Appendix B
County Human Services Plan Template

The County Human Services Plan (Plan) is to be submitted using the template outlined below. It is to be submitted in conjunction with Appendices A and C (C-1 or C-2, as applicable) to the Department of Human Services (DHS) as instructed in the Bulletin 2026-01.

PART I: COUNTY PLANNING PROCESS (Limit of 3 pages)

Describe the county planning and leadership team and the process utilized to develop the Plan for the expenditure of human services funds by answering each question below.

1. Please identify, as appropriate, the critical stakeholder groups, including:
    a. Individuals and their families
    b. Consumer groups
    c. Providers of human services
    d. Partners from other systems involved in the county's human services system.

    The Fulton County Commissioners first formed a human services planning team in June 2012 in order to explore opportunities that might arise from piloting the block grant in joinder counties. The initial planning team was composed largely of those persons representing agencies currently receiving funding. Through the years, it has grown to be deliberately more inclusive and team members now look more at data and make decisions based more on outcomes than on specific allocations. Each year has built on the previous year and each year, additional members are added to the team. The current planning team includes:

NAME	STAKEHOLDER GROUP	REPRESENTING
Connie Brode	Human Services Partner	H/B/F Area Agency on Aging
Scott Graham	Consumer Group	Mental Health Assoc. of Franklin Fulton
Stacey Brookens	Human Services Provider	Franklin/Fulton MH/IDD/EI
Christine McQuade	Human Services Partner	Fulton Co. Services for Children
James Eagler	Human Services Provider	Franklin/Fulton Drug & Alcohol
Erin Glenn	Human Services Provider	TrueNorth Wellness
Dan Miller	Human Services Partner	Fulton County Probation Office
Elen Ott	Individuals and Families	Fulton County Family Partnership, Inc.
Wendy Melius	Human Services Provider	Center for Community Action
Gen Harper	Human Services Partner	Tuscarora Managed Care Alliance
Tawnya Hurley	Non-Voting	Franklin Co. Human Services Admin
Julia Dovey	Non-Voting	Fulton County Human Services
Steven Wible	Non-Voting	Fulton County Commissioner
Randy Bunch	Non-Voting	Fulton County Commissioner
Hervey Hann	Non-Voting	Fulton County Commissioner

2. Please describe how these stakeholders were provided with an opportunity for participation in the planning process, including information on outreach and engagement efforts.

   The planning team is currently responsible for developing the plan for the expenditure of human services funds for the past 2025-26 fiscal year as well as for monitoring outcomes of the expenditures in the plan. The committee is also charged with considering the various reallocation of funds throughout the year and that is done through an application process that has been developed. The planning team met twice over the last year and received email updates. The planning team is also informed by the advisory boards and the community coalition "Partners" process (see below.)

3. Please list the advisory boards that participated in the planning process.

   a. Fulton County Family Partnership, Partner Coalition – consists of more than 60 partners who represent other agencies, non-profits, churches and consumers. This is the 501(c)3 which provides human services planning for the county. (Meets monthly). The "Partners" regularly engage in cross systems collaboration. They regularly review strategic plans, data and information from various human services. These include Fulton County Medical Center's Community Health Needs Assessment, Fulton County Schools PA Youth Survey, Mental Health Association Suicide Prevention Coalition. Opioid Settlement planning committee and others.
   b. Fulton County Services for Children Advisory Board – includes 12 members including three student members. (Meets 6 times/year)
   c. Fulton County Housing Committee/CHNA Housing Committee – members include managers of local housing for the elderly, mentally ill and low-income families, landlords and local housing support programs. This committee has provider and consumer participation. (Meets quarterly)
   d. Franklin/Fulton County MH/IDD/EI Advisory Board holds recurring meetings throughout the fiscal year rotating between Franklin and Fulton County. The members have the option to attend virtually to ensure ease of access for everyone. The Board members offer feedback and input into programming. Members of the board partner with program specialists and complete program monitoring and evaluations every year.
   e. The Franklin/Fulton Drug & Alcohol Advisory Board meets regularly throughout the fiscal year, with sessions alternating between Franklin and Fulton counties to ensure regional accessibility and engagement. This Board plays a key advisory role by reviewing service trends, shaping funding priorities, and offering recommendations that directly inform the development and implementation of the Block Grant plan. Board members are voting representatives from a broad range of sectors, including Criminal Justice, Business and Industry, Labor, Education, Healthcare, Behavioral Health, Student and Youth Services, Senior Services, and individuals with lived experience. The Advisory Board maintains a balanced composition in terms of gender and geographic representation, with equal participation from both Franklin and Fulton counties.
   f. Opioid Settlement Coordination – With the addition of Opioid Settlement funds in the county, an advisory group was formed to review funding requests and make recommendations to the Commissioners. The initiatives identified by the advisory group will be coordinated with HSBG funding as needed.

4. Please describe how the county intends to use funds to provide services to its residents in the least restrictive setting appropriate to their needs. The response must specifically address providing services in the least restrictive setting.

   The flexibility of the block grant allows counties to serve consumers in the least restrictive setting. It is now possible to assess and address need(s) at the local level and to provide the supports that are necessary for all consumers – aging, adult, children as well as those with mental health, intellectual disability, autism and drug and alcohol challenges to be served in the community. Fulton County works with Franklin County for Mental Health, Intellectual & Developmental Disabilities and Drug & Alcohol programs to ensure the least restrictive setting.

   Franklin/Fulton County MH/IDD/EI partners with the community to develop and assure the availability of quality MH/IDD/EI services and supports for individuals and families. We have developed programs and supports such as co responders, crisis staff and a mobile psychiatric nurse that meet people where they are, in the community, and engage with them to determine needs. The Franklin and Fulton Drug and Alcohol Program delivers a full continuum of care, including prevention, intervention, treatment, and recovery support services, in settings that best meet the needs of each individual.

   Prevention programming is provided primarily to youth in school and after-school environments that are age appropriate and aligned with selected evidence-based models. Intervention services are offered through a network of contracted providers and focus on identifying and engaging individuals who may be at risk.

   Treatment placement is determined using the criteria set forth by the American Society of Addiction Medicine (ASAM), as adopted by the Pennsylvania Department of Drug and Alcohol Programs. This ensures individuals are matched to the level of care that is most clinically appropriate, delivered in an environment that offers the least restriction necessary. Intensive services, such as residential treatment and medically monitored detoxification, are provided in structured settings with around-the-clock clinical support. Less intensive services, such as halfway house, partial hospitalization, intensive outpatient, outpatient, and early intervention, are offered in community-based settings by providers selected by the individual whenever possible.

   Recovery support and recovery housing services are tailored to meet the individual’s current stage of recovery and may address both treatment needs and life domains that support long-term recovery. The department works closely with each person to identify and access the supports and services that best align with their recovery goals.

5. Please describe any substantial programmatic and funding changes being made as a result of last year’s outcomes.

   There have been no substantial programmatic or funding changes for the 2026-2027 fiscal year.

PART II: PUBLIC HEARING NOTICE

Two (2) public hearings are required for counties participating in the Human Services Block Grant. One (1) public hearing is needed for non-block grant counties.

1. Proof of publication;
    a. Please attach a copy of the actual newspaper advertisement(s) for the public hearing(s).
        i. Proof of Publication is included as Attachment E
    b. When was the ad published?
    c. When was the second ad published (if applicable)?

    *If other media options were utilized, such as social media, internet, etc., for the public hearing announcement, please attach a copy(screenshot) of the notice, along with the date(s) posted.
        - The Advertisement for both meetings was run in the Fulton County News on 6/24/2026, 7/1/2026, and 7/8/2026. Other notifications were sent to community groups and organizations via email with the regular community partner updates.

2. Please submit a summary and/or sign-in sheet of each public hearing.
        i. Please see attachment F for summaries of the public hearings and a listing of individuals who attend either virtually or in person.

NOTE: The public hearing notice for counties participating in local collaborative arrangements (LCA) should be made known to residents of all counties. Please ensure that the notice is publicized in each county participating in the LCA.

PART III: CROSS-COLLABORATION OF SERVICES

For each of the following, please explain how the county works collaboratively across the human services programs; how the county intends to leverage funds to link residents to existing opportunities and/or to generate new opportunities; identify partners and agencies involved in the provision of services; and provide any updates to the county's collaborative efforts and any new efforts planned for the coming year. (Limit of 4 pages)

1. Employment:
    Franklin/Fulton Transition Councils collaborate with the Office of Vocational Rehabilitation (OVR) in identifying individuals who will benefit from Pre-employment Transition Services, Paid Work Experiences and Job Shadowing within the school districts as well as students who need to connect with adult services. The Franklin/Fulton IDD Program participates in the Transition Council, which includes representative from OVR, School Districts and providers to promote and support the Employment First Model as well as facilitation of student to adult transition reviews.

    Fulton Employment and Training is the county's CareerLink portal. The agency assists with resume building, career training and resources. FCE&T is an integral part of the employment linkage in the community. They work across employers and with local agencies to engage people where they are with meaningful employment.

    In 2024, Fulton focused on employment for people in recovery called Fulton Inspires Recovery Employment (FIRE). Fulton County Family Partnership received a grant from the Appalachian Regional Commission to focus on a recovery to employment initiative supporting individuals to obtain or maintain meaningful employment. This is a blend of several services. The FIRE initiative engages employers helping them to create recovery supportive workplaces. The local single county authority integrates a case manager in the local community to assist individuals in access treatment and recovery resources. A certified recovery specialist works with all

individuals in the program to help overcome barriers and connect with employment. Fulton has blended local opioid settlement, Behavioral Health Managed Care reinvestment, Community Action agency and Employment & Training local supports as well as local recovery programs to support this initiative. During the last year the initiative expanded it's work with local employers and served numerous consumers.

2. Housing:

Fulton County's Housing Assistance program is a perfect example of how Fulton County has used the block grant to leverage funds to eliminate a waiting list in our housing assistance program for both rental assistance and assistance with utilities. Housing and Homeless Assistance Programming is challenging. Fulton does not have a significant population that meets the federal definition of homeless. Our county uses HAP funds to help fill the gaps. HAP receives a state base allocation of $18,279, but through the block grant is regularly allocated over double that utilizing reallocation and/or retained funds. Through the Center for Community Action, some case management is now offered to housing consumers and our Homeless Assistance Planning Committee utilizes the membership of landlords to identify housing gaps and to try to identify ways to generate resources to meet those needs.

During the 2022-2023 fiscal year, Fulton revitalized the Fulton County Housing committee. This committee had not met as frequently during the COVID years. During 2025-2026, the group continued to meet regularly offering both in person and virtual options. . This offers the opportunity for landlords and property managers to have an open dialog with human service agencies and local consumers. This is part of an initiative through Fulton County's Community Health Needs Assessment to increase awareness of housing resources and to educate the community on needs and utilization. During 2026-2027, the group hopes to work on initiatives around the expansion of housing opportunities.

PART IV: HUMAN SERVICES NARRATIVE

MENTAL HEALTH SERVICES

The discussion in this section should take into account supports and services funded (or to be funded) with all available funding sources, including state allocations, county funds, federal grants, HealthChoices, reinvestment funds, and other funding.

a) Program Highlights: *(Limit of 6 pages)*

Please highlight the achievements and other programmatic improvements that have enhanced the behavioral health service system in FY 25-26.

- Since the AOPC Behavioral Health Regional Council Summit, TrueNorth Wellness Services, Fulton County Family Partnership and the Courts partnered to improve access to mental health and substance use services and, when possible, divert individuals from involvement in the criminal justice system. This collaboration helps connect individuals with needed treatment and support while promoting more effective and compassionate outcomes. The outcome has been significant – by diverting from the front end, the County has seen significant decreases in jail

days. Comparing the last twelve months and the twelve prior, the jail has decreased from about 700 inmate days per month to about 490, which comes out to a huge amount of money saved. That impact includes other efforts as well, such as probation and court, but the reduction in jail days makes a big difference. The money saved is about $20,000/month.

- TrueNorth Wellness Services continues to offer weekly open-access appointments through its outpatient services program. These appointments allow individuals to access an initial assessment and begin the process of connecting with mental health services without the need for a scheduled referral, helping to reduce barriers to care and improve timely access to treatment.

- The Fulton County Library serves as an important part of the community—not only as a place to access books, but also as a welcoming space where individuals can find connections, access valuable resources, and receive support. The strong attendance at the dementia and memory loss support group highlights the library's vital role in bringing people together and addressing community needs. The library system offers a wide range of groups, programs, and activities that engage diverse populations and foster meaningful connections throughout the community. These opportunities help bring people together, promote lifelong learning, and provide valuable social support for individuals of all ages and backgrounds.

Franklin/Fulton Muli County Highlights

- TrueNorth Wellness Services provides a supported living program with eighteen (18) apartments for individuals working toward recovery and greater independence. Through a partnership with Shippensburg University's Psychology Department, residents and students collaborate on wellness-focused activities and community events. Recent initiatives have included a Wellness Talent Show, a Wellness Carnival promoting socialization and community engagement, and educational stations providing information and peer support related to mental health diagnoses. These activities support recovery, skill development, community integration, and stigma reduction.

- FindHelp, locally branded as HereToHelpAll.org, and PA Navigate have been introduced to the community to improve resource navigation and referral coordination. Providers are encouraged to maintain current information within the platforms, which are being rolled out among community-based organizations to streamline referrals and support successful service connections. Early implementation efforts have included outreach, technical assistance, and assessments of organizational readiness.

- The **Bridge Rental Assistance Subsidies** provide tenant-based supportive housing for individuals while also creating a structured link to long-term housing options. All individuals housed utilizing these subsidies receive supportive living services to assist in maintaining housing stability within Franklin County. The Franklin County services focus on individualized support from the time of identification to acceptance in the Bridge Rental Assistance Subsidy Program and throughout the tenant’s leasing life within the two-year program. Fulton County Services focus on individualized support from identification through the subsequent two years with the goal of maintaining independent, long-term housing within the county. In 2025, there were 88 individuals that were engaged in the Housing Program. The average age of consumer was 43 years, spanning 19 years old to 63 years old. The Bridge Rental Assistance Subsidy was successfully utilized by six participants. On average, based on quarterly reporting throughout 2025, 73% of

participants were either housed or eviction was prevented through the program. Additionally, at the end of the reporting period, 86% of active participants were successfully maintaining housing.

- The **Social Determinants of Health** (SDoH) **Reinvestment** plan focuses on utilizing Community Navigators to address the SDoH needs of our members in Franklin and Fulton County through Contingency Funds. These funds are utilized when there are no other options for funding to address SDoH needs. The majority contingency fund requests in 2025 were for issues related to housing. These individuals are often employed but are facing life circumstances that have strained their finances. Examples of these circumstances include separations from partners, fleeing domestic violence, or pregnancy limited the amount of time they are able to work. We learned through these funds and our Community Navigator work that these individuals are often just making enough to cover their regular bills and a small cold snap resulting in an increase in utility bills which disrupts their monthly budget. This plan also provides; 1. Laundry services for MA eligible families to provide clean and hygienic clothing through providing funds in various laundromats around our two-county region. 2. School-aged children with up to $300 per season for low-cost clothing necessities through this reinvestment plan. These funds are managed by our Community Navigators, but the children or their families aren’t required to be a part of that program.

- In 2025, the **Recovery Oriented Systems of Care Specialist** (ROSC) Specialist coordinated an agreement with the Emergency Health Services Federation to implement the Compassionate Overdose Response Education training program in Franklin County. The initiative focuses on reducing stigma and improving communications and connections with individuals in need of recovery services. EMS, First Responders and Law Enforcement providers were the key stakeholders about the training program. Additionally, the ROSC Specialist created opportunities for pro-social activities for individuals with substance use disorders. These events help build healthy social connections, reduce isolation, and lower risk of relapse. This strengthens recovery capital by providing resources such as supportive relationships, skills, and a sense of purpose—all of which are critical for long-term sobriety. They also promote inclusion, reduce stigma, and improve mental and physical health while offering structured engagement that replaces idle time with positive experiences. The ROSC Specialist assisted with the placement of a Certified Recovery Specialist (CRS) at the Franklin County jail. This is vital for addressing substance use disorders and supporting successful re-entry into the community. CRS professionals provide peer-based support, build trust, and connect individuals to treatment and resources before release. Their involvement reduces recidivism, prevents overdose through education and harm reduction, and ensures continuity of care in the community.

- Our Crisis Intervention Team (CIT) program continues to evolve and strengthen. This past year, CIT Enhanced Officers were introduced to further improve responses to behavioral health crises. These officers completed an additional 24-hour advanced training program focused on recognizing and responding to serious mental illnesses and related behaviors. The enhanced training increases law enforcement's ability to de-escalate crises, improve outcomes for individuals in need, and support diversion from the criminal justice system whenever possible. These officers will serve as CIT champions and as a resource for fellow officers.

b) Strengths and Needs by Populations: *(Limit of 8 pages #1-11 below)*

Please identify the strengths and needs of the county/joinder service system specific to each of the following target populations served by the behavioral health system. When completing this assessment, consider any health disparities impacting each population. Additional information regarding health disparities is available at https://www.samhsa.gov/resource/tta/national-network-eliminate-disparities-behavioral-health-nned.

1. Older Adults (ages 60 and above)

- Strengths:
  - The Fulton County Older Adults Advocacy Team (FCOAAT) continues to meet to coordinate services for older adults in need of human services support. The team includes representatives from mental health, aging services, housing, community outreach, and other key partners. FCOAAT also serves as a resource during crisis situations, convening emergency meetings as needed to coordinate responses and support vulnerable older adults.
  - Older adults throughout Fulton County enjoy a variety of activities, learning opportunities, and special events, as well as a sense of community at three (3) **Senior Centers**. These sites are conveniently located throughout the region to provide a warm, welcoming environment for older adults to gather and enjoy programs and services designed to offer older adults opportunities for social engagement, educational programming, health and wellness activities, crafts, clubs, and a daily lunchtime meal. These centers play an important role in supporting the health, independence, and quality of life of older adults in the community.
  - The Mental Health Association's Senior Reach program provides older adults with weekly phone calls from trained call specialists. These regular check-ins help reduce social isolation, alleviate stress, and promote emotional well-being by decreasing feelings of loneliness and depression.

- Needs:
  - As our community ages, there is a growing need for case management/advocate services that support older adults in managing daily living responsibilities. Many individuals face challenges with mail, paperwork, and applications necessary to maintain benefits and access services. Ongoing support and routine check-ins would help ensure their safety, promote independence, and connect them with resources needed to remain successfully engaged in the community.
  - A gap exists in transportation services for adults who do not meet eligibility requirements for the current transportation programs. These individuals still require dependable transportation to attend medical appointments, maintain employment, access groceries and services, and remain engaged in the community. Expanding transportation options would help promote independence, improve access to care and resources, and support overall quality of life.

2. **Adults (ages 18 to 59)**

   - Strengths:
     - Tuscarora Managed Care Alliance (TMCA), our managed care organization, has a Bridge Rental Subsidy Supportive Housing Program which assists Medicaid Eligible members to apply for housing choice vouchers, locate rental properties of the individual's choice, maintain landlord relationships and enter into leases in the member's name. The program will pay rent until the individual becomes eligible for HUD Housing Choice vouchers. Reinvestment Contingency funds are available for security deposit and utility deposits. Post placement, supportive living staff are available to assist the member to maintain housing with activities such as budgeting, household maintenance, community support linkage and navigation, landlord relationships and neighbor relationships. As of May 2024, the program has served 90 Franklin and Fulton County residents with a behavioral health identified need.
     - Access to mental health services has improved through TrueNorth Wellness Services weekly open-access appointments in its outpatient program. This same-day or walk-in access has reduced barriers to care and significantly decreased wait times for individuals seeking mental health services, allowing them to receive assessments and begin treatment.

   - Needs:
     - The same transportation gap mentioned above also exists here for the adult population. Their need for transportation could also include the need to access care and provide essential services for dependent children as well as for themselves.
     - There is a need for affordable housing that enables individuals and families to live in safe, stable homes without excessive financial burden, allowing them to meet basic needs, maintain good health, access education and employment opportunities, and contribute to strong, thriving communities.

3. **Transition age Youth (ages 18-26) -** Counties are encouraged to include services and supports assisting this population with independent living/housing, employment, and post-secondary education/training.

   - Strengths:
     - TMCA has used reinvestment dollars to create, the Transition Age Youth Housing Services. This program encourages youth to thrive in independent living situations and set them up to maintain their independence into adulthood. This program can support up to 3 transitional age youth (TAY) to find, teach and maintain their independent living with various staffing and financial supports. They will also be supported financially through rental subsidies that are congruent with current HUD fair housing limits while they are in the program.
   - Needs:
     - The same transportation gap mentioned above also exists here for the transition age youth population. Transportation barriers limit their access to work, educational programs, healthcare appointments, and community supports. Dependable transportation options for this population would help increase independence,

improve access to essential services, and support successful transitions into adulthood.

4. **Children (under age 18) -** Please describe your county's efforts to support children, youth, and families through home and community-based services. Please be specific in describing how you believe these efforts will decrease Psychiatric Residential Treatment Facility utilization.

   - Strengths:
     - Child and Adolescent Service System Program (CASSP) services are available to all children who are experiencing behavioral/mental health concerns. CASSP is able to get families and providers around the table to determine the best services and support for the child in need.
     - TMCA offers the following evidence-based practices (EBP) for children: Parent Child Interactive Therapy (PCIT), Alternative for Families Cognitive Behavioral Therapy (AF-CBT), Trauma Focused CBT (TF-CBT), Applied Behavioral Analysis, (ABA), Family Based Mental Health Services (FBMHS), Peer Support Services, and Multisystemic Therapy (MST)
     - School-based mental health counseling services are available in most public schools in Fulton County.

   - Needs:
     - According to the 2025 Pennsylvania Youth Survey, PAYS, data, 34.3% of Fulton County students reported the most common depressed thought was "at times I think I am no good at all 37.1% of students reported they felt sad or depressed MOST days in the past 12 months. Overall, 14.0% of students had seriously considered attempting suicide, compared to 13.9% of students at the state level.
     - There is a lack of credentialed counselors for commercial insurance which makes it difficult for children and adolescents with private insurance to access outpatient therapy.
     - Extensive wait times exist for Intensive Behavioral Health Services which help children with behaviors that cause difficulties in their lives which can get in the way of learning and positive family relationships.
     - Partial Hospitalization program would provide an appropriate step down from inpatient treatment and potentially serve as a diversion from inpatient psychiatric admissions.
     - There are no Community Rehabilitation Residentials (CRR) available within our community and very few across the state for children or adolescents to utilize before placement at a Residential Treatment Facility (RTF).

Please identify the strengths and needs of the county/joinder service system (including any health disparities) <u>specific</u> to each of the following special or underserved populations. If the county does not currently serve a particular population, please indicate and note any plans for developing services for that population.

5. **Individuals transitioning from state hospitals**

   - Strengths:
     - Franklin/Fulton County and Service Access Management (SAM) continue to foster and maintain a strong, collaborative and productive working relationship with Danville State Hospital personnel. This ongoing collaboration enhances transition

planning and supports individuals in successfully reconnecting with county services and community-based resources following discharge.
    - Mental Health Association (MHA) maintain an active Community Support Program (CSP) that meets monthly. Each meeting includes an educational presentation and updates on community resources, services, and initiatives. The meetings are offered in a hybrid format, allowing participants to attend either virtually or in person, which helps increase accessibility and encourages broader community participation.
    -
- Needs:
    - Individuals returning to the community from state hospitals often face barriers to successful reintegration due to the limited availability of supported housing options. There is a need for programs that provide structured support, housing assistance, and resource coordination during this transition period. These services are essential to foster stability, promoting recovery, and increasing the likelihood of long-term success in the community.

6. **Individuals with co-occurring mental health/substance use disorder**

- Strengths:
    - Gaudenzia Outpatient collaborates with mental health providers throughout the community to coordinate care when individuals have co-occurring mental health and substance use treatment needs. This partnership helps ensure that individuals receive comprehensive, integrated services that address both aspects of their recovery and overall well-being.
- Needs:
    - A key need is the development or restoration of supportive relationships. Building strong support networks can enhance recovery, increase resilience, and provide ongoing encouragement and accountability throughout the recovery process.

7. **Criminal justice-involved individuals -** Counties are encouraged to collaboratively work within the structure of County Criminal Justice Advisory Boards (CJABs) to implement enhanced services for individuals involved with the criminal justice system including diversionary services that prevent further involvement with the criminal justice system as well as reentry services to support successful community reintegration.

- Strengths:
    - In an effort to increase access to mental health and substance use disorder services, TrueNorth Wellness Services provides a mental health professional, and Fulton County Family Partnership provides a Certified Recovery Specialist (CRS), during preliminary court hearings. Individuals interested in exploring support and services within the human services system can begin the assessment process at that time, helping to connect them with appropriate resources, treatment options, and recovery support as early as possible.

- The Bedford County Jail has expanded access to mental health services for individuals during their incarceration. Providers from Fulton County are now able to meet with incarcerated individuals and begin the process of connecting them to needed services and supports. This coordination helps ensure that appropriate care and resources are in place prior to their reentry into the community, promoting continuity of care and successful reintegration.

- The Courts in Franklin and Fulton Counties have committed to creating a protocol/process where the District Attorney, Public Defender and judges are alerted to individuals with an Autism Spectrum Disorder (ASD), or similar situation, in which certain aspects of court may be difficult for them, such as sensory issues, attention issues, etc. They would like to develop a protocol for things like assessments or checklists that can be completed prior to court hearings that will give the court staff some insight into what to expect from individuals once they are in the courtroom so that court staff can be sensitive to their needs and better prepare for those court hearings.
-

- Needs:
  - There is a need for housing options that provide supportive living skills services to assist individuals with successful reentry and community reintegration. Access to stable housing combined with support in areas such as daily living skills, employment, financial management, and community engagement can help individuals become reestablished and maintain long-term stability within the community.

8. **Veterans** - counties are encouraged to collaboratively work with the Veterans' Administration and the PA Department of Military and Veterans' Affairs (DMVA) and county directors of Veterans' Affairs (found at the site): https://www.pa.gov/agencies/dmva/pennsylvania-veterans/county-director-of-veterans-affairs.html

   - Strengths:
     - When needed, the Department of Veterans Affairs helpline has been a valuable resource for our residents, providing information, support, and connections to services for veterans and their families.
   - Needs:
     - There is a need for easier access to mental health supports and services through the Department of Veterans Affairs. Improving the availability and accessibility of these services can help veterans obtain timely assessments, treatment, and ongoing support to address their mental health needs and enhance their overall well-being.

9. **Lesbian/Gay/Bisexual/Transgender/Questioning/Intersex (LGBTQI)**

   - Strengths:
     - Pride Franklin County maintains a website that serves as a centralized resource hub for the LGBTQ+ community. resources are available. The website provides

information and referrals related to healthcare, mental health services, support groups, educational opportunities, and other community resources.
    - The Mental Health Association of Franklin and Fulton Counties hosts a support group, called THRIVE, that provides individuals with an opportunity to connect, share experiences, and receive peer support. This group currently has around 20 members ranging in age from youth to adult and meets twice a month.
    - Pride Franklin County hosts an annual pride festival at Wilson College in the fall to celebrate diversity and inclusion and is free and open to the community and includes free, family - friendly activities and vendors that support the LGBTQIA and ally community; 2000+ participants.
- Needs:
    - Stigma toward the LGBTQ+ community continues to be a challenge within the community, creating barriers to inclusion, access to services, and overall well-being.

10. Racial/Ethnic/Linguistic Minorities (RELM) including individuals with Limited English Proficiency (LEP)

- Strengths:
    - A number of mental health outpatient providers have secured bilingual staff who can provide clinical services in Spanish, improving access to care and enhancing service delivery for Spanish-speaking community members.
- Needs:
    - There is an ongoing need to ensure that individuals have access to services that are culturally responsive and aligned with their beliefs, values, and lived experiences.

11. Other populations, not identified in #1-10 above (if any, specify) (including tribal groups, people living with HIV/AIDS or other chronic diseases or impairments, acquired brain injury (ABI), fetal alcohol spectrum disorders (FASD), or any other groups not listed)

- Strengths:
    - Keystone Health Services provides community outreach services which bring HIV education, risk assessment, and testing to individuals and groups in the community. Their education program is designed to accommodate the diversity of our community. They tailor the presentations to meet the needs of the audience, focusing on making education an interactive experience with an open dialogue of questions and answers. Their goal is to share scientifically proven information that will dispel the myths and misinformation about HIV/AIDS. Education can take place in churches, schools, workplaces, housing developments, clinics, hospitals, colleges, businesses, health fairs, newspapers, and on radio and television. They partner with local organizations to provide an education and/or testing event. The services are free for both hosting organizations and participants.
- Needs:

- Our community has limited resources and support available for individuals living with a traumatic brain injury (TBI). The cognitive, behavioral, and emotional challenges associated with TBI can become difficult for families to manage without assistance. Currently, there is a significant gap in funding and service options to provide the ongoing support, care coordination, and respite services that individuals with TBI and their caregivers often need.

c) <u>Recovery-Oriented Systems Transformation (ROST):</u> *(Limit of 5 pages)*

i. *Previous Year List:*
   - Provide a brief summary of the progress made on your FY 25-26 plan ROST priorities:
     i. Priority 1
     ii. Priority 2
     iii. Priority 3

Priority	***Narrative***	***Action Steps***	***Timeline***	***Progress Made***	
1. Crisis Intervention Service system (☒ Continuing from prior year ☐ New Priority)	a. Mental Health secured grant funding for a crisis system assessment and for implementation toward the SAMHSA best practice model	Creating mobile crisis teams.	June 2026	County is working towards the purchase of a software system for the crisis system. Managed Care and the County are working to secure funding to support "someone to call" and "somewhere to go". The plan is then to secure "someone to respond".	
2. Increase access to high quality mental health care (☒ Continuing from prior year ☐ New Priority)	a. Increase awareness and availability of mental health resources	i. MH will purchase license agreement with PESI, for training and consider other training as they become available	continual	Funding prohibited the purchase of a license agreement with PESI this year. Other free training opportunities were shared with providers.	
		ii. Provide training and support for local community to include: business, neighbors, providers etc.	continual		
	b. Promote mental health prevention, treatment resources and tools that can be used without clinical support.	i. Promote Move for Mental Health campaign ii. Promote Everybody Walk Across PA in fall and spring iii. Promote Thriving Thoughts Global Grounded Events (third Thursday)		i.Move for Mental Health campaign launched in May and will be continual throughout the year. Resources will be added as they become available. 262 sessions landing page (Jul-Dec) ii. Fall - 16 teams/individuals (22 HFC incentive participants & 5600+ miles logged.317	

				blog post views Spring – 51 registrations from franklin county. iii.Thriving Thoughts offered a class for individuals to learn how to work on their mental wellness. They continue to send out email messages.	
		ii. Continue and expand existing community campaigns that educate the public about effective ways to manage mental wellness. Walk the Walk		Walk the Walk was held in September	
3. Housing placements and supportive services needed for individuals with intense behaviors (☒ Continuing from prior year ☐ New Priority)	a. Housing need for our mental health forensic population	i. In partnership with Cumberland/Perry County MH/ID, we have secured a provider of the LTSR. We are working in conjunction with architects to create blueprints and then begin building.	June 2026	This project continues to move forward. Due to environmental protection, there were bats that needed to be relocated and now groundbreaking is scheduled for summer of 2026.	

ii. Coming Year List:

- Based on Section b **Strengths and Needs by Populations,** please identify the top three (3) to five (5) ROST priorities the county plans to address in FY 26-27 at current funding levels.
- For each coming year (FY 26-27) ROST priority, please provide:

a. A brief narrative description of the priority including action steps for the current fiscal year.
b. A timeline to accomplish the ROST priority including approximate dates for progress steps and priority completion in the upcoming fiscal year.
   - Timelines which list only a fiscal or calendar year for completion are not acceptable and will be returned for revision.

c. Information on the fiscal and other resources needed to implement the priority. How much the county plans to utilize from state allocations, county funds, grants, HealthChoices, reinvestment funds, other funding and any non-financial resources.
d. A plan mechanism for tracking implementation of the priorities.
   - Example: spreadsheet/table listing who, when and outputs/outcomes

Priority	***Narrative***	***Action Steps***	***Time line***	***Resources Needed***	***Tracking Mechanism***
1. Crisis Intervention Service system (☒ Continuing from prior year ☐ New Priority)	a. Mental Health Managed Care, D&A are working to move our crisis system toward the SAMHSA best practice model	i. Implement a unified software platform for crisis system providers. ii. Create a working plan of a sustainable crisis system for our county joinder.	Sept 2026 June 2027	$45,750.00	This is monitored through Franklin/Fulton County MH/IDD/EI, TMCA, DHS
		Waiting for the crisis regulations in order to implement into our system.			
2. Increase access to high quality mental health care (☒ Continuing from prior year ☐ New Priority)	a. Promote mental health prevention, treatment resources & tools that can be used without clinical support.	i. Promote the programs in existence and plan campaigns for identified gaps. - Move for Mental Health -Everybody Walks Across PA	continual	$10,000	This is monitored through Healthy Franklin County, Fulton County Partnership, Franklin/Fulton County MH/IDD/EI,
		ii.continue to educate the community residents on 988	continual		
	b. Reduce the rate of suicides in Franklin & Fulton Counties	i. Provide QPR training throughout Counties for free		$1,000.00	This is monitored through MHA, Healthy Franklin County, Fulton County Partnership & MH/IDD/EI.
		ii. Implement Suicide Prevention Month Campaign initiatives. -Purple lights/Ribbons -Proclamation -Training -988 advertisement -Promote Manthearpy		$9,500.00	This is monitored through MHA, Healthy Franklin County, Fulton County Partnership & MH/IDD/EI.

		-Carnival of Care			
		i. Introduce trauma training to the community. While providing train the trainer opportunities to add capacity to our communities.		$50,500.00	This is monitored by Franklin/Fulton MH/IDD/EI
3. Housing placements and supportive services needed for individuals with intense behaviors (☒ Continuing from prior year ☐ New Priority)	a. Housing need for our mental health forensic population	i. In partnership with Cumberland/Perry County MH/ID, we have secured a provider of the LTSR. We are working in conjunction with architects to create blueprints and then begin building.	Jan 2027	The needed funds will be determined during action steps.	This is monitored through Franklin/Fulton MH/IDD/EI, Cumberland/Perry MH/ID and DHS
	b. Explore opportunities of other housing programs.	i. Housing programs / opportunities will be researched as well as partners to create more affordable housing.	June 2027	The needed funds will be determined during action steps.	This is monitored through MH/IDD/EI, Human Services, Courts

d) <u>Strengths and Needs by Service Type:</u> *(#1-7 below)*

1. Describe telehealth services in your county *(limit of 1 page)***:**

a. How is telehealth being used to increase access to services?
- TrueNorth Wellness Services has the ability to provide telehealth outpatient services to the community for those that feel that is the best option for their treatment.
- Keystone Behavioral Health is contracting with a telehealth service that allows the extension of available hours and access to credential staffed that increases the commercial insurance companies allowing more individuals access.
- WellSpan is utilizing telehealth in the behavioral health unit to access psychiatric services for patients.
- Many providers have access to providing telehealth services inside their own practices. Individuals with interest can arrange to access their services via telehealth if they choose.

b. Is the county implementing innovative practices to increase access to telehealth for individuals in the community*? (For example, providing technology or designated spaces for telehealth appointments)*
   - Currently, there is no plan to increase access to telehealth for individuals in this community.

c. *What are the obstacles the county encounter in the deployment of telehealth services? (limited access to reliable internet, digital literacy, privacy concerns, and cultural and language barriers).*
   - Being a rural community, there are still areas that do not have access to reliable internet. There are homes that do not have access to the equipment and some families that are not interested in receiving services via technology.

2. Is the county seeking to have service providers embed trauma informed care initiatives (TIC) into services provided?

☐ Yes ☐ No
If yes, please describe how this is occurring. If no, indicate any plans to embed TIC in FY 26-27. (Limit of 1 page)

- County Mental Health successfully secured grant dollars and entered into a contract with The Lincoln Center to provide Advanced De-Escalation & Trauma-Comprehension training. The training focuses on several key areas, including understanding trauma, implementing trauma-informed approaches, applying effective de-escalation techniques, recognizing and addressing vicarious trauma, building resilience, increasing awareness, and promoting post-traumatic growth.

  Due to the comprehensive nature of the initiative, the program will be implemented in phases. Initial training sessions will be followed by a Train-the-Trainer component to support long-term sustainability and expand local training capacity.

  The target audience includes CIT members, school district counselors, school resource officers, law enforcement personnel, fire and EMS professionals, 911 dispatchers, probation and corrections officers, and other human services and healthcare professionals. The goal is to enhance participants' ability to effectively respond to individuals experiencing crisis while fostering trauma-informed practices across multiple disciplines and systems.

- Franklin/Fulton MH/IDD/EI continues to update and expand the trauma-informed resources available on its website, ensuring that community members and service providers have access to current information, tools, and supports related to trauma-informed care and practices.
- The Department of Emergency Services secured grant funding to provide training locally with an emphasis on first responder wellness, resilience and mental health support. The primary goal of the Deadly Calls & Fatal Encounters training is to enhance the safety, decision-making, and situational awareness of Telecommunicators, Law Enforcement Officers, and other Emergency Services personnel by examining the often-overlooked hazards within routine calls for service. This course seeks to reduce complacency, mitigate risk, and ultimately save lives—both of responders and the public.

3. Is the county currently utilizing Cultural and Linguistic Competence (CLC) Training?

☐ Yes ☒ No

If yes, please describe the CLC training being used, including training content/topics covered, frequency with which training is offered, and vendor utilized (if applicable). If no, counties may include descriptions of plans to implement CLC trainings in FY 26-27. *(Limit of 1 page)*

- While many agencies mandate annual cultural competence training for their employees, there is currently no countywide training initiative or coordinated effort to promote cultural competence across service systems.
- AmeriHealth Caritas, Medicaid managed care organization, in the spirit of their mission, whole-person care model leverages Culturally and Linguistically Appropriate Services. Through community outreach, collaboration with providers and their staff, and 24/7 access to interpretation services, they ensure members get unique care and services they need.

4. Are there any Diversity, Equity, and Inclusion (DEI) efforts that the county has completed to address health inequities?

☒ Yes ☐ No
If yes, please describe the DEI efforts undertaken. If no, indicate any plans to implement DEI efforts in FY 26-27. *(Limit of 1 page)*

- As a result of the Community Health Needs Assessment, one of the strategic goals is to improve access to comprehensive specialty care for the community. The objective is to increase patient access at Fulton County Medical Center by recruiting additional providers and expanding the range of services offered through Fulton Specialty Services. Planned strategies include increasing the number of specialty care practitioners, assessing the feasibility of expanding in-home care services, exploring opportunities to enhance telehealth services, evaluating current specialty care offerings to identify gaps, growing surgical service capacity, and strengthening marketing efforts to increase community awareness of available services.
- AmeriHealth Caritas offers community-based health education on a range of wellness topics. The organization provides bilingual presenters to ensure that educational opportunities are accessible to individuals with diverse language needs and to promote greater community engagement.

5. Does the county currently have any suicide prevention initiatives which addresses all age groups?

☐ Yes ☐ No
If yes, please describe the initiatives and any age-specific initiatives. If no, counties may describe plans to implement future initiatives in the coming fiscal year. *(Limit of 1 page)*

The Suicide Prevention Coalition of Franklin & Fulton Counties was established in 2013 by the Mental Health Association of Franklin and Fulton Counties (MHAFF) to bring together community partners committed to addressing suicide and promoting mental wellness across both counties. Since its formation, the coalition has existed in various capacities, adapting to community needs while maintaining a shared commitment to prevention, collaboration, and support.
The coalition was created with the goal of uniting a diverse group of stakeholders—including community organizations, service providers, local systems, and individuals with lived experience—to evaluate the current state of suicide in Franklin and Fulton Counties and to collaboratively develop

prevention strategies, plans, and activities. By fostering a space for shared learning and coordination, the coalition works to reduce duplication of efforts and strengthen the overall impact of suicide prevention initiatives.
Membership reflects a broad cross-section of the community and includes representatives from mental and behavioral health providers, healthcare systems, schools, social service agencies, faith-based organizations, first responders, local government, nonprofit organizations, and individuals personally impacted by suicide. This diversity ensures that coalition efforts are informed by multiple perspectives and grounded in both professional expertise and lived experience.
The coalition serves the large rural communities of Franklin and Fulton Counties, where access to mental health resources and support can vary. Through collaboration, education, advocacy, and data-informed planning, the Suicide Prevention Coalition of Franklin & Fulton Counties seeks to strengthen protective factors, address risk factors, and ensure individuals and families know where to turn for help.

Our goals are listed below for the complete Strategic Plan please reach out to Mental Health Association of Franklin and Fulton Counties

Strategic Goal 1: Reduce stigma surrounding suicide and mental health by increasing community awareness, understanding, and open dialogue.

Strategic Goal 2: Develop and promote accessible support networks and increase awareness of available supports so individuals and families impacted by suicide feel connected, supported, and not alone.

Strategic Goal 3: Expand access to evidence-based education to equip community members with the skills and knowledge to prevent suicide and respond effectively.

Strategic Goal 4: Establish and strengthen collaborative partnerships to create a coordinated, community-wide approach to suicide prevention.

Strategic Goal 5: Reduce access to lethal means by promoting safe storage, awareness, and community-based prevention strategies.

Strategic Goal 6: Include those with lived experience to ensure suicide prevention efforts are compassionate, relevant, and guided by those most impacted.

Strategic Goal 7: Strengthen data collection, analysis, and reporting to inform decision-making and enhance suicide prevention efforts.

6. Individuals with Serious Mental Illness (SMI): Employment Support Services

The Employment First Act (Act of Jun. 19, 2018,P.L 229, No 36 Cl. 35 EMPLOYMENT FIRST ACT ENACTMENT, 2018) requires county agencies to provide services to support competitive integrated employment for individuals with disabilities who are eligible to work under federal or state law. For further information on the Employment First Act, see Employment-First-Act-three-year-plan.pdf (pa.gov)

a. Please provide the following information for your County MH Office Employment Specialist single point of contact (SPOC).
   - Name: Cori Seilhamer

- Email address: caseilhamer@franklincountypa.gov
- Phone number: 717-264-5387

b. Please indicate if the county **Mental Health office** follows the SAMHSA Supported Employment Evidence Based Practice (EBP) Toolkit:
☐ Yes ☒ No

Please complete the following table for all supported employment services provided to **only** individuals with a diagnosis of Serious Mental Illness (SMI), defined as persons age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral or emotional disorder that is listed in the current DSM that has resulted in functional impairment, which substantially interfere with or limits one more major life activities.

Previous Year: FY 25-26 County Supported Employment Data for **ONLY** Individuals with Serious Mental Illness		
• Please complete all rows and columns below • If data is available, but no individuals were served in a category, list as **zero (0)** • Only if no data available for a category, list as **N/A** and provide a brief narrative explanation. *Include additional information for each population served in the **Notes** section. (For example, 50% of the Asian population served speaks English as a Second Language, or number served for ages 14-21 includes juvenile justice population).*		
Data Categories	**County MH Office Response**	**Notes**
i. Total Number Served	0	Service is available if needed
ii. # served ages 14 up to 21	0	
iii. # served ages 21 up to 65	0	
iv. # of male individuals served	0	
v. # of female individuals served	0	
vi. # of non-binary individuals served	0	
vii. # of Non-Hispanic White served	0	
viii. # of Hispanic and Latino served	0	
ix. # of Black or African American served	0	
x. # of Asian served	0	
xi. # of Native Americans and Alaska Natives served	0	
xii. # of Native Hawaiians and Pacific Islanders served	0	
xiii. # of multiracial (two or more races) individuals served	0	
xiv. # of individuals served who have more than one disability	0	
xv. # of individuals served working part-time (30 hrs. or less per wk.)	0	
xvi. # of individuals served working full-time (over 30 hrs. per wk.)	0	
xvii. # of individuals served with lowest hourly wage (i.e.: minimum wage)	0	
xviii. # of individuals served with highest hourly wage	0	
xix. # of individuals served who are receiving employer offered benefits (i.e., insurance, retirement, paid leave)	0	

7. Supportive Housing:

a. Please provide the following information for the County MH Office Housing Specialist/point of contact (SPOC).

Name: Jennifer Hutchinson
Email address: jchutchinson@franklincountypa.gov
Phone number: 717-264-5387 ext 21249

b. Please indicate if the county **Mental Health office** follows the **SAMHSA Permanent Supportive Housing Evidence-Based Practices** toolkit:
☐ Yes ☐ No

DHS' five-year housing strategy, Supporting Pennsylvanians Through Housing is a comprehensive plan to connect Pennsylvanians to affordable, integrated and supportive housing. This comprehensive strategy aligns with the Office of Mental Health and Substance Abuse Services (OMHSAS) planning efforts, and OMHSAS is an integral partner in its implementation.

Supportive housing is a successful, cost-effective combination of affordable housing with services that helps people live more stable, productive lives. Supportive housing works well for people who face the most complex challenges—individuals and families who have very low incomes and serious, persistent issues that may include substance use, mental illness, and HIV/AIDS; and may also be, or at risk of, experiencing homelessness.

c. **Supportive Housing Activity** *to include:*
- *Community Hospital Integration Projects Program funding (CHIPP)*
- *Reinvestment*
- *County Base funded*
- *Other funded and unfunded, planned housing projects*

i. Please identify the following for all housing projects operationalized in SFY 25-26 and 26-27 in each of the tables below**:**
- Project Name
- Year of Implementation
- Funding Source(s)

ii. Next, enter amounts expended for the previous state fiscal year (SFY 25-26), as well as projected amounts for SFY 26-27. If this data isn't available because it's a new program implemented in SFY 26-27, do not enter any collected data.

- Please note: Data from projects initiated and reported in the chart for SFY 26-27 will be collected in next year's planning documents.

1. Capital Projects for Behavioral Health	Check box ☐ if available in the county and complete the section.

Capital financing is used to create targeted permanent supportive housing units (apartments) for consumers, typically, for a 15–30-year period. Integrated housing takes into consideration individuals with disabilities being in units (apartments) where people from the general population also live (i.e., an apartment building or apartment complex).

1. Project Name	2. Year of Implementation	3. Funding Sources by Type (Including grants, federal, state & local sources)	4. Total Amount for SFY 25-26 (only County MH/ID dedicated funds)	5. Projected Amount for SFY 26-27 (only County MH/ID dedicated funds)	6. Actual or Estimated Number Served in SFY 25-26	7. Projected Number to be Served in SFY 26-27	8. Number of Targeted BH United		9. Term of Targeted BH Units (e.g., 30 years)
Totals									
Notes:									

2. Bridge Rental Subsidy Program for Behavioral Health	Check box ☐ if available in the county and complete the section.

Short-term tenant-based rental subsidies, intended to be a "bridge" to more permanent housing subsidy such as Housing Choice Vouchers.

1. Project Name	2. Year of Implementation	3. Funding Sources by Type (include grants, federal, state & local sources)	4. Total $ Amount for SFY 25-26	5. Projected $ Amount for SFY 26-27	6. Actual or Estimated Number Served in SFY 25-26	7. Projected Number to be Served in SFY 26-27	8. Number of Bridge Subsidies in SFY 25-26	9. Average Monthly Subsidy Amount in SFY 25-26	10. Number of Individuals Transitioned to another Subsidy in SFY 25-26
Bridge Rental Assistance Subsidies	2025	HealthChoices Reinvestment	*$64,800*	*$64,800*	6	10	6	$647.34	1
Totals			$64,800	$64,800	6	10	6	$647.34	1
Notes:									

3. Master Leasing (ML) Program for Behavioral Health				Check box ☐ if available in the county and complete the section.					
Leasing units from private owners and then subleasing and subsidizing these units to consumers.									
1. Project Name	2. Year of Implementation	3. Funding Source by Type (include grants, federal, state & local sources)	4. *Total* $ Amount for SFY 25-26	5. Projected $ Amount for SFY 26-27	6. Actual or Estimated Number Served in SFY 25-26	7. Projected Number to be Served in SFY 26-27	8. Number of Owners/ Projects Currently Leasing	9. Number of Units Assisted with Master Leasing in SFY 25-26	10. Average Subsidy Amount in SFY 25-26
Totals									
Notes:									

4. Housing Clearinghouse for Behavioral Health				Check box ☐ if available in the county and complete the section.					
An agency that coordinates and manages permanent supportive housing opportunities.									
1. Project Name	2. Year of Implementation	3. Funding Source by Type (include grants, federal, state & local sources)	4. *Total* $ Amount for SFY 25-26	5. Projected $ Amount for SFY 26-27	6. Actual or Estimated Number Served in SFY 25-26			7. Projected Number to be Served in SFY 26-27	8. Number of Staff FTEs in SFY 25-26
Totals									
Notes:									

5. Housing Support Services (HSS) for Behavioral Health				Check box ☐ if available in the county and complete the section.					
HSS are used to assist consumers in transitions to supportive housing or services needed to assist individuals in sustaining their housing after move-in.									
1. Project Name	2. Year of Implementation	3. Funding Sources by Type (include grants, federal, state & local sources)	4. *Total* $ Amount for SFY 25-26	5. Projected $ Amount for SFY 26-27	6. Actual or Estimated Number Served in SFY 25-26			7. Projected Number to be Served in SFY 26-27	8. Number of Staff FTEs in SFY 25-26
PATH	2005	Federal	$54,558	39				35	1
		State	$18,186						
Totals			$72,744	39				35	1
Notes:									

6. Housing Contingency Funds for Behavioral Health				Check box ☐ if available in the county and complete the section.					
Flexible funds for one-time and emergency costs such as security deposits for apartment or utilities, utility hook-up fees, furnishings, and other allowable costs.									
1. Project Name	2. Year of Implementation	3. Funding Sources by Type (include grants, federal, state & local sources)	4. *Total* $ Amount for SFY 25-26	5. Projected $ Amount for SFY 26-27	6. Actual or Estimated Number Served in SFY 25-26			7. Projected Number to be Served in SFY 26-27	8. Average Contingency Amount per person
Totals									
Notes:									

7. Other: Identify the Program for Behavioral Health				Check box ☐ if available in the county and complete the section.				
Project Based Operating Assistance (PBOA) is a partnership program with the Pennsylvania Housing Finance Agency in which the county provides operating or rental assistance to specific units then leased to eligible persons; **Fairweather Lodge (FWL)** is an Evidenced-Based Practice where individuals with serious mental illness choose to live together in the same home, work together and share responsibility for daily living and wellness; **CRR Conversion** (as described in the CRR Conversion Protocol), **other.**								
1. Project Name (include type of project such as PBOA, FWL, CRR Conversion, etc.)	2. Year of Implementation	3. Funding Sources by Type (include grants, federal, state & local sources)	4. *Total* $ Amount for SFY 25-26	5. Projected $ Amount for SFY 26-27	6. Actual or Estimated Number Served in SFY 25-26			7. Projected Number to be Served in SFY 26-27
Housing Expansion	2005	State & Local	$18,480	$18,500	2			1
Totals								
Notes:								

e) <u>Certified Peer Specialist Employment Survey:</u>

Certified Peer Specialist (CPS) is defined as:

An individual with lived mental health recovery experience who has received the Department approved peer services training and certified by the Pennsylvania Certification Board.

<u>In the table below</u>, please include CPSs employed in <u>any</u> mental health service in the county/joinder including, but not limited to:

- case management
- inpatient settings
- psychiatric rehabilitation centers
- intensive outpatient programs
- drop-in centers
- HealthChoices peer support programs
- consumer-run organizations
- residential settings
- ACT or Forensic ACT teams
- Crisis

County MH Office CPS Single Point of Contact (SPOC)	Name: Cori Seilhamer Email: caseilhamer@franklilncountypa.gov Phone number: 717-264-5387
Total Number of CPSs Employed	**11**
Average number of individuals served (ex: 15 persons per peer, per week)	**Average of 10 peers per CPS (Some have fewer and some have more)**
Number of CPS working full-time (30 hours or more)	**4 (CEO and CPS Manager are certified but do not routinely see peers, there are 2 FT staff who work as CPS but their time is split into other programs as well)**
Number of CPS working part-time (under 30 hours)	**1**
Hourly Wage (low and high), *seek data from providers as needed*	**High 22.25 Low 17.00**
Benefits, such as health insurance, leave days, etc. (Yes or No), *seek data from providers as needed*	**FT Yes, there are incentives in place for PT to earn PTO**
Number of New Peers Trained in CY 2025	**2**

f) Existing County Mental Health Services

Please indicate all currently available services and the funding source(s) utilized.

Services by Category	Currently Offered	Funding Source (Check all that apply)
Outpatient Mental Health	☒	☒ County ☒ HC ☒ Reinvestment
Psychiatric Inpatient Hospitalization	☒	☐ County ☒ HC ☐ Reinvestment
Partial Hospitalization - Adult	☒	☐ County ☒ HC ☐ Reinvestment
Partial Hospitalization - Child/Youth	☒	☐ County ☒ HC ☐ Reinvestment
Family-Based Mental Health Services	☐	☐ County ☐ HC ☐ Reinvestment
Assertive Community Treatment (ACT) or Community Treatment Team (CTT)	☐	☐ County ☐ HC ☐ Reinvestment
Children's Evidence-Based Practices	☒	☐ County ☒ HC ☐ Reinvestment
Crisis Services	☐	☐ County ☐ HC ☐ Reinvestment
Telephone Crisis Services		
Walk-in Crisis Services	☒	☒ County ☒ HC ☐ Reinvestment
Mobile Crisis Services	☒	☒ County ☒ HC ☐ Reinvestment
Crisis Residential Services	☐	☐ County ☐ HC ☐ Reinvestment
Crisis In-Home Support Services	☐	☐ County ☐ HC ☐ Reinvestment
Emergency Services	☒	☒ County ☐ HC ☐ Reinvestment
Targeted Case Management	☒	☒ County ☒ HC ☐ Reinvestment
Administrative Management	☒	☒ County ☐ HC ☐ Reinvestment
Transitional and Community Integration Services	☐	☐ County ☐ HC ☐ Reinvestment
Community Employment/Employment-Related Services	☒	☒ County ☐ HC ☐ Reinvestment
Community Residential Rehabilitation Services	☒	☒ County ☐ HC ☐ Reinvestment
Psychiatric Rehabilitation	☐	☐ County ☐ HC ☐ Reinvestment
Children's Psychosocial Rehabilitation	☐	☐ County ☐ HC ☐ Reinvestment
Adult Developmental Training	☐	☐ County ☐ HC ☐ Reinvestment
Facility-Based Vocational Rehabilitation	☒	☒ County ☐ HC ☐ Reinvestment
Social Rehabilitation Services	☒	☒ County ☐ HC ☐ Reinvestment
Administrator's Office	☒	☒ County ☐ HC ☐ Reinvestment
Housing Support Services	☒	☒ County ☐ HC ☒ Reinvestment
Family Support Services	☒	☒ County ☒ HC ☐ Reinvestment
Peer Support Services	☒	☒ County ☒ HC ☐ Reinvestment
Consumer-Driven Services	☒	☒ County ☒ HC ☐ Reinvestment
Community Services	☒	☒ County ☐ HC ☐ Reinvestment
Mobile Mental Health Treatment	☒	☐ County ☒ HC ☐ Reinvestment
Behavioral Health Rehabilitation Services for Children and Adolescents	☒	☐ County ☒ HC ☐ Reinvestment
Inpatient Drug & Alcohol (Detoxification and Rehabilitation)	☒	☒ County ☒ HC ☐ Reinvestment
Outpatient Drug & Alcohol Services	☒	☒ County ☒ HC ☐ Reinvestment
Methadone Maintenance	☒	☐ County ☒ HC ☐ Reinvestment
Clozapine Support Services	☒	☐ County ☒ HC ☐ Reinvestment
Additional Services (Specify – add rows as needed)	☐	☐ County ☐ HC ☐ Reinvestment

Note: HC= HealthChoice

g) Evidence-Based Practices (EBP) Survey

Please include both county and HealthChoices funded services.

(Below: if answering Yes (Y) to **#1. Service available,** please answer questions #2-7)

Evidenced-Based Practice	1. Is the service available in the County/ Joinder? (Y/N)	2. Current number served in the County/ Joinder (Approx.)	3. What fidelity measure is used?	4. Who measures fidelity? (agency, county, MCO, or state)	5. How often is fidelity measured?	6. Is SAMHSA EBP Toolkit used as an implementation guide? (Y/N)	7. Is staff specifically trained to implement the EBP? (Y/N)	8. Additional Information and Comments
Assertive Community Treatment	No	0	N/A	N/A	N/A	N/A	N/A	N/A
Supportive Housing	Yes		N/A	Agency/County	Annually	No	N/A	N/A
Supported Employment	Yes		N/A	Agency/County	Annually	No	N/A	Include # Employed
Integrated Treatment for Co-occurring Disorders (Mental Health/SUD)	Yes	N/A	CodeCat	Agency/County	Annually	No	N/A	
Illness Management/ Recovery	No	N/A	N/A	N/A	NA	N/A	N/A	
Medication Management (MedTEAM)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Therapeutic Foster Care	Yes		N/A	N/A	N/A	N/A	N/A	Provided by C&Y
Multisystemic Therapy	Yes		TAM/SAM	Agency	Monthly	N/A	Yes	Funded by HC
Functional Family Therapy	No	N/A	N/A	N/A	N/A	N/A	N/A	
Family Psycho-Education	Yes		N/A	N/A	N/A	N/A	N/A	Information not tracked

SAMHSA's EBP toolkits: https://www.samhsa.gov/libraries/evidence-based-practices-resource-center?f%5B0%5D=resource_type%3A20361

h) Additional EBP, Recovery-Oriented and Promising Practices Survey:

- Please include both county and HealthChoices funded services.
- Include CPS services provided to all age groups in total, including those in the age break outs for TAY and OAs.

(Below: if answering yes to **#1. service provided**, please answer questions #2 and 3)

Recovery-Oriented and Promising Practices	1. Service Provided (Yes/No)	2. Current Number Served (Approximate)	3. Additional Information and Comments
Consumer/Family Satisfaction Team	Yes	1,195	HC FY 24/25 Franklin 1,061 Fulton 99
Compeer	No	N/A	
Fairweather Lodge	Yes	6	Run independently without County or HC
MA Funded Certified Peer Specialist (CPS)- Total**	Yes	161	HC funded FY25-26 Franklin 145 Fulton
CPS Services for Transition Age Youth (TAY)	Yes		Included in above total
CPS Services for Older Adults (OAs)	Yes		Included in above toatl
Other Funded CPS- Total**	Yes	22	County funded FY25-26
CPS Services for TAY	Yes		Included in above total
CPS Services for OAs	Yes		Included in above total
Dialectical Behavioral Therapy	Yes	N/A	Can't see this LOC broken out
Mobile Medication	No	N/A	
Wellness Recovery Action Plan (WRAP)	Yes		Step by Step
High Fidelity Wrap Around	No	N/A	
Shared Decision Making	No	N/A	
Psychiatric Rehabilitation Services (including clubhouse)	No	N/A	
Self-Directed Care	No	N/A	
Supported Education	No	N/A	
Treatment of Depression in OAs	No	N/A	
Consumer-Operated Services	Yes	1	MHA of Franklin/Fulton Counties
Parent Child Interaction Therapy	Yes		HC only
Sanctuary	No	N/A	
Trauma-Focused Cognitive Behavioral Therapy	Yes		HC only
Eye Movement Desensitization and Reprocessing (EMDR)	Yes		Can't see this LOC broken out
First Episode Psychosis Coordinated Specialty Care	No	N/A	
Other (Specify)	Yes		AF-CBT, MST, TARGET

i) Involuntary Mental Health Treatment

1. During CY 2025, did the County/Joinder offer *Assisted Outpatient Treatment (AOT)* Services under PA Act 106 of 2018?
   - ☒ No, chose to opt-out for all of CY 2025
   - ☐ Yes, AOT services were provided from: _____ to _____ after a request was made to rescind the opt-out statement
   - ☐ Yes, AOT services were available for all of CY 2025

2. If the County/Joinder chose to provide AOT, list all outpatient services that were provided in the County/Joinder for all or a portion of CY 2025 (check all that apply):
   - ☐ Community psychiatric supportive treatment
   - ☐ ACT
   - ☐ Medications
   - ☐ Individual or group therapy
   - ☐ Peer support services
   - ☐ Financial services
   - ☐ Housing or supervised living arrangements
   - ☐ Alcohol or substance abuse treatment when the treatment is for a co-occurring condition for a person with a primary diagnosis of mental illness
   - ☐ Other, please specify: _____

3. If the County/Joinder chose to opt-out of providing AOT services for all or a portion of CY 2025:
   a. Provide the number of written petitions for AOT services received during the opt-out period. __N/A_____
   b. Provide the number of individuals the county identified who would have met the criteria for AOT under Section 301(c) of the Mental Health Procedures Act (MHPA) (50 P.S. § 7301(c)). _N/A_____

4. Please complete the following chart as follows:
   a. Rows I through IV fill in the number
      i. **AOT services column**:
         1) Available in your county, BUT if no one has been served in the year, enter 0.
         2) Not available in your county, enter N/A.
      ii. **Involuntary Outpatient Treatment (IOT) services column:** if no one has been served in the last year, enter 0.
   b. Row V fill in the administrative costs of AOT and IOT

	AOT	IOT
I. Number of individuals subject to involuntary treatment in CY 2025	0	335 (undup includes out of county individuals)
II. Number of involuntary inpatient hospitalizations following an IOT or AOT for CY 2025	0	6 (306 hearings)
III. Number of AOT modification hearings in CY 2025	0	

IV. Number of 180-day extended orders in CY 2025	0	52
V. Total administrative costs (including but not limited to court fees, costs associated with law enforcement, staffing, etc.) for providing involuntary services in CY 2025	0	$40,570.00

j) Consolidated Community Reporting Initiative Data reporting

DHS requires the County/Joinder to submit a separate record, or "pseudo claim," each time an individual has an encounter with a provider. An encounter is a service provided to an individual. This would include, but not be limited to, a professional contact between an individual and a provider and will result in more than one encounter if more than one service is rendered. For services provided by County/Joinder contractors and subcontractors, it is the responsibility of the County/Joinder to take appropriate action to provide the DHS with accurate and complete encounter data. DHS' point of contact for encounter data will be the County/Joinder and no other subcontractors or providers. It is the responsibility of the County/Joinder to take appropriate action to provide DHS with accurate and complete data for payments made by County/Joinder to its subcontractors or providers. DHS will evaluate the validity through edits and audits in PROMISe, timeliness, and completeness through routine monitoring reports based on submitted encounter data. (Pennsylvania General Assembly, (1966). *Mental Health and Intellectual Disability Act of 1966*, P.L. 96, No. 6 Section 305. http://www.legis.state.pa.us/wu01/li/li/us/pdf/1966/3/006..pdf)

File	Description	Data Format/Transfer Mode	Due Date	Reporting Document
837 Health Care Claim: Professional Encounters v5010	Data submitted for each time an individual has an encounter with a provider. Format/data based on HIPAA compliant 837P format	ASCII files via SFTP	Due within 90 days of the county/joinder accepting payment responsibility; or within 180 calendar days of the encounter	HIPAA implementation guide and addenda. PROMISe™ Companion Guides

❖ Have all available claims paid by the county/joinder during CY 2025 been reported to the state as an encounter? ☒Yes ☐ No

k) Categorical State Base Funding (to be completed by ALL counties)

Please provide a brief narrative as to the services that would be expanded or new programs that would be implemented with increased base funding:

- The community would benefit from the development of mobile crisis intervention teams based on Substance Abuse and Mental Health Services Adminstration (SAMHSA) best practice standards. These teams could provide rapid, community-based behavioral health crisis response, promote diversion from higher levels of care and connect individuals to ongoing treatment and support services.

- There is a growing need for transportation services for the community. Reliable transportation is essential for accessing employment, education, healthcare, behavioral health services, and other community resources. Without adequate transportation options, many face barriers to achieving independence, maintaining stability, and pursuing personal and professional opportunities.

- Additional housing options, including residential and supportive living environments, are needed within our community. This need spans across multiple populations, including individuals transitioning from higher levels of care, those reentering the community following incarceration, transition age youth needing to acquire independent living skills, and older adults who require assistance with daily living but do not need intensive care. Expanding these housing resources would help provide stable, supportive environments that promote independence, reduce recidivism and rehospitalization, and improve the overall quality of life.

l) Categorical State Funding-FY 26-27 [ONLY to be completed by counties not participating in the Human Services Block Grant (i.e. Non-Block Grant)]

If an allocation is expected in the following categoricals for FY 26-27, please describe the services to be rendered with these funds, estimates of number of individuals served, and plans to use any carryover funds, if approved, from FY 25-26:

Respite services:

Consumer Drop-In Centers:

Direct Care Worker Recruitment & Retention:

Forensic ACLU Projects:

Children's Funds Non-Categorical:

Children's Base (100% categorical):

Student Assistance Program:

m) Federal Grant Funding (to be completed by all counties, where appropriate). Please limit response to no more than one page for each question.

- **CMHSBG – Non-Categorical (70167): Please describe the services to be rendered with these funds for the expected FY 26-27 allocation:**

- **CMHSBG – General Training (70167): Please describe the plans to use any carryover funds from FY 25-26:**

- **Social Service Block Grant (70135): Please describe the services to be rendered with these funds for the expected FY 26-27 allocation:**

- **KEEP EMPOWERING YOUTH - PARTNERS, PROVIDERS, LIVED EXPERIENCE KEY-PPLE (71022) - Please describe the project milestones you expect to achieve with these funds and plans to use any carryover funds from FY 25-26.**

SUBSTANCE USE DISORDER SERVICES (Limit of 10 pages for entire section)

The following sections should be used to describe the entire substance use service system available to all county residents *regardless* of funding sources.

Please provide the following contact information for the individual who is filling out the information in this section:

Name: James Eagler Title: Administrator
Entity (Single County Authority (SCA) or other county agency: Franklin/Fulton SCA
Email address: jmeagler@franklincountypa.gov
Phone number: 717-263-1256

Please provide the following information for FY 25-26:

1. **Wait List Information:** Please complete the table below for fiscal year 25-26. If the average weekly wait time (days) for placement does not adhere to placement as referenced in the Department of Drug and Alcohol Programs (DDAP's) Case Management & Clinical Services (CMCS) Manual for withdrawal management (within 24 hours) or all others (within 14 days after LOCA completion), a narrative explanation should be provided.

LOC American Society of Addiction Medicine (ASAM) 3rd Edition Criteria	Services	Average Weekly Number of Individuals*	Average Weekly Wait Time (days)
4 WM	Inpatient Withdrawal Management	0	
4	Medically Managed Intensive Inpatient	0	
3.7 WM	Medically Monitored Inpatient WM	1.8	Same day
3.7	Medically Monitored Intensive Inpatient	0	

3.5	Clinically Managed High Intensity Residential	4.3	Same day
3.1	Clinically Managed Low Intensity Residential	0	
2.5	Partial Hospitalization Program	0	
2 WM	Ambulatory Withdrawal Management with Extended On-Site Monitoring	0	
2.1	Intensive Outpatient	3.3	1-3 days
1 WM	Ambulatory Withdrawal Management without Extended On-Site Monitoring	0	
1	Outpatient	19.9	1-3 days
Other	Specify		

*Average weekly number of individuals for FY 25-26

**Average weekly wait time (days) for placement in FY 25-26

a. What is the source of the data reported in the table above?

Data reported in the table above reflects two sources: SCA encounter export data maintained through the county's service authorization and billing system, and Pennsylvania Department of Drug and Alcohol Programs (DDAP) Treatment Episode Data Set (TEDS) data. Together, these sources capture authorized service utilization across ASAM levels of care for individuals served in Franklin and Fulton Counties.

2. **Overdose Survivors' Data**: Please identify which model (SCA Agency, Contracted Provider, Certified Recovery Specialist (CRS), Treatment Provider, Hospital Staff, or other DDAP models, as identified in DDAP's CMCS Manual) the county uses to offer overdose survivors direct referral to treatment for FY 25-26.

Referral Model(s)	# of Overdose survivors*	# Referred to Treatment	# Refused Treatment
Warm Hand Off	0	0	0

*An overdose, as defined in DDAP's Case Management & Clinical Services Manual, is a situation in which an individual is in a state requiring emergency medical intervention as a result of the use of drugs or alcohol.

a. What is the source of the data reported in the table above?

The data reported in the table come directly from the Warm Handoff Survey – Data Collection Form, which was provided by the WHO vendor, Gaudenzia OP, based on Warm Handoff calls they received from hospital emergency departments. Although there were no overdose survivors recorded in the dataset, the WHO vendor still documented multiple Warm Handoff engagements, including individuals who were referred to treatment as well as those who refused treatment. The table reflects these engagement outcomes even in the absence of overdose-related encounters.

3. **Levels of Care (LOC)**: Please provide the following information for the county's contracted providers.

LOC American Society of Addiction Medicine (ASAM) 3rd Edition Criteria	# of Providers	# of Providers Located In-County	# of Co-Occurring/enhanced Programs
4 WM	2	0	0
4	2	0	0
3.7 WM	20	0	0
3.7	6	0	2
3.5	11	0	0
3.1	5	0	0
2.5 WM	0	0	0
2.1	4	1	2
1 WM	0	0	0
1	5	1	2
Other: 2.5	2	0	0

a. What is the source of the data reported in the table above?

Data reported in the table above reflects two sources: provider counts and co-occurring/enhanced program designations were drawn from DDAP's Treatment Needs Assessment 2026–2030, and the number of providers located in-county was determined by the SCA through a review of current contracted provider agreements.

4. **Treatment Services Needed in County**: Please provide a brief overview of the current services needed in the county for FY 26-27 in sections a, b, and c below.

    a. Provide a brief overview of the current services needed in the county to afford access to appropriate clinical treatment services:

Fulton County remains a rural county with limited local treatment infrastructure and transportation challenges that can impact access to care. Gaudenzia Outpatient is currently the only DDAP licensed treatment provider physically located within Fulton County and offers ASAM Level 1 Outpatient and ASAM Level 2.1 Intensive Outpatient services. The provider also offers medications for opioid use disorder (MOUD), medications for alcohol use disorder (MAUD), recovery support services, and early intervention services. While there are currently no significant treatment capacity concerns, patient volume remains relatively low and long term sustainability of services continues to be monitored by the Behavioral Health Managed Care Organization (BH MCO), the SCA, and community partners. Additional access to low barrier MOUD and MAUD services within the county would further strengthen the continuum of care. Transportation remains a barrier for some residents; however, transportation assistance coordinated through the Fulton County Family Partnership, Medical Assistance Transportation Program (MATP), and grant funded transportation resources helps reduce barriers to treatment access. The recent opening of an opioid treatment program (OTP) in Chambersburg provides Fulton County residents with a significantly closer option for methadone services than previous providers located in Harrisburg or Blair County.

    b. Provide an overview of any expansion or enhancement plans for existing or new providers to meet the current treatment needs within the county:

The SCA continues to work closely with treatment providers, the BH MCO, healthcare systems, and community partners to monitor treatment needs and identify opportunities for expansion. Fulton Medical Center is currently in the process of being acquired by WVU Medicine, creating potential opportunities for future integration of addiction medicine services and specialty care within the county. The SCA also continues to support expansion of recovery oriented systems of care, including recovery support services, recovery navigation, and peer based supports. Current grant funded Certified Recovery Specialist services are approaching capacity, and the SCA continues to pursue grant and funding opportunities to expand recovery support availability. The SCA is also working with community partners to increase naloxone access, strengthen care coordination, and explore opportunities to expand recovery housing access. While a recovery house located directly within Fulton County may not currently be sustainable, expansion of recovery housing capacity in neighboring Franklin County could improve access and bed availability for Fulton County residents.

c. Provide an overview of any use of HealthChoices reinvestment funds to develop new services during the reporting year:

HealthChoices reinvestment funding continues to support recovery oriented services and initiatives designed to address social determinants of health and reduce barriers to care. A portion of reinvestment funding supports the SCA's Recovery Oriented Systems of Care (ROSC) Specialist position, which coordinates recovery support initiatives, overdose prevention activities, and community engagement efforts. Reinvestment funding also supports contingency funding administered through Community Navigators embedded within two local nonprofit organizations to address unmet social determinants of health needs that may impact treatment engagement and recovery outcomes. The SCA continues to work collaboratively with the BH MCO and community stakeholders to identify emerging service needs and evaluate future opportunities for reinvestment funding that improve access to treatment, recovery supports, transportation, housing, and other recovery related services.

5. **Access to and Use of Naloxone in County**: Please describe the entities that have access to Naloxone, any training or education done by the SCA or other entities and coordination efforts to provide Naloxone.

The Franklin/Fulton Drug & Alcohol Program (SCA) continues to support naloxone access, education, and overdose prevention efforts throughout Fulton County. The SCA's ROSC Specialist conducts Operation Save a Life (OSAL) trainings that educate community members and professionals on recognizing and responding to opioid overdoses, including the administration of naloxone. In addition, the SCA maintains a full-time Case Manager assigned to Fulton County who works two days per week within Fulton County Probation. The Case Manager is able to provide overdose education, complete OSAL trainings, and distribute naloxone directly to individuals receiving services and community members as appropriate. The SCA also partners with the Fulton County Family Partnership, where prevention staff, a full-time Certified Recovery Specialist (CRS), and a Recovery Navigator support naloxone distribution and overdose prevention initiatives within the community.

Through the Fulton County Overdose Coalition and Project SAAFE, the county is actively working to expand naloxone access through the development of community naloxone access points and kiosks. Current planning efforts include placement of naloxone kiosks at Fulton County Medical Center and other strategic community locations identified through local overdose and service utilization data. Gaudenzia Outpatient Services serves as an additional naloxone distribution site, providing naloxone

and overdose education to individuals receiving services, including those participating in medication assisted treatment (MAT).

Fulton County continues to explore additional overdose prevention initiatives, including leave-behind naloxone kit programs in partnership with local EMS agencies, as well as training opportunities focused on stigma reduction, compassion fatigue, and improving community responses to substance use disorders. These coordinated efforts help ensure naloxone remains readily available to individuals, families, first responders, and community partners throughout Fulton County.

6. **County Warm Handoff Process:** Please provide a brief overview of the current warm handoff protocols established by the county including challenges and program successes. Protocols include offering 24/7 direct referrals to treatment services for individuals who experienced an overdose or have been hospitalized.

    a. **Warm Handoff Data: FY 25-26**

# of Individuals Contacted	# of Individuals who Entered Treatment	# of Individuals who Completed Treatment
17	9	N/A

1. What is the source of the data reported in the table above?

The data reported in the Warm Handoff table are sourced from the county's standardized Warm Handoff documentation process, including the Warm Handoff Survey – Data Collection Form submitted by the contracted WHO provider, Gaudenzia OP, which captures all Warm Handoff calls they receive from hospital emergency departments and documents contacts, referrals to treatment, refusals, and outcomes. This information is supplemented by Warm Handoff reporting procedures established through the county's DDAP-aligned survey requirements and ongoing Warm Handoff process oversight, which confirm that although no overdose survivors were recorded during the reporting period, the provider continued to document all Warm Handoff engagements and connections to treatment.

INTELLECTUAL DISABILITY SERVICES

The Office of Developmental Programs (ODP), in partnership with the county programs, is committed to enabling individuals with an intellectual disability and autism live rich and fulfilling lives in their community. It is important to also afford the families and other stakeholders access to the information and support needed to help be positive members of the individuals' teams.

This year, we are asking the county to focus more in depth on the areas of the Plan that will help us achieve the goal of an Everyday Life for all individuals.

With that in mind, please describe the continuum of services to registered individuals with an intellectual disability and autism within the county. In a narrative format, please include the strategies that will be utilized for all individuals registered with the county, regardless of the funding stream. In completing the chart below regarding estimated numbers of individuals, please include only individuals for whom Base or HSBG funds have been or will be expended. Appendix C should reflect only Base or HSBG funds

except for the Administration category. Administrative expenditures should be included for both base and HSBG and waiver administrative funds.

**Please note that under Person-Directed Supports (PDS), individuals served means the individual used Vendor Fiscal/Employer Agent (VF/EA) or Agency with Choice (AWC) for at least one service during the fiscal year. The percentage of total individuals served represents all funding streams. The percentage might not add to 100 percent if individuals are receiving services in more than one category.*

The mission of Franklin/Fulton Mental Health/Intellectual & Developmental Disabilities/ Early Intervention is to work collaboratively with the community to ensure the availability of high-quality MH/IDD/EI services and supports for individuals and families. Using a person-centered planning approach and the Prioritization of Urgency of Need for Services (PUNS) process, the IDD program helps individuals access needed services and supports within their communities, regardless of funding. PUNS gathers information from the person-centered planning process and is used to identify both current and future service needs. This information guides budgeting, service planning, and the development of programs that meet community needs. Program supports promote engagement and provide access to services to employment, training, housing, and family support as appropriate. In Fiscal Year 2025-2026, the Franklin/Fulton Intellectual and Developmental Disabilities program supported 39 registered individuals in Fulton County. In the accompanying chart, PDS/AWC and PDS/VF reflect individuals receiving waiver-funded services.

Individuals Served

	Estimated Number of Individuals served in FY 25-26	*Percent of total Number of Individuals Served*	*Projected Number of Individuals to be Served in FY 26-27*	*Percent of total Number of Individuals Served*
Supported Employment	1	3	2	6
Pre-Vocational	0			
Community participation	0			
Base-Funded Supports Coordination	3	8	1	3
Residential (6400)/unlicensed	0			
Lifesharing (6500)/unlicensed	0			
PDS/AWC	2	5	3	6
PDS/VF	0			
Family Driven Family Support Services	4	11	6	17
Assistive Technology	0			
Remote Supports	0			

Supported Employment: “Employment First” is the policy of all Commonwealth executive branch agencies under the jurisdiction of the governor. ODP is strongly committed to competitive integrated employment for all.

- Please describe the services that are currently available in the county such as discovery, customized employment, and other services.
- Please identify changes in the county practices that are proposed for the current year that will support growth in this area and ways that ODP may assist the county in establishing employment growth activities.
- Please add specifics regarding the Employment Pilot if the county is a participant.

The concept of "Employment First" encourages competitive integrated employment. By emphasizing competitive, integrated work as the ideal outcome for people with disabilities, the Franklin/Fulton IDD program is promoting this idea in a number of ways. The concept of Employment First emphasizes that everyone can secure a competitive, integrated job, including individuals with severe disabilities. Through meaningful work, ODP's Employment First initiative aims to give people with disabilities the chance to become financially independent, develop self-confidence, and fully engage in their communities.

The Transition to Adult Life Success (TALS) program provides structured support to young adults with disabilities as they prepare for adulthood. The program focuses on building self-determination skills and exploring career pathways through both group and individualized activities. Group sessions include presentations on employability skills, community resources, and post-secondary opportunities. Individual services may involve connecting participants with potential employers, arranging job shadowing experiences, facilitating community-based work assessments, and offering work incentive counseling. The TALS program is offered through all Fulton County school districts, though no students are currently participating.

Supported Employment Services consist of both direct and indirect supports delivered in a range of community-based workplaces alongside employees without disabilities. These services create opportunities for individuals to obtain and maintain competitive, community-integrated employment of their choosing. Through Supported Employment Services, individuals earn wages at or above minimum wage, paid directly by their employer. Providers offering these services aim to successfully place individuals with intellectual disabilities into competitive employment. There is currently one (1) person in Fulton County in the Supported Employment Services program.

Discovery is a targeted service for a participant who wishes to pursue competitive integrated employment but, due to the impact of their disability, their skills, preferences and/or potential contributions, cannot be best captured through traditional, standardized means, such as functional task assessments, situational assessments and/or traditional normative assessments which compare the participant to other or arbitrary standard of performance and/ or behavior. Discovery involves a comprehensive analysis of the participant in relation to the following:

- Strongest interest toward one or more specific aspects of the labor market;
- Skills, strengths, and other contributions are likely to be valuable to employers or valuable to the community if offered through self-employment; and
- Conditions necessary for successful employment or self-employment.

All employment providers use Discovery as part of their supported employment process. At this time, no one in Fulton County uses Discovery as a discrete service. Information on certification for this process continues to be shared with providers.

Community Participation Support is designed to provide individuals with opportunities and assistance that promote community inclusion, foster personal interests, and build skills that enhance the potential for competitive, integrated employment. These services are intended to support meaningful involvement in a wide range of community-based activities that reflect each participant's preferences, strengths, and desired outcomes related to employment, community engagement, and social connection.

Community Participation Support is structured to complement and reinforce community life, with employment as the primary goal. Services take place in integrated community settings and involve participation alongside individuals without disabilities who are not paid caregivers. The intent of this service is to help participants develop and maintain valued social roles, strengthen natural supports, increase independence, enhance employment potential, and experience meaningful community integration.

The Franklin/Fulton IDD Program remains committed to supporting providers in delivering Community Participation Support. During FY 2025–2026, no individuals used base funding for this service. However, two (2) new providers opened licensed Community Participation Support facilities during the fiscal year.

The IDD Department continues to prioritize Competitive Integrated Employment, including supported employment, as part of its Quality Management Goal (see Appendix E). The Quality Management outcome is that "people who choose to work are employed in the community." As of June 2026, one (1) individual is employed in Competitive Integrated Employment. The Franklin/Fulton IDD Program and its employment providers will continue to assist individuals in maintaining current employment or securing new job opportunities.

The Fulton Transition Council works collaboratively with the Office of Vocational Rehabilitation (OVR) to identify students who may benefit from Pre-Employment Transition Services, Paid Work Experiences, and Job Shadowing opportunities within local school districts. The Franklin/Fulton IDD Program actively participates in the Transition Council, which includes representatives from OVR, school districts, and provider agencies, and is facilitated by the Tuscarora Intermediate Unit #11, to advance and support the Employment First model.

OVR and the Franklin/Fulton IDD Program jointly facilitate Student Transition to Adult Review (STAR) meetings for students and their families. These meetings focus on each student's transition plan, including their interests, goals, current skill levels, employment aspirations, independent living needs, and the supports required to achieve their outcomes. STAR meetings also provide an opportunity for students to register with the IDD Program and OVR if they have not done so previously.

During the pandemic, the Franklin/Fulton Transition Councils developed virtual transition sites to share helpful resources, presentations, and guidance that school districts and families can access at any time, which have since resumed to in-person meetings.

The IDD Program and the Supports Coordination Organizations (SCOs) continue to collaborate with OVR through joint training on the implementation of the Workforce Innovation and Opportunity Act (WIOA). The IDD Program has established and utilizes a formal OVR referral process to streamline, track, and support individuals in accessing OVR services in Franklin & Fulton Counties.

Supports Coordination:

- Please describe how the county will assist the supports coordination organization (SCO) to engage individuals and families to explore the communities of practice/supporting families model using the life course tools to link individuals to resources available in the community.
- Please describe how the county will assist supports coordinators to effectively engage and plan for individuals on the waiting list.
- Please describe the collaborative efforts the county will utilize to assist SCOs with promoting self-direction.

Base-funded Supports Coordination includes home and community-based case management for individuals in nursing facilities, individuals living in Intermediate Care Facilities (ICFs), and those who do not qualify for MA. Base funds are only used for individuals who have been denied MA coverage. Currently, three (3) people receive base-funded Supports Coordination because they are either ineligible for MA or experienced a lapse in their MA coverage during the year. Additionally, one (1) individual is enrolled in the Community Health Choices (CHC) waiver.

The IDD Program maintains close collaboration with Supports Coordination Organizations (SCOs) through monthly meetings with SCO supervisors. These meetings address individuals with higher support needs or those with an Emergency Prioritization of Urgency of Need for Services (PUNS). Discussions focus on natural supports as well as any additional resources required. Individuals may be added to the discussion list at any time. Each monthly meeting follows a consistent agenda that includes review of PUNS, Individual Support Plans (ISPs), Levels of Care, incident management, provider risk assessments, Independent Monitoring for Quality (IM4Q), and other key areas.

The SCO participates in the Transition Councils and is encouraged to attend trainings such as State Employment Leadership Network (SELN) sessions, Community of Practice employment calls, and Secondary Transition Conferences to promote community-integrated employment. Franklin/Fulton County is also part of the South-Central Regional Collaborative for the Community of Practice, with the SCO represented as a stakeholder. The State Community of Practice focuses on family engagement, employment, and Supports Coordination. Support Coordinators use LifeCourse principles and tools to help individuals and families plan for the future, and SCOs support these statewide initiatives. Additional details on Regional Collaboratives can be found in the Administrative Funding section.

Beyond these initiatives, the SCO also participates in the Risk Management Committee and the Quality Improvement Council.

Franklin and Fulton Counties currently have two (2) Supports Coordination Organizations: Service Access & Management, Inc. (SAM) and Expert Community Care Management (ECCM). The addition of

a second SCO provides individuals and families the ability to choose their Supports Coordination provider at intake and throughout service delivery.

Lifesharing and Supported Living:

- Please describe how the county will support the growth of Lifesharing and Supported Living as an option.
- Please describe the barriers to the growth of Lifesharing and Supported Living in the county.
- Please describe the actions the county found to be successful in expanding Lifesharing and Supported Living in the county despite the barriers.
- Please explain how ODP can be of assistance to the county in expanding and growing Lifesharing and Supported Living as an option in the county.

According to 55 Pa. Code Chapter 6100 regulations: “Family Living Homes are somewhat different than other licensed homes as these settings provide for Lifesharing arrangements. Individuals live in a host Lifesharing home and are encouraged to become contributing members of the host Lifesharing unit. The host Lifesharing arrangement is chosen by the individual, his or her family and team, and with the Lifesharing host and Family Living provider agency, in accordance with the individual’s needs. Licensed Family Living Homes are limited to homes in which one (1) or two (2) individuals with an intellectual disability, who are not family members or relatives of the Lifesharing host, reside.” Satisfaction surveys have shown that individuals in Lifesharing living arrangements are more satisfied with their lives.

The Franklin/Fulton County IDD Program will continue to support the growth of Lifesharing in the following ways:

• The Administrative Entity (AE) and Supports Coordination Organizations (SCOs) will continue educating individuals and families about the values and benefits of Lifesharing and addressing the misconception that it is the same as “adult foster care.” Outreach efforts will emphasize that Lifesharing offers a supportive, mentoring, and relationship-focused environment that strengthens a person’s natural supports.

• The AE has encouraged local Lifesharing providers to develop new licensed homes that can be used for periodic and emergency respite when needed. Having these homes available has allowed for faster emergency placements, some of which have developed into long-term Lifesharing arrangements.

• The AE will collaborate with providers to implement the expanded Lifesharing service definition, which now includes individuals living in their own homes or the home of a relative while receiving agency-managed Lifesharing services.

• The AE actively participates in both the Central Region and Statewide Lifesharing Coalitions.

• The AE continues partnering with the MH/IDD/EI Advisory Board to promote Lifesharing and increase educational opportunities for agency providers, families, and healthcare professionals.

Lifesharing remains the first residential option offered to individuals needing a residential placement, and this is documented in each Individual Support Plan. Currently, one (1) person in Fulton County lives in a Lifesharing home supported through waiver funding.

Some barriers to expanding Lifesharing in Franklin/Fulton Counties include a limited number of families interested in becoming Lifesharing providers and the complex support needs of many individuals seeking this option. Lifesharing providers ultimately determine whom they are able to support, and individuals with more complex needs are often more difficult to match with an appropriate long-term family. Additionally, many existing Lifesharing caregivers are aging and may no longer be able to meet the required level of care.

Despite these challenges, the region continues to see many long-term successes. Several individuals have lived in their Lifesharing homes for more than 20 years. One Lifesharing provider has been especially successful in recruiting new families and transitioning individuals from Community Residential Rehabilitation (CRR) homes and Children's Foster Care into Lifesharing as they age out of the children's system.

The Community Living Waiver (CLW) provides funding up to $97,000, which is generally sufficient to support individuals with a low Supports Intensity Scale (SIS) Needs Group in a Lifesharing home, provided they are employed or not attending a traditional day program.

Cross-Systems Communications and Training:

- Please describe how the county will use funding, whether it is HSBG or Base funding, to increase the capacity of the county's community providers to more fully support individuals with multisystem needs, and complex medical needs.
- Please describe how the county will support effective communication and collaboration with local school districts in order to engage individuals and families at an early age and promote the life course/supporting families paradigm.
- Please describe how the county will communicate and collaborate with local children and youth agencies, the Area Agency on Aging, and the mental health system to enable individuals and families to access community resources, as well as formalized services and supports through ODP.

The IDD Program collaborates with several agencies to enhance supports for individuals with multiple or complex needs. IDD staff participate in Child and Adolescent Service System Program (CASSP) meetings to discuss supports needed in both school and community settings. Staff also work directly with Home Health Aide providers to assist individuals with medical needs in their homes and communities. The Managed Care Organization's Specialized Needs Unit is available to support eligible individuals under age 18.

Collaboration with local school districts includes providing informational sessions for parents and teachers. IDD staff attend IEP meetings upon request to assist with problem-solving and to share intake or service information. STAR meetings, facilitated by the school districts, are attended by OVR and the IDD Program Specialist to discuss transition needs and plan for services after graduation. The IDD

Program also partners with school districts and the PA Family Network to offer resources and host family workshops, including events following Back-to-School Nights. As the Administrative Entity (AE) and facilitator of the Transition Council, the IDD Program participates in Transition Fairs at all county high schools.

The IDD Program works closely with Children and Youth Services (CYS) through CASSP, and joint efforts between CYS and IDD staff have frequently resulted in positive outcomes for children while upholding their rights. Additionally, the AE staff, CASSP Coordinator, SCO supervisors, and Mental Health supervisors meet quarterly to ensure coordinated communication and best practices for individuals served across multiple systems.

The IDD Program continues to collaborate with Mental Health, CASSP, school districts, Tuscarora Managed Care Alliance, and PerformCare to support individuals with a dual diagnosis.

The IDD Program staff continue to deliver the Intellectual and Developmental Disabilities services module as part of the Crisis Intervention Team (CIT) training curriculum. This training supports police officers, mental health professionals, and first responders by equipping them with the knowledge and strategies needed to respond safely and effectively when interacting with individuals with disabilities. The course is designed to enhance understanding, improve communication, and strengthen responder confidence during these critical encounters. The IDD module has been updated to better meet the needs of law enforcement and first responders. Most local first responder agencies and police departments now have the majority of their staff CIT trained. CIT sessions were held in September and April during FY 2025–2026, with additional training planned for FY 2026–2027.

Franklin/Fulton County continues to see an increase in individuals being discharged from the jail or prison system. While some individuals are already known to the Administrative Entity (AE), others are not connected to the IDD system, which can delay access to services. Many individuals also lack necessary documentation for eligibility determination, further complicating the process. To address these challenges, Franklin County has established a Complex System Triage Team to review high-need cases involving multiple systems and to develop coordinated policies and procedures to support these individuals effectively.

The AE also participates in the Autism Judicial Task Force. This group aims to educate court personnel and identify strategies to assist individuals with Autism and their families in navigating the judicial system. The Task Force includes representation from the Autism Services Education Resource and Training Collaborative (ASERT) and the PA Family Network, ensuring a broad and collaborative approach.

Emergency Supports:

- Please describe how individuals in an emergency situation will be supported in the community (regardless of availability of county funding or waiver capacity).
- Please provide details on the county's emergency response plan including:
    - Does the county reserve any base or HSBG funds to meet emergency needs?

  - What is the county's emergency plan in the event an individual needs emergency services, residential or otherwise, whether within or outside of normal working hours?
  - Does the county provide mobile crisis services?
  - If the county does provide mobile crisis services, have the staff been trained to work with individuals who have an ID and/or autism diagnosis?
  - Do staff who work as part of the mobile crisis team have a background in ID and/or autism?
  - Is training available for staff who are part of the mobile crisis team?
  - If the county does not have a mobile crisis team, what is the county's plan to create one within the county's infrastructure?
- Please submit the county 24-hour emergency crisis plan as required under the Mental Health and Intellectual Disabilities Act of 1966.

If waiver capacity is unavailable during an emergency, individuals may be supported through Block Grant funding. Base dollars can be used to provide day program services (typically 9:00 a.m. to 3:00 p.m.) and transportation so individuals can remain safely in their homes and so caregivers can maintain employment. The Franklin/Fulton IDD Department will continue expanding access to Family Aide services, day programs, transportation, adaptive equipment, home modifications, and respite to help individuals remain at home rather than entering more costly residential programs. The IDD Department reserves 28 days of Emergency Respite using base funds. Two (2) day programs are available — one (1) for individuals who are independently ambulatory and another equipped to support individuals with all levels of functioning. Both programs anticipate expanding services and geographic coverage in FY 2026–2027.

The IDD Independent Apartment Program includes 10 individuals who live in their own apartments with fewer than 30 hours of support per week. Base funds are used to subsidize their rent. This program offers the least restrictive housing option for individuals seeking independent living. There are currently no Fulton County individuals involved with this program.

The Administrative Entity (AE) maintains a Risk Management Committee that meets quarterly to review incident management practices, restrictive procedures, and risk mitigation strategies. In alignment with ODP guidance, the Franklin/Fulton IDD Department conducts Provider Risk Assessments as a proactive measure to evaluate provider operations. During the year, the AE reviewed two (2) residential providers for which Franklin/Fulton serves as the assigned AE and shared findings with other AEs as needed. The AE will continue completing Provider Risk Assessments, including those for unlicensed providers identified by the Office of Developmental Programs (ODP).

The IDD Department responds to emergencies outside of standard business hours according to Procedure Statement IDD505: Risk Mitigation. Program Specialists and the MH/IDD/EI Administrator are listed as after-hours contacts, and providers are trained in this policy. Initial incidents are reviewed daily—including weekends and holidays—to ensure the safety and well-being of individuals. The County reserves base-funded respite to authorize emergency respite services and coordinates with providers, Adult Protective Services, and Supports Coordination Organizations to arrange these services at any

time of day. When necessary, emergency placements may involve Lifesharing or 6400 residential services to support both immediate safety and long-term stability.

The MH/IDD Department maintains mission-essential functions designed to sustain operations during emergencies. These functions must be operational within 12 hours of a major event and remain sustainable for up to 30 days through the recovery period.

The IDD Program utilizes TrueNorth Wellness for Crisis Intervention Services, available 24 hours a day, seven days a week, 365 days a year. Individuals may access services by calling 988, the local crisis line, or by walking into the Emergency Department. Mobile Crisis services are available, and many crisis workers have experience supporting individuals with Autism and intellectual disabilities. Training is offered to staff upon request. When an individual with IDD or Autism uses crisis services, Crisis staff notify the Supports Coordinator or the AE if the person is not yet registered. The Co-Responder program is also a way to divert individuals with disabilities from being incarcerated and to seek the community resources help that they need. More information is available in the Mental Health Section.

The Franklin/Fulton IDD Program supports Community Services Group (CSG) in expanding mobile MH/IDD Behavioral Intervention Services. This short-term service is designed to assess immediate needs, develop intervention strategies, provide direct support, offer consultation, and build skills within existing support systems for individuals with a dual diagnosis who are struggling to achieve stability in daily life.

The County's 24-hour Emergency Response Plan, required by the Mental Health and Intellectual Disabilities Act of 1966, is maintained on file and can be provided upon request due to the inclusion of personal contact information.

Administrative Funding: ODP has engaged the PA Family Network to provide support and training in the community. The PA Family Network will be providing individuals who are person-centered trainers.

- Please describe the county's interaction with PA Family Network to utilize the network trainers with individuals, families, providers, and county staff.
- Please describe other strategies the county will utilize at the local level to provide discovery and navigation services (information, education, skill building) and connecting and networking services (peer support) for individuals and families.
- Please describe the kinds of support the county needs from ODP to accomplish the above.
- Please describe how the county will engage with the Health Care Quality Units (HCQUs) to improve the quality of life for individuals in the county's program. The function of the HCQUs is to enhance the health and wellness of individuals with an intellectual disability or autism through collaboration with providers, counties, Supports Coordinators/Targeted Support Managers and health care providers, as outlined in ODP Bulletin 00-18-03, Health Care Quality Units.
- Please describe how the county will use the data generated by the HCQU as part of the Quality Management Plan process.
- Please describe how the county will engage the local Independent Monitoring for Quality (IM4Q) Program to improve the quality of life for individuals and families. The IM4Q provides ODP with data on the quality of services to consumers, as required in the county's Administrative Entity Operating Agreement.

- Please describe how the county will support local providers to increase their competency and capacity to support individuals who present with higher levels of need related to aging, physical health, behavioral health, communication, and other reasons.
- Please describe how ODP can assist the county's support efforts of local providers.
- Please describe what risk management approaches the county will utilize to ensure a high quality of life for individuals and families.
- Please describe how the county will interact with individuals, families, providers, advocates and the community at large in relation to risk management activities.
- Please describe how ODP can assist the county in interacting with stakeholders in relation to risk management activities.
- Please describe how the county will utilize the county housing coordinator for people with autism and intellectual disabilities.
- Please describe how the county will engage providers of service in the development of an Emergency Preparedness Plan.

The Administrative Entity (AE) has a Mobile Community Nurse available daily to offer support to consumers, families, providers, and community members. The nurse offers resources, medical technician training, CPR and First Aid training, education on diabetes and other diagnoses, and provides medication administration, well-check visits, and other medically related services, as needed, to consumers in their homes, day programs, or community locations who have an IDD or a dual-diagnosis. This service has been in place for nearly two (2) years and has been beneficial in providing necessary medication oversight/administration, training of support staff, and general education to the community. During the 2025-2026 fiscal year, the Community Mobile Nurse served an average of 24 individuals/families in Franklin/Fulton counties per month.

As part of the Community of Practice Regional Collaborative, the PA Family Network serves as a stakeholder alongside the AE. The PA Family Network continues to host weekly Family Forums via Zoom, and the Regional Collaborative will maintain its focus on the priority areas previously identified. An IDD Program Specialist serves as the Franklin/Fulton Chair of the Regional Collaborative and is also a LifeCourse Ambassador. The Regional Collaborative Action Plan for FY 2026–2027 includes ongoing management of an online PADLET resource hub, maintained jointly by Franklin/Fulton IDD and two (2) parent advocates. This resource provides families, staff, providers, and supporters with access to information about trainings, activities, events, community engagement opportunities, health resources, and updates related to ODP and local services.

Both local SCOs use the LifeCourse framework and incorporate its tools throughout the Individual Support Plan (ISP) process to ensure person-centered planning. The Transition/Employment Council, together with the Regional Collaborative representative, meets throughout the school year to discuss educational changes, ODP service updates, employment opportunities, and networking efforts to support students and maintain strong communication for ongoing success.

The IDD program uses the vast experience of the Health Care Quality Units (HCQU). Trainings by the HCQU are held virtually, which allows individuals to participate in any scheduled training regardless of county of residence. They also provide individualized training as requested by providers and families. The Top Five Topics requested by individuals are Healthy Relationships/Boundaries, Healthy Nutrition, Internet/Social Media Safety, Effective Communication, and Recognizing Abuse. The Top Five Topics requested by Providers and Families are Medication Errors/Polypharmacy, Trauma-Informed Care, The Fatal Five, Behavioral De-escalation, and Compromised Skin Integrity. In FY 24/25, Franklin/Fulton

individuals and providers accessed 63 classroom trainings for a total of 240 people trained. In FY 25/26, Franklin/Fulton individuals and providers accessed 80 classroom trainings for a total of 267 persons trained (an 11% increase from the previous year).

The IDD program supports local providers by encouraging them to develop a relationship with the HCQU for trainings needed for their staff to support individuals with higher levels of need. The HCQU can also do biographical timelines, Consumer Data Collection (CDCs), medication/pharmacy reviews, and provide training. CDCs were being scheduled for all residential homes on a routine basis. Providers have been utilizing the Health Risk Screening Tool (HRST) to improve the quality of life for individuals.

The Risk Management Committee holds quarterly meetings to assess incidents to establish a higher quality of life for individuals. The Risk Management Committee realized that Individual to Individual (I-2-I) abuse was an issue that needed to be addressed. The QM Plan addresses the I-2-I abuse issue. The outcome, “People are abuse-free,” is measured by the objective of reducing the number of I-2-I abuse incidents by 5%. The number of incidents of I-2-I abuse will be measured through quarterly analysis of the Home and Community Services Information System (HCSIS) Incident Data, and the target trends to prevent future incidents will be analyzed by the Risk Management Team. The baseline data was one (1) incident of I-2-I abuse for 2023-2024. The 2024-2025 data showed two (2) incidents through June 2025 (a 100% increase from the baseline). For 2025-2026, there was one (1) incident of I-2-I abuse through June 2026, which was a 100% decrease. The Risk Management Committee will continue to monitor the data for trends and respond to providers accordingly.

The IDD Program partners with the County Housing Program to support the Independent Living Apartment Program, which serves individuals living in their own apartments who require fewer than 30 hours of support per week. Base funds are used to subsidize rent, allowing participants to live in safer, more affordable housing. There are currently 10 individuals enrolled in this program, although no individuals are from Fulton County.

For the 2023–2026 Quality Monitoring Plan, the Administrative Entity (AE) established two (2) new outcomes. The first aligns with the Information Sharing and Advisory Committee (ISAC) recommendation to advance racial equity. The Franklin/Fulton AE’s goal is to ensure equal access to supports and funding for all individuals, regardless of race. The objective focuses on collecting data on racial diversity in both counties and comparing it with the racial demographics of individuals enrolled in the IDD program.

The second outcome addresses the need for families to connect with one another and with supportive services. This aligns with the Front Porch initiative and centers on developing a family mailing list to distribute information about events, trainings, and community resources. Current data indicates that racial diversity within the IDD program is consistent with census representation. Both outcomes are reviewed by the Quality Management Specialist and adjusted as needed through the Plan–Do–Check–Act cycle. Progress toward the second outcome includes the creation of an online PADLET resource—updated weekly by IDD staff and parent advocates—to help families and individuals access information on services, trainings, and community events in Franklin and Fulton counties.

The new 2026–2029 Quality Monitoring Plan includes three goals.
Goal 1 is to collect and publish data from prevocational services providers (including licensed day habilitation and prevocational facilities) on the rate at which individuals transition to Competitive

Integrated Employment (CIE). The desired outcome is an increase in individuals receiving employment services that support the move to CIE, with a target of improving competitive employment rates by 20% by 2029.

Goal 2 is to ensure individuals are supported in achieving and maintaining optimal medical health. The outcome focuses on expanding the use of physical and behavioral health data to better understand health, wellness, and safety needs, and to inform ODP's planning efforts, including waiver development and HCQU and ASERT activities. The target objective includes increasing HCQU educational outreach and community nurse referrals to support the well-being of individuals in Franklin and Fulton counties.

Goal 3 is to ensure individuals are safe in their homes and communities, with an outcome focused on freedom from abuse. The target objective is to reduce the number of I-2-I abuse incidents by 5% by June 30, 2028.

The County engages providers by ensuring all Individual Support Plans (ISPs) include backup and emergency plans. The Franklin/Fulton AE continues to meet monthly with providers—an approach originally adopted during the pandemic but maintained due to its ongoing benefit. Through IM4Q feedback, the counties assembled emergency folders using information from the Department of Emergency Services and Ready.gov. Because the local Department of Emergency Services discontinued its prior notification forms, the AE, Crisis Intervention Team, and Regional Collaborative are exploring alternative ways to notify first responders that a person with a disability resides in a home. This work is ongoing and will continue to be developed and implemented.

Participant Directed Services (PDS):

- Please describe how the county will promote PDS (AWC, VF/EA) including challenges and solutions.
- Please describe how the county will support the provision of training to SCOs, individuals and families on self-direction.
- Are there ways that ODP can assist the county in promoting or increasing self-direction?

Fulton County currently has no individuals or their families using VF/EA services. These families receive assistance from a Support Broker to help navigate and manage self-directed services. Because this process is still relatively new in the counties, Supports Coordinators check in with families regularly. When VF/EA is explained, many families choose Agency With Choice (AWC) if they prefer a self-direction model. Fulton County currently has two (2) families using AWC services. Both VF/EA and AWC supports are funded entirely through ODP waiver funding. The County provides training for families through the Arc of Franklin/Fulton Counties, the AWC provider, as well as through the HCQU.

The primary challenges for AWC remain difficulty in recruiting staff, particularly in rural areas. Contributing factors include low wages, limited transportation options, geographic distance from service providers, and families' limited familiarity with the IDD system or changes in service definitions. Families also report feeling overwhelmed by the required documentation and training. Support from ODP could help identify creative solutions to these challenges and offer additional training opportunities for families using AWC.

Community for All: ODP has provided the county with the data regarding the number of individuals receiving services in congregate settings.

- Please describe how the county will enable individuals in congregate settings to return to the community.

Franklin/Fulton Counties currently have six (6) individuals living in congregate settings. One (1) individual resides in a State Center and has been offered the opportunity to move into the community; however, he has expressed that he is satisfied with his current home and does not wish to relocate. Two (2) individuals previously lived in a private ICF/ID and transitioned to 6400-licensed community homes during FY 2025–2026. The remaining four (4) individuals reside in nursing facilities. No Fulton county residents use waiver-funded assistive technology or waiver-funded remote supports.

The exception is a woman who is younger than typical nursing home residents but repeatedly declines suitable residential options that have been offered. Although she has been determined to require long-term care by ODP, she continues to refuse alternative placements. The Supports Coordinator will continue to discuss and encourage consideration of more appropriate residential options with her.

Technology: ODP supports the use of assistive technology and remote supports in order for individuals to achieve their goals and live more independently.

- Please describe how the county will enable individuals to access technology as a means to support greater independence.

Many individuals in Franklin/Fulton Counties use various forms of assistive technology, and the Administrative Entity (AE) actively encourages its use whenever appropriate. The AE has met with remote support providers to learn more about available technologies and services that could benefit individuals. At present, no Fulton County individuals use waiver-funded assistive technology or other waiver-funded remote supports.

HOMELESS ASSISTANCE PROGRAM SERVICES

DHS encourages Homeless Assistance Program (HAP) partners to participate in their Continuum of Care (CoC). Continuums of Care are regional or local planning bodies that coordinate housing and services funding for families and individuals experiencing homelessness. Please describe the continuum of services to individuals and families within the county who are experiencing homelessness or facing eviction. An individual or family is facing eviction if they have received either written or verbal notification from the landlord that they will lose their housing unless some type of payment is received.

Bridge Housing Services:

- Please describe the bridge housing services offered. Include achievements and improvements in services to families at risk or experiencing homelessness, as well as unmet needs and gaps.

- How does the county evaluate the efficacy of bridge housing services? Please provide a brief summary of bridge housing services results.
- Please describe any proposed changes to bridge housing services for FY 26-27.
- If bridge housing services are not offered, please provide an explanation of why services are not offered.

Bridge Housing Services are not offered in Fulton County due to the limited availability of funding.

Case Management:

- Please describe the case management services offered. Include achievements and improvements in services to families at risk or experiencing homelessness, as well as unmet needs and gaps.
- How does the county evaluate the efficacy of case management services? Please provide a brief summary of case management services results.
- Please describe any proposed changes to case management services for FY 26-27.
- If case management services are not offered, please provide an explanation of why services are not offered.

Case Management services will be provided by the Center for Community Action for a total allocation of $8,779. HAP Case Management is the component for coordination of all the activities needed by the client from the service provider agency and other community resources to achieve the goal of self-sufficiency. Case Management involves the establishment of the on-going client/caseworker relationship. Case Management services are available to all clients applying for the Homeless Assistance Program (HAP). As a prerequisite to receiving rental and utility assistance, clients are required to participate in Case Management services.

Individuals who are seeking any type of housing assistance and appear to qualify for Homeless Assistance are required to complete a formal intake interview conducted by the Housing Intake Specialist, as soon as it can be arranged. The Housing Intake Specialist determines whether the client meets HAP requirements for eligibility, documents the reason(s) for needing services, identifies other services the client may benefit from, and checks to see if the client has received any financial assistance from the HAP program in the past 24 months, which all data from previous years is in the Homeless Management information System (HMIS), which allows for case managers to quickly see if the consumer is eligible for assistance. The Housing Intake Specialist makes every effort to interview the applicant on the next available business day.

The client’s role in HAP is a voluntary one, however, once the client receives HAP assistance; they are required to participate in at least one Financial Literacy workshop. Once clients complete the written intake process and their housing need (s) are identified, a written Housing Service Plan is completed by the client with the assistance of the Housing Intake Specialist. The Housing Service Plan establishes expected client outcomes and is signed by the client. Copies of pertinent written forms such as Intake, Housing Service Plan, consent to Release Information, Legal Rights to appeal, etc. are issued to the client during this meeting. The Housing Intake Specialist reviews the Housing Service Plan and updates the plan when necessary, in order to insure applicants are successfully networked into appropriate community and supportive services and are eventually able to obtain the services needed to maintain their housing. The Housing Service Plan utilizes the Arizona Self- Sufficiency Matrix, in order to see where the client needs to improve upon in order to reach Self- Sufficiency.

The involvement of a network of community referral resources is imperative in assisting clients toward attaining housing stability. Clients are referred to any number of resources as deemed necessary throughout their program participation. Most direct coordination of services between the Housing Intake Specialist and significant community agencies occur when the client is present and able to participate. All referrals are documented in the client file and a warm-handoff to providers is the preferred referral process.

Following the intake and Housing Service Plan reviews, all meetings between clients and the Housing Intake Specialist take place based on household need (s) and are documented in the case notes. Case notes are maintained to track client progress and are in the individual client files, and also placed in the house data base system CAP 60.

The Housing Intake Specialist contacts the landlords to verify their willingness to rent to the client. Clients are first referred to the Fulton County Assistance Office to see if that agency can be a source of assistance. If the client is a TANF client and/or receives cash, the County Assistance Office will make the determination of whether and by what amount that agency will assist. Clients who have been approved for Emergency Housing Assistance through the County Assistance Office will be referred to HAP to determine eligibility. In most cases, clients will be eligible for the balance of funds the Assistance Office does not provide.

Eligibility is determined once a supervisor approves the file. The Housing Intake Specialist provides the client with a written decision approving or denying the request for assistance.

When a client is determined eligible for HAP assistance, the Housing Intake Specialist contacts the landlord regarding payment of rent and/or security deposit. Prior to any financial assistance, the Housing Intake Specialist will inspect the housing unit to assure it meets habitability standards. The client signs a Service Plan and agrees to notify the Housing Intake Specialist of any changes. The landlord signs an agreement to accept HAP funding. Follow-up contact is made at the end of 60 days.

The Housing Intake Specialist verifies homelessness and/or near homelessness, the amount necessary to resolve the crisis, the landlord’s agreement to rent and follow-up with written documentation.

Homeless Assistance Program Case Management services include, but are not limited to the following:

- Intake and assessment for individuals and families who need supportive services
- Assessing service needs, eligibility, and availability
- Preparation and review of written service plans, with measurable objectives and expected client outcomes, developed in cooperation with and signed by the client
- Coordination services of clients and referrals for the provision of necessary supportive services
- Providing support to ensure the satisfactory delivery of requested services and support for homeless or near homeless families in search of permanent housing
- Establishing linkages on behalf of homeless children with local school districts, housing authorities and local housing programs for low income housing opportunities
- Housing inspection to assure the client is in a habitable rental unit
- Follow-up to evaluate the effectiveness of services and outcomes
- Maintaining client confidentiality

Case Management Sessions are entered into the in-house data base called CAP60. Within this system, case managers log case notes and goals that the clients set, along with the financial literacy attendance. Each meeting consists of reviewing goals and the progress that has been made towards the goals are discussed. Once the client is exited from case management, the case manager will then follow up with the client sixty days and ninety days from the closed date to see how the client is and if any additional assistance is needed at that time. Case Managers also use the data base HMIS (Homeless Management Information System). This is a great way for case managers to record data such as income, place staying when entering program, mainstream benefits, and health concerns. This same information is recorded when exiting the program. Human Service Director will also use this information to gauge if successful case management has been completed by evaluating if additional income has been achieved, mainstream benefits are there, and if a stable residence has come from the case management. There are also end of the year reports that can be pulled out of the HMIS system to make reporting less cumbersome at the end of the fiscal year for HAP.

Upon completion of case management within the program, the Center for Community Action Human Services Director will review the amount of case management sessions the clients had with case managers, and what the outcomes were of these sessions. The CCA Human Service Director will also pull quarterly reports from the HMIS database to see if clients are progressing while enrolled in the program. If there is no progression being shown, the Director will discuss the lack of progress with the case managers and send case managers to additional training, such as motivational interviewing.

For FY 26-27 There are no programmatic changes being made to the HAP case management plan.

Rental Assistance:

- Please describe the rental assistance services offered. Include achievements and improvements in services to families experiencing or at risk for homelessness, as well as unmet needs and gaps.
- How does the county evaluate the efficacy of rental assistance services? Please provide a brief summary of rental assistance services results.
- Please describe any proposed changes to rental assistance services for FY 26-27.
- If rental assistance services are not offered, please provide an explanation of why services are not offered.

Futon County’s Rental Assistance program is administered by Center for Community Action (CCA). The total funding proposed for FY 26-27 is $20,500. CCA has an office in Fulton County which is open daily and is able to provide services to consumers in Fulton County.

Rental Assistance is the payment for rent, security deposit and/or utilities made on behalf of clients to prevent and/or end homelessness or near homelessness by maintaining clients in their own residences and, as appropriate, case management services. Utility payments will be made on behalf of client not eligible for payment from the Department of Human Service’s Low-Income Home Energy Assistance Program (LIHEAP), when LIHEAP funds are not available, or when all LIHEAP funds have been exhausted. Rental assistance includes assistance to prevent homelessness or near homelessness by intervening where an eviction is imminent. The program is also used to expedite the movement of individuals out of shelters into existing housing.

Rental Assistance is provided to those applicants who are near homeless or homeless county residents, are eighteen (18) years of age or older and meet HAP requirements. An individual

seventeen (17) years of age and younger who is married, separated from a spouse, or has children is considered an emancipated minor and is able to receive services.

HAP Rental Assistance funds are used for the following:

- first month's rental payment
- one-time security deposit
- no more than three current months rental arrearage and only when any balance has been paid
- the lesser of three current months utility arrearage or the amount on the shutoff notice and only when any balance has been paid
- utility connection/hook-up
- trailer lot rental payment
- heating oil assistance

The only substantial programmatic update being made is to the Homeless Assistance Program (HAP) is that instead of implanting the previous $1,000 for an adult only household, or $1,500.00 for households with children, The HAP provider will now utilize the Fair Market Rent (FMR)/ Metropolitan Statistical Area (MSA) x 150 percent 2026 Fair Market Rent. This will provide additional rental assistance to households due to the increased rent amounts that have followed since the pandemic.
Returning clients, within the twenty-four (24) months, will receive intensive case management. The client will be referred to other services in an effort to cease repetition as needed, i.e. CareerLink (for job training and job search), Drug and Alcohol (for D&A assessment), and budget counseling and money management courses.

The Housing Intake Specialist will establish written agreements with all clients receiving assistance which describe the client's obligation in the service plan and the distribution of the rental and utility assistance payments. All payments are made directly to the landlord and/or utility vendor. Under no circumstances do clients receive direct payment.

When determining client eligibility, the agency does not ascertain whether or not the client has received assistance from another county in the past twenty-four (24) months.

Fulton County's HAP services, the bulk of which is dedicated to Rental Assistance Funds is regularly monitored by both the Human Services Block Grant Committee and the Fulton County Housing Committee. Fulton County's Section 8 housing is managed by the Huntingdon County Housing Authority. Fulton County effectively manages consumers and finds outside resources (homeless shelters, etc.) for the homeless or near homeless. The block grant has assisted with providing extra funding for our program through reallocation of unspent funds from other categories in previous years. Within the Block Grant if any additional funding is available the housing committee is able to allocate additional funds as needed, to avoid a wait list for housing services. Housing continues to be a need within Fulton County, as rents had drastically increased during COVID and have continued to increase with the cost of living.

Center for Community Action (CCA) actively participates in the Eastern PA Continuum of Care (COC) which encompasses thirty-three counties. Director of Human Services for CCA chairs the South Central Regional Homeless Advisory Board (RHAB) which consists of 9 counties (Centre, Cambria, Blair, Huntingdon, Somerset, Huntingdon, Bedford, Fulton, Franklin, and Adams) and actively sits on the Eastern PA COC Board as the chair. The mission of the Eastern PA COC is to

end and prevent homelessness. CCA actively holds a Continuum of Care (COC) Grant that covers Fulton County- to be eligible for assistance households must fall into either Category 1 or Category 4 of HUDs Homeless definitions

Fulton County has an active Housing Committee. It meets three to four times a year. The meetings were held: August 22, 2024; November 21, 2024; February 13, 2025; and May 20, 2025 (in conjunction with the Fulton County Partner meeting). There are various committee members with approximately 15 regular attendees and they are representative of:
Consumers, Human Services Administration, Fulton County Charity Committee (former Catholic Mission), Area Agency on Aging, Center for Community Action, Fulton County Family Partnership, Fulton County Commissioners, Fulton County CDBG/Fair Housing, Fulton County Medical Center, Cardinal Glen Apartments (low-income), Mountain View apartments (elderly), Huntingdon County Housing Authority (HUD Voucher program), Fulton County Planning, Veterans Housing Representative, Fulton County Food Basket, Center for Independent Living, local landlords, Franklin/Fulton MH/ID.

Emergency Shelter:

- Please describe the emergency shelter services offered. Include achievements and improvements in services to families at risk or experiencing homelessness, as well as unmet needs and gaps.
- How does the county evaluate the efficacy of emergency shelter services? Please provide a brief summary of emergency shelter services results.
- Please describe any proposed changes to emergency shelter services for FY 26-27.
- If emergency shelter services are not offered, please provide an explanation of why services are not offered.

Emergency Shelter service are not provided due to limited funding and the lack of hotels in the county.

Innovative Supportive Housing Services:

- Please describe the other housing supports services offered. Include achievements and improvements in services to families experiencing or at risk for homelessness, as well as unmet needs and gaps.
- How does the county evaluate the efficacy of other housing supports services? Please provide a brief summary of other housing supports services results.
- Please describe any proposed changes to other housing supports services for FY 26-27.
- If other housing supports services are not offered, please provide an explanation of why services are not offered.

An Innovative Supportive Housing Service that Center for Community Action would like to continue into FY 26-27 is called New Beginnings Baskets. Center for Community Action is proposing to place $2,000.00 into this project, which will be anticipated to serve approximately eight homeless families, at approximately two hundred and fifty dollars a basket. These baskets will include but not be limited to the following: bath towels, dish towels, wash clothes, small crock pots, dishes, pots and pans, utensils such as silverware and cooking utensils, can openers, broom and dustpan, cleaning supplies, etc. These items are basic household items that many homeless families do usually not have when moving into a new home and are needed for the basic needs such as cooking, bathing, and cleaning. Center for

Community Action does not currently have any other funding streams that allow for this type of item to be purchased for households and finds that it is a critical need for homeless families. Case managers will check consumer eligibility for New Beginnings Baskets to ensure families are eligible under HAP guidelines. These baskets were a great addition last year to families that were moving into Housing Units. Consumers continue to be very thankful for these baskets and help them get started in their new housing unit.

Homeless Management Information Systems:

DHS encourages counties and HAP partners to participate in their Continuum of Care (CoC) and for eligible providers to collect and track client-level data and services in their CoC's Homeless Management Information System (HMIS). HMIS tracks and analyzes the characteristics and service needs of people at-risk or experiencing homelessness.

Please describe the county's utilization of HMIS to include how HAP providers enter data and enrollments into HMIS for any or all components of the program.

- If the HAP provider does not utilize HMIS, describe how the provider collects client-level data and data on the provision of housing services. Is this data provided to the CoC that coordinates housing and services funding for families and individuals experiencing homelessness?

- Describe any change the county has identified in the service needs of families or individuals experiencing homelessness over the past program year.

Fulton County has actively participated in HMIS, entering data from existing programs: Two Supporting Housing Programs and one Shelter Plus Care Program. Because Fulton County operates the Homeless Assistance Program locally, it is Franklin County and the Bedford/Huntingdon/Fulton Center for Community Action who utilizes HMIS and enters data for Fulton County. Data for the county's Homeless Assistance is now being entered in HMIS by the Center for Community Action agency. In Franklin County, PAHMIS is used for three HUD funded programs, which total 30 independent apartments. Of those 30 apartments, three apartments can be located in Fulton County. Currently one Fulton County apartment is occupied with the potential of adding up to two additional apartments should the need arise for someone who meets the established criteria.

Center for Community action provides the Homeless Management Information System (HMIS) for Homeless Assistance Program. All HAP clients are entered and tracked using HMIS. Clients are also entered into the CAP 60 in house database which tracks the programs and services the client receives in CCA. Both systems track the client/household from intake to exit. The reports pulled from the system included: number of individuals/households that received an intake, case management, financial assistance, financial literacy, programs client was enrolled into, length of stay in the program, did the client exit into permanent housing, and did the income in the household increase upon exit. The reports are evaluated on a quarterly basis to identify success, trends, gaps in services, and numbers served in each service. The year-end reports are also compared to previous years for trend analysis.

HUMAN SERVICES AND SUPPORTS/ HUMAN SERVICES DEVELOPMENT FUND (HSDF)

Please use the fields and dropdowns to describe how the county intends to utilize HSDF funds on allowable expenditures for the following categories. (Please refer to the HSDF Instructions and Requirements for more detail.)

Dropdown menu may be viewed by clicking on "Please choose an item." Under each service category.

Copy and paste the template for each service offered under each categorical, ensuring each service aligns with the service category when utilizing Adult, Aging, Children and Youth, or Generic Services.

***Adult Services**: Please provide the following:*
Program Name: Fulton County Family Partnership supplemental transportation
Description of Services:
The Family Partnership only provides supplemental transportation for those individuals (only a small number – adult category) who do not qualify for other forms of transportation available such as MATP, Welfare to Work or Shared Ride. For example, transportation would be provided to an individual who does not have access to a vehicle and needs to go to a medical appointment, but does not qualify for other types of transportation services listed above. If not funded, these transportation services would not be available
Service Category: Transportation - Activities which enable individuals to travel to and from community facilities to receive social and medical service, or otherwise promote independent living. The service is provided only if there are no other appropriate resources.

Aging Services: Please provide the following:
Program Name: Fulton County Family Partnership supplemental transportation
Description of Services:
The Family Partnership only provides supplemental transportation for those individuals (only a small number – aging catgegory) who do not qualify for other forms of transportation available such as MATP or Shared Ride. For example, transportation would be provided to an individual who does not have access to a vehicle and needs to go to a medical appointment, but that appointment is located outside of the Shared Ride Service Area. If not funded, these transportation services would not be available.
Service Category: Transportation (Passenger) - Activities which enable individuals to travel to and from community facilities to receive social and medical service, or otherwise promote independent living.

Children and Youth Services: Please provide the following:
Program Name:
Description of Services:
Service Category: Please choose an item.

Generic Services: Please provide the following:
Program Name:
Description of Services:
Service Category: Please choose an item.
Please indicate which client populations will be served (must select at least **two**):
☐ Adult ☐ Aging ☐ CYS ☐ SUD ☐ MH ☐ ID ☐ HAP

Specialized Services: Please provide the following: (Limit 1 paragraph per service description)
Program Name: Literacy Services, Center for Community Action

Description of Services:
Center for Community Action has an office in McConnellsburg and a HiSET instructor who provides adult literacy and/or HiSET instruction. The office is staffed daily. HiSET instruction is given to those

individuals who test as HiSET Prep ready. Individuals receive grade-level training to prepare them to take and pass the HiSET test. The instructor also coordinates with the Fulton County Library to continue with the literacy council and to provide remediation when needed. Consumers are given the TABE test to show grade level and to identify a starting point to create lesson plans. HiSET practice tests are given to all individuals prior to registering them for the actual test. This is an indicator of how ready for the test the individuals may be. When individuals are deemed ready, the HiSET instructor will assist them with registering to take the test. Funds will be budgeted to assist the low-income individuals with the cost of the HiSET exam. The cost of the exam is $120 and can be a hardship to anyone wishing to take the test.

Interagency Coordination: (Limit of 1 page)
If the county utilizes funds for Interagency Coordination, please describe how the funding will be utilized by the county for planning and management activities designed to improve the effectiveness of categorical county human services. The narrative should explain both:

- how the funds will be spent (e.g., salaries, paying for needs assessments, and other allowable costs).
- how the activities will impact and improve the human services delivery system.

Fulton County traditionally uses interagency coordination funds to support Fulton County Family Partnership, Inc. which is a non-profit 501(c)3 agency that coordinates human services planning for the county. The funds are used to set up meetings, secure venues and coordinate planning among agencies providing human services. Funds are also used for needs assessments, resource directories, consumer satisfaction surveys, etc. Fulton County's resource directory is transitioning from a county resource to utilize statewide services. FCFP is working with it's partners this year to transition to its resource directory to PA 211 and PA Navigate larger platforms. FCFP operates a Human Services Collaborative facilitated by the Community Mobilizer. The collaborative has approximately 60 members with approximately 30-40 attending regular monthly meetings.

The Family Partnership has always worked closely with Fulton County's Human Services Administration to facilitate collaboration and planning. In 2019, the Fulton County Commissioners entered into a 5 year contract with Fulton County Family Partnership for the Executive Development Director to serve as Human Services Director. This was renewed in 2024 for another 5 years. This encompasses approximately 50%+ of a full time position. As such, the HSD provides oversight to Human Services contracts and requirements as well as maintains the human services planning activities that previously occurred within the block grant funds. This year funding will also be used for: a portion of the Family Partnership director's salary as it pertains to planning, coordination, and a portion of the Family Partnership's Community Mobilizer salary as it pertains to planning and coordination of block grant or block grant-related activities. Block grant funds are used for 3% of the director's salary and 40% of the community mobilizer salary. NOTE: Both positions are full-time, but are funded by other funding streams to cover their activities that are not directly block-grant related. Job descriptions are attached as **Appendix G**

The Family Partnership is the Communities That Care site for Fulton County. In this capacity, they assist with the administration of the PA Youth Survey. The Community Mobilizer pulls together a committee to review and analyze the results of the PAYS. The initial analysis of the 2025 PAYS occurred in June of 2026. The Community Mobilizer is facilitating a workgroup to address the challenge areas identified in the 2025 PAYS. In the fall, the Community Mobilizer along with the PAYS workgroup will complete

completed a final report and work plan for the next 2-3 years based on the PAYS Goals. This assists with planning and evidence-based programming for county human services.

FCFP collaborates with the Fulton County Medical Center on their Community Health Needs Assessment (CHNA). This process occurs every three years the Assessment was completed in November of 2025. Primary and secondary data gathering will occur over the summer along with focus groups and key community leader interviews. Data analysis and prioritizations will be the focus of the process during the late fall. In the fall of 2025, the plan with goals and objectives was mapped for the community health and human services for the next 3-5 years. The Family Partnership has grown the process since the initial CHNA in 2013. The focus has shifted from primarily health outcomes to broader human service and community needs. The result will be that human services will have an updated Needs Assessment, which will be used to drive our planning efforts for all our human services agencies as well as for the Block Grant. Priorities in areas of Food Insecurity, Housing and Behavioral Health have been identified. The group is working on goals and objectives to work on in those areas for the next 3 years.

In the summer of 2023, the Community Mobilizer started the planning process for a recovery to workforce initiative. This brings together the SUD recovery community, local employers, adult education and the justice system with a goal of programming to support gaining and sustaining meaningful employment for those in SUD recovery. This is partially funded through Opioid Settlement funds but will also be leveraged with Interagency Coordination funding used to support the Mobilizer position. This resulted in the submission of two workforce and recovery related grants to the Appalachian Regional Commission and Health Resources Services Administration in the spring of 2024. This grant was funded and work started in late 2024. The services have grown in 2025-26. The Mobilizer focuses on working with employers to have a recovery supported place of employment.

APPENDIX E - proof of publication

PROOF OF PUBLICATION

STATE OF PENNSYLVANIA, COUNTY OF FULTON, ss:

_____, being duly sworn, deposes and says: that The Fulton County News was established in 1899, that it is a weekly newspaper of general circulation, published weekly, as defined by the Act of Assembly approved May 16, 1929, P.L. 1929, page 784, and that its place of business is McConnellsburg Borough, Fulton County, Pennsylvania, and that the attached printed notice is a copy of the legal advertisement, exactly as printed in the said publication in its issue of 6-25-26, 7-2-26, 7-9-26.

That the affiant is not interested in the subject matter of the advertisement or advertising and that I, Heath H. Himes, am the publisher of The Fulton County News and that all allegations of the statement as to the time, place and character of publication are true.

Heath H. Himes

Sworn to and subscribed before me this 13th day of July, A.D., 20 26

Laurel M. Grimes

My commission expires My Commission Expires January 01. 2030

NOTICE

The Fulton County Commissioners will hold two public hearings on the planned use of 2026-2027 Human Services Block Grant funds in Fulton County. The first hearing will be held on Tuesday, July 7, 2026, at 9:00 a.m. This will be during the regular Fulton County Commissioner meeting. The July 7 meeting will be in-person only at the Fulton County Commissioners Office located at 101 Lincoln Way West, McConnellsburg, PA 17233.

The second hearing will be held on Tuesday, July 14, at noon. This meeting will be in conjunction with the Partner Meeting of the Fulton County Family Partnership. The July 14 meeting will be virtual only via Microsoft Teams. Individuals can access the Teams Meeting meeting using Meeting ID: 285 943 396 492 138 Passcode: HD2Uh6UA.

The block grant consists of five funding streams and allows counties the flexibility to decide where the money is needed most. Those funding streams are; Mental Health Community Programs; Intellectual Disabilities, Community Base; Homeless Assistance Program; Act 152 (Drug & Alcohol) Behavioral Health Services Initiative, and Human Services Development Fund.

Draft plan documents will be available at the public meetings and electronically upon request. Questions and comments, both written and/or oral, are invited and welcomed. Also, if you are unable to attend either hearing or wish to make oral comments or questions, you may make special arrangements by calling Julia Dovey at 717-485-6767.

County of Fulton,
Board of Commissioners Randy H. Bunch, Chair
Steven L. Wible, Vice-Chair
Hervey P. Hann
6-25-3x

APPENDIX F
PUBLIC HEARINGS
ATTENDANCE AND MEETING NOTES

Summary of Public Hearing Comments:

FIRST PUBLIC HEARING - Tuesday, July 7, 2026 at 9:00 a.m. in person at the Fulton County Commissioners office

12 in attendance (Attendance sheet attached)

An overview of the plan for presentation on the Block Grant programming and funding for FY26-27, was given by Julia Dovey, Fulton County Human Services Director. Each program administrator reviewed the highlights and initiatives planned for this year. The members reviewed the proposed allocations. Those in attendance were given the opportunity to ask questions and/or give comments.

Cori Seilhamer, Franklin Fulton Mental Health Program Specialist discussed the program highlights and new initiatives for next year in Mental Health. This focused on building the crisis system for Substance Abuse and Mental Health.

Erin Nye, shared IDD services offered. HSBG services for IDD are available for those without the waiver. Program Highlights included supported employment and quality management plan.

James Eagler, Franklin Fulton D&A Administrator, reviewed the substance use disorder services available through the block grant and discussed expanding access to medication-assisted treatment- MAT., recovery resources, Naloxone distributions, medications for AUD and OSAL presentation.

Julia Dovey, Fulton County Human Services Director reviewed the proposed homeless assistance programs. She shared about the supply baskets for homeless families. Julia went through the allocation of Human Services Development funds for service coordination, literacy, GED testing and transportation initiatives.

Commissioner Hervey Hann had the following questions about the allotment of funds:

- Does Fulton County get a percentage of the funds? – It was explained that these funds are 100% Fulton and not shared with Franklin, though Franklin operates the programs(s).
- Is the Intellectual and Developmental Disabilities program the area of least certainty, the area of most flexibility? – It was discussed that historically, the IDD program has been where Fulton has funds available to reallocate. This is because most eligible individuals are covered through waiver programs.

APPENDIX F
PUBLIC HEARINGS
ATTENDANCE AND MEETING NOTES

Attendance Sheet

Name	Representing
Bunch, Randy	County Commissioner
Dovey, Julia	Fulton Co. Human Services
Eagler, James	Franklin/Fulton Drug & Alcohol
Hann, Hervey	County Commissioner
Miller, Dan	Fulton County Probation
Nye, Erin	Franklin/Fulton MH/ID
Cori Seilhamer	Franklin/Fulton MH/ID
Sharer, Tiea	Fulton Co. Family Partnership
Shives, Stacey	Fulton Co. Chief Clerk
Wible, Steven	County Comissioner
Reed, Sue	Fultion Co. Fiscal
Boyd, Justice	Fulton Co. Family Partnership

APPENDIX F
PUBLIC HEARINGS
ATTENDANCE AND MEETING NOTES

Summary of Public Hearing Comments:

SECOND PUBLIC HEARING - Tuesday, July 14 at 12:00 p.m. via Zoom Video only

28 in attendance (Attendance sheet attached)

An overview of the plan for presentation on the Block Grant programming and funding for FY26-27, was given by Julia Dovey, Fulton County Human Services Director. Each program administrator reviewed the highlights and initiatives planned for this year. The members reviewed the proposed allocations.Those in attendance were given the opportunity to ask questions and/or give comments.

Cori Seilhamer, Franklin Fulton Mental Health Program Specialist discussed the program highlights and new initiatives for next year in Mental Health. This focused on building the crisis system for Substance Abuse and Mental Health.

Stacey Brookens, Franklin Fulton IDD Program Specialist, shared IDD services offered. HSBG services for IDD are available for those without the waiver. Program Highlights included supported employment and quality management plan.

Julia Dovey, Fulton County Human Services Director, reviewed the substance use disorder services available through the block grant and discussed expanding access to medication-assisted treatment- MAT., recovery resources, Naloxone distributions and OSAL presentation.

Julia Dovey, Fulton County Human Services Director, reviewed the proposed homeless assistance programs. Julia Dovey, Fulton County Human Services Director, went through the allocation of Human Services Development funds for service coordination, literacy and transportation initiatives.

There were no public comments regarding the proposed block grant plan.

APPENDIX F
PUBLIC HEARINGS
ATTENDANCE AND MEETING NOTES

SECOND PUBLIC HEARING ON 26-27 BLOCK GRANT
Tuesday, July 14, 2026 at 12:00 PM
Via Microsoft Teams Video
ATTENDANCE – 28

NAME	REPRESENTING
Bowers, Leslie	Fulton County Drug and Alcohol
Boyd, Justice	Fulton County Family Partnership
Brookens, Stacey	Franklin/Fulton Mental Health Intellectual & Developmental Disabilities/EI
Carbaugh, Amanda	Franklin/Fulton Drug and Alcohol
Decker, Kara	TrueNorth Wellness Services
Dovey, Julia	Fulton County Human Service Admin
Fischer, Renee	Fulton County Family Partnership
Flood, Danielle	Fulton County Assistance Office
Gantz, Zachary	Franklin County IDD Fiscal Officer
Gannon, Brian	Perform Care
Glenn, Erin	TrueNorth Wellness Services
Graham, Scott	Mental Health Association

APPENDIX F
PUBLIC HEARINGS
ATTENDANCE AND MEETING NOTES

Hann, Mary	Fulton County Probation
Heidi, Lucas	Franklin/Fulton Mental Health Intellectual & Developmental Disabilities/EI
Hollis, Laurie	Allegheny Lutheran Social Ministries
Johnston, Karen	Healthy Communities Partnership
Lafferty, Linda	Fulton County Medical Center
Leese, April	Fulton County Library
Lucas, Kim	AmeriHealth Caritas
Masters, Melissa	Center for Community Action
McCartney, Ashley	Franklin Fulton Mental Health Fiscal
McQuade, Christine	Fulton County Services for Children
Nye, Erin	Franklin/Fulton Mental Health Intellectual & Developmental Disabilities/EI
Peterson, Shannon	Franklin Fulton Drug and Alcohol
Seilhamer, Cori	Franklin/Fulton Mental Health Intellectual & Developmental Disabilities/EI
Raley, Cheyenne	Peerstar

APPENDIX F
PUBLIC HEARINGS
ATTENDANCE AND MEETING NOTES

Sharer, Tia	Fulton County Family Partnership
Strueber, Nancy	Franklin/Fulton Mental Health Intellectual & Developmental Disabilities/EI
Truax, Amanda	Center for Community Action

APPENDIX G - HSDF Job Descriptions

TITLE: Executive Development Director

SUPERVISION: BOARD OF DIRECTORS

Position Classification: Full-Time - Exempt Employee - Salary

JOB SUMMARY:
The Executive Development Director shares responsibility as Administrators of the Fulton County Family Partnership with Executive Program Director. Together, the Board, Executive Development Director and the Executive Program Director assure Fulton County Family Partnership's relevance to the community, the accomplishment of the organization's mission and vision, and the accountability of Fulton County Family Partnership to its diverse constituents.

The Board delegates responsibility for the management and day-to day operations of the organization to the Executive Development Director and Executive Program Director who have authority to carry out these responsibilities, in accordance with the direction and policies established by the Board.

The Executive Development Director and Executive Program Director provide direction and assist the Board as it carries out its governance functions.

Duties performed include but are not limited to the following:

1. **Planning and Setting Objectives**
    - Oversee and manage the financial performance and human resource functions of the organization to ensure sustainability of operations.
    - Oversee and manage the community collaborative portion of the agency which is responsible for planning and management activities designed to improve the effectiveness of county human services. Including oversight of the Community Mobilizer position responsible for human services planning.
    - Implement fiscal management and control systems to assure that the Board has appropriate and adequate information to meet its fiduciary responsibilities.
    - Direct the development of program financial plans and budgets including all operating costs, in-kind, capital and extraordinary expenditures.
    - Submit or cause to be submitted to Board of Directors an annual budget showing in detail anticipated revenues and expenditures.
    - Pursue additional grant and funding opportunities consistent with the mission and in order to expand capacity to meet the needs of the community and to increase the financial sustainability of organization.
    - Facilitate the development and implementation of an overall strategic plan. Ensure that the goals and objectives presented in grant proposals and business plan are consistent with the aims of the long-term strategic plan. Develop organizational policies and direct activities to ensure objectives are met.
    - Prepare information to be considered by Board on the determination of policy and ensure compliance with federal and state regulations.
    - Maintain strict confidentiality as legally defined and in accordance with policy.

2. Organizing, Evaluating and Monitoring

- Provide monthly comparisons of actual results of operations to the budget and recommend any changes as required.
- Monitor budget expenditures and prepare as needed budget revisions.

- Prepare and assist in annual audit. Work to resolve audit exceptions and implement management recommendations.
- Maintain inventory and property records.
- Serve as the primary liaison with funding agency regarding fiscal issues. Ensure that all required fiscal reporting requirements are met in full.
- Establish administrative policies and procedures that assure efficient program operations and compliance with all contractual terms, conditions and obligations.

3. Motivating and Communicating

- Serve as liaison between the organization, grantee programs, and community agenda.
- Create an atmosphere where upward communication is valued and encouraged.
- Promote good public relations by serving on boards and committees, participating in community activities, and speaking to church or civic groups about organization as requested.
- Serve as advocate for organization.

4. Personnel Management

- Administer personnel policies, benefits, and procedures as established by Board.
- Keep personnel informed of pertinent policies and procedures affecting the department and/or their jobs.
- Ensure compliance with all federal and state laws concerning hiring and promotion.
- Coordinate staff recruitment and retention.
- Review and make recommendations on personnel actions such as employment, salary review, retention, promotion, suspension, discipline, and termination.
- Be responsible and accountable to the Board of Directors, keeping them informed of pertinent matters relating to operations.

Qualifications/Specific Requirements:

The Executive Program Director will be thoroughly committed to Fulton County Family Partnership's mission. All candidates should have proven leadership, coaching and relationship management experience. Concrete demonstrable experience and other qualifications include:

- Bachelor's degree in related field and/or at least 10 years of senior management experience
- Track record of effectively leading an outcomes-based organization and staff
- Unwavering commitment to quality programs and data-driven program evaluation
- Excellence in organizational management with the ability to coach staff, manage, and develop high-performance teams, set and achieve strategic objectives, and manage a budget.
- Past success working with a board of directors with the ability to cultivate board member relationships
- Strong marketing, public relations, and fundraising experience with the ability to engage a wide range of stakeholders and cultures
- Strong written and verbal communication skills
- Action-oriented, entrepreneurial, adaptable, and innovative approach to business planning.
- Passion, idealism, integrity, positive attitude, mission-driven, and self-directed
- Able to read, write and speak English in an understandable manner.
- Must possess management, supervisory and leadership ability to work with professional and nonprofessional staff.
- Ability to plan, organize, develop and interpret component goals, objectives, policies and procedures necessary to provide quality services.

FULTON COUNTY
FAMILY PARTNERSHIP

- Must function independently and with flexibility, personal integrity, and the ability to work effectively with families, personnel and support agencies.
- Must be able to relate to and work with a variety of people with differing abilities and perspectives.
- Employment contingent on clear Child Abuse and Criminal Record Clearances (PA and FBI) reports.
- Must have an initial physical exam and TB test and repeat physical bi-annually.
- Must have a valid driver's license and personal vehicle available for use.
- Must maintain current CPR and First Aid.

Working Conditions

- Works in FCFP Administrative office and in community settings.
- Sits, stands, bends, lifts and moves intermittently during working hours.
- Works flexible hours as needed to meet needs of organization.
- Must possess sight/hearing senses or use prosthetics that will enable these senses to function adequately so that the requirements for this position can be fully met.
- Must be able to lift, push, pull and move a minimum of twenty five pounds.

FCFP reserves the right to modify, interpret or apply this job description in any way the company desires. This job description in no way implies that these are the only duties to be performed by the employee occupying this position. This job description is not an employment contract, implied or otherwise. The company remains and "At-Will" employer. Qualified employees who require reasonable accommodations to perform the essential function of the position should notify the Board of Directors

I have reviewed and acknowledge my job duties as stated in the above job description.

Job Description Title: _____

Employee Signature: _____

Supervisor Signature: _____

Date: _____

APPENDIX G

FULTON COUNTY
FAMILY PARTNERSHIP

Job Title: Community Mobilizer

SUPERVISION: Executive Program Director and Executive Development Director

Classification: Full-Time Hourly – Non-exempt

Education: Bachelor's degree related to Human Development, Juvenile Justice, Social Work or other related field and/or equivalent experience. Preference for previous grant management and/or supervisory experience.

Reports to: Executive Development Director

Overview: Position is responsible for initiating, implementing and evaluating county-wide human services planning. The position will be responsible for facilitating the local collaboration of health and human service agencies (Partners) to provide an integrated seamless, comprehensive and easily accessed network of services Will be responsible for linking school, public and private agencies, churches, businesses, civic organizations and individuals in an effort to reduce community risk factors and enhance protective factors to provide optimal environment for children, youth and families. Additionally, are expected to lead the collaborative in identifying, instituting and promoting new practices and procedures that improve service outcomes.

Specific responsibilities:

1. Oversee the development and implementation of Human Service Collaborative (Partners) in Fulton County. Cooperatively plan and participate in monthly collaborative meetings – guide and assist efforts to achieve goals in community plan.
2. Participate in professional development activities related to Human Service Collaborative (Partners) and prevention practices.
3. Participate in and actively contribute to community groups to advocate and champion the collaborative process.
4. Research, develop and/or write grant applications to assist with securing sustainable funding sources for collaborative goals and prevention programs.
5. Assist with needs assessment and outcome tracking for the Human Services Block Grant.
6. Assist with Community Health Needs Assessment (CHNA).
7. Maintain and monitor goals and objectives related to county human services as established by the CHNA plan
8. Assist with coordination and monitor effectiveness of evidence-based prevention programs being delivered by various providers in Fulton County. Provide summary reports to coalition to assist in evaluation of effectiveness of efforts and progress towards achieving community goals/priorities.
9. Maintain an awareness of new developments in programming and evaluate their appropriateness for integration into the services. Serve as resource to coalition providing suggestions of programs specifically designed to target community priorities.
10. Assist in the preparation of grant applications as requested to aid in achieving coalition goals.

11. Develop, implement, and maintain an ongoing evaluation system to ensure quality control of all programs identified in community plan. Provide coalition with feedback summary of programs and progress towards reaching community outcomes.
12. Attend and participate in Community Collaborative Committee meetings and special committees to obtain guidance, provide leadership and coordinate the activities of these groups.
13. Prepare monthly report to be distributed to FC Family Partnership Board with program outcomes and progress on goals.
14. Coordinate administration and analysis of PAYS in county schools to provide coalition with ongoing data about community needs and monitor progress towards the identified outcomes.
15. Assist in monthly update to Community Action Plan and provide to coalition.
16. Attend Regional meetings and trainings as available.
17. Other duties as directed by Executive Director

Required Knowledge, Skills and Abilities:

1. Skills in management, including effective communication both oral and written
2. Organizational skills in developing successful community relations and network with county leaders (county government, community leaders, families, health care professionals and educators)
3. Strong leadership ability, supervisory and organizational skills.
4. Ability to work independently, make decisions and recommendations and organize work load with minimal supervision
5. Willingness to travel, give presentations and attend meetings at various hours including evening and weekends as required
6. Ability to utilize technology for program management and presentations to include work processing, database and spreadsheets.

This is not a comprehensive list of responsibilities, but rather an indication of some of the key concepts that must be achieved.

In compliance with ADA, the employer will provide reasonable accommodations to qualified individuals with disabilities and encourages both prospective employees and incumbents to discuss potential accommodations with the Employer

This is not intended to be a complete list of every duty, rather an example of how the responsibilities are shared by the three identified staff persons. Separation of Job Responsibilities as related to the County Human Services Collaborative (Partners):

Executive Development Director	Executive Program Director	Community Mobilizer/Prevention Coordinator
Oversee and manage the financial performance and human resource functions of the organization to ensure sustainability of operations.	Initiate prevention planning discussion with community providers	Assist with coordination and monitor effectiveness of evidence-based prevention programs being delivered by various providers in Fulton County. Provide summary reports to coalition to assist in evaluation of effectiveness of efforts and progress towards achieving community goals/priorities.
Pursue additional grant and funding opportunities consistent with the mission and in order to expand capacity to meet	Assist community providers in the development of outcomes collection	Maintain an awareness of new developments in programming and evaluate their appropriateness for integration into the

FULTON COUNTY
FAMILY PARTNERSHIP

the needs of the community and to increase the financial sustainability of organization.	& analysis plans for evidence-based programs in Fulton.	services. Serve as resource to coalition providing suggestions of programs specifically designed to target community priorities
Monitor budget expenditures and prepare as needed budget revisions.	Ensure communication between prevention providers and coalition to assist in the analysis of effective programming practices	Assist in the preparation of grant applications as requested to aid in achieving coalition goals.
Lead the community conversation around prevention planning at monthly Partner meetings and ensure compliances with grant funders.	Make recommendations to coalition about effective programs and funding priorities	Regularly provide coalition with updated listing of community resources related to prevention to include activities: Promising Practices, Polices and Good Work.
Facilitate the development and implementation of an overall community prevention plan. Ensure that the goals and objectives presented in grant proposals are consistent with the aims of the long-term plan.	Guide coalition discussions to focus on identification of the of the most effective delivery of prevention programs	Develop, implement, and maintain an ongoing evaluation system to ensure quality control of all programs. Provide coalition with feedback summary of programs and progress towards reaching community outcomes.
Serve as the primary liaison with funding agency regarding fiscal and program issues. Ensure that all required fiscal and program reporting requirements are met in full.	Chair PA Youth Survey Resource Committee – schedule, plan, facilitate and summarize committee work and provide info back to full coalition	Attend and participate in CCC Committee meetings and special committees to obtain guidance, provide leadership and coordinate the activities of these groups.
Communicate with collaborative group progress, action steps and needs of community	Guide and supervise Community Mobilizer to ensure effective coalition efforts	Prepare monthly report to be distributed to FC Partnership (Coalition) with program outcomes and progress on goals.
Coordinate vision of Key Leaders with work of FC Partnership Collaborative members	Oversee completion of necessary program reports to PCCD and/or other funders to ensure compliance with funding requirements.	Coordinate administration of PAYS in county schools to provide coalition with ongoing data about community needs and monitor progress towards the identified outcomes.
Attend and participate in monthly collaborative meetings – guide and assist efforts to achieve goals in community plan	Attend and participate in monthly collaborative meetings – guide and assist efforts to achieve goals in community plan	Assist in monthly update to Community Action Plan and provide to coalition.
		Attend Regional meetings and trainings as available
		Communicate to collaborative members and general public the work and successes of the collaborative
		Attend and participate in monthly collaborative meetings – guide and assist efforts to achieve goals in community plan

FULTON COUNTY
FAMILY PARTNERSHIP

I have reviewed and acknowledge my job duties as stated in the above job description.

Job Description Title: _____

Employee Signature: _____

Supervisor Signature: _____

Date: _____