Activity Description	Each Sub-Contractor will complete an annual attestation form.
Tools:	Annual Sub-Contractor Attestation form provided by the subcontractor.
Frequency:	Occurring 1 time per fiscal year.
Target:	100% of sub-contractors will complete the annual attestation form.

Expectation # 3	**The reporting and monitoring of subcontracts.** • The Wood Group (Crisis Respite Unit, Assisted Living Unit, Hospital Transition Home) • Avail Solutions (Crisis Hotline) • Dr. Shipley (MMPI) • Abilene Recovery Council (OSAR) The elements specifically reviewed in accordance with Texas Administrative Code • 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. • Satisfaction of consumers and family members. • Utilization of resources. • Training and Technical Assistance.
Activity Description	Each sub-contractor will be monitored monthly according to contract and performance standards. Each sub-contractor will provide their monthly documentation to the quality management department for review and reconciliation.
Tools:	Varies by sub-contractor
Frequency:	Monthly monitoring and quarterly reporting.
Target:	100% of sub-contractors will submit reporting documents each month.

FY 2027 QM Plan for Mental Health Services
Child and Adolescent Services
Attachment K

Mental Health Services	
Expectation # 1	**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.**
Activity Description:	**Step 1:** Designated Quality Management (QM) staff will select medical records to monitor mental health services provided. A sample is taken from each Case Manager and Family Partner staff as indicated on the Scheduling Grid. Any specialty programs such as Wraparound and RTC project will be audited according to the Scheduling Grid. Each staff member will be audited during the year. Only exception at this time, will be if they are still in training. **Step 2:** Medical record cases will be selected randomly and will be audited on an approved audit tool. For any scores not meeting set guidelines, a Quality Management Action Plan (QMAP) will be completed for needed actions/ response. If refresher training has been identified, this will be set up between the auditor and the staff member. **Step 3**: Audit results will be sent to audited staff member or supervisor along with the QMAP, if applicable. **Step 4:** For any low compliance scores, the Supervisor will be consulted to discuss QM actions. **Step 5:** A two-week response time is assigned for the QMAP Request to be returned to the QM auditor. Extensions may be granted if a justified reason. **Step 6**: All completed QMAP responses with the staff and the QM auditor's signature will be maintained on file with the audit. A copy of the audit/ QMAP/ and Training record will be provided to the Supervisor for their files. An email to @HR will also be sent with any training records completed. **Step 7**: Any organizational trends found in the audits, will be brought to the attention of supervisors and staff through the Adult Staffing Meetings. On a quarterly basis, a Summary Report will be provided on each audited category to leadership.
Activity Guidelines:	• For any audit that scores **90% or greater on average:** No formal Quality Management Plan (QMAP) will be issued but the results of the audits will be shared for ongoing communication on the No scores. Staff are required to complete corrective actions or learn from error for future activities. • Any audit that receives **89% or below on average:** A formal QMAP will be completed and sent to the staff member which identifies the actions needed from them. The staff have two-weeks to respond. They are to indicate their understanding of the audit; any corrective actions taken and sign the QMAP response. They are to return the completed QMAP to the QM auditor who will review the actions and only follow up if needed. After acceptance, the QM auditor will sign the QMAP as well and file. **NOTE**: The QM auditor will have the discretion to forego the initiation of a QMAP based on the

	following considerations: a) the number of audit questions were minimal and therefore the % was not representative of their work, or b) the improvement identified on the audit as compared to early audits was significant, therefore the staff may not receive a formal QMAP but will be advised of any pending areas to work on. • Any audit that receives **below <u>76% on average</u>**: A formal QMAP will be required. The staff have two-weeks to respond. They are to indicate their understanding of the audit; any corrective actions taken and sign the QMAP. They are to return the completed QMAP to the QM auditor who will review the actions and only follow up if needed. After acceptance, the QM auditor will sign the QMAP, may schedule the refresher training and document on HFC # 535 with copies being provided to Human Resources (#HR) and filed within our files. • If two medical records pulled score an average of 90% or above no formal QMAP will be issued. The audit results will be shared for ongoing communication on the No scores. • For audits that score below the 76%, additional auditing will be completed as time allows by the QM auditor with a goal of them reaching compliance.
Tools:	Based on the Health and Human Services Commission (HHSC) Monitoring Tool, all audits are completed using locally approved formats within Survey Monkey; a QMAP and a Training Record as applicable.
Frequency:	Time frames in accordance with Scheduling Grid. (On file)
Target:	76% compliance on average.

Expectation # 2	**Case Managers will complete and maintain certifications and required training. Training includes Wraparound, YES Waiver (if applicable), skills training curriculum, and job required training.**
Activity Description:	• Staff will complete required training in a timely manner to maintain good standings. • Director of CAS will monitor training requirements for program specific training through Relias or other platforms.
Tools:	Relias, other approved platforms (if applicable)
Frequency:	Quarterly monitoring
Target:	95% completion of training

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.**
Activity Description:	Designated QM staff will participate in the UM Committee for review of performance measures noted above and will consult on capacity decisions based on this data.
Tools:	UM Report.
Frequency:	Monthly through Target Report at IOC and Quarterly through UM meetings.
Target:	100% of committee meetings will occur timely.

FY 2027 QM Plan for Mental Health Services
Medical Services
Attachment L

Medical Services	
Expectation # 1	**In accordance with the Scheduling Grid, medical record audits are completed to ensure quality care and timely services.**
Activity Description:	**Step 1:** Designated Quality Management (QM) staff will select medical records to monitor medical services provided. A sample is taken from each medical provider as indicated on the Scheduling Grid. Each medical provider will receive at least one audit annually, with additional audits conducted based on risk indicators, previous audit findings, or organizational priorities identified through Quality Management activities. The only exception will be if they are still in training. **Step 2:** Medical record cases will be selected using a random sampling methodology that ensures equitable representation of each provider's medical records. Medical record cases will be audited on an approved audit tool. For any scores not meeting set guidelines, a Quality Management Action Plan (QMAP) will be completed for needed actions/ response. If refresher training has been identified, this will be set up between the auditor and the staff member. **Step 3**: Audit results will be sent to audited staff member or supervisor along with the QMAP, if applicable. **Step 4:** For any low compliance scores, the Supervisor will be consulted to discuss QM actions. Repeated audit scores below established performance thresholds may result in progressive quality improvement interventions, including increased audit frequency, focused education, performance improvement plans, supervisory review, or referral through established Human Resources processes, as applicable. **Step 5:** A two-week response time is assigned for the QMAP Request to be returned to the QM auditor. Extensions may be granted by the QM auditor or designee when a documented and reasonable justification is provided by the staff member or supervisor. **Step 6**: All completed QMAP responses with the staff and the QM auditor's signature will be maintained on file with the audit. A copy of the audit/ QMAP/ and Training record will be provided to the Supervisor for their files. Documentation of required retraining activities will be maintained by QM and submitted to Human Resources in accordance with organizational training record requirements. **Step 7**: Organizational trends, systemic deficiencies, and recurring audit findings will be analyzed quarterly to identify opportunities for quality improvement, staff education, policy revision, and risk mitigation. Results will be provided to the Chief Medical Officer. Education opportunities will be provided through the quarterly Medical Staff meeting. On a quarterly basis, a Summary Report will be provided on each audited category to leadership.

Activity Guidelines:	• For any audit that scores **90% or greater on average:** No formal Quality Management Plan (QMAP) will be issued but the results of the audits will be shared for ongoing communication on the "No" scores. Staff are required to complete corrective actions or learn from error for future activities. • Any audit that receives **89% or below on average:** A formal QMAP may be completed if deemed appropriate by the Chief Medical Officer. The QMAP will be sent to the staff member which identifies the actions needed by them. The staff have two weeks to respond. They are to indicate their understanding of the audit; any corrective actions taken and sign the QMAP response. They are to return the completed QMAP to the QM auditor who will review the actions and only follow up if needed. After acceptance, the QM auditor will sign the QMAP as well and file. **NOTE**: The QM auditor will have the discretion to forego the initiation of a QMAP based on the following considerations: a) the number of audit questions were minimal and therefore the % was not representative of their work, or b) improvement identified on the audit as compared to early audits was significant, therefore the staff may not receive a formal QMAP but will be advised of any pending areas to work on. • Any audit that receives **below 76% on average**: A formal QMAP will be required. The staff have two weeks to respond. They are to indicate their understanding of the audit; any corrective actions taken and sign the QMAP. They are to return the completed QMAP to the QM auditor who will review the actions and only follow up if needed. After acceptance, the QM auditor will sign the QMAP, may schedule the refresher training and document on HFC # 535 with copies being provided to Human Resources (HR) and filed within our files. • If two medical records pulled score an average of 90% or above no formal QMAP will be issued. The audit results will be shared for ongoing communication on the No scores. • Peer review activities are confidential and separate from the Quality Management audit process. QM staff may facilitate record selection, collection, and distribution of results but shall not alter peer review findings or use peer review outcomes for disciplinary purposes outside established peer review procedures.
Tools:	• Based on the Health and Human Services Commission (HHSC) Monitoring Tool, all audits are completed using locally approved formats within Survey Monkey.
Frequency:	• Time frames in accordance with Scheduling Grid. (On file)
Target:	• Achieve and maintain an average compliance score of 76% or greater across all audited medical record reviews annually, with corrective actions implemented for identified deficiencies and trends monitored through the Quality Management Program.

Expectation # 2	**Medication Reconciliation**
Activity Description:	• Medical providers will review and reconcile each individual's medication list at every psychiatric appointment. • Within the E&M note, the provider will select the **Medication Reconciliation** radio button to document that all external and internal medications have been reviewed and reconciled.
Tools:	SmartCare reporting
Frequency:	Quarterly monitoring
Target:	The Medication Reconciliation radio button will be completed in **90% or more of all psychiatric appointments**.

Expectation # 3	Self -Administration of Medication (SAM)
Activity Description:	• Medical providers will assess each individual's ability to safely self-administer prescribed medications. • If concerns are identified regarding an individual's ability to self-administer medications, the provider will: o Complete a SAM note documenting the assessment and concerns. o Submit a referral to the **@SAM email group** for additional medication education, support, and follow-up as appropriate.
Tools:	• SmartCare reporting • Internal auditing tool • Internal SAM tracking spreadsheet
Frequency:	• Quarterly monitoring
Target:	• **90% compliance** with SAM assessments and required referrals/documentation when concerns regarding self-administration are identified.

FY 2027 QM Plan for Mental Health Services
TCOOMMI Services
Attachment M

TCOOMMI Services	
Expectation # 1	**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.**
Activity Description:	**Step 1:** Designated Quality Management (QM) staff will select medical records to monitor TCOOMMI services provided. A sample is taken from each Case Manager as indicated on the Scheduling Grid. Each staff member will be audited during the year. Only exception at this time, will be if they are still in training. **Step 2:** Medical record cases will be selected randomly and will be audited on an approved audit tool. For any scores not meeting set guidelines, a Quality Management Action Plan (QMAP) will be completed for needed actions/ response. If refresher training has been identified, this will be set up between the auditor and the staff member. **Step 3**: Audit results will be sent to audited staff member or supervisor along with the QMAP, if applicable. **Step 4:** For any low compliance scores, the Supervisor will be consulted to discuss QM actions. **Step 5:** A two-week response time is assigned for the QMAP Request to be returned to the QM auditor. Extensions may be granted if a justified reason. **Step 6**: All completed QMAP responses with the staff and the QM auditor's signature will be maintained on file with the audit. A copy of the audit/ QMAP/ and Training record will be provided to the Supervisor for their files. An email to @HR will also be sent with any training records completed. **Step 7**: Any organizational trends found in the audits will be brought to the attention of supervisors and staff through the Adult Staffing Meetings. On a quarterly basis, a Summary Report will be provided on each audited category to leadership.
Activity Guidelines:	• For any audit that scores **90% or greater on average:** No formal Quality Management Plan (QMAP) will be issued but the results of the audits will be shared for ongoing communication on the No scores. Staff are required to complete corrective actions or learn from error for future activities. • Any audit that receives **89% or below on average:** A formal QMAP will be completed and sent to the staff member which identifies the actions needed from them. The staff have two-weeks to respond. They are to indicate their understanding of the audit; any corrective actions taken and sign the QMAP response. They are to return the completed QMAP to the QM auditor who will review the actions and only follow up if needed. After acceptance, the QM auditor will sign the QMAP as well and file. **NOTE**: The QM auditor will have the discretion to forego the initiation of a QMAP based on the

	following considerations: a) the number of audit questions were minimal and therefore the % was not representative of their work, or b) the improvement identified on the audit as compared to early audits was significant, therefore the staff may not receive a formal QMAP but will be advised of any pending areas to work on. • Any audit that receives **below <u>76% on average</u>**: A formal QMAP will be required. The staff have two-weeks to respond. They are to indicate their understanding of the audit; any corrective actions taken and sign the QMAP. They are to return the completed QMAP to the QM auditor who will review the actions and only follow up if needed. After acceptance, the QM auditor will sign the QMAP, may schedule the refresher training and document on HFC # 535 with copies being provided to Human Resources (#HR) and filed within our files. • If two medical records pulled score an average of 90% or above no formal QMAP will be issued. The audit results will be shared for ongoing communication on the No scores. • For audits that score below the 76%, additional auditing will be completed as time allows by the QM auditor with a goal of them reaching compliance.
Tools:	Based on the Health and Human Services Commission (HHSC) Monitoring Tool, all audits are completed using locally approved formats within Survey Monkey; a QMAP and a Training Record as applicable.
Frequency:	Time frames in accordance with Scheduling Grid. (On file)
Target:	76% compliance on average.

Expectation # 2	Enrollment numbers per program and location
Activity Description:	Monitor enrollment numbers for the five TCOOMMI programs. 1. Intensive CM- Wise County 2. Transitional CM- Wise County 3. Intensive CM- Wichita County 4. Transitional CM- Wichita County 5. Continuity of Care (COC)- All counties
Tools:	SmartCare reports
Frequency:	Quarterly monitoring
Target:	The targets for enrollment are as follows: • ICM program minimum is 20 participants • TCM program minimum is 50 participants

	• Rural ICM program minimum is 10 participants • COC does not have any minimum participants

Expectation # 3	Continuity Of Care (COC) monitoring
Activity Description:	• Quality Management or TCOOMMI Director will use SmartCare reporting to ensure monthly monitoring of individuals enrolled in the TCOOMMI COC program.
Tools:	SmartCare reports
Frequency:	Monthly monitoring and quarterly reporting
Target:	100% of clients in the COC program will receive monthly monitoring.

FY 2027 QM Plan for Mental Health Services
Crisis Services
Attachment N

Crisis Services	
Expectation # 1	**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.**
Activity Description:	**Step 1:** Designated Quality Management (QM) staff will select medical records to monitor crisis services provided. A sample is taken from each Case Manager as indicated on the Scheduling Grid. Each staff member will be audited during the year. Only exception at this time will be if they are still in training. **Step 2:** Medical record cases will be selected randomly and will be audited on an approved audit tool. For any scores not meeting set guidelines, a Quality Management Action Plan (QMAP) will be completed for needed actions/ response. If refresher training has been identified, this will be set up between the auditor and the staff member. **Step 3**: Audit results will be sent to audited staff member or supervisor along with the QMAP, if applicable. **Step 4:** For any low compliance scores, the Supervisor will be consulted to discuss QM actions. **Step 5:** A two-week response time is assigned for the QMAP Request to be returned to the QM auditor. Extensions may be granted if a justified reason. **Step 6**: All completed QMAP responses with the staff and the QM auditor's signature will be maintained on file with the audit. A copy of the audit/ QMAP/ and Training record will be provided to the Supervisor for their files. An email to @HR will also be sent with any training records completed. **Step 7**: Any organizational trends found in the audits will be brought to the attention of supervisors and staff through the Adult Staffing Meetings. On a quarterly basis, a Summary Report will be provided on each audited category to leadership.
Activity Guidelines:	• For any audit that scores **90% or greater on average:** No formal Quality Management Plan (QMAP) will be issued but the results of the audits will be shared for ongoing communication on the No scores. Staff are required to complete corrective actions or learn from error for future activities. • Any audit that receives **89% or below on average:** A formal QMAP will be completed and sent to the staff member which identifies the actions needed from them. The staff have two-weeks to respond. They are to indicate their understanding of the audit; any corrective actions taken and sign the QMAP response. They are to return the completed QMAP to the QM auditor who will review the actions and only follow up if needed. After acceptance, the QM auditor will sign the QMAP as well and file. **NOTE**: The QM auditor will have the discretion to forego the initiation of a QMAP based on the

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Tools:	Based on the Health and Human Services Commission (HHSC) Monitoring Tool, all audits are completed using locally approved formats within Survey Monkey; a QMAP and a Training Record as applicable.
Frequency:	Time frames in accordance with Scheduling Grid. (On file)
Target:	76% compliance on average. 90% compliance for Crisis Assessment

Expectation # 2	Crisis Follow-Up within 24 hours
Activity Description:	• Crisis office will assign a case manager to follow up with an individual who had completed a crisis assessment. • The assigned case manager will call the individual within 24 hours. • Once contact is made the case manager will notify the crisis office and follow up is documented within an internal spreadsheet.
Tools:	Internal monitoring spreadsheet maintained by the crisis office; Info Item V, CCBHC guidelines
Frequency:	Quarterly monitoring
Target:	Crisis office will report during FY 2027 to establish a baseline.

Expectation # 3	Jail Based Competency Restoration- audit expectation of 76%
Activity Description:	Jail Based Competency Restoration (JBCR) will be audited according to the Scheduling Grid.
Tools:	Internal auditing tool collected on Survey Monkey.
Frequency:	1st and 3rd quarter of the FY year
Target:	76% on average

FY 2027 QM Plan for Mental Health Services
Care Coordination
Attachment O

Care Coordination Services	
Expectation # 1	**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.**
Activity Description:	**Step 1:** Designated Quality Management (QM) staff will select medical records to monitor TCOOMMI services provided. A sample is taken from each Case Manager as indicated on the Scheduling Grid. Each staff member will be audited during the year. Only exception at this time, will be if they are still in training. **Step 2:** Medical record cases will be selected randomly and will be audited on an approved audit tool. For any scores not meeting set guidelines, a Quality Management Action Plan (QMAP) will be completed for needed actions/ response. If refresher training has been identified, this will be set up between the auditor and the staff member. **Step 3**: Audit results will be sent to audited staff member or supervisor along with the QMAP, if applicable. **Step 4:** For any low compliance scores, the Supervisor will be consulted to discuss QM actions. **Step 5:** A two-week response time is assigned for the QMAP Request to be returned to the QM auditor. Extensions may be granted if a justified reason. **Step 6**: All completed QMAP responses with the staff and the QM auditor's signature will be maintained on file with the audit. A copy of the audit/ QMAP/ and Training record will be provided to the Supervisor for their files. An email to @HR will also be sent with any training records completed. **Step 7**: Any organizational trends found in the audits, will be brought to the attention of supervisors and staff through the Adult Staffing Meetings. On a quarterly basis, a Summary Report will be provided on each audited category to leadership.
Activity Guidelines:	• For any audit that scores **90% or greater on average:** No formal Quality Management Plan (QMAP) will be issued but the results of the audits will be shared for ongoing communication on the No scores. Staff are required to complete corrective actions or learn from error for future activities. • Any audit that receives **89% or below on average:** A formal QMAP will be completed and sent to the staff member which identifies the actions needed from them. The staff have two-weeks to respond. They are to indicate their understanding of the audit; any corrective actions taken and sign the QMAP response. They are to return the completed QMAP to the QM auditor who will review the actions and only follow up if needed. After acceptance, the QM auditor will sign the QMAP as well and file. **NOTE**: The QM auditor will have the discretion to forego the initiation of a QMAP based on the

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Tools:	Based on the Health and Human Services Commission (HHSC) Monitoring Tool, all audits are completed using locally approved formats within Survey Monkey
Frequency:	Time frames in accordance with Scheduling Grid. (On file)
Target:	76% compliance on average.

Expectation # 2	**Conduct required number of contacts according to assigned tier**
Activity Description:	• Care Coordination staff will complete the required number of contacts to each individual enrolled into a care coordination tier. • The required number of contacts is defined within the tier outline • Quality Management will take a sample of individuals enrolled in care coordination and use SmartCare reporting to determine if the appropriate number of contacts were delivered to the participants. Internal audits may be used to supplement the sample.
Tools:	Care Coordination Tier outline, internal SmartCare reporting, and internal audits.
Frequency:	Quarterly monitoring
Target:	75% of individuals enrolled in a care coordination tier received the appropriate number of contacts.

Expectation # 3	Ensure Care Coordination Agreements are current and meet CCBHC required partnerships.
Activity Description:	• Director of Adult Mental Health Services will engage with local entities to enter into a care coordination agreement. • Agreements will be monitored and updated as required. • Emails and other communications will be documented as proof of HFC's engagement in pursuing care coordination agreements.
Tools:	CCBHC Guidelines, internal tracking spreadsheet
Frequency:	Semi-annually
Target:	Meet 90% of care coordination agreements defined by CCBHC guidelines

HELEN FARABEE CENTERS

Continuous Quality Improvement Plan
Fiscal Year 2027

Table of Contents

Contents

Introduction to CQI

The activities described in this plan are supported by the principles of **Continuous Quality Improvement (CQI):**

- ***Individual-Centered Focus****: CQI is respectful of and responsive to individual patient preferences, needs, and values, prioritizing quality of life for clients and families.*
- ***Data-Driven Decision Making****: CQI relies on the systematic collection and analysis of data to identify areas for improvement and evaluate the impact of changes, rather than relying on anecdote.*
- ***Iterative Testing (PDSA cycles)****: Using Plan-Do-Study-Act (PDSA) cycles to test changes on a small scale, study the results, and refine approaches before implementing them system-wide.*
- ***Proactive Prevention****: Designing systems that prevent errors and poor outcomes, rather than fixing problems after they occur.*
- ***Leadership and Staff Involvement****: Active engagement from leadership to provide resources, paired with a multidisciplinary team approach that includes providers and consumers.*
- ***Evidence-Based Practices****: Utilizing established clinical evidence and best practices to guide improvements.*
- ***Addressing Health Disparities****: Addressing health disparities by disaggregating data to track outcomes for underserved populations and reducing barriers to care. The Center promotes these values to individuals, families, and other stakeholders in the provision of our services:*

Purpose of the CQI Plan

The CQI Plan acts as an extension of the Quality Management plan. The Quality Management plan is a structured oversight plan that does not allow for the fluidity needed for continuous improvement. Projects will be introduced and may change several times over the course of a fiscal year.

The purpose of the CQI Plan is to guide the organization's activities based on improving services and outcomes. This is achieved through data collection, analysis, and planning. The plan requires ongoing collaboration with leadership to create Center goals for improvement.

Process

The process for selecting CQI projects for the plan is based on data collection information. Helen Farabee Centers submits metrics for Directed Payment Program- Behavioral Health (DPP-BH), Certified Community Behavioral Health Clinic (CCBHC) measures, Health and Human Services, and other contracts. The Quality Management department also conducts internal reviews to uncover any issues within programs. The leadership and the Quality Management department analyze the data reported to identify gaps in services, low trending numbers compared to other Local Mental Health Authorities, and other concerns.

Once a topic has been identified as a need, the Quality Management department will start preliminary work with an A3 outline. This outline aids the creation of a Plan-Do-Study-Act cycle worksheet.

The worksheet utilizes the four phases of this problem-solving model.

- **Plan:** Define the objective, ask questions, make predictions, and develop a data collection plan.
- **Do:** Carry out the plan on a small scale, document problems, and begin data analysis.
- **Study:** Analyze the data, compare it to predictions, and summarize the learning.
- **Act:** Decide to **Adopt** (implement), **Adapt** (modify), or **Abandon** the change, and initiate the next cycle

Continuous Quality Improvement Teams

- **CQI Committee:** Each PDSA will be comprised of different members based on expertise, department, and leadership. The goal of the committee is to implement the PDSA plan and meet regularly to study the outcomes. The Quality Management department will be the branch that collects, monitors, and presents data to the committee. The committee will study and adjust the plan based on the information provided.

- **Oversight and Improvement Committee (IOC):** This committee is comprised of all leadership from every department. Center-wide decisions are discussed at this committee. The committee will be informed of the PDSAs to provide feedback and input on each project.

- **Board of Trustees (BOT):** The BOT will be informed of Continuous Improvement projects during BOT committee meetings. The BOT is required to approve any changes made to the Quality Management Plan; however, the CQI plan does not require signature approval for changes. This allows for immediate response to barriers and challenges that may occur.

Annual Evaluation of CQI Plan

On an annual basis, the CQI plan will be evaluated along with the Quality Management Plan. The evaluation will identify any additions, deletions, or changes needed to the plan.

Specific Continuous Quality Improvement Projects:

1. Skills Training and Psychosocial Rehabilitation Improvement
2. Food Insecurity/ SDOH
3. Alcohol Counseling
4. CCBHC Quality Measures

PDSA Charter	
Lead Program: Adult and Child Mental Health Project Title: Skills Training and Psychosocial Rehab (PSR) Increase Project Domain: CCBHC 5.b.1- Improve the quality of services provided	
Problem Statement:	Skills training and psychosocial rehabilitation are valuable services offered by Helen Farabee Centers (HFC). HFC recognized this service was being underutilized. In fiscal year 2024, only 27% of case managers' direct time was skills based.
Project Lead:	Project Team Members:
Cara Mullenix-Artigue- Director of UM/QM Sandra Rapson- Quality Assurance Coord	Courtney Brown- UM reviewer Taryn Fergel- UM/QM reviewer Andy Martin- Associate Executive Director
Project Goals:	
The goal of this project is to monitor the amount of skills training billed by case managers and increase skills training and PSR billing to 30% of case manager's direct time. This would be an 11% improvement.	
Customers:	Success Metrics:
Adult and child clients enrolled in Mental Health services. Mental Health staff (primarily case managers/ QMHPs)	The success of this project will be measured by an increase of skills training and PSR service provided. The Client Service Billing Report will be used to monitor skills training provided by staff.
Reasoning: (direct or indirect improvements)	
• Increase staff direct time • Improvement in PHQ9 depression scale measure- Teaching skills to reduce depression symptoms (CCBHC 5.a.2- Depression remission at Six Months) • Improve engagement and rapport with clients – Fewer no showed appts. • Reduction in crisis episodes- Teaching skills to manage symptoms to prevent escalation to a crisis episode. (CCBHC 5.b.1- improve patterns of care delivery, such as reductions in emergency department use, rehospitalization, and repeated crisis episodes) • Reduce staff burnout by building relationships and seeing progress with clients • Skills training prepares clients for counseling (fewer dropouts during counseling)	
Considerations: (constraints, obstacles, risks?)	
• Lack of training and understating of skills curriculum • As a new case manager, they are not seeing skills training during shadowing • Staff turnover • Time management issues for preparing sessions • Time to complete documentation to meet fidelity requirements • Client's willingness to participate in skills training	
Milestones	Date of Milestones
Monthly tracking	Monthly results will be sent to the team for discussion
Quarterly tracking	UM/QM department will review quarterly during QM plan meeting.
Six Month review	Six month update of data
Yearly tracking	Results for the year will be published with the Annual QM report.

PDSA Charter	
Lead Program: Adult and Child Mental Health Project Title: Food Insecurity Project Domain: CCBHC 5.b.3 Addressing populations experiencing health disparities.	
Problem Statement:	Food insecurity is a non-medical driver of health that can impact a person's mental health recovery. HFC aims to reduce food insecurity among our population.
Project Lead:	Project Team Members:
Cara Mullenix-Artigue- Director of UM/QM Sandra Rapson- Quality Assurance Coord	Courtney Brown- UM reviewer Taryn Fergel- UM/QM reviewer Andy Martin- Associate Executive Director Lauren Hargrove- Director of Adult Services Amanda Cantu- Director of CAS Michael Stephenson- Director of MIS
Project Goals:	
• Update the SDOH form to better measure food insecurity and follow up efforts to address • Collect baseline data of HFC's population experiencing food insecurity • Report food insecurity numbers and follow up efforts for the DPP-BHS measure • Reduce food insecurity to HFC's target population	
Customers:	Success Metrics:
Adult and child clients enrolled in Mental Health services.	Using the SDOH assessment in SmartCare to gather data and monitor progress.
Reasoning: (direct or indirect improvements)	
• Reduce food insecurity in HFC's catchment area • Improve engagement and rapport with individuals from meeting basic needs • Report positive measures for DPP-BHS for continued funding	
Considerations: (constraints, obstacles, risks?)	
• Limited resources in rural areas • Parents may be reluctant to answer truthfully due to fear of CPS reporting • Current SDOH form is not adequate for this reporting requirement • Inconsistent monitoring from case managers	
Milestones	Date of Milestones
Quarterly tracking Six Month review Yearly tracking	UM/QM department will review quarterly with CQI Committee Six month update of data Results for the year will be published with the Annual QM report.

PDSA Charter	
Lead Program: Medical staff and Intake staff members Project Title: Alcohol Screening and Brief Treatment Project Domain: CCBHC 5.a.2 (ASC)	
Problem Statement:	Low report of individuals receiving the Alcohol Screening and Brief Treatment
Project Lead:	Project Team Members:
Cara Mullenix-Artigue- Director of UM/QM Sandra Rapson- Quality Assurance Coord	Taryn Fergel- UM/QM reviewer Andy Martin- Associate Executive Director Michael Stephenson- Director of MIS Dr. Nati- Chief Medical Director
Project Goals:	
• Determine where the information for the measure is being reported • Train staff to enter the information needed for reporting • Monitor for improvements	
Customers:	Success Metrics:
Adults age 18+	Improvement on CCBHC Data Workbook
Reasoning: (direct or indirect improvements)	
• Improvement in tracking alcohol use in adults • Early intervention when a problem is noted • Information is communicated to the psychiatric staff team when a problem is discovered that may interact with prescribed medication. • Possible reduction of alcohol related deaths	
Considerations: (constraints, obstacles, risks?)	
• Limited resources in rural areas for treatment and referrals • Adults may be reluctant to answer truthfully	
Milestones	Date of Milestones
Quarterly tracking	UM/QM department will review quarterly with CQI Committee
Six-Month review	Six-month update of data
Yearly tracking	Results for the year will be published with the Annual QM report.

PDSA Charter	
Lead Program: Adult and Child Mental Health Project Title: Quality Measures Project Domain: CCBHC 5.a.2 Report and Monitoring of CCBHC Quality Measures	
Problem Statement:	Improve Quality Measures for CCBHC reporting
Project Lead:	Project Team Members:
Cara Mullenix-Artigue- Director of UM/QM Sandra Rapson- Quality Assurance Coord	Andy Martin- Associate Executive Director Michael Stephenson- Director of MIS
Project Goals:	
• Review reporting from MBOW to determine in parameters are correct • Locate how the report is pulling information • Train staff to enter information correctly for reporting • Track and monitor for improvement in measures	
Customers:	Success Metrics:
CCBHC Data Team	Improvement in low scoring metrics
Reasoning: (direct or indirect improvements)	
• Improve service delivery • Improve quality of services	
Considerations: (constraints, obstacles, risks?)	
• Length of time in reporting- difficult to track progress • MBOW database	
Milestones	Date of Milestones
Quarterly tracking Six Month review Yearly tracking	UM/QM department will review quarterly with CQI Committee Six month update of data Results for the year will be published with the Annual QM report.

5 RECOMMENDATIONS
D. FACILITIES AND EQUIPMENT
1) PLUMBING REPAIRS AT 516 DENVER ST.

RECOMMENDED ACTION: That the Board of Trustees ratify the expenditure of $40,000.00 for sewer repairs at 516 Denver St.

BACKGROUND INFORMATION:

A. A camera was put through the line, revealing a break in the cast iron pipes that will require replacement.

B. As the tunnel was being excavated further issues with the 4-inch main sewer line were discovered.

C. Tunneling extended an additional 40 ft to a point the line was not deteriorated beyond repair, resulting in the additional cost.

SUPPORTING INFORMATION:

A. Center policy requires Board of Trustee approval for any expenditure over $10,000.

B. The Board approved the initial expenditure of $14,000 for this repair on 7/2/2026.

INVOICE

TP Plumbing
PO Box 546
Holliday, TX 76366-0546

tpplumbing25@gmail.com
+1 (940) 851-9905

Bill to
helen farabee
helen farabee

Ship to
helen farabee
helen farabee

Invoice details

Invoice no.: 1071
Invoice date: 07/09/2026
Due date: 08/08/2026

#	Product or service	Description	Qty	Rate	Amount
1.	**Re-pipe by means of tunnel**	We will excavate and/or tunnel as necessary to access the existing sewer line serving the residence. All existing damaged, deteriorated, or non-code-compliant sewer piping (including but not limited to cast iron, clay, Orangeburg, or other obsolete materials) will be removed and replaced with new Schedule 40 PVC sewer piping and approved DWV fittings. The new sewer line will be properly graded to ensure correct flow and will be connected to the existing city sewer main or approved tie-in location. New cleanouts will be installed as required by current plumbing code to allow for proper access and maintenance. All sewer piping installed will be glued, bedded, and supported in accordance with current plumbing code and manufacturer specifications. Upon completion, the new sewer line will be tested to verify proper drainage and operation. Excavated or tunneled areas will be backfilled and compacted once work is completed. This scope does not include concrete replacement, flooring, landscaping, asphalt, or other cosmetic repairs unless specifically stated in writing. All work will be performed in accordance with applicable plumbing codes and local regulations. This scope includes labor and materials. Permit fees are included unless	1	$40,000.00	$40,000.00

otherwise noted.
6year warranty under normal use

Total **$40,000.00**

Ways to pay

VISA DISCOVER AMEX BANK

View and pay

5 RECOMMENDATIONS
D. FACILITIES AND EQUIPMENT
2) NEW MAINTENANCE VAN REPLACEMENT

RECOMMENDED ACTION: That the Board of Trustees ratify the expenditure of $42,279.53 for the purchase of one new (replacement) maintenance vehicle.

BACKGROUND INFORMATION:

A. One of the two maintenance vehicles purchased was involved in a wreck, rear-ended, which the insurance company then declared a total loss.

B. Insurance paid $33,446.00 for the totaled vehicle. Based on this check, the difference is $8,833.53.

C. The same dealerships were contacted, and each stated they would honor their previous bid.

D. Due to the pressing need, a replacement vehicle was purchased from Lipscomb.

SUPPORTING INFORMATION:

A. Center policy requires Board of Trustee approval for any expenditure over $10,000.

B. The Board approved $84,000 for the purchase of 2 maintenance vehicles at the June 2026 meeting.

(do not staple)

HELEN FARABEE CENTERS

All invoices should be mailed to: P. O. Box 8266, Wichita Falls, TX 76307

Vendor #: L0910 | **Purchase Order#:** 26-0703

Vendor: LIPSCOMB AUTO CENTER | **INVOICE #:** LI080526

Attn: | **INVOICE DATE:** 8/5/2026

Mailing address: PO BOX 1699 | **DUE DATE:** 8/10/2026

TOTAL OF INVOICE: $42,279.53

City, ST Zip: BOWIE, TX 76230

Requested by: Bruce Sperry

SHIP TO/SERVICE ADDRESS - Or Person Item is (if none-leave blank) | **Date:** 8/5/2026

Attn: Bruce Sperry

Address of Delivery or Service: 1000 Brook Ave.

Approved by: Gianna Harris

Date: 08/05/2026

Account # (B/O use only)	Category	Detail	QTY needed	Unit of Measure	QTY Rec'd	Price	Total	BLDG DT / Project #
3-3005	VEHICLE	2026 Chevrolet Cargo Van - VEH 324 1GCWGAF71T1229009	1	EA	1	$42,279.53	$42,279.53	

REPLACING VEH # 315 TOTALED BY INSURANCE COMPANY

Shipping Cost if any | **TOTAL $** $42,279.53

VENDOR INSTRUCTIONS (ordering party should advise Vendor of the following):

1. **Show PO number on all packing slips, invoices, and references to this order.**
2. Include Packing Slips with each shipment received on this order
3. Send all invoices to the Wichita Falls address at the top of this form
4. **Remove all sales tax charges. Request Tax Exemption Certificate if needed.**

TAX INFORMATION

Helen Farabee Centers meets the requirements for exemption as a government entity and a non-profit organization.

Helen Farabee Centers' Federal Tax ID is 75-1241976

HFC SHIPPING AND RECEIVING INSTRUCTIONS:

BEFORE sending to Purchasing:

1. Verify ALL quantities and sign/date "Items rec'd by."
2. Verify and note all back orders.
3. Notify Purchasing of damaged (take pictures of damage) or incomplete orders.

Purchasing Clerk Jessica Odom

Date 8/6/2026

Scanned to AP: 8/6/2026

Buyer's Order

Lipscomb Auto Center

P.O. Box 1699
BOWIE, TX 76230
(940) 872 - 5455

Stock Number
8/7/2026
Date
HENRY BROADUS
Salesman
Home
Work (940) 397 - 3100

Helen Farabee
Purchase's Name(s)

Street	City	County	State	Zip	Driver's License Number(s)	Date of Birth
1720 4th Street	Graham	Young	TX	76450		

I (or we) hereby agree to purchase from you ONE [XX] NEW [ ] USED [ ] DEMO

Year	Make	Model	Body	Cyl	Serial Number	Color	Stock #	Miles
2026	Chevrolet	Express Carg	Cargo	8	1GCWGAF71T1229009	White		1

Trade-in Information:

Year	Make	Model	Body	Cyl	Serial Number	Color	Stock #	Miles

Payoff Information: Good Until _____
Bank Name
Street
City State Zip
Contact & Phone

Vehicle Insurance Information
Company
Policy#
Agent
Street
City State Zip
Phone#
Valid Dates

Lienholder Information
Name
Street
City State Zip
Contact & Phone

Vehicle Net Selling Price	44,725.00
Accessories	N/A
Maintenance	N/A
State Fees	29.50
PRICE	44,754.50
Trade-in Allowance	N/A
DIFFERENCE	44,754.50
Doc Fee	150.00
SUB TOTAL	44,904.50
Sales Tax 0.00 % Young	47.03
Title (28.00) Tag #######	28.00 ~~160.00~~
Service/Warranty Contract	N/A
GAP	N/A
Life A&H	N/A
SUB TOTAL	45,111.53
Payoff on Trade-In	N/A
Cash Down Payment	N/A
Rebate(s)	2,700.00
BALANCE	~~42,411.53~~ 42279.53

DISCLAIMER OF WARRANTIES

The seller, ,Lipscomb Auto Center hereby expressly disclaims all warranties, either expressed or implied, including any implied warranty of merchantability or fitness for a particular purpose and the seller, Lipscomb Auto Center, neither assumes nor authorizes any other person to assume for it any liability in connection with the sale of the herein described vehicle.

Manager Signature 08/07/2026 Date
Must be signed & dated by dealership manager to be valid

Purchaser #1 Signature 08/07/2026 Date

Purchaser #2 Signature Date

Application for Texas Title and/or Registration

Applying for (please check one):
■ Title & Registration ☐ Title Only ☐ Registration Purposes Only ☐ Nontitle Registration

For a corrected title or registration, check reason:
☐ Vehicle Description ☐ Add/Remove Lien ☐ Other: _____

TAX OFFICE USE ONLY
County: _____
Doc #: _____
☐ SPV ☐ Appraisal Value $ _____

1. Vehicle Identification Number	2. Year	3. Make	4. Body Style	5. Model	6. Major Color	7. Minor Color
1GCWGAFP6T1257596	2026	CHEVROLET	CARGO	EXPRESS G2	WHITE	N/A

8. Texas License Plate No.	9. Odometer Reading (no tenths)	10. This is the Actual Mileage unless the mileage is:	11. Empty Weight	12. Carrying Capacity (if any)
	22	☐ Not Actual ☐ Exceeds Mechanical Limits ☐ Exempt	5200	

13. Applicant Type
☐ Individual ☐ Business ☐ Government ☐ Trust ☐ Non-Profit

14. Applicant Photo ID Number or FEIN/EIN

15. ID Type
■ U.S. Driver License/ID Card (issued by: _____) ☐ NATO ID ☐ U.S. Dept. of State ID
☐ Passport (issued by: _____) ☐ U.S. Military ID ☐ U.S. Dept. of Homeland Security ID
☐ U.S. Citizenship & Immigration Services/DOJ ID ☐ Other Military Status of Forces Photo ID

16. Applicant First Name (or Entity Name)	Middle Name	Last Name	Suffix (if any)
Helen Farabee			

17. Additional Applicant First Name (if applicable)	Middle Name	Last Name	Suffix (if any)

18. Applicant Mailing Address	City	State	Zip	19. Applicant County of Residence
1000 Brook St Wichita Falls, TX 76301				WICHITA

20. Previous Owner Name (or Entity Name)	City	State	21. Dealer GDN (if applicable)	22. Unit No. (if applicable)
Lipscomb Auto Center P.O. Box 1699 BOWIE, TX 76230			P12332	

23. Renewal Recipient First Name (or Entity Name) (if different)	Middle Name	Last Name	Suffix (if any)

24. Renewal Notice Mailing Address (if different)	City	State	Zip

25. Applicant Phone Number (optional)	26. Email (optional)	27. Registration Renewal eReminder	28. Communication Impediment?
(940) 397-3100		☐ Yes (Provide Email in #26)	☐ Yes (Attach Form VTR-216)

29. Vehicle Location Address (if different)	City	State	Zip
1000 Brook St Wichita Falls, TX 76301			

30. Multiple (Additional) Liens	31. Electronic Title Request	32. Certified/eTitle Lienholder ID Number (if any)	33. First Lien Date (if any)
☐ Yes (Attach Form VTR-267)	☐ Yes (Cannot check #30)		8/4/2026

34. First Lienholder Name (if any)	Mailing Address	City	State	Zip

35. Check only if applicable:
MOTOR VEHICLE TAX STATEMENT
☐ I hold Motor Vehicle Retailer (Rental) Permit No. _____ and will satisfy the minimum tax liability (V.A.T.S., Tax Code §152.046[c])
☐ I am a dealer or lessor and qualify to take the Fair Market Value Deduction (V.A.T.S., Tax Code, §152.002[c]). GDN or Lessor Number _____

36. Trade-In (if any)	Year	Make	Vehicle Identification Number	37. Additional Trade-In(s)
☐ Yes (Complete)				☐ Yes

38. Check only if applicable:

SALES AND USE TAX COMPUTATION

☐ (a) Sales Price ($ 2,700.00 rebate has been deducted)	$ 40,237.65	☐ $90 New Resident Tax – (Previous State) _____
(b) Less Trade-in Amount, described in Box 36 above	$ (N/A)	☐ $5 Even Trade Tax
(c) For Dealers/Lessors/Rental ONLY – Fair Market Value Deduction, described in Box 36 above	$ (0.00)	☐ $10 Gift Tax – Attach Comptroller Form 14-317 ☐ $65 Rebuilt Salvage Fee
(d) Taxable Amount (Item a minus Item b or Item c)	$ 40,237.65	☐ 2.5% Emissions Fee (Diesel Vehicles 1996 and Older > 14,000 lbs.) _____
(e) 6.25% Tax on Taxable Amount (Multiply Item d by .0625)	$ N/A	☐ 1 % Emissions Fee (Diesel Vehicles 1997 and Newer > 14,000 lbs.) _____
(f) Late Tax Payment Penalty ☐ 5% or ☐ 10%	$ N/A	☐ Exemption claimed under the Motor Vehicle Sales and Use Tax Law because:
(g) Tax Paid to _____ (STATE)	$ N/A	_____
(h) AMOUNT OF TAX AND PENALTY DUE (Item e plus Item f minus Item g)	$ N/A	■ $28 or $33 Application Fee for Texas Title (Contact your county tax assessor-collector for the correct fee.)

CERTIFICATION – State law makes falsifying information a third degree felony

I certify all statements in this document are true and correct to the best of my knowledge and belief, and I am eligible for title and/or registration (as applicable). I also certify (check if applicable): ☐ I have physically inspected the vehicle described and verified the vehicle identification number above. ☐ The vehicle is unrecovered stolen, and I am unable to verify the vehicle identification number above. ☐ I am applying for a corrected title and the original Texas Certificate of Title is lost or destroyed.

Sign Here

Signature(s) of Seller(s), Dealer(s), or Trader(s)	Printed Name(s) (Same as Signature(s))	Date
	LIPSCOMB AUTO CENTER	8/4/2026
Signature of Applicant/Owner	Printed Name (Same as Signature)	Date
	Helen Farabee	8/4/2026
Signature(s) of Additional Applicant(s)/Owner(s)	Printed Name(s) (Same as Signature(s))	Date

ODOMETER DISCLOSURE STATEMENT

Federal and State law require that you state the mileage upon transfer of ownership. Failure to complete or providing a false statement may result in fines and/or imprisonment.

I, Lipscomb Auto Center (SELLER'S NAME, *PRINT*) state that

the odometer now reads 22 (NO TENTHS) miles and to the best of my knowledge that it reflects

the actual mileage of the vehicle described below, unless one of the following statements is checked.

☐ (1) I hereby certify that the odometer reading reflects the amount of mileage in excess of its mechanical limits.

☐ (2) I hereby certify that the odometer reading is ***not*** the actual mileage.
WARNING—ODOMETER DISCREPANCY.

MAKE	BODY STYLE	YEAR MODEL	SERIES MODEL
CHEVROLET	CARGO	2026	EXPRESS G2

VEHICLE IDENTIFICATION NUMBER	LAST PLATE STATE YEAR NUMBER
1GCWGAFP6T1257596	

Sign Here

Ken Rhoades (SELLER'S SIGNATURE) Lipscomb Auto Center (SELLER'S NAME, HAND PRINTED)

P.O. Box 1699 (SELLER'S ADDRESS) (STREET)

BOWIE, TX 76230 (CITY) (STATE) (ZIP CODE)

(BUYER'S SIGNATURE – ACKNOWLEDGING MILEAGE READING AS CERTIFIED)

Helen Farabee (BUYER'S NAME, *HAND PRINTED*)

1000 Brook St (BUYER'S ADDRESS) (STREET)

Wichita Falls, TX 76301 (CITY) (STATE) (ZIP CODE)

08/04/2026 (DATE OF CERTIFICATION)

GENERAL MOTORS

GM Customer Incentive Acknowledgement Form

Customer Name: Helen Farabee

New VIN: 1 /G /C /W /G /A /F /P /6 /T /1 /2 /5 /7 /5 /9 /6

Qualifying VIN: ___/___/___/___/___/___/___/___/___/___/___/___/___/___/___/___/___

Delivery Type Code: _____

1. **GM subvented Financing Program Acknowledgement**

☐ GM APR Support ☐ GM Lease Support ☐ N/A

2. **Customer Incentive Program Acknowledgement**

Pgm #	Incentive Program Description	Incentive Code	Amount	Transferred (Y/N)
			2,700.00	

Pgm #	Program Description with a Certificate or Approval Code	Incentive Code	Amount	Certificate or Approval #

Total Incentive Amount Received: 2,700.00

I am the ultimate purchaser or lessor of the vehicle bearing this vehicle identification number, which was sold/leased to me by the Dealer, named below. This vehicle was not purchased/leased for export or resale and I took delivery on 8/4/2026. I acknowledge receipt of incentive(s) described above and release GM from any future claim or obligation for incentives on this unit.

Purchaser Signature: Ken Moody **Date:** 8/4/2026

Sign Here

The undersigned Dealer Representative, certifies that the information on this application is true and correct and the incentive payments have been provided to the purchaser/lessee who has taken delivery of the referenced unit through this dealership and that properly completed accurate documentation has been forwarded to General Motors

Authorized Dealer Signature: _____ **Date:** 8/4/2026

Dealership Name: Lipscomb Auto Center **Dealer Code:** _____

Dealer Note: This is a required document and it must be completed, signed, and retained in EVERY DEAL FILE for all customers even if there are no incentives or rate support available. A copy of the completed form should be provided to the customer. (GM379509-08012018) (12/1/2018)

OPTIONAL PRODUCT DISCLOSURE

Contract Date 8/4/2026

Lipscomb Auto Center
Dealer Name

P.O. Box 1699 | BOWIE | TX | 76230
Dealer Address | City | State | Zip Code

Helen Farabee
Customer Name

Re: Contract to Purchase or Lease CHEVROLET (Make) EXPRESS G2 (Model)
1GCWGAFP6T1257596 (VIN) 016984 (Contract Number)

We offer the following products in connection with your purchase or lease of a motor vehicle:

( ) Service Contract
( ) Extended Warranty Agreement
( ) Debt Cancellation Agreement
( ) Debt Suspension Agreement
( ) Credit Life Insurance
( ) Credit Disability Insurance
( ) Other: _____
( ) Other: _____

You are not required to purchase any of these products. Any purchase is voluntary and is not required to receive and installment sale contract or lease or contain credit.

By signing below, you acknowledge that: (1) we gave you the above disclosure verbally and in writing prior to execution by you or by us of the installment sale contract or lease identified above (the "Contract"); and (2) you received this written disclosure and an unexecuted copy of the Contract at the same time.

Sign Here

_____ 8/4/2026
Signature of Customer Date

_____ _____
Signature of Co-Customer Date

From:	Harris, Gianna
To:	@Purchasing
Subject:	FW: NEW VAN
Date:	Wednesday, August 5, 2026 2:49:49 PM
Attachments:	VAN .pdf image001.png LIPSCOMB CHEVROLET L0905 - PO Form.xlsx image002.png

---

From: Sperry, Bruce W. <SperryB@helenfarabee.org>
Sent: Wednesday, August 5, 2026 12:10 PM
To: Harris, Gianna <harrisg@helenfarabee.org>
Subject: FW: NEW VAN

Bruce Sperry
Property Manager/ Maintenance Supervisor
Helen Farabee Centers
Office 940-397-3110
Cell 940-531-8443
sperryb@helenfarabee.org

From: Dove, Angela L. <dovea@helenfarabee.org>
Sent: Wednesday, August 5, 2026 11:43 AM
To: Sperry, Bruce W. <SperryB@helenfarabee.org>
Subject: FW: NEW VAN

Please be requestor & forward to Gianna to approve

From: Dove, Angela L.
Sent: Wednesday, August 5, 2026 10:55 AM
To: Sperry, Bruce W. <SperryB@helenfarabee.org>
Subject: NEW VAN

Thank you,

Angela Dove


TEXAS
SK 9244
EXPRESS


LIPSCOMB
EXPRESS
TEXAS
WSK 9244
The Lone Star State
BOWIE BURKBURNETT

5 RECOMMENDATIONS
E. POLICIES AND PROCEDURES
1) POLICY STATEMENT SUMMARY

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

- 300.1.1 Charity Care Policy Statement – No changes

BACKGROUND INFORMATION: Helen Farabee Centers ensures Policy Statements are available for each department as a guide for developing procedures.

SUPPORTING INFORMATION: As part of our annual review process, these Policy Statements are due at this time.

SPECIFIC REASONS WHY THESE ACTIONS ARE NECESSARY FOR THE CENTER:
The review of Policies and Procedures are held on an annual basis or revised when needed.

HELEN FARABEE CENTERS	
FISCAL MANAGEMENT POLICY 300.1.1	
SECTION: CHARITY CARE	
SUBJECT: POLICY STATEMENT	Page 1 of 7

EFFECTIVE: 09/03/2026	ORIGINAL: 09/01/2022
APPROVED BY: Linda Poenitzsch **Linda Poenitzsch** **Chief Financial Officer**	REVIEWED BY: Cara Mullenix **Cara Mullenix-Artigue** **Director of Utilization and Quality Management**
CONCURRED: Gianna Harris **Gianna Harris** **Executive Director**	APPROVED BY: **J. Brian Eby** **Chair, Board of Trustees**

POLICY:

PURPOSE:

1. Helen Farabee Centers (the Center) is committed to providing charity care to persons who have healthcare needs and are uninsured, underinsured, or otherwise unable to pay, for medically necessary care based on their individual financial situation. The Center strives to ensure the financial capacity of individuals served who need quality healthcare services does not prevent them from seeking or receiving care.

2. Accordingly, this policy which has been approved by our Board of Trustees:

   2.1. Includes eligibility criteria for financial assistance – free and discounted (partial charity care).

   2.2. Describes the basis for calculating amounts charged to clients served eligible for financial assistance under this policy.

   2.3. Describes the method by which clients served may apply for financial assistance.

   2.4. Describes how the Center will widely publicize the policy to the Community.

2.5. Limits the amounts the Center will charge for eligible services provided to individuals qualifying for financial assistance to the amount generally billed (received by) the Center for private and public insurance (Medicaid, Medicare, etc.).

3. The individuals we serve are expected to cooperate with the Center's procedures for obtaining charity care or other forms of payment or financial assistance, and to contribute to the cost of their care based on their individual ability to pay subject to the rules, regulations, and contractual requirements of the Center's various funding agencies.

4. To manage its resources responsibly and to allow the Center to provide the appropriate level of assistance to the greatest number of people in need, the Board of Trustees establishes the following guidelines for the provision of client charity care.

DEFINITIONS:

5. For this policy, the terms below are defined as follows:

6. **Charity Care:** Healthcare services that have been or will be provided but are never expected to result in cash inflows. Charity care results from the Center's policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

7. **Bad Debt:** Healthcare services that have been or will be provided and cash inflow is anticipated for all or a portion of the charge. Includes the monthly Sliding Scale Fee Schedule charges not collected for individuals above 150% of FPL. Bad debt is not eligible for reimbursement from federal charity care programs.

8. **Family:** According to the Census Bureau, a group of two (2) or more people who reside together and who are related by birth, marriage, or adoption. In addition, according to Internal Revenue Service rules, if an individual claims someone as a dependent on his/her income tax return, that person may be considered a dependent for purposes of the provision of financial assistance.

9. **Family Income:** Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

9.1. Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources,

9.2. Noncash benefits (such as food stamps and housing subsidies) do not count,

9.3. Determined on a before-tax basis,

9.4. Excludes capital gains or losses, and

9.5. If a person lives with a family, includes the income of all family members (non- relatives, such as housemates, do not count).

10. **Uninsured:** A person who has no level of insurance or third-party assistance with meeting his/her payment obligations.

PROCEDURES:

11. **Services Eligible Under This Policy.** For purposes of this policy, "charity care" or "financial assistance" refers to healthcare services provided by the Center without charge or at a discount to qualifying individuals. The following healthcare services are eligible for charity care:

    11.1. Behavioral health services,

    11.2. Immunizations,

    11.3. Public health services, and

    11.4. Other preventative services

12. **Eligibility for Charity Care.** Eligibility for charity care will be considered for those individuals who are uninsured, underinsured, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of charity care is based on an individualized determination of financial need, and does not consider age, gender, race, social or immigrant status, sexual orientation, or religious

affiliation.

13. Method by Which Individuals May Apply or be Assessed for Charity Care.

13.1. Financial need is determined in accordance with procedures that involve an individual assessment of financial need; and may

13.1.1. Include an application or assessment process, in which the client or the individual's Legally Authorized Representative (LAR) are required to cooperate and supply personal financial and other information and documentation relevant to determining financial need.

13.1.2. Include the use of external publicly available data sources that provide information on an individual's or LAR's ability to pay (such as credit scoring).

13.1.3. Include reasonable efforts by the Center to explore appropriate alternative sources of payment and coverage from public and private payment programs, and to assist individuals to apply for such programs.

13.1.4. Consider the individual's available assets, and all other financial resources available to the individual.

13.1.5. Include a review of the individual's outstanding accounts receivable for prior services rendered and the individual's payment history.

13.2. A request or assessment for charity care and a determination of financial need can be done at any point in the collection cycle but is preferred to be completed within the first thirty (30) days of treatment. The need for financial assistance is re-evaluated annually and whenever a significant change has occurred which affects the individual's or LAR's eligibility for charity care.

13.3. The Center's values of human dignity and stewardship shall be reflected in the application, financial need determination and granting of charity care. Requests for charity care shall be processed promptly with notification to the individual or LAR in writing within thirty (30) days of receipt of a completed application or assessment.

14. **Presumptive Financial Assistance Eligibility.** There are instances when an individual may appear eligible for charity care discounts, but there is no financial assistance form on file due to a lack of supporting documentation. Often there is adequate information provided by the individual or through other sources, which provide sufficient evidence to provide the individual with charity care assistance. In the event there is no evidence to support an individual's eligibility for charity care, the Center can use outside agencies in determining estimated income amounts for the basis of determining charity care eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumptive circumstances, the only discount that can be granted is a 100% write-off of the account balance. Presumptive eligibility may be determined based on individual life circumstances that may include:

    14.1. State-funded prescription programs,

    14.2. Homeless or received care from a homeless clinic,

    14.3. Participation in Women, Infants and Children programs (WIC),

    14.4. Food stamp eligibility,

    14.5. Subsidized school lunch program eligibility,

    14.6. Eligibility for other state or local assistance programs that are unfunded (e.g., Medicaid spend-down),

    14.7. Low income/subsidized housing is provided as a valid address, and

    14.8. Individual is deceased with no known estate.

15. **Eligibility Criteria and Amounts Charged to Individuals.** Services eligible under this policy are made available to individuals on Sliding Scale Fee Schedules, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of the determination. The basis for the amounts charged to individuals who qualify for financial assistance is as follows:

    15.1. Individuals whose family income is at or below 400% of the FPL are eligible to receive services at a discount of 100%.

15.2. Individuals whose family income is above 400% but not more than 500% of the FPL are eligible to receive services at a discount (partial charity care) at rates discounted using Sliding Scale Fee Schedules. Uncollected fees assessed are Bad debt and ineligible for reimbursement under federal charity care programs.

15.3. Individuals whose family income exceeds 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the Center; however, the discounted rates shall not be greater than the amounts generally billed to private or public insurance and discounted using Sliding Scale Fee Schedules. Uncollected fees assessed are Bad debt and ineligible for reimbursement under federal charity care programs.

16. **Communication of the Charity Care Program to Individuals and Within the Community.** Notification about charity care available from the Center, includes a contact number, and is disseminated by various means, which includes, but are not limited to, the publication of notices in monthly statements and by posting notices in clinics, waiting areas, intake and assessment, business offices, and financial services that are located in Center facilities, and other public places as elected. The Center widely publicizes a summary of this charity care policy on the Center website, in brochures available in access sites and at other places within the community served by the Center. Such notices and summary information are provided in accordance with the Center's Cultural Competency Plan.

17. **Relationship to Collection Policies.** The Center develops policies and procedures for internal and external collection practices that consider the extent to which the individual qualifies for charity care, an individual's good faith effort to apply for charity care from the Center, and an individual's good faith effort to comply with his or her payment agreements with the Center. For individuals who qualify for charity care and who are cooperating in good faith to resolve their discounted bills, the Center may offer extended payment plans, will not send unpaid bills to outside collection agencies, and will cease all collection efforts. The Center will not impose extraordinary collections actions such as wage garnishments; liens on primary residences, or other legal actions for any individual without first making reasonable efforts to determine whether that individual is eligible for charity care under this

financial assistance policy. Reasonable efforts shall include:

17.1. Validating the individual owes the unpaid charges and that all sources of third-party payment have been identified and billed by the Center,

17.2. Documentation the Center has attempted to offer the individual the opportunity to apply or be assessed for charity care pursuant to this policy and the individual has not complied with the Center's financial assessment requirements,

17.3. Documentation the individual does not qualify for financial assistance on a presumptive basis.

17.4. Documentation the individual has been offered a payment plan but has not honored the terms of that plan.

18. **Regulatory Requirements.** Implementation of this Policy does not negate or supersede compliance with all other federal, state, and local laws, rules, and regulations applicable to the services outlined herein.

19. **Staff Training Requirements.** The Center staff will adhere to parameters outlined in Texas Administrative Code (TAC) Rule §355.8215 and Healthcare Financial Management Association guidance found in the June 2019 Statement 15: "Valuation and Financial Statement Presentation of Charity Care, Implicit Price Concessions and Bad Debts by Institutional Health Care Providers" in relation Charity Care.

20. **List of all providers/entities encompassed by this policy.** A list of the providers/entities encompassed by the Charity Care policy can be found at www.helenfarabee.org under the Local Plans section.

Signature: Cara Mullenix

Email: mullenixc@helenfarabee.org

Signature: Linda Poenitzsch
Linda Poenitzsch (Aug 5, 2026 10:37:54 CDT)

Email: poenitzschl@helenfarabee.org

Signature: Gianna Harris
Gianna Harris (Aug 5, 2026 10:43:30 CDT)

Email: harrisg@helenfarabee.org

300.1.1 Charity Care Policy Statement

Final Audit Report 2026-08-05

Created:	2026-08-05
By:	Cara Mullenix (mullenixc@helenfarabee.org)
Status:	Signed
Transaction ID:	CBJCHBCAABAAveCljDIL0G-6waiX-ZbOT7xWpdrYio7b

"300.1.1 Charity Care Policy Statement" History

Document created by Cara Mullenix (mullenixc@helenfarabee.org)
2026-08-05 - 3:33:13 PM GMT

Document emailed to Cara Mullenix (mullenixc@helenfarabee.org) for signature
2026-08-05 - 3:33:17 PM GMT

Email viewed by Cara Mullenix (mullenixc@helenfarabee.org)
2026-08-05 - 3:36:02 PM GMT

Document e-signed by Cara Mullenix (mullenixc@helenfarabee.org)
Signature Date: 2026-08-05 - 3:36:19 PM GMT - Time Source: server - Signature Appearance Selected: IMAGE

Document emailed to Linda Poenitzsch (poenitzschl@helenfarabee.org) for signature
2026-08-05 - 3:36:21 PM GMT

Email viewed by Linda Poenitzsch (poenitzschl@helenfarabee.org)
2026-08-05 - 3:37:40 PM GMT

Document e-signed by Linda Poenitzsch (poenitzschl@helenfarabee.org)
Signature Date: 2026-08-05 - 3:37:54 PM GMT - Time Source: server - Signature Appearance Selected: TYPE

Document emailed to Gianna Harris (harrisg@helenfarabee.org) for signature
2026-08-05 - 3:37:57 PM GMT

Email viewed by Gianna Harris (harrisg@helenfarabee.org)
2026-08-05 - 3:43:17 PM GMT

Document e-signed by Gianna Harris (harrisg@helenfarabee.org)
Signature Date: 2026-08-05 - 3:43:30 PM GMT - Time Source: server - Signature Appearance Selected: TYPE

Agreement completed.
2026-08-05 - 3:43:30 PM GMT

5 RECOMMENDATIONS
F. PROGRAM AND PERSONNEL
1) PUBLIC INFORMATION OFFICER APPOINTMENT

RECOMMENDED ACTION: That the Board of Trustees delegates the responsibility of responding to Public Information Act request to a Public Information Officer, Connie Johnston.

BACKGROUND INFORMATION: To establish guidelines for responding to and assessing charges for responding to Requests For Information submitted to Helen Farabee Centers under the Texas Public Information Act, Texas Government Code, Chapter 552.

SUPPORTING INFORMATION:

1. Directions have been placed on our website that instruct the public how to make a request.

2. Public Information Officer will be registered with the Attorney General.

SPECIFIC REASONS WHY THESE ACTIONS ARE NECESSARY FOR THE CENTER:

Required by the Texas Public Information Act, Texas Government Code, Chapter 552

AGENDA ITEM: **09030226-6C1** **MEETING DATE:** **SEPTEMBER 3, 2026**

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

RECOMMENDED ACTION: Information Item Only

BACKGROUND INFORMATION: In June, The Health & Human Services Commission (HHSC) Facility Licensure Compliance Unit inspected our Wichita Falls, Vernon, and Olney sites. These regulatory inspections are unannounced and take place every two years.

SUPPORTING INFORMATION: All Helen Farabee Centers locations that provide substance use disorder services are required by Texas Administrative Code 564 to be a Licensed Chemical Dependency Treatment Facility and adhere to those rules set forth in the standards. There were two findings at the Wichita Falls location. One was the Client Bill of Rights (Spanish) was not posted. The other was a discharge summary was completed late. There were two findings at the Vernon location. One was orientation training was provided after the employee began duties at the facility. The other was the sting relief pad in the 1st aid kit that had expired in 2022. There were four findings at the Olney location. One was the Commission's current poster on reporting complaints and violations was not in a prominent location. One was the Client Bill of Rights (Spanish) was not posted. One was orientation training was provided after the employee began duties at the facility. The final one was an assessment was conducted that did not include a diagnosis. All corrective action plans (CAP) were to be submitted by 7/24/2026. All were submitted, HHSC accepted, and all corrections have been made.

SPECIFIC REASONS WHY THESE ACTIONS ARE NECESSARY FOR THE CENTER: These inspections ensure Helen Farabee Centers follows the rules and regulations set by the state to make sure individuals are treated in safe environments by competent professionals.