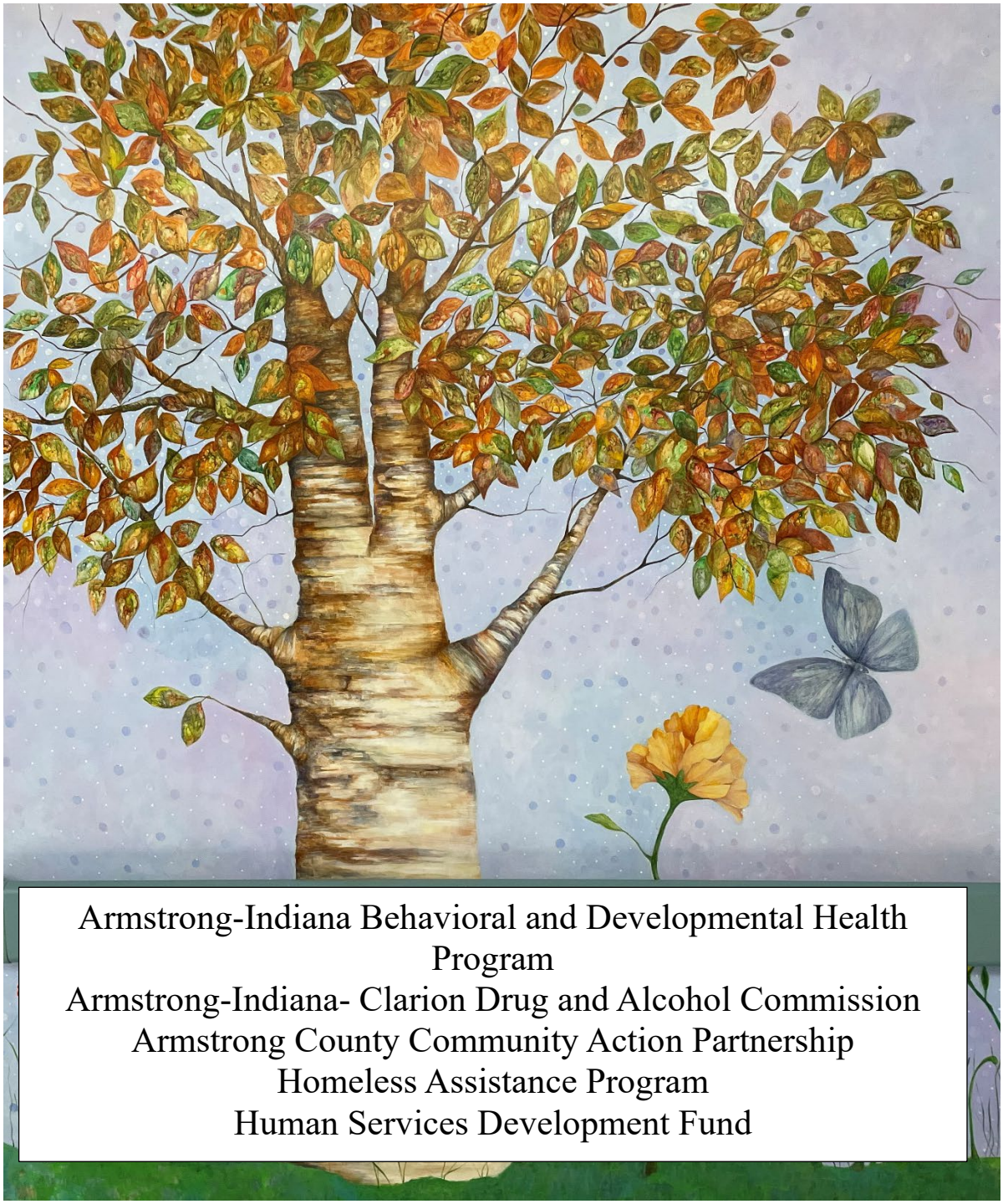
Armstrong County
Human Services Block Grant Plan
FY 2026-2027



Armstrong-Indiana Behavioral and Developmental Health Program
Armstrong-Indiana- Clarion Drug and Alcohol Commission
Armstrong County Community Action Partnership
Homeless Assistance Program
Human Services Development Fund

This picture is part of the mural painted by volunteers at the ACMH Inpatient Unit. Details are provided in the highlight section of the plan.

Appendix B
Armstrong County Human Services Plan
FY 2026-2027

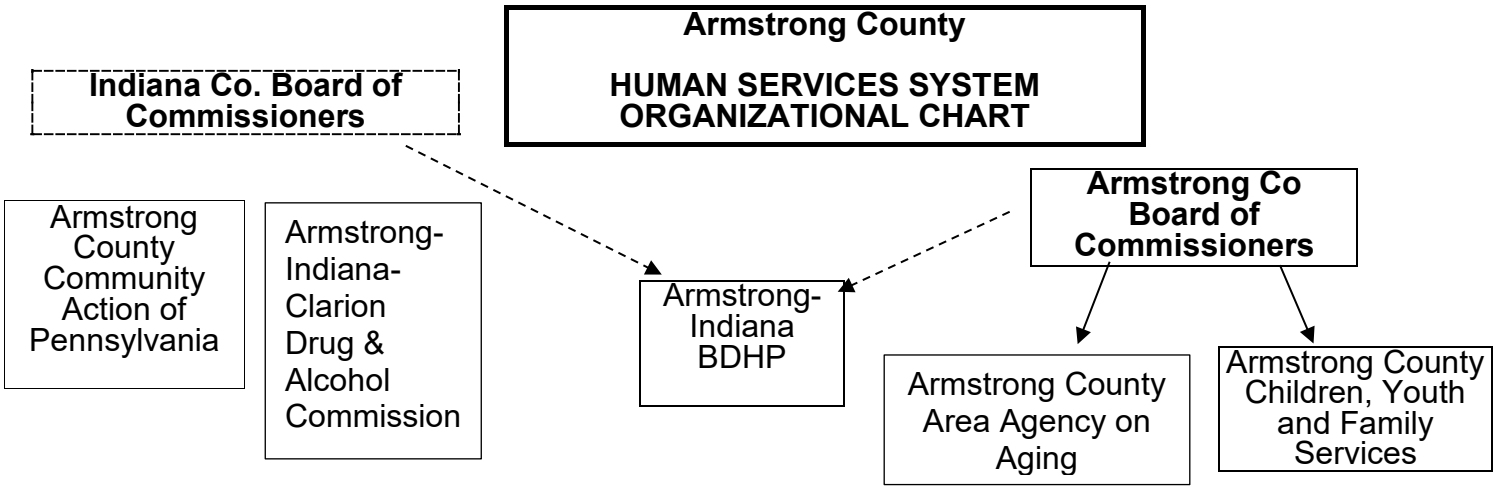
Armstrong County Organizational Structure

Through a joinder agreement between Armstrong County and Indiana County, the Armstrong-Indiana Behavioral and Developmental Health Program (AI-BDHP) was created as a quasi-governmental agency that operates as the Administrative Entity for oversight of the Mental Health, Intellectual Disabilities and Early Intervention Programs. AI-BDHP is governed by the Commissioners of both counties. A commissioner from each county sits on the 13 member AI-BDHP Advisory Board.

The Armstrong County Community Action Partnership is a single county private, non-profit agency.

Armstrong-Indiana-Clarion Drug and Alcohol Commission (AICDAC), the designated Single County Authority, is also a private, non-profit agency serving a three-county joinder.

Armstrong County Commissioners have direct authority over the Area Agency on Aging and the county Children, Youth and Family Services program; both directors report directly to the Commissioners.



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

The following section describes the county planning process in Armstrong County

1. Critical stakeholder groups and Community input

Armstrong County Community Action Agency, D/B/A, Armstrong County Community Action Partnership (ACCAP) employs a comprehensive approach to data collection to identify its focus areas. This process includes conducting a Community-Wide Needs Assessment every three years, as required by the Pennsylvania Department of Community and Economic Development. This assessment is integral to ACCAP's Strategic Plan and involves several stages of data collection. The first stage involves gathering demographic data from specific programs and the U.S. Census Bureau, supplemented by Policy Map software to ensure the information is current and accurate. This data helps the agency identify trends and service gaps. Next, ACCAP collects input through a public survey designed to address potential areas of need in the community. This survey targets all stakeholders within the agency

and county, encouraging unbiased opinions on community needs. This survey is accessible via the agency's website and Facebook page, asking respondents to reflect on how the issues impact them or their immediate families. After the surveys are completed, ACCAP uses the collected data to finalize a Community Needs Assessment document, which outlines the community's needs and focus areas for services. The agency's planning committee then reviews the public input and uses it to develop the agency's Strategic Plan. The committee identifies key areas of need and creates actionable items to address and mitigate the community's challenges.

In addition to the Community-Wide Needs Assessment of the Agency, the ACCAP's Housing Department conducts client satisfaction surveys to help assist the staff to plan and improve the delivery of services to the homeless clients who are served. These surveys help track housing performance outcomes, speed of service, as well as, satisfaction with the services that are received. In addition, ACCAP coordinates the Local Housing Advisory Committee which serves Armstrong County as the Local Housing Options Team (LHOT). This committee meets quarterly and works together to address the various housing issues and problems in the County. Most all of the members of this committee are providers of human services in the county and a partner with the Agency in many of their endeavors. Paige Hockenberry, the Manager of the Housing Department of ACCAP, also attends Western Pennsylvania Continuum of Care (CoC) meetings. Significant knowledge and insight are garnered from attending these meetings. Other housing staff also attend many of the trainings that are offered by the Western PA CoC. These trainings and meetings often alert staff trends, events, or offers other knowledge of things happening at large that could, or can, affect our agency at the local level. All of the information gathered by staff helps to keep them up-to-date on the pressing needs of our County's homeless populations, as well as helps adjust their planning for the next year based upon these issues.

2. **Stakeholder opportunities for participation in the planning process, including information on outreach and engagement efforts**.

In addition to the Community-Wide Needs Assessment of the Agency, the ACCAP's Housing Department conducts client satisfaction surveys to help assist the staff to plan and improve the delivery of services to the homeless clients who are served. These surveys help track housing performance outcomes, speed of service, as well as satisfaction with the services that are received.

Throughout the fiscal year, there are a number of meetings that are held not only to provide information to stakeholders but also to provide opportunities for stakeholders to share concerns and input into improving and shaping the behavioral and developmental health service system for Armstrong County. Because two of our human service programs are joinders (AI-BDHP, AICDAC), there will be references to both Armstrong and Indiana Counties throughout this section.

A brief summary of stakeholder engagement meetings follows:

- Monthly Community Support Program (CSP) meetings are held in Armstrong and Indiana Counties. During these meetings consumers discuss relevant topics such as transportation, support needs and system gaps. County representation is present at all CSP meetings to compile this information and to keep abreast of current needs. This information is then used in the planning process.

- Annually Consumer Focus Groups are held in Armstrong and Indiana Counties. The focus groups were facilitated by the Consumer and Family Satisfaction Team Supervisor who is employed by National Alliance on Mental Illness (NAMI). A list of relevant questions is developed each year in order to solicit input from consumers and other stakeholders who utilize or work in our local behavioral health system. The Armstrong County Focus Group meeting was held June 25, 2026, with 19 people participating (15 in person and 4 virtual) and the Indiana County Focus Group was

held on June 4, 2026, with 26 in attendance (20 in person and 6 virtual). This year both meetings offered a virtual option for attending.

- Five times per year, the Armstrong-Indiana BDHP Advisory Board meets. This is a published public meeting and time is allotted in each meeting for public comment.

- Semi-annually, AI-BDHP hosts both Behavioral Health and Intellectual Disabilities Provider meetings. At these meetings providers are updated on pertinent program information and given the opportunity to provide feedback regarding service needs.

- Monthly individual ACMH and IRMC hospital meetings with local providers and D&A Commission are held to discuss individual case issues and problem resolution.

- Quarterly joint hospital meetings are held at each of our local hospitals and facilitated by staff from Armstrong-Indiana BDHP. There is also a virtual option for participation. Various inpatient providers who admit our consumers are in attendance, as are local outpatient providers of both behavioral health and substance abuse. This gives our local providers and stakeholders a forum to review admission and discharge protocols, get updates on local initiatives and provide input as we collaborate to review and improve our service delivery system.

- The AIBDHP staff participate in numerous committees where information is exchanged for proposed system changes and providing input into the plan. Some of these committees are Suicide Task Force, Personal Care Home Risk Management Committee, County Criminal Justice Advisory Boards (CJAB), and the Housing Consortium meetings.

- Also, on an ongoing basis, AIBDHP staff work closely with the CFST teams in each county. CFST feedback helps highlight gaps with services or with system issues in general. This feedback is especially important to our process since this comes directly from consumers and/or family members. The CFST also has the capability of holding focus groups, if necessary, to discuss trends or ongoing issues in more detail.

- AIBDHP Staff regularly participate in the Western Region Behavioral Health Stakeholder Advisory Committee meetings which offer a regional and state perspective on topics relevant to the consumers we serve.

- The AIBDHP Administrator and various staff are involved with the Pennsylvania Association of County Administrators of Mental Health and Developmental Services (PACA MH/DS). We regularly attend committee meetings that address current topics and issues related to mental health, intellectual disabilities, early intervention and HealthChoices programs. This information is shared with our local stakeholders.

  To get the applicable stakeholders engaged in the previously described meetings, numerous announcements were distributed via email, mail, social media forums and as specifically identified for the Advisory Board meetings through public notice in the newspaper.

3. **Advisory boards that participated in the planning process**.

Armstrong County Community Action Partnership – BOD

The ACCAP plans and adjusts its plans according to the direction of the Board of Directors and the monthly fiscal reports that are received by all Agency Staff. The Agency Board of Directors is a tri-

partite board made up of public officials, private industry, and representatives of the low-income community. Therefore, stakeholder groups are a natural part that is incorporated into the ACCAP governing fabric.

Armstrong-Indiana BDHP Advisory Board
Five times per year, the Armstrong-Indiana BDHP Advisory Board meets. There are thirteen members of the AI-BDHP Advisory Board. Seven members are appointed by the board of commissioners from Indiana County and six from Armstrong County. The Board is kept abreast of the activities occurring in all the BDHP programs as well as regional and state issues impacting our programs. This is a published public meeting and time is allotted in each meeting for public comment.

4. **Services provided to its residents in the least restrictive setting appropriate to their needs**

In both the behavioral health and the intellectual disabilities systems an intake and assessment process are utilized to determine the needs of the consumer. A plan of care is developed, and services are initiated. In many cases multidisciplinary team meetings are held to perform person centered planning and determine an individual's needs. Through these efforts funds are then utilized in carrying out the person-centered plan, which will ensure that the individual is in the least restrictive appropriate level of care.

The Armstrong County Community Action of Pennsylvania abides by all the rules and regulations of its' funding sources, but it always attempts to provide services to the eligible population that it serves in the least restrictive settings that is appropriate to their needs. All funds received by ACCAP through the Human Services Block Grant will continue to be provided in this manner. For instance, the ACCAP abides by HUD's "Housing First" regulations for all of their housing programs that they operate. "Housing First" forbids any undue restrictions to be put upon program clients such as sobriety requirements, treatment requirements or mandatory service requirements.

5. **Substantial programmatic and funding changes being made as a result of last year's outcomes**.

A substantial programmatic change for Armstrong or Indiana Counties was the opening of a regional walk-in crisis center on the campus of the Indiana Regional Medical Center in Indiana, PA which occurred on June 13, 2026. A $3.3 million dollar CMHSBG ARPA grant was obtained for the creation of this center in late 2022. Since then, there have been countless hours of work on the development of the program along with leadership changes at the Open Door, uncertainties about the new Crisis Regulations and various other barriers and obstacles along the way but everyone involved in the project persevered. Now that the center is open, we will be able to utilize these funds.

Another project that has taken over a year to get started is our CHIPP funded Enhanced Supportive Housing project. Finding the right home for the development of this three-bed home has been extremely challenging for the provider but finally a property was purchased in May 2026 so these funds will now also be able to be utilized. Both of these projects will have a significant programmatic impact on our local behavioral health system. By having increase walk in crisis services available along with offering an additional housing option, individuals can live in and receive services in their local community.

The Armstrong-Indiana Human Services Block Grant Oversight Committee is responsible for not only providing oversight and monitoring the human services block grant for Armstrong and Indiana Counties but also for the creation and oversight of the block grant retained earnings plan. The members of the committee were the Armstrong-Indiana Behavioral and Developmental Health Program, the Armstrong, Indiana, Clarion Drug and Alcohol Commission, the Indiana County Department of Human Services, and the Armstrong County Community Action Agency. All the agencies in the block grant retained their existing allocation levels.

The retained earning funds for FY 25-26 were used to support plans submitted by our Mental Health, Intellectual Disabilities and D&A Providers. These plans will be used to fund an educational advocate, training programs, computer equipment, upgraded electronic health records, online psychiatric testing tools, a new roof, and much needed furniture, appliances and vehicles.

PART II: PUBLIC HEARING NOTICE

Armstrong County Two Public Hearings Documentation
Two public hearings were held to review the programs funded through the block grant and to solicit input to the development of the 26-27 Human Services Block Grant plan. The dates and times of the public meetings were July 13, at 3:00 PM and July 27, 2026, at 2:30 PM.

1. Proof of publication;
    a. The following copy provides proof of the notice placed in the Leader Times announcing the meetings.
    b. The notice was published on July 7, July 9 and July 11, 2026.
    c. Additionally, the meeting announcement was posted on the AI-BDHP website at www.aibdhp.org and sent out through our email distribution lists.

2. The following is a summary of each of the hearings along with copies of the sign-in sheet from each public hearing.
    a. The July 13, 2026 – 3:00 PM Armstrong County meeting was held in person at the Armstrong-Indiana Behavioral and Developmental Health Program office located at 120 South Grant Ave., Kittanning PA 16201 and via Zoom. There were six attendees in person and five attendee through the zoom option. The agenda for the meeting included a welcome and introductions, an overview of the plan process and what is included in the plan and plan due date. Presentations were then made by the Armstrong County Community Action Partnership regarding the Homeless Assistance Program and HSDF sections; the Armstrong-Indiana-Clarion Drug and Alcohol Commission presented on the Act 152, and BHSI D&A sections; and the Armstrong-Indiana Behavioral and Developmental Health Program, presented on the Mental Health and Intellectual Disabilities sections of the plan. This was followed by a time for questions and comments.

    b. The July 27, 2026 – 2:30 PM Armstrong County meeting was held in person at the Armstrong-Indiana Behavioral and Developmental Health Program office located at 120 South Grant Ave., Kittanning PA 16201 and via Zoom. There were six attendees in person and zero attendees through the zoom option. The agenda for the meeting included a welcome and introductions, an overview of the plan process and what is included in the plan and plan due date. Presentations were the made by the Armstrong County Community Action Partnership regarding the Homeless Assistance Program and HSDF sections; the Armstrong-Indiana-Clarion Drug and Alcohol Commission presented on the Act 152 and BHSI D&A sections; and the Armstrong-Indiana Behavioral and Developmental Health Program, presented on the Mental Health and Intellectual Disabilities sections of the plan. This was followed by a time for questions and comments.

Proof of Publication of Notice

In Leader Times Under the Act of July 9, 1976, P.L. 877, No. 160,

State of Pennsylvania, County of Armstrong

Amy Schaffhauser, Sales Rep of West Penn Media, a corporation of the Commonwealth of Pennsylvania, publisher of the Leader Times, of the County State aforesaid, being duly sworn, deposes and says that the Leader Times, a newspaper of general circulation published at Kittanning, County and State aforesaid, was established January 10, 1898, since which date the Leader Times has been regularly issued in said county, and that the printed notice or publication attached hereto is exactly the same as printed and published in the regular editions and issues of the said Leader Times on the following dates.

7th, 9th, and the 11th of July 2026

Affiant further deposes that she is an officer duly authorized by West Penn Media, publisher of the Leader Times, a newspaper of general circulation to verify the foregoing statement under oath, and affiant is not interested in the subject matter of the foresaid notice or advertisement, and that all allegations in the foregoing statements as to time, place and character of publication are true.

NOTICE OF ARMSTRONG COUNTY HUMAN SERVICES PLAN FOR 2026-2027

The County of Armstrong will hold two Public Hearings on the 2026-2027 Consolidated County Human Services Plan for Armstrong County to provide the public with the opportunity for input into the plan prior to submission to the PA Department of Human Services.
The human services involved are: Mental Health Community Based Funded Services, Behavioral Health Services Initiative, Intellectual Disabilities Community Based Funded Services, Drug and Alcohol ACT 152 funding, Homeless Assistance Program funding, and the Human Service Development Fund. **The hearings will be held on Monday, July 13, 2026 at 3:00 PM and Monday, July 27, 2026 at 2:30 PM** at the Armstrong Indiana Behavioral and Developmental health Program office, 120 South Grant Avenue, Kittanning, PA 16201, Suite 5 entrance and also via Zoom. Please go to www.aibdhp.org website for the Zoom information.
For additional information, contact 724-548-3451.
7/7, 7/9, 7/11

Amy Schaffhauser, Leader Times

Sworn to and subscribed before me this 13th of July, 2026

Julea A Jordan

My Commission Expires:

Commonwealth of Pennsylvania - Notary Seal
JULIA A JORDAN - Notary Public
Armstrong County
My Commission Expires June 28, 2028
Commission Number 1080564

Statement of Advertising
For publishing the notice or publication attached **$212.65**

rtising Costs Leader Times, a newspaper of general circulation, hereby acknowledges receipt of the
tion cost and certifies that the same been duly paid.

Armstrong Human Services Plan Public Meeting

Sign In Sheet

Meeting Date/Time and Location: July 13, 2026 @ 3:00 pm @ Armstrong Indiana BDHP
120 South Grant Avenue, Kittanning, PA 16201

Name	Agency	Phone	E-mail
1. Jeff Boarts	ACCAP	724-548-3408	jeffb@armstrongcapi.com
2 Susan Chestnut	ACCAP	724-548-3408	x3459 susanc@armstrongcapi.com
3. Samantha Johns	ACCAP	724-548-3408x3121	samanthaj@armstrongcapi.com
4. Kami Anderson	AICDAC x302	724-354-2746	kanderson@aicdac.org.
5. Amy Cline	AI-BDHP	7242722024	acline@aibdhp.org
6. Tammy Calderone	AI-BDHP	724-548-3451	tlcalder@aibdhp.org
7. Aggie Hockensberry	ARM-IND CEST	ZOOM	
8. MICHELLE Barnhart	The Open Door	ZOOM	
9. Becky Bennett	Community Options Inc	ZOOM	
10. Barb Ponterio	AmeriHealth Caritas	ZOOM	
11. Shani Montgomery	AI BDHP	ZOOM	
12.			
13.			

Armstrong Human Services Plan Public Meeting

Sign In Sheet

Meeting Date/Time and Location: July 27, 2026 @ 2:30 pm @ Armstrong Indiana BDHP
120 South Grant Avenue, Kittanning, PA 16201

Name	Agency	Phone	E-mail
1. Jeff Boarts	ACCAP		jeffb@armstrongcap.com
2 ERICA BOWSER	ACCAP		ericab@armstrongcap.com
3. DAVE SHAEFFER	FCC		DESHAEFFER@FCCAC.ORG
4. Dave Faris	FCC		daFaris@FCCAC.org
5. Tammy Calderone	AIBDHP		tlcalderone@aibdhp.org
6. Kami Anderson	AICOAC.		kanderson@aicoac.org
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			

PART III: CROSS-COLLABORATION OF SERVICES

1. **Employment:**

Employment Coalition Efforts

Armstrong and Indiana Counties have an established Employment Coalition. This coalition meets quarterly and is made up of employers, providers, supports coordinators, OVR and the county AIBDHP office. This coalition continues to play a key role in determining the employment initiatives for our counties and will once again be including employment as a priority in this year's plan. All the details related to **Priority # 2 – Continued Efforts to Increase Employment Opportunities and Workforce Development** can be found in the Priorities Section of this plan. This year's employment priority will be to locate employment assessment sites, encourage employment goal setting and promote the benefits of employing the individuals we serve.

Employment Services for Behavioral Health Consumers

It is widely recognized that securing meaningful employment can be a key component in maintaining good mental health. Having programs in place to help build skills and expand employment opportunities is essential. In order to provide these opportunities for residents, especially those with behavioral health and physical health challenges, collaboration among services and leveraging existing funds is crucial. In Armstrong and Indiana Counties, funding is leveraged and collaboration exists among both intellectual disability waiver funding and the mental health base, as well as the Community/Hospital Integration Project Program (CHIPP) funding (provided by the Armstrong/Indiana Behavioral and Developmental Health Program), grant funding (provided from a variety of sources), and funding provided by the Office of Vocational Rehabilitation. The primary employment support services for consumers in Armstrong and Indiana Counties are provided by the Progressive Workshop located in Armstrong County and the ICW Vocational Services located in Indiana County. The programs provided through these agencies/facilities aim at assessing and using the individual's skills and abilities to match them with paid employment opportunities in the community. Through the cross-collaboration of funding, the following employment-based opportunities currently exist in our two counties:

- **Community Participation Support** - This service provides opportunities and support for not only community inclusion, but also for building interest in and developing skills and potential for competitive integrated employment. This service may be provided in community locations, community hubs, licensed adult training facilities, licensed older adult daily living centers and/or licensed vocational facilities.
- **Small Group Employment Services**- Small Group Employment services consist of supporting individuals in transitioning to competitive integrated employment through work that occurs in a location other than a facility. The goal of Small Group Employment services is competitive integrated employment. Small Group Employment service options include mobile workforce, workstation in industry, affirmative industry, and enclave.
- **Supported Employment** - Supported Employment services are provided in a variety of community settings for the purposes of supporting individuals in obtaining and sustaining competitive integrated employment. Competitive integrated employment refers to full or part-time work at minimum wage or higher, with wages and benefits similar to workers without disabilities performing the same work and fully integrated with coworkers without disabilities.

Both agencies are continually searching for new employers and experiences for individuals who wish to become employed. Staff also consistently search for new funding resources such as grants and special initiatives that can be used for further opportunities.

While Armstrong County Community Action Partnership does not have a program that specifically targets employment, all of its housing programs make referrals to employment training services when a program participant is eligible.

2. Housing:

Armstrong County Community Action Partnership works with several county organizations to collaboratively assist those at risk for homelessness or who are homeless. All of our housing participants are offered referrals to the following services: The Coordinated Entry System from the Western PA Continuum of Care, Food Stamps, Head Start, Child Care, Drug and Alcohol Services, Mental Health Services, Food Bank, Medical Transportation, the County Assistance Office, PATH, the Armstrong County Housing Authority and Section 8, and the Armstrong County Agency on Aging.

Armstrong County Community Action Partnership has received PA Housing Affordability and Rehabilitation Enhancement Fund (PHARE) funding and uses it for scattered site emergency shelter apartments in collaboration with Armstrong County Children, Youth, and Family Services, Armstrong-Indiana Behavioral and Developmental Health, Armstrong-Indiana-Clarion Drug and Alcohol Commission, and Armstrong County Jail and Probation.

Armstrong County Community Action Partnership also collaborates with other agencies in the area regarding individual participants, and in our Western PA Continuum of Care, leveraging funds where available to provide the most we can for our county's population. We coordinate services with the two emergency shelters and transitional shelters in the county, HAVIN and Mechling/Shakely Veterans Center. We have been able to pay security deposits for participants so that they can be accepted into the local Housing Authority. We work with the PATH program for our participants to leverage additional funds to secure permanent housing. Through the Continuum of Care's Coordinated Entry System, we are able to coordinate housing for homeless individuals across the whole continuum, offering our county's participants an opportunity for housing if they are willing to relocate.

Armstrong County Community Action Partnership and Armstrong-Indiana-Clarion Drug and Alcohol Commission collaborate on the State Response Grant Providing Housing and Supports for Individuals with Opioid Use Disorders. This grant services eligible participants with housing assistance, emergency financial assistance, and case management services.

In the FY 24-25 the Armstrong County Community Action Partnership became the community based organization (CBO) for the distribution of the Armstrong County Social Determinant of Health (SDOH) commodity funds. These funds are part of a Southwest Six County regional HealthChoices Reinvestment plan. As the CBO, ACCAP is responsible for the distribution of SDOH funds to behavioral health individuals eligible for MA based on their need. This could include funds for childcare, clothing, financial strain, food insecurity, housing instability, transportation or utilities. The goal of the program is to support the individual's immediate need to maintain their community tenure yet not foster dependency. ACCAP will be working with individuals to establish goals and action steps that will enhance their ability to become self-sufficient in meeting their own future needs.

PART IV: HUMAN SERVICES NARRATIVE

MENTAL HEALTH SERVICES

The Armstrong-Indiana Behavioral and Developmental Health Program (AI-BDHP) was established in 1969 by the Commissioners of Armstrong and Indiana Counties. This local collaborative arrangement was created in accordance with the provisions of the Mental Health and Intellectual Disabilities Act of

1966 and the Mental Health Procedures Act of 1976 to assure that the mandated services, as outlined in the Acts, are available to the constituents of Armstrong and Indiana Counties. The 2018-19 Fiscal Year was the first year that Armstrong and Indiana Counties participated in the block grant.

Administrative Functions – AI-BDHP is the administrative entity for Armstrong and Indiana Counties that oversees all behavioral health, intellectual disability, and early intervention services, and performs the following functions on behalf of the counties:

A. **Block Grant Fiduciary** AI-BDHP is the designee appointed by the Boards of Commissioners from Armstrong and Indiana Counties to act as the fiduciary for all funds included in the block grant.

B. **Management of Funds included in the Block Grant** AI-BDHP directly manages all Mental Health (MH) Community Base Funds, Behavioral Health Services Initiative (BHSI) Funds, and Intellectual Disabilities (ID) Community Base Funds.

C. **Administrative Entity Operating Agreement** AI-BDHP holds the contract with DHS and the Office of Developmental Programs (ODP) to act as the Administrative Entity conducting the administrative functions of the Consolidated (CMS #PA.0147), Person/Family Directed Support (P/FDS) (CMS #PA.0354) and Community Living (CMS #PA.1486) Waivers for individuals and Waiver participants with intellectual disability residing in Armstrong and Indiana Counties. AI-BDHP intends to continue to comply with and perform all the duties and functions that are outlined in the Administrative Entity Operating Agreement.

D. **Management of HealthChoices** The program contracts with Southwest Behavioral Health Management (SBHM) in all matters related to the HealthChoices program for Armstrong and Indiana Counties.

E. **Management of Service Provider Contracts** AI-BDHP obtains, prepares, and monitors the MH and ID contracts with provider agencies.

F. **Monitoring and Oversight** AI-BDHP staff provides program oversight and monitoring as regulated and required by the appropriate Office of Mental Health and Substance Abuse Services (OMHSAS) and the Office of Developmental Programs (ODP).

a) <u>Program Highlights:</u> *(Limit of 6 pages)*

The following list highlights the achievements and other programmatic improvements that have enhanced the behavioral health service system in Armstrong and Indiana Counties in FY 25-26.

The Open Door's New Regional Crisis Walk in Center Opens

The Armstrong-Indiana Behavioral and Developmental Health Program was excited to take part in the Open House and Ribbon cutting ceremony that took place on June 4, 2026, for the new Regional Crisis Walk in Center that will be operated by The Open Door of Indiana County and located on the Indiana Regional Medical Center Campus. This project has garnered great local support and this was evident by the over 200 people that attended the Open House event. This project has been in development for over three and a half years. In December 2022 we were notified that we had been awarded a three year $3.3 million dollar CMHSBG ARPA grant. Since January 2022 the Open Door, along with many stakeholders have been working to create a crisis center based on national best practice guidelines. By having a 24/7 Walk in Crisis Center co-located on the IRMC grounds we will better meet the needs of our community. The Walk in Crisis Center will help divert individuals from the Emergency Room, provide a better environment for someone experiencing a mental health crisis, assist law enforcement, and offer short term bridge services until an individual is connected to

appropriate community resources. The Walk in Center officially opened on June 13, 2026. It will initially be operating from 8:00 AM – 8:00 PM daily.

Trainings Impact Professionals and Community
A number of training opportunities took place in FY 25-26 these included instruction to professionals on a new therapy model as well as the community received education on resources and supports available in Armstrong and Indiana Counties.

- **Hearing Voices Simulation Training** - Armstrong/Indiana Behavioral and Developmental Health Program Forensic Case Worker /CIT Coordinator presented The Hearing Voices Simulation at the July 8, 2025, Armstrong Disaster Team meeting. The simulation is an immersive experience designed to help participants understand what it might be like to live with auditory hallucinations. These experiences are common in individuals with conditions such as schizophrenia, PTSD, and severe depression. It provides a glimpse into the invisible world—where voices echo beyond the mind. This simulation is not meant to replicate the exact experience of those who hear voices, but rather to foster empathy, awareness, and insight into the challenges they face daily. The training was well received by the group.

- **EMDR Training** – at the end of September 2025 AI-BDHP was notified that we were awarded a CMHSBG Training Grant in the amount of $56,000. These funds were used to provide Eye Movement Desensitization and Reprocessing (EMDR) training for licensed clinicians in Armstrong and Indiana Counties. EMDR is an evidence-based psychotherapy which is effective for treating trauma and other mental health conditions. Research supports its efficacy across diverse populations. We contracted with Scaling Up, LLC. to provide these trainings.

  The training funds allowed twenty (20) clinicians to receive the EMDR Basic Training. Part 1 of the five day training began with a three day in person sessions starting on Friday January 30, 2026, and was completed until Sunday February 1. This in person training was held at our Kittanning Office and because of the grant we were able to offer this free of charge to the registered clinicians. The EMDR Basic Training is a comprehensive course designed to equip clinicians with the foundational knowledge and skills to deliver EMDR therapy effectively. The last two days of the training were held virtually. In total the basic training provided 40 hours of live, interactive training in a hybrid format; Supervised Practice Sessions; 10 hours of consultation with experienced facilitators to ensure mastery of techniques; and access to supplemental resources such as manuals, recorded sessions, and ongoing consultation for clinical application.

  The training grant also supported us offering ten (10) clinicians the opportunity to become certified in EMDR. EMDR certification empowers therapists to provide specialized, effective trauma care, making it a valuable addition to their professional toolkit.

  The final piece of this training plan is to support 1 clinician to become a consultant. Through having a consultant locally, we will be able to certify more clinicians.

  AI-BDHP's Dually Diagnosed Clinical Care Manager attended the EMDR Basic Training and is going through the certification process.

- **HAVIN Town Hall Meeting** - On December 5, 2025, HAVIN hosted the Armstrong County Town Hall and Resource Fair. AIBDHP's ID Director and Administrator participated, discussing information on intellectual disability, autism and mental health services. This was a virtual event with the intended audience being residents in the most rural parts of Armstrong County, who are interested in learning more about what we can offer them. Unfortunately, not a lot of residents participated, but the event was recorded and we hope it can be shared as needed.

Mountains Behavioral Health Adolescent and Adult Units Open
As highlighted in last year's plan, Indiana Regional Medical Center opened a brand new 44-bed facility on June 10, 2025. The 31,000 square foot facility has 12 Geriatric Beds, 24 Adult Beds and 8 Adolescent Beds. Due to staffing, there was delay in the Adolescent unit and one of the Adult unit's opening. Fortunately, this has been addressed and Mountains Behavioral Health was able to open their adolescent unit on Dec. 2, 2025, and the second 12 Adult Bed unit began service patients on June 24, 2026. This brings the facility to full capacity. IRMC's Mountains Behavioral Health has been working hard to meet the needs of individuals in the community.

Carnival of Opportunities
On April 2, 2026, AI-BDHP, along with the Alliance for Non-Profit Resources, hosted a Carnival of Opportunities at the West Kittanning Fire Hall from 5pm to 7pm. This was our 2nd annual Carnival. We could not have asked for better day or weather! This event was open to the public but focused on providing valuable resources to individuals with intellectual disabilities and autism. We had various agencies and providers participate, showcasing their programs, services and community resources. Each table had a 'carnival' game for people to play. We also had a magic show, photo booth, 3 food trucks and face painting! Over 250 individuals and community members attended.

Team Friends and Self Advocacy Groups:
Both Team Friends and our monthly self-advocacy groups are flourishing. We continue to see numbers around 100+ for Team Friends events. Both individuals and family members enjoy this social time. We knew this was a missing piece in our counties, and we are so happy to see it being filled. Recent trips have been to a Pirates baseball game and Kennywood. The self-advocacy groups are generally limited to 20 people. These groups are purposely smaller so we can hold more conversations and provide meaningful education. The HCQU has been a strong partner for these groups.

We are especially excited about the Speed Friending Event that took place in February and the Regional 'Move Your Way' Initiative (Line Dancing in March) we have started with Butler, Beaver and Lawerence Counties! Another new program included adaptive CrossFit classes for individuals with disabilities. We are committed to helping individuals, families and staff find fun ways to move their bodies for a healthier lifestyle.

Meet and Greet Events:
On October 16, 2025, the HAVIN and AI-BDHP held our annual Meet and Greet with First Responders at the West Kittanning Firehall. This year's highlights included the Armstrong County K9 Officer Loki and Deputy Brice. The 'Jaws of Life' was also demonstrated. In total we had 85 individuals and 59 caregivers in attendance.

This year Indiana held a Meet and Greet event for the first time. This event was organized by The ARC of Indiana County and the Community Disability Awareness Workgroup and was held on June 18, 2026, at the Indiana Senior High parking lot and cafeteria. Highlights included the jaws of life and police dogs including Indiana's fire station dalmatian.

Events like this encourage hands-on learning and exposure for both individuals with disabilities and emergency responders. Participants can become familiar with the sights, sounds, movements, and equipment used by emergency personnel, helping individuals better understand what to expect in a crisis. Likewise, first responders gain insight into the unique needs and communication styles of individuals with disabilities, better preparing them for real-world interactions

Strong Minds Bright Futures Event

On September 29, 2025, three AIBDHP staff attended the Children's Mental Health Listen Tour hosted by Strong Minds, Bright Futures Partnership (SMBF), a coalition of more than 95 organizations working together to build a better, more accessible mental health system for children and youth across Pennsylvania. The Indiana PA event was hosted at the Indiana University of Pennsylvania Kovalchick Convention and Athletic Complex (KCAC) from 5:00 to 7:00 PM. It brought together families, youth, providers, educators, and local leaders to share their experiences and explore solutions to strengthen children's mental health services in Pennsylvania. The discussion was facilitated by Deanna Dyer, the Health Policy Director at Children First, and Mrs. Courtney Kuncelman, Indiana School District Behavior & Mental Health Coordinator/School Psychologist. A mother and daughter who went through the RTF process agreed to be one of the speakers. They both did an awesome job telling their story and journey through the mental health system. It was also great to hear the information that students from Indiana Area school District shared about the Green Bandanna Project. There was a large group discussion about what the barriers are, what could be done better and what the strengths are in our community. The event was well attended. Similar events are taking place around the commonwealth. The Children's First Group is compiling the information collected during these events.

Drop in Center Opening

On December 8, 2025, Goodwill Industries officially opened the new Drop-In Center in Indiana County. It is located at 1690 Warren Road, Indiana, PA 15701. In addition to a new space the center has also changed its name to the Drop-In Center formerly New Beginnings Drop-In Center. The name change was prompted because of the number of inquiries they would get thinking that it was a child care center.

The renovations were made possible through reinvestment dollars along with Goodwill funds. The space is roomy, bright and welcoming. There are several computer workstations, TVs and gaming systems, and a large, beautiful kitchen. The space will accommodate the local monthly CSP meetings. Goodwill is hoping to also increase the membership at the Center. Some other benefits of the new location are that it is on a bus line, and close to Goodwill's Indiana store location. They are hoping to develop some work/training opportunities through this close proximity.

On June 23, 2026, an open house event was held inviting the community and local behavioral health partners to tour the center and learn about all the activities taking place. This event also highlighted the new Drop in Center bus that was purchased through a HealthChoices reinvestment plan. The bus will be used for transporting individuals from more rural areas of Indiana to attend the center. A daily round trip goes from Rossiter to Indiana Drop in Center. Having this bus will allow the opportunity for additional transportation routes to be developed.

Law Enforcement Treatment Initiative – Behavioral Health

Indiana became the fifth county in the state that offers both the SUD and BH LETI program. A press conference was held on March 30 to announce this program. The Law Enforcement Treatment Initiative (LETI) is a collaborative program with participating District Attorney's in Pennsylvania, spearheaded by the Office of the Attorney General, that aims to combat the opioid crisis, substance use disorder and concerns of behavioral health by connecting individuals to treatment or service options with the purpose of diverting individuals away from the criminal justice system and into treatment. LETI aims at bridging gaps between law enforcement, the community and the resources available to them.

AIBDHP, local outpatient and inpatient providers, and crisis will be partnering with Indiana County District Attorney and the Attorney General's office to implement this new initiative, LETI/BH. This initiative will divert our mentally ill consumers from the criminal justice system and into necessary services to assist them with their needs. LETI was originally designed to assist consumers with a substance use disorder that were also involved in the criminal justice system. Our local Drug and

Alcohol Commission has had many successes attributed to LETI, we are hopeful for the same result with our consumers.

Law Enforcement Collaboration Activities
AI-BDHP Forensic Caseworker, and Armstrong- Indiana Crisis have met with both Kittanning and Indiana State Police to continue to strengthen relationships. These meetings will be ongoing as needed to continue our collaboration with law enforcement. Additional Crisis Intervention Training (CIT) classes took place in the fiscal year. Participants in the classes have been diverse with police, sheriff's deputies, EMS, Crisis, Humane Officers and Deputy Jail Wardens. The trainings have been very well received and appreciated. One of the participants said it was by far the best training that he has been too. And shortly after the class, local EMS made a call to crisis for services for an individual they felt needed assistance.

Indiana Suicide Task Force Sticker Campaign
The Suicide Task Force of Indiana County partnered with the Green Bandana Project at Indiana Area School District (IASD) to roll out a campaign for suicide awareness in Indiana County. The Task Force Co-Chair and Coordinator worked with Task Force Member and IASD Psychologist to create a campaign by partnering with local coffee shops in Indiana County. The task force wanted to target at-risk populations, and Indiana residents love their coffee. This campaign was funded by donations from the Lieb family, in memory of their brother, Brian Lieb, who died by suicide.

The campaign wanted to promote the Indiana-Armstrong County Crisis Hotline and normalize reaching out for help in the moments that it is needed most. Coffee shops that participated featured a sticker designed by a student from IASD, highlighting the Armstrong-Indiana County Crisis Hotline number. The Green Bandana Project worked with students in the senior high to hold a contest to create the stickers, and the task force's executive committee held a vote for the best design. A winner was chosen from each grade and a flyer was posted at the coffee shops that their sticker was featured in the month of May. Additionally, they were featured on social media with a small bio about themselves and their respective designs.

ACMH Mural Project
Members of the Harvest Community Church located in Armstrong County approached ACMH and A-I BDHP with a request to make the inpatient wing at ACMH more inviting through painting a mural on the hallways of the unit. The hospital and our office wholeheartedly supported this idea. After meetings were held to determine the mural theme and all approvals were obtained by hospital administration, the artists from the church began working on the mural in early fall 2024. The volunteer artists put hundreds of hours into painting beautiful garden vines, flowers, life like birds, and a special tree of life. They completed their labor of love in September 2025. The volunteers expressed great joy in being able to work on this project and having the opportunity to get to know the ACMH staff and patients they interacted with along the way. AI-BDHP was happy to financially support this project through purchasing the supplies and truly appreciated the Harvest Community Church members time, talents and dedication that went in to completing this one of a kind mural!

Family Friendly Activities

- **Family Fun Fest** - The Children's Advisory Council 23rd Family Fun Fest took place at the Indiana Mall on March 21, 2026. This year's theme was Red, White and You in honor of the USA celebrating 250 years. The activity room had games from the 1700, 1800, 1900, and 2000 eras. There were 40 plus agencies/providers who attended and provided information to families and an activity for children. There was also various entertainment scheduled throughout the day. There were 342 adults and 404 children who registered at the event for a total of 746

participants. During the event, there was also a car seat collection, and 20 car seats were collected.

- **Family Nature Palooza** - The annual Family Nature Palooza was held on June 6, 2026 at Blue Spruce Park in Indiana County. There were 423 people checked in for a total of 115 Families. There were 223 Children and 200 Adults. There were a lot of activities that families could participate in throughout the day. Some of the activities were Disc Golf, Creekside Fire Department Station, Fishing/Fly Fishing, Obstacle Course, Green Roof Acres Petting Zoo, Baby Ladybugs, Planting, and Foam glider. This is a popular event that provides families an opportunity to be outside and spend time together.

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

A wide array of recovery-oriented behavioral health services is offered to residents of Armstrong and Indiana Counties. The following bullet points highlight strengths of services available for the target populations indicated, as well as brief descriptions of unmet needs or gaps.

1. Older Adults (ages 60 and above)

Strengths:

- Indiana Area Agency on Aging has been selected as the first of five AAAs in Pennsylvania to receive consulting support through the Department of Aging's new initiative, *Consulting Support for Elder Abuse Multidisciplinary Team (MDT) Development*, offered in partnership with Weill Cornell Medicine. This is an important opportunity for our community and one that underscores the strength of our existing partnerships and our shared commitment to protecting older adults. AI-BDHP will be participating on the MDT.
- AI-BDHP team worked closely with P4A, CHC, Carelon, ACMH-2A to problem solve a difficult placement for an older man that had been inpatient for nearly 1 year. A home with good supportive services was located and this man was finally able to transition to his new home.
- AI-BDHP participates in the local Personal Care Home Risk Assessment Committee. This team brings Department of Human Services licensing staff together with local mental health/intellectual disabilities providers and other human service agency staff to monitor the personal care homes in the area, identify problems within the homes and with residents, create ideas to improve the care of residents within the homes and provide communication and collaboration between local agencies regarding individual consumers.
- Armstrong County Senior Expo – the Clinical Care Manager and Case Worker 3 represented AIBDHP and the Senior Care Task Force at the Armstrong County Senior Expo Event held at the Kittanning Twp Firehall on August 27, 2025. Booklets developed by the Senior Care Task Force were distributed.
- The Clinical Care Manager and Case Worker 3 engage in Recovery Supports Meetings facilitated by Carelon BH-MCO, for older adults receiving treatment in a behavioral health inpatient unit. The goal of these meetings is to assist with appropriate discharge planning for a Skilled Nursing Facility and outpatient treatment upon discharge.
- The Clinical Care Manager and Case Worker 3 engage in the monthly IRMC Psychiatric Assistant Liaisons (PALS) meeting facilitated by the PALS Supervisor.
- The Clinical Care Manager and Case Worker 3 engage in the Bi-Monthly Behavioral Health ACMH Meetings. Identified complex care cases from the emergency department and BH Unit which often involve older adult individuals.
- Enhanced Transitional House Program – An individual who is in their early 70's continues to thrive in the community and is on a housing list to get her own apartment. The Enhanced Transitional House staff are supportive of her medical needs and assist with transportation. The

individual continues to engage in behavioral health treatment with the Modified ACT Team and has not needed a BH inpatient stay.

- Modified ACT Team Treatment –Six older adults are currently receiving treatment services though the ACT Team.
- The Clinical Care Manager attends the PA Statewide Quarterly PH/BH – During these meetings, OMHSAS, DDAP, and OMAP present Commonwealth updates; presentations are made by PH/BH MCO's regarding various topics such as Complex Case Best Practices, Integrated Health Care Plans, Best Practices to treat Dementia; and community providers present on various services.
- The Clinical Care Manager and Case Worker 3 engage in Torrance State Hospital Community Support Team Meetings to assist with discharge planning for older adults receiving treatment there.
- The Clinical Care Manager and Case Worker 3 engaged in several Recovery Support Team Meetings in an effort to assist ACMH BH inpatient units with discharge plans for those older adults who are in need of a Skilled Nursing Facility. The Clinical Care Manager has engaged the Regional OMHSAS for assistance when appropriate.

Needs:

- Assess and actively implement a plan(s) for affordable (SSI beds) living at Personal Care Homes and Skilled Nursing Facilities. Not only have Armstrong/Indiana counties lost more PCH beds due to closures, the trend of continuous decrease with availability of SSI beds and significant increase in monthly rent. The average cost of monthly rent at a PCH in the two counties is around $3,650+. Many PCHs deny admission for individuals with SMI diagnoses and individuals ready for discharge from TSH. The same trends also apply to Skilled Nursing Facilities across PA. Many SNFs have changed from long-term to short-term beds, which has been an increasing barrier for individuals to be discharged from BH inpatient units, and state hospitals.
- Improved, and easier access to behavioral health services from CHC MCO's
- We have seen an increase in older people 60 and over with significant mental health needs being incarcerated. Charges are often due to lack of supports and appropriate mental health care, along with neurocognitive declines. If there was safe, appropriate housing-law enforcement and the courts are often willing to lower the charges and allow the person to live in a safe, structured setting.
- Acute inpatient units are holding people 60 and older longer, waiting for guardianships to process thru the court and also find appropriate skilled nursing facilities.
- Continuing assistance is needed regarding outreach and the referral process for residents who are discharge ready from mental health inpatient to be admitted to a skilled nursing facility.
- Improved access for outpatient providers and behavioral health administrations to PH/BH-MCOs' Integrated Health Care plans when individuals sign a release of information. Consumers don't often receive the Integrated Care Plans.
- Continued need for DHS to update the personal care home, and SNF facility lists on their website.
- Critical assistance from government officials to allocate funding to keep open the remaining PCHs, and open new facilities.
- Improved education with skilled nursing facilities and personal care homes on how to provide support and care for people with behavioral health needs, such as a crisis plan.
- Improved access to therapists in OP settings, and Mobile Therapy.
- Clarification with billing when individuals have Medicare as primary, and Medicaid secondary.
- Do away with the need for a denial letter for Medicaid to pay for community BH outpatient services, and LTC treatment facilities (LTSR, EAC) that Medicare does not cover.

2. Adults (ages 18 to 59)

Strengths:

- Our two Partial Hospitalization Programs in Armstrong and Indiana have 'redesigned' to allow more flexibility for our consumers that may be working and or have other obligations
- Monthly meetings are being held with AI-BDHP staff and IRMC-MBH staff to discuss cases, staffing, coordination of care and other logistics surrounding admissions and discharges
- A new prospective PCH that will take clients with SSI/SSD is planning to open in Indiana County within the next several months-this will serve 32 clients.
- We now have monthly meetings with crisis, IRMC-ED, IRMC-MBH, AI-BDHP and IPG in regard to the flow and process of having clients go from the ED to crisis and vice versa
- The Clinical Care Manager and Case Worker 3 engage in weekly clinical coordination meetings with assigned Carelon Care Manager, and monthly with Highmark Whole Care-PH-MCO Care Manager regarding consumers with complex needs.
- Enhance Transitional Housing Program – 13 individuals have benefited from the ETH since opening in March 2020. The Enhanced Transitional House operated by the SPHS staff offers a supportive and integrated team collaborative approach. Every two to three months, each individual has a Treatment Team Review at the A/I BDHP office. Team members include, but are not limited to community providers, consumer identified natural supports, BH-MCO Value Recovery Coordinator, and A/I BDHP Clinical Care Manager and Caseworker 3.
- Assertive Community Treatment (ACT) Team began providing services in November 2022. ACT provides BDHP with updates, and data on a regular basis. There are regularly scheduled meetings with CCM and CW3. Monthly meetings are held with upper management ACT and AI-BDHP, Carelon to review staffing, case load and barriers
- IRMC finished construction on a new 44 bed behavioral health inpatient facility which includes two 12 Bed adult units. Currently, individuals are receiving treatment in one adult unit. The 2nd adult unit had a soft open in June 2026
- The Clinical Care Manager and Case Worker 3 engage in monthly Clinical Collaboration Meetings with Highmark Whole Care, PH-MCO and Carelon BH-MCO, and a PH/BH Social Worker from Indiana Physicians Group. Other providers are also invited to participate when they are involved with the individual. Examples of other providers include: the ACT Team Lead; CHIPP/BSU Liaison; A/I BDHP Dual Clinical Care Manager. The goal of these meetings is to identify/share consumer PH/BH needs; provide information for Integrated Care Plans that are developed by Highmark Whole Care in cooperation with Carelon; identify and assign tasks.
- The Clinical Care Manager attends the PA Statewide Quarterly PH/BH – During these meetings, OMHSAS, DDAP, and OMAP present Commonwealth updates; presentations are made by PH/BH MCO's regarding various topics such as Complex Case Best Practices, Integrated Health Care Plans, Best Practices to treat Dementia; and community providers present on various services.

Needs:

- A SLP provider is needed in Armstrong County to provide support services for this population
- The annual Consumer Focus Groups identified; affordable housing, transportation, and lack of mental health providers as the top three needs this year.
- Workforce Recruitment and Retention - The agency's greatest need is attracting and retaining a qualified workforce. Responses consistently identified staff turnover, difficulties recruiting applicants, shortages of licensed professionals, and challenges retaining employees as significant barriers to service delivery. Strengthening recruitment efforts, improving retention strategies, and supporting staff development are viewed as essential to maintaining high-quality care and meeting community needs.

- Funding and Reimbursement - Financial sustainability remains a major priority for the agency. Respondents emphasized the need for higher reimbursement rates, increased mileage reimbursement, stable funding sources, and legislative support to offset rising operational costs. Adequate funding is critical to maintaining current services, supporting staff compensation, and expanding programs in response to community demand.
- Service Capacity and Client Access - Expanding services and reducing barriers to care is another key priority. Staff identified needs such as improved transportation, additional licensed providers and psychiatric coverage, housing supports, more foster homes, enhanced post-hospitalization services, and expanded community-based programming. Addressing these needs would improve access to care, strengthen the continuum of services, and better support individuals throughout the recovery process.
- Expand Access to Behavioral Health Services and Workforce - Many respondents emphasized the need to improve access to timely behavioral health care by increasing the number of providers, reducing wait times, and expanding specialized services. Priorities included increasing reimbursement for behavioral health services, improving access to mobile therapy, psychiatric evaluations, medication management, evening programming, crisis services, and supporting workforce development through education incentives and provider training.
- Strengthen Housing, Transportation, and Community Supports - A significant theme focused on addressing the social factors that impact recovery. Respondents identified the need for more housing options and independent living supports, increased transportation funding and services, vocational opportunities, and recovery supports such as peer services, coaching, and community-based programs. These resources were viewed as essential to helping individuals maintain stability and remain engaged in treatment.
- Increase Prevention, Family Education, and Community Collaboration - Respondents highlighted the importance of prevention and community engagement through mental health education, family and caregiver support groups, free community trainings, and greater awareness of available resources. They also recommended improving collaboration among providers through regular meetings and coordinated efforts to help individuals navigate services, strengthen partnerships, and build a more informed and supportive community.

3. Transition age Youth (ages 18-26)

Strengths:

- To address the needs of the Transition-Age Youth (TAY) population, the Child and Adolescent Service System Program (CASSP) case workers and Adult Services staff of the AI-BDHP work closely on a case-by-case basis to transition young adults from child/adolescent services to adult services. Because of this close working relationship, many youths have been able to successfully move into adult levels of care and independence seamlessly.
- The Clinical Care Manager and Case Worker 3 engage with a TAY in weekly clinical coordination meetings with assigned Carelon Care Manager, and monthly with Highmark Whole Care-PH-MCO Care Manager regarding consumers with complex needs.
- TAY can be referred to the Assertive Community Treatment (ACT) Team, the Enhance Transitional Housing Program and to I&A Residential for either CHIPPS or CRR housing.
- Monthly meeting held with AI-BDHP staff and IRMC-MBH staff to discuss cases, staffing, coordination of care and other logistics surrounding admissions and discharges
- Some Indiana University of Pennsylvania students reside in local CRR programs. This residential program has allowed students to remain in school and remain engaged in their mental health recovery.

Needs:

- Increased housing opportunities that focus on TAY only with extra services to help address the specific needs of someone in that age group who needs extra support learning to live independently.
- Employment services/training for the TAY population such as job coaches or job shadowing programs is an identified need. While these programs exist through our vocational providers in each county, the funding is primarily for those with intellectual disabilities. Additional funding for vocational/employment services for the mentally ill would provide more opportunities for the TAY population to gain employment by providing them with valuable employment skills and coaching.
- Daily/independence skills
- A SLP provider is needed in Armstrong County to provide support services for this population

4. Children (under age 18)-

Strengths:

- Foundational to providing children's behavioral health services in both Armstrong and Indiana Counties are the use of Child and Adolescent Service System Program (CASSP) principles and Family Group Decision Making in our local service delivery system.
- Currently, AI-BDHP employs a CASSP Coordinator and one Children's Service Navigator. We offer Service Navigation Meetings, CASSP meetings, Individual Planning meetings, and Complex Case Meetings. These team meetings allow us the opportunity to discuss service options with families helping to divert from higher levels of care such as an RTF.
- AI-BDHP staff also facilitate meetings for RTF and CRR recommendations and monitor the children and adolescents serviced in those levels of care.
- The Children's Advisory County 23rd Family Fun Fest took place at the Indiana Mall on March 21, 2026, and the annual Family Nature Palooza was held on June 6 at Blue Spruce Park. Combined there were more than 1,200 children and adults that participated in these two events. More details about these events are noted in the highlights section of this plan.
- Other Services available to Children in Armstrong and Indiana Counties include:
    - Two Site Based Autism Programs are available in Indiana County.
    - Multisystem Therapy (MST) is being utilized as a preventative service for Indiana and Armstrong County Children, Youth and Family Services (CYFS).
    - School Based Outpatient Mental Health Treatment Services are available in all school districts in Armstrong and Indiana Counties.
    - The Base Service Units in each county employees a Student Assistance Program (SAP) Liaison.
    - An Elementary SAP position is available for the Indiana County School Districts.
- Within the AI-BDHP office the CASSP staff and the Early Intervention coordinator participate in multiple collaborative committees together including Indiana's Children's Advisory Committee, the Early Childhood Education Committee, and the Interagency Behavioral Support Committee
- AI-BDHP staff for children's mental health, intellectual disabilities, and early intervention along with the Administrator continue to meet quarterly with CYS staff from both Armstrong and Indiana Counties. During these meetings difficult and complex cases are discussed. These meetings have been beneficial for improved communication and better understanding of each of our systems.
- IRMC has opened a new 44 bed behavioral health inpatient facility. Eight (8) adolescent beds are now available to serve this population.
- Teen Mental Health First Aide is being offered to high school students in six school districts in Indiana County.
- Monthly meetings held with AI-BDHP staff and IRMC-MBH staff to discuss cases, staffing, coordination of care and other logistics surrounding admissions and discharges

- Meetings were facilitated by the Commissioners in Armstrong and Indiana Counties and ARIN IU 28, with the respective school district superintendents in each county to discuss mental health and Drug and Alcohol service needs for children in May and June 2026.

Needs:

- The lack of qualified IBHS staff is having a significant impact on children getting services in Armstrong and Indiana Counties. Providers are unable to recruit qualified staff causing a waiting list for IBHS. Children are waiting for long periods of time before services can be offered.
- The lack of Community Residential Rehabilitation Host Homes within our two counties has resulted in children/adolescents being placed on waiting lists.
- Staff shortages continue to decrease the number of placements available at Residential Treatment Facilities. As a result, children/adolescents are either waiting on inpatient units or at home for acceptance into an RTF.
- A system wide need that has been identified by behavioral health professionals and providers is a lack of child psychiatrists in our counties.
- Even though we have access to a respite provider often there are no available openings, so children/adolescents are unable to utilize this service. More respite services are needed.
- A system that is easier for families to navigate to reactivate their child's medical assistance when the child becomes inactive.
- Develop a planning process for complex cases specifically for teenage females that require RTF level of care

5. Individuals transitioning from state hospitals.

Strengths:

- Clinical Care Manager, Caseworker 3 and CHIPPS Liaisons from FCC and CGC work together with TSH staff to develop placement ideas for potential discharges. We attend monthly treatment team meetings and CSP meetings with TSH and bi-weekly meetings with the CHIPPS Liaisons.

Needs:

- More community housing and alternative housing options in the community. There are fewer personal care home beds available due to closures and the desire of the personal care homes to admit more private pay residents as opposed to those who cannot afford to pay the private rates and who qualify for the PCH supplement. PCH administrators have reported that the supplement amount is still too low.

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

Strengths:

- The AI-BDHP Administrator is a member of the Opioid Settlement Committees in each county.
- Improved integrated care between AICDAC and ARC Manor with OP providers, and BDHP.
- Improvement with various forms of communication, and engagement in Recovery Support and Community Integrated Care Meetings.
- AICDAC and D&A providers participate and share data at the PALS, Joint Hospital, and ACMH meetings.
- AICDAC presented to AI-BDHP mental health staff regarding drug trends and levels of care.

Needs:

- Analysis of data results show increased housing needs for consumers with dual diagnoses (drug and alcohol and mental health) Increased need for housing, including halfway houses for individuals who have substance use/mental health treatment needs.

- Education regarding housing opportunities through AICDAC and other providers. Increased outpatient and inpatient treatment options/providers for dual drug/alcohol and mental health treatment.

7. Criminal justice-involved individuals

Strengths:

- AI-BDHP's Forensic Caseworker/ CIT Coordinator serves as a critical liaison between the Armstrong-Indiana Behavioral Health Developmental Program (BDHP) Office and key stakeholders in the criminal justice and behavioral health systems. This role facilitates communication and coordination among law enforcement agencies, local jails, judicial court systems, Torrance State Hospital Forensic unit, GJR Forensic LTSR, OMHSAS, the Mobile Competency Restoration Team (MCRT), and Law Enforcement Liaisons. The following contacts were made in FY 25-26 - 17 competency evaluation referrals, 2 admissions to TSH-Forensic for competency restoration, 7 MCRT, 4 MCRT maintenance, 4 Neurological evaluations, 1 re-eval for competency, 1 304 to TSH-F. 5 inmates diverted from TSH-Forensic
- The Forensic caseworker also attends quarterly MH Forensic meetings for both Armstrong (created this year) and Indiana, quarterly Police Chiefs meetings arranged by DA office, CJAB meetings, and Armstrong County Disaster Relief Team meetings. Frequently visits both county jails to see inmates and assist with complex cases.
- The Forensic Caseworker facilitates meetings between local law enforcement and Crisis to help strengthen relationships. Built a working relationship with IUP police academy. Additionally, the Caseworker assists in competency restoration efforts, monitors case progress, and helps navigate complex legal and clinical pathways to promote recovery and reduce recidivism.
- CIT Coordinator has facilitated in 25-26 FY 3 CIT classes, one IUP Police cadet class, 2 first responder classes which included jail staff, police officers, probation, dog wardens, crisis, and EMTs
- AI-BDHP Forensic caseworker has provided ‘hearing voices’ and de-escalation to ACJ and ICJ staff. She has also provided ‘hearing voices’ training to our local crisis department
- The Forensic Caseworker and AI-BDHP Court Coordinator participated as trainers in the local Purple One Training put on through HAVIN. Purple One is a four-hour training that teaches individuals how to Recognize, Respond to and Refer victims of domestic violence. Following the training, organizations with a physical location can apply to become Purple One Safe Places for Domestic Violence Victims allowing them to display the Purple One Dot on their business window or office door.
- The Armstrong County Jail inmates were trained in suicide prevention by a QPR trainer that is a member of the Armstrong County Suicide Task Force. The inmates indicated that this was a very beneficial training to them.
- Armstrong and Indiana Law Enforcement Liaisons (LEL’s) are able to utilize ACLU funds to support individuals in the community, have knowledge and relationships with all local providers, support treatment courts, have contact with the AOPC and attend conferences that address mental health, addiction and other topics
- The MH LELs make referrals as needed, assist with discharge plans, provide information and education regarding consumer involvement with the Criminal Justice System, and facilitate communication between the criminal justice system, providers, and BDHP.
- From July 1, 2025, until June 30, 2026, the Armstrong County LEL engaged in services and supports of 59 individuals. 50 individuals were new, and 9 were repeat clients. 20 had a verified mental health diagnosis, 4 were SDU with no verified mental health, 5 had an ASD/IDD diagnosis, 27 were diagnosed with cooccurring disorders and 7 had no information. 3 were inmates returning from the DOC. 2 had Sexual Offense charges. Of the individuals assisted 17

were women and 42 were men, the average age of 36-50 and the majority of referrals were provided by the Provider, closely followed by the District Magistrate and Public Defender's Office.

- The Law Enforcement Liaison of Indiana County has served 67 individuals between July 1st 2025 - June 30th 2026 and continues to grow. The LEL has assisted with coordinating individuals within the program to appropriate treatment. LEL has successfully assisted with 39 individuals going into treatment. Treatment has included 25 outpatient therapy/medication management, 9 partial hospitalization and 3 Merakey ACT, 1 LTSR and 1 TSH. LEL has assisted with completing 1 FLSTR referral. LEL has also assisted with finding housing for individuals coming out of incarceration. LEL has worked with 21 unhoused individuals and has successfully found placement for 13 individuals. Home plans have included 2 Personal care homes, 2 I&A Residential Housing, 2 Shelters and 7 Family/Friends.
- AI-BDHP Forensic Caseworker and Indiana LEL have set up quarterly meetings with Primecare Medical that oversees all physical and behavioral health needs for inmates currently at Indiana County Jail.
- LETI-BH initiative in Indiana County- As noted in the highlight section. Indiana County became the fifth county in the Commonwealth to have dual behavioral health and Substance Use Disorder Law Enforcement Treatment Initiative.
- The Forensic Caseworker and the A-I BDHP Court Coordinator have started providing ongoing trainings as needed for law enforcement and court related personnel in recognizing the behavioral symptoms and characteristics of a child or adult who has autism, and to learn the basic response techniques.

Needs:

- Improved assistance from the State Correctional Facilities to locate housing.
- Improved mental health treatment in the county jails.
- Continued Crisis Intervention Training (CIT), MH First Aid, and Mental Health Procedures training for law enforcement and court-related personnel.
- Specialized adaptation and training for individuals with autism/idd who have an incarceration sentence.
- Independent housing for those with criminal histories, including housing opportunities and landlord education.
- Employment programs/opportunities for individuals with criminal histories for training/retraining, skill building, and local employer relationship building and education to help encourage employers to hire individuals with mental illness who also have criminal histories.
- Improved coordination, collaboration, and communication with local and state offices of Probation and Parole, including education for both mental health staff and probation and parole officers.
- We have seen an increase in 60 and older people with significant mental health needs being incarcerated. Charges are often due to lack of supports and appropriate mental health care, along with neurocognitive declines. If there was safe, appropriate housing-law enforcement and the courts are often willing to lower the charges and allow the person to live in a safe, structured settings.

8. Veterans

Strengths:

- Armstrong and Indiana Counties have a Veterans Treatment Court (VTC) to address the growing number of Veterans involved in the criminal justice system.
- The VTC is a huge benefit to the county, the ability to follow the APOC and unify treatment courts is an advantage in that it allows us to prepare for other treatment courts and begin building treatment relationships with providers so we can support a multifaceted population. This creates

the opportunity for treatment-based education to a variety of disciplines which helps in the overall goal of diversion from the criminal justice system.
- One of our local clinicians and member of our Indiana STF is now offering a Veterans Suicide awareness training
- 2 staff from AI-BDHP have been involved with the Veterans Group-both Armstrong and Indiana.
- We have provided assistance at the Indiana County Fair at the Veterans table which has allowed us to interact with the veterans and explain services available.
- We also had a table at the Indiana County Veterans expo held in November 2025

Needs:
- Ongoing education is needed to make Veteran's aware of the behavioral health services that are available to them.
- Change in government funding has reduced resources, lack of funding to cover trainings, conflicting schedules making trainings hard to schedule.
- Long term MH treatment options need to be readily available at the VA Centers to avoid state hospitalization. It is not uncommon for the VA to deny long term treatment services saying that individuals are too acute for their care. This results in the AI-BDHP having to look at placing the individual at Torrance if an appropriate diversion is not available. Fortunately, we don't see a large number of veterans who require extended treatment, but it does happen.

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

Strengths:
- Recent contract with our MCO and Persad Center that specializes in providing therapy, medication management and groups to the LGTBQ+ community
- PERSAD Center representatives have been actively participating in provider meetings, joint hospital meetings and various other stakeholder meetings and events. These relationship building activities provide a great opportunity for this population to learn about the services that are available.
- Identified a local support/social group in Indiana County and added to the A/I BDHP Behavioral Health Resource Guide.
- Identified and added to the resource guides national crisis support programs for LGBTQI individuals.

Needs:
- Encourage providers to develop more specialized services to serve LGBTQI persons as well as become more welcoming and affirming to all persons.
- Monitor and collect data regarding suicide and mental health needs for LGBTQI

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

Strengths:
- Recent contract with our MCO and APM that specializes in providing services to the Spanish speaking population has been established.
- Although access to language assistance does not appear to be a great need in our counties, the Armstrong-Indiana Behavioral and Developmental Health Program strives to ensure that assistance is readily available to the behavioral health population when it is needed.
- AI-BDHP encourages each provider agency to have a memorandum of understanding in place or contract with an interpreter service provider for those who have a limited working knowledge of the English language or in need of ASL.

Needs:

- As with the previous target population there is a need for ongoing educational opportunities. Any training sessions that become available we will pass this information on to our community stakeholders and providers so they can become more aware of the unique issues faced by our consumers that would be considered minorities, as well as on ways to become more welcoming and affirming to all persons who differ from us.
- Our counties frequently serve individuals from the Amish and Mennonite Communities. Providers need to be sensitive to the strongly held beliefs and practices of this population.

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

***Previous Year List**:*
The following is a summary of the progress made on our FY 25-26 plan ROST priorities:

a. Priority #1 – Continued Efforts to Address the Mental Health Housing Shortage

Enhanced Supportive Housing
I am happy to report that Southwest Pennsylvania Human Services, Inc., was finally successful in finding a property to create an Enhanced Supportive Housing program. The property purchased in May 2026 is a "single family" home because there was no availability of the subdivided property we were hoping to find. We believe that the home purchased will be comfortable for three individuals to live independently with minimal supports. Since the property was in need of some renovations SPHS is hoping to have the home ready for individuals to move in ready by September 2026.

Personal Care Home Access
The partner we were hoping to work with in last years plan did not transpire. We continued to pursue multiple leads and are currently working on a project with Westmoreland County using an already approved HealthChoices Reinvestment plan. This project would purchase a personal care home that is for sale in Armstrong County. This facility when opened would offer 16 personal care home beds to individuals in need of this level of care. This project is currently being developed and will be indicated as a Priority for FY 26-27.

Housing Partnerships
In Indiana County, Commissioner Bonni Dunlap created the Indiana County Human Services Cabinet. This group is made up of the directors for the human services programs in the county. This includes the Department of Human Services, the Drug and Alcohol Commission, AI-BDHP, Indiana County Community Action Program, Indiana Housing Authority, the Indiana planning office and the Children & Youth Agency. We meet on a monthly basis and the purpose is to assess cross system and program needs and utilization of resources. The first area of focus has been and continues to be housing and transportation. Through these efforts we are working with the Commissioners and the Indiana County Development Corp. to develop a plan for a duplex that instead of being torn down can be renovated to house seniors that have been diagnosed with mental health needs. This will be included in our housing priority for FY 26-27.

b. Priority #2 – Expanding Employment Opportunities through Building Community Partnerships

Minimal progress was made related to the Employment Opportunities priority. The Armstrong Indiana Employment Coalition met on October 7, 2025, and on April 21, 2026. The Coalition continues to have good attendance and robust discussions at their meetings. Due to everyone's busy schedules no spring 2026 event was held. The Administrator and the ID Director did meet with both ICW and Progressive

Workshop to discuss the status of current programs and employment possibilities for the future. From these discussions it was determined that limited Mental Health funding and lack of transportation for individuals to get to vocational or employment sites limits expansion for employment programs in both counties especially for MH individuals. Transportation issues significantly impact individuals with ID as well. We will be keeping this priority for the 26-27 plan year.

c. Priority # 3 – Transportation Solutions Workgroups

Despite this being an ongoing need, no progress was made on this priority. We have determined that without the funding to hire a transportation project manager or transportation coordinator it will be difficult to make any progress on this priority. We will not be carrying this priority forward. Instead, we will be incorporating individualized transportation needs into our proposed priorities for FY 26-27. Additionally, we will be continuing to work on collaborative efforts with our other systems partners to see if we can address this ongoing issue.

d. Coming Year List:

1. Priority #1 - New Mental Health Housing Projects

☒ Continuing from prior year ☐ New Priority

a. Narrative:

For the fourth consecutive year Armstrong-Indiana will be keeping Mental Health Housing as the #1 Priority for FY26-27. This year, however, the focus will be on the development of three projects. One that has been in development and two that are new.

Enhanced Supportive Housing

Through a previously approved CHIPP plan, we have been working with Southwest Pennsylvania Human Services, Inc. (SPHS) over the last two years to create an Enhanced Supportive Housing (ESH) unit. The concept of this home was developed to promote independent living but with 24/7 access to staff. Although our original intent was to locate a property that had individual apartments in one complex, a subdivided property like this proved to be impossible in our area to find. Therefore, we pivoted and instead found a large single family home that will provide ample space for individuals to have independence but also have support of housemates along with daytime staff. The property was purchased in May 2026. Renovations, home set up, and hiring staff is currently taking place. The anticipated opening of this home is set for September 2026.

Enhanced Personal Care Home

The decline in the number of personal care home (PCH) beds has been an ongoing issue documented in our human service plans and in our CHIPP proposals over the last four years. Since 2018 there has been a 30% decrease in the capacity of PCH beds. The most recent numbers, as reported on the OLTL website, indicate a combined Licensed Capacity Personal Care Home beds in Armstrong and Indiana Counties as being 823. This is a 12% decrease from 2025.

In 2021 an approved Southwest Regional Enhanced Personal Care Home Healthchoices Reinvestment plan, the counties of Armstrong, Indiana, Butler, Lawrence, Washington and Westmoreland, identified the increased need for long term residential services and supports for residents with more complex serious mental health disorders. The specific priority population for this program will be for those individuals currently residing in or diverted from a clinically intensive level of mental health residential services, such as a local or state psychiatric inpatient unit, Extended Acute Care (EAC) unit, or Long Term Structured Residence (LTSR) that have the need for a personal care home level of care.

Through utilizing these funds Armstrong-Indiana and Westmoreland will be partnering with two long time provider agencies to develop a new 16 bed Enhanced Personal Care Home in Armstrong County. The Nonprofit Development Corporation (NDC) will be purchasing and managing the facility site. SPHS, who is experienced with operating a licensed personal care home, will be contracted with Armstrong/Indiana and Westmoreland to staff and run the EnPCH. The proposed site was formerly licensed as a personal care home. We have agreed that 8 beds will be utilized for Armstrong/Indiana and 8 will be used for individuals from Westmoreland.

Residents of the EnPCH will be provided access to mental health treatment and other community services and supports to enhance their recovery. These could include outpatient mental health treatment, mobile psychiatric rehabilitation, intensive case management, peer support, as well as the standard physical health, dental care and linkages to vocational and educational opportunities as appropriate. These services and supports will be provided to residents through agreements and partnerships with local community agencies. Additional onsite psychiatric services and medication management supports and education for residents will be provided as well. Natural supports including family, peers/friends, faith-based supports, etc., will also be encouraged to be involved with the development and implementation of the individual's recovery, support and/or crisis plan.

It will be several months before we can expect this project to be completed. Following the purchase process, renovations will need to be completed, then licensing and staffing.

Senior Enhanced Supportive Housing Project
Indiana County faces a severe senior housing shortage, driven by low rental availability, long waiting lists, and a shrinking pool of licensed care facilities. For every 100 extremely low-income senior and disabled renter households in the county, only 46 affordable rental units exist. The Indiana County Development Corporation (ICDC) is leading a major senior housing project to convert some former student apartment complexes into an affordable independent senior living community. One of the existing buildings will be completely renovated into multi-layout independent senior living apartments. The other larger building is slated for demolition due to its restrictive structural layout. On this site, one-level, cottage-style senior homes will be built around a central courtyard.

A third smaller one story duplex was also targeted to be demolished, but due to the efforts of the Indiana County Commissioners and the discussions that took place with Indiana County Human Services Cabinet the idea was brought forth to save this duplex and use it for a specialized population. A brief service description of this proposed project follows:

The Senior Enhanced Supportive Housing program would be located in Indiana Borough at a county owned duplex (each unit is one story with two bedrooms) and provide a place for four seniors with diagnosed behavioral health needs to live. This step-down to independent living option will offer an opportunity for someone to live without the support of 24/7 staff. Ages 50 and over individuals enrolled in this program will have on-site access to program staff based on individual need and will have remote access to staff 24 hours/day. Program staff will proactively gauge the needs of the individuals in the program and design specific services and frequencies of services based on their individual needs. This could include light housekeeping and meal preparation.

Through the Senior Enhanced Supportive Housing program, individuals will be encouraged to maintain independent living skills with the assistance of program staff. Although individuals can remain in the unit indefinitely, the goal for everyone will be to develop the highest level of independence based on their ability. If the program, the individual, and all other supportive services determine that additional assistance beyond the scope of this program are needed, a plan will be developed to transition the individual to another appropriate longer term setting. Additional behavioral health services will be

utilized as needed for individuals. These could be in home services such as Mobile Medication Nurse, Assertive Community Treatment, or Peer Specialist; or in the community such as outpatient, partial hospitalization, psych rehab, drop in center or others.

Final approval of this project is yet to be granted. We will be advocating for this project along with our system partners.

b. Timeline/ Action Steps

Target Date	**Action Steps - ESH**	**Person(s) Responsible**
July – August 2026	Enhanced Supportive Housing Home • Renovations completed • Furniture and set up of house • Hiring staff	SPHS management & staff
July – August 2026	Referral process and program planning meetings with BDHP staff	SPHS staff BDHP Clinical Care Manager and Case Worker 3
September 2026	New Enhanced Supportive Housing Unit opens	SPHS management & staff
Target Date	**Action Steps – Enhanced PCH**	**Person(s) Responsible**
July – September 2026	Purchase PCH property • Closing Date to be determined • Meet to set timeline for renovations	NDC – Provider AIBDHP Westmoreland County
October – December 2026	Renovations to be completed	NDC
December 2026 – April 2027	• Get facility licensed • Hire staff	SPHS - PCH Partner
May – June 2026	Begin serving individuals	SPHS - PCH Partner
Target Date	**Action Steps – Senior ESH**	**Person(s) Responsible**
August 2026	Seek approval of Senior Enhanced Supported Housing Project from ICDH	Indiana County Commissioner AIBDHP Administrator
September 2026 – June 2027	• Determine ESH partner • Work with Indiana Planning office to determine timeline for property renovations	AIBDHP Administrator & Staff

c. **Fiscal and Other Resources**:

- HealthChoices Reinvestment funds will be used to fund the purchase and renovations of the new 16 bed Enhanced Personal Care Home.

- Annualized CHIPP funds will be used to support the new Enhanced Supportive Housing Programs and the Enhanced Personal Care Home.
- A new joint (Armstrong/Indiana and Westmoreland) CHIPP proposal was submitted for consideration to be used for the operation of the new Enhanced Personal Care Home.

d. **Tracking Mechanism**:

- We will follow the appropriate CHIPP reporting requirements for any CHIPP funds utilized.
- For the HealthChoices Reinvestment Funds –
    - Southwest Behavioral Health Management (SBHM) will contract with NDC which will impose restrictions on property related to long term use of the property and implications if the property is sold.
    - SBHM will hire an outside entity to monitor the use of the reinvestment funds related to renovations.
- We will be reporting to our advisory board and during provider meetings regarding the progress of this priority.
- Finally, we will provide updates during our ongoing housing stakeholder meetings as Indiana County Human Services Cabinet

2. Priority # 2 – Continued Efforts to Increase Employment Opportunities and Workforce Development

☒ Continuing from prior year ☐ New Priority

a. Narrative:

Armstrong and Indiana Counties are taking steps to ensure that anyone who wants to work has the support to do so. As indicated in last year's employment priority Armstrong and Indiana Counties believe that employment is a cornerstone of recovery and independence. By continuing to focus on employment opportunities for any individual regardless of their diagnosis (Intellectual Disability or Mental Health) we are affirming the dignity and value of every person in our community. Together, we are building a future where everyone has the opportunity to thrive.

Employment Coalition Efforts

A robust Employment Coalition meets quarterly, bringing together employers, service providers, supports coordinators, the Office of Vocational Rehabilitation (OVR), local legislative office representatives and the county AIBDHP office. Through the discussions that take place during these meetings it was identified that our employment support agencies are having a difficult time finding local businesses that will permit their business to be used as an assessment site. These agencies have indicated that they have to take individuals to Pittsburgh in order to do an assessment. As a result, the Coalition has determined that they want to form a smaller sub-committee to develop a plan to address this issue and set this as a goal for FY26-27. One of our local community employment providers has indicated that they will take the lead on this project. The provider, along with an ID BDHP staff member and possibly another coalition member, will be setting up individualized meetings with local businesses to discuss the need for assessment sites and to discuss the benefits of hiring the population we serve.

Project Search

We are pleased to report that discussions related to Project Search with Armstrong County Memorial Hospital (ACMH) have started again. In our Human Services Block Grant Plan for FY 24-25 Project Search was introduced. Unfortunately, due to funding cuts at OVR and staff turnover this project had to be put on hold. Recently we were notified by OVR that they are permitted to restart these efforts. As a refresher, Project Search, as described on their website, is a Transition-to-Work Program. It is a unique,

business-led, one-year employment preparation program that takes place entirely at the workplace. Total workplace immersion facilitates a seamless combination of classroom instruction, career exploration, and hands-on training through worksite rotations. The program culminates in individualized job development.

As previously mentioned, Armstrong County Memorial Hospital has agreed to partner with our office to be our local Project Search location in Armstrong County. Meeting dates are set to restart the planning efforts. We will need to find additional partners related to training and employment. This will be a large undertaking for our county but the benefits will be significant.

Mental Health Employment Goal Planning
We have been working to strengthen our drop in centers, and meeting with our mental health providers more frequently to ensure that the needs of the individuals receiving behavioral health services are understood. We will be urging our vocational programs, psychiatric rehabilitation services, peer support programs, and drop-in centers to create a seamless network of employment support and encouraging the exploration of vocational and employment goal setting for individuals being served. Collaborations with CareerLink offices will be initiated to develop strategic plans for outreach and engagement, ensuring that individuals with mental health diagnoses are not left behind. Additionally, we will be working on determining what trainings or workshops individuals might need related to employment efforts.

As the impacts of HR1 are rolled out in 2027 we will also be encouraging our providers to work with all individuals enrolled in Medical Assistance to maintain their eligibility. It will be vitally important that individuals are meeting all necessary work requirements if they are not in an exemption category.

Workforce Promotion
Through the planned efforts of the employment coalition to meet with local businesses we are hopeful that these interactions will develop the relationships to support employment opportunities for the individuals that we serve. By encouraging participation in employment-focused events such as the ODP Employment Symposium, we aim to spotlight the talents and potential of individuals with behavioral health challenges.

To further support these efforts AIBDHP plans on participating in Indiana County's Career Link Day to be held September 11, 2026. This event will highlight: employment opportunities, career services, partner agencies, and community resources.

All these efforts will help dismantle stigma, promote recovery through meaningful work, and build a more inclusive labor market.

b. Timeline/ Action Steps

Target Date	**Action Steps – Employment Coalition**	**Person(s) Responsible**
July 2026 – June 2027 (Ongoing)	Employment Coalition will hold Quarterly meetings	Employment Coalition Members AIBDHP Staff Provider Agencies SCO Employers OVR
August - September 4, 2026	Encourage attendance of the Office of Developmental	Employment Coalition Members AIBDHP Staff Provider Agencies

	Programs' 2026 Employment Symposiums	
August 2026	Employment Coalition – Subcommittee for Business Partner Development Meeting(s)	Employment Coalition Members AIBDHP Staff
September – December 2026	Schedule Meetings with Local Businesses	Employment Coalition Members
Target Date	**Action Steps – Project Search**	**Person(s) Responsible**
September 2026 – June 2027 (ongoing)	Project Search Planning Meetings	AIBDHP Staff OVR ACHM Project Search Partners
Target Date	**Action Steps - Employment Goal Planning**	**Person(s) Responsible**
January – June 2027	Determine Trainings for Behavioral Health Individuals • Benefit Concerns • Employment Training Opportunities	AIBDHP Staff Provider Partners Career Link / OVR
Target Date	**Action Steps – Workforce Promotion**	**Person(s) Responsible**
September 11, 2026	Attend Indiana Career Link Event	AIBDHP Staff

c. **Fiscal and Other Resources**:

There are various expenses which will be incurred for the following proposed employment projects.

Employment Project	**Estimated Costs**	**How will this be funded?**
Employment Goal Planning	$2,000 - $5,000 Allocate for Trainings	ID or MH Base Funds / CMHSBG Training Funds
Project Search	This is in the early stage of development and exact costs are not yet known. We are estimating between $25,000 - $50,000 per year for the following cost. Instructor, curriculum, supplies Sponsors student interns to support skills training and job development.	OVR funds, ID Base Funds, and Training grants

d. **Tracking Mechanism**:

The AIBDHP staff will provide updates on Employment Coalition meetings to the ID/A Director, the MH Director and the Administrator. All event announcements will be distributed through listservs and through posting on the AI-BDHP Websites and other appropriate Facebook pages.

Updates will be provided at both ID and Mental Health Provider agency meetings.

The Advisory Board will be given updates on all the Employment Priority projects at our scheduled Advisory Board meetings.

3. Priority #3 – Building Capacity for Transition Age Youth

☐ Continuing from prior year ☒ New Priority

a. Narrative:

Transition-age youth (ages 14–26) in Pennsylvania face a critical gap in mental health care as they age out of child-focused systems and struggle to navigate complex adult systems. Key challenges include service drop-offs, eligibility barriers, and a lack of tailored independent living support.

The "Cliff Effect" for services like specialized family-based therapy or school-tied services and supports abruptly stop at age 18 or 21. Young adults must switch to unfamiliar adult mental health models with less care coordination. This population also often experiences High Need, Low Use. Ages 18 to 25 feature high rates of emotional distress and psychosis triggers, but the lowest utilization of ongoing treatment.

As noted previously in the TAY strengths and needs section, in order to address the needs of the Transition-Age Youth (TAY) population in Armstrong and Indiana Counties, the Child and Adolescent Service System Program (CASSP) case workers and Adult Services staff of the AI-BDHP work closely on a case-by-case basis to transition young adults from child/adolescent services to adult services. Because of this close working relationship, many youths have been able to successfully move into adult levels of care and independence seamlessly.

Through working with this population our staff have identified some ongoing challenges that need to be addressed. These include:

- *Housing* - Increased housing opportunities that focus on TAY only. This age group needs extra support learning to live independently.
- *Coordination of Care* – As mentioned previously the cliff effect of services often leaves these young adults and the service providers struggling to navigate systems. There is no dedicated case manager or system navigator available to help coordinate and follow the TAY through the transition of services.
- *Daily/independence skills training* - Adolescents who have been in residential treatment settings or unstable living arrangements in most cases have not learned the skills necessary to live independently. These include cooking, housekeeping, and financial management.
- *Soft skills development* - Transition-age youth face a critical period of independence, and soft skills—such as communication, problem-solving, self-management, and relationship-building—are essential for navigating education, employment, housing, and personal growth. Development of these skills empower youth to build confidence and resilience, navigate complex systems (education, employment, housing), make informed life decisions, and maintain healthy relationships and personal boundaries
- *Employment training* - Employment services/training for the TAY population such as job coaches or job shadowing programs is an identified need. While these programs exist through our vocational providers in each county, the funding is primarily for those with intellectual disabilities. Additional funding for vocational/employment services for the mentally ill would provide more

opportunities for the TAY population to gain employment by providing them with valuable employment skills and coaching.

Through this priority AIBDHP would pull together a targeted work group of professionals along with family members and/or youth. Preliminarily we would expect this work group to look at current services available and obtain feedback from providers. More importantly there would be an expectation that transition age youth would provide insight into what the needs are and how the system could be more helpful for them.

Based on this information we would look to see if changes could be made to our existing system to better support TAY or determine what new services need to be developed.

b. Timeline/ Action Steps

Target Date	**Action Steps – Development of TAY Work Group**	**Person(s) Responsible**
July 2026 – October 2026	• AIBDHP Staff meet to determine work group members • Assemble Work Group • Start holding meetings	AIBDHP Staff
October – November 2026	Assess current services available to TAY in all systems	AIBDHP assigned staff TAY Work Group Members
December 2026 – February 2027	Work Group Develop Proposal for building capacity for TAY	AIBDHP Assign Staff TAY Workgroup
March - June 2027	Work Group Proposal is presented to AIBDHP and Stakeholders Next Steps are determined	TAY Workgroup AIBHP TAY Stakeholders

c. Fiscal and Other Resources:

We do not anticipate that the work group activities will require any financial support. Once a proposal for the TAY capacity is developed we would expect this to include a need for additional funds.

d. **Tracking Mechanism**:

- The AIBDHP staff will provide updates on TAY Workgroup to the MH Director and the Administrator.
- Updates will be provided at Mental Health Provider agency meetings.
- The Advisory Board will be given updates on TAY Priority at our scheduled Advisory Board meetings.

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?

- *Expanding access to care*: Telehealth is used to provide behavioral health services to individuals and families who may have difficulty attending in-person appointments.
- *Supporting continuity of services*: Agencies use telehealth to ensure services continue when in-person care is unavailable due to staffing challenges, transportation barriers, illness, weather conditions, or other circumstances.
- *Providing flexibility for clients and families*: Telehealth allows for greater scheduling flexibility, including supporting families in different locations, coordinating sessions across households, and providing services when clients are temporarily away from their usual area.
- *Supporting multiple behavioral health services*: Telehealth is utilized for services including outpatient therapy, case management, psychiatric services, medication management, behavioral services (including BC-ABA/BA), family support, and occasional check-ins.
- *Used as a supplement to in-person care:* Most agencies indicated that in-person services remain the preferred method of care, with telehealth offered when clinically appropriate or when barriers prevent face-to-face meetings.
- *Implemented based on individual needs:* Some agencies provide telehealth broadly, while others determine its use on a case-by-case basis depending on client needs, service type, and clinical considerations.

b. Is the county implementing innovative practices to increase access to telehealth for individuals in the community*?*

- *Expanded technology options*: Some programs have increased access by allowing clients to participate in appointments using various devices, including phones, tablets, and computers.
- *Telehealth education and support*: Staff are assisting individuals and families with hands-on guidance to help them navigate telehealth platforms, including accessing applications, joining virtual sessions, understanding confidentiality expectations, and becoming comfortable with the process.
- *Blended in-person and telehealth approach*: Some agencies require an initial face-to-face appointment before offering telehealth options, helping establish care while providing flexibility for future visits.
- *Use of alternative communication platforms*: One agency reported using social media-based communication tools, such as Facebook Messenger, to support access and communication.
- *Limited implementation of new initiatives:* Most respondents indicated that they are not currently implementing additional innovative practices specifically focused on expanding telehealth access.

c. What are the obstacles the county encounter in the deployment of telehealth services?

- *Limited internet and cellular access***:** The most frequently identified barrier is inadequate broadband availability, unreliable internet connections, and limited cellular service, particularly in rural areas.
- *Lack of technology equipment*: Some individuals do not have access to necessary devices such as computers, tablets, or smartphones needed to participate in telehealth appointments.
- *Limited digital literacy and familiarity***:** Some consumers and families may find telehealth confusing or intimidating due to limited experience with virtual platforms, difficulty accessing applications, or challenges troubleshooting connectivity issues.
- *Limited data or Wi-Fi access***:** Barriers include insufficient phone data plans and lack of reliable Wi-Fi access, which can prevent successful participation in virtual appointments.
- *Need for in-person clinical services:* Certain services require face-to-face visits due to clinical needs, such as physical health monitoring related to medication management.

- *Overall access disparities*: Responses indicate that technology availability, internet infrastructure, and individual comfort with digital tools continue to impact equitable access to telehealth services.

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

   ☒ Yes ☐ No

   Overall, our providers indicated a strong commitment to implementing trauma-informed care (TIC) across their organizations through staff training, evidence-based practices, and organizational culture. Several agencies reported requiring trauma-informed care training for all staff, with some mandating ongoing annual or semiannual professional development. Others highlighted specialized certifications, including trauma-certified clinicians and organizational certifications such as the Sanctuary Model.

   Many organizations described integrating trauma-informed principles into daily operations, clinical supervision, staff interventions, and treatment planning. One agency noted conducting routine trauma screenings for children at intake and every six months thereafter, with referrals to specialized trauma-focused services when indicated. Additional efforts included providing trauma-informed training for foster parents and developing wellness rooms to support staff well-being and reduce burnout. Overall, the responses reflect a widespread emphasis on embedding trauma-informed practices into both client care and organizational operations.

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

   ☒ Yes ☐ No

   The majority of agencies provide cultural and linguistic competency training: Most respondents indicated that their agency offers training to support culturally responsive and inclusive services.

   Agencies that offer cultural and linguistic competency training generally provide it on an annual basis, with efforts focused on improving staff awareness, communication, and equitable access to behavioral health services.

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

   ☒ Yes ☐ No

   Agencies are making progress toward addressing health inequities through DEI-focused activities,

- Nearly all providers stated they are serving individuals with different ethnic backgrounds, religions, who speak other languages, and who identify as a different gender.
- Most agencies are providing cultural training on a yearly basis.
- Majority of individuals staffed identify as White with a few staff being bilingual in Spanish.

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

   ☒ Yes ☐ No

   Armstrong and Indiana Counties both have established and active Suicide Task Forces.

Armstrong County SPTF

The Armstrong County Suicide Prevention Task Force (SPTF) continues to offer support to the community by way of education and increased awareness. In the 25-26 FY QPR training reached over 180 people, including Lenape Nursing Students, 911 Dispatchers, civil air patrol, churches and the newest groups are male and female inmates at Armstrong County Jail. The inmates have found this training to be extremely helpful and informative.

The Armstrong County SPTF has also been instrumental in bringing Maverick's Mission to West Shamokin School District. Maverick's Mission was started by a local family after their son took his life. Several students at W.S. stated after the presentation that it saved their lives. This presentation is planned for the Armstrong School District in the fall.

SPTF is also planning to pay for several participants, survivors and clinicians to attend the AFPC training in order to establish a Bereavement Group for suicide loss in Armstrong County, this training is scheduled for October 2026. We are also working on a 'pocket' resource card that will be distributed throughout the community.

Indiana County Suicide Task Force

The Indiana County Suicide Task Force remains focused on bringing awareness to the community, providing education and reducing stigma. The following provides a listing of the awareness and training efforts that took place in FY 25-26:

- 'Pocket' resource cards have been developed and distributed throughout the county.
- STF has presented at CIT and also to high school students at an event held at IUP.
- STF has been active with the MH carnival and Indiana Co. Pride event
- QPR has been held for high school students, IUP Police cadets, IUP navigators, senior centers, HAIC, hospital staff and the conservation district.
- The 13th Annual Walk for a Wonderful Life (Suicide Awareness Walk) had over 200 participants again this year with 27 vendor tables.
- We have also joined the Black Rose 'initiative', where a box is given to families of someone that has died by suicide. This box contains grief information, resources and comfort items.
- Our local Crisis Director has been trained in CALM and has completed 1 CALM training in March with another training scheduled in September 2026
- As noted in the highlight section. With the help of Indiana High School artists-we were able to print stickers to promote suicide awareness and our local crisis center's contact information-these stickers were distributed to several local coffee shops and were attached to the coffee sleeve.
- One of our local clinicians and member of our Indiana STF is now offering a Veterans Suicide awareness training
- Indiana STF partnering with Clarvida does offer a bereavement support group for people that have lost loved ones to suicide.

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: Caroline Veronesi
   - Email address: cveronesi@aibdhp.org
   - Phone number: 724-548-3451 Ext 648

   ICW Vocational Services
   - Name: Dennis Miranda
   - Email address: dmiranda@icwvocational.com
   - Phone number: 724-349-1211

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	60	OVR Funded
ii. # served ages 14 up to 21	22	OVR Funded
iii. # served ages 21 up to 65	38	OVR Funded
iv. # of male individuals served	40	OVR Funded
v. # of female individuals served	20	OVR Funded
vi. # of non-binary individuals served	0	Not Disclosed
vii. # of Non-Hispanic White served	56	OVR Funded

viii. # of Hispanic and Latino served	0	Not Disclosed
ix. # of Black or African American served	4	OVR Funded
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	33	OVR Funded
xv. # of individuals served working part-time (30 hrs. or less per wk.)	6	OVR Funded
xvi. # of individuals served working full-time (over 30 hrs. per wk.)	8	OVR Funded
xvii. # of individuals served with lowest hourly wage (i.e.: minimum wage)	0	
xviii. # of individuals served with highest hourly wage	8	OVR Funded
xix. # of individuals served who are receiving employer offered benefits (i.e., insurance, retirement, paid leave)	4	OVR Funded

7. Supportive Housing:

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

Name: Caroline Veronesi
Email address: cveronesi@aibdhp.org
Phone number: 724-548-3451, Ext 648

b. Please indicate if the county **Mental Health office** follows the **SAMHSA Permanent Supportive Housing Evidence-Based Practices** toolkit:

☐ Yes X 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 Units		9. Term of Targeted BH Units (e.g., 30 years)
Multi- County Enhanced Personal Care Home Project	2026	HealthChoices Reinvestment	$0	$513,000	0	8	Total 16 beds		20 years
Enhanced Supportive Housing Home	2026	CHIPP	$205,125		0	3	3		20 Years
Totals			$205,125	$513,000	0	11	19		
Notes:	Multi-County Project EnPCH – Armstrong, Indiana & Westmoreland is partnering to utilize HC Reinvestment funds to purchase and renovate a PCH in Armstrong County. The facility will be licensed 16 individuals. We are hopeful that this project will be operational some time in 2027.								

	Enhanced Supportive Housing Home – A home was purchased in Armstrong County by SPHS. They will be opening an Enhanced Permanent Supportive Housing home in September 2026.

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
Totals									
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
Housing Support Services	2010	MH Base	$210,361	$216,672	64			64	2
		BHSI	$68,080	$68,080					
	2006	State PATH	$5,624	$9,202	10			10	1
		Federal PATH	$16,871	$27,589					
	2021	HC CHW	$10,850	$128,324	5			60	1
	2024	HC CBCM	$78,432	$87,357	29			50	1
Enhanced Supportive Housing Programs	2020	MH Base	$440,477	$428,406	4			4	6.25
	2026	CHIPP	$0	$441,525	3			3	5
Totals			$390,218	$537,224	115			191	16.25
Notes:	This year's chart includes re-classification of the enhanced supportive housing programs. One has been operating since 2020 and the second will be starting in September of 2026. We will be assessing our CHW and CBCM utilization in FY 26-27.								

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
Housing Contingency	2016	State PATH	$198	$0	1			0	$792
		Federal PATH	$594						
Social Determinants of Health Southwest Six Regional Plan	2024	HC SDOH ICCAP	$17,356	$20,000	17			20	$1,020
		HC SDOH ACCA	$111,303	$116,000	54			60	$2,061
Totals			$129,451	$136,000	72			80	
Notes:	Armstrong and Indiana utilizes a Regional HealthChoices Social Determinants of Health Reinvestment plan to cover the costs of the Various SDOH needs.								

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
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: Caroline Veronesi Email: cveronesi@aibdhp.org Phone number: 724-548-3451 Ext 648
Total Number of CPSs Employed	**36**
Average number of individuals served (ex: 15 persons per peer, per week)	**94**
Number of CPS working full-time (30 hours or more)	**14**
Number of CPS working part-time (under 30 hours)	**22**
Hourly Wage (low and high), *seek data from providers as needed*	**Low $16.00 – High $21.00 per hour**
Benefits, such as health insurance, leave days, etc. (Yes or No), *seek data from providers as needed*	**yes**
Number of New Peers Trained in CY 2025	**13**

f) <u>Existing County Mental Health Services</u>

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		
Telephone Crisis Services	☒	☒ County ☒ HC ☐ Reinvestment
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	Y	43	TMACT		Yearly	Y	Y	
Supportive Housing	Y	86						
Supported Employment	Y							Include # Employed
Integrated Treatment for Co-occurring Disorders (Mental Health/SUD)	Y	24	ACT numbers served			N	N	
Illness Management/ Recovery	Y	85	N/A			Y	N	
Medication Management (MedTEAM)	Y	250	Chart audits, Peer review audits, Supervision, Staff Training	Agency	Ongoing	N	Y	
Therapeutic Foster Care	n							
Multisystemic Therapy	Y	19	ACES, Genogram, Ecomap	Agency	Ongoing	N	Y	
Functional Family Therapy	N							
Family Psycho-Education	N							

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	804	
Compeer	No		
Fairweather Lodge	No		
MA Funded Certified Peer Specialist (CPS)- Total**	Yes	18	
CPS Services for Transition Age Youth (TAY)	No		
CPS Services for Older Adults (OAs)	No		
Other Funded CPS- Total**	No		
CPS Services for TAY	No		
CPS Services for OAs	No		
Dialectical Behavioral Therapy	Yes	218	
Mobile Medication	Yes	40	
Wellness Recovery Action Plan (WRAP)	Yes	61	
High Fidelity Wrap Around	No		
Shared Decision Making	Yes	2,762	
Psychiatric Rehabilitation Services (including clubhouse)	Yes	53	
Self-Directed Care	Yes	2,762	
Supported Education	Yes	30	
Treatment of Depression in OAs	Yes	140	
Consumer-Operated Services	Yes	50	
Parent Child Interaction Therapy	Yes	5	
Sanctuary	Yes	2,762	
Trauma-Focused Cognitive Behavioral Therapy	Yes	122	
Eye Movement Desensitization and Reprocessing (EMDR)	Yes	45	
First Episode Psychosis Coordinated Specialty Care	No		
Other (Specify)			

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. _____0_____
   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)). __Unknown we do not track this_____

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	N/A	10
II. Number of involuntary inpatient hospitalizations following an IOT or AOT for CY 2025	N/A	4
III. Number of AOT modification hearings in CY 2025	N/A	
IV. Number of 180-day extended orders in CY 2025	N/A	17
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	N/A	$57,451

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 **We are continuing to work with our software company and providers to report all services.**

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:

Any increased base funding would be used to support increased costs for new and existing residential programs, on-going support for our drop in centers, and sustaining our existing base service units. Any remaining funds would be used for the development of programs for expanding employment opportunities and meeting transportation needs for our mental health consumers. FY 26-27 will be final year we will be able to utilize our CMHSBG funds to support our new Regional Crisis Walk in Center. If needed we will utilize mental health base funds to fund the center.

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:

<u>m) Federal Grant Funding</u> (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:**

The CMHSBG Non- Categorical funds for Armstrong-Indiana are used to fund the Housing Support Services through our primary residential provider I&A Residential. Housing Support staff provide individualized in-home support to individuals living in the community.

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

The CMHSBG General Training carryover funds will be used to support our ongoing Crisis Intervention Training for our local law enforcement. We will also be assessing what trainings will be needed to support our Employment Opportunities Priority.

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

The Social Service Block Grant funds are used to support mental health consumers receiving Vocational Rehabilitation services.

- **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. N/A**

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

ARMSTRONG COUNTY PLAN for FY 26/27

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: Kami Anderson Title: Executive Director
Entity (Single County Authority (SCA) or other county agency: Armstrong-Indiana-Clarion Drug and Alcohol Commission
Email address: kanderson@aicdac.org
Phone number: 724-354-2746, ext. 302

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	1	0
4	Medically Managed Intensive Inpatient	0	0
3.7 WM	Medically Monitored Inpatient WM	3	0
3.7	Medically Monitored Intensive Inpatient	0	0
3.5	Clinically Managed High Intensity Residential	2	0
3.1	Clinically Managed Low Intensity Residential	0	0
2.5	Partial Hospitalization Program	0	0
2 WM	Ambulatory Withdrawal Management with Extended On-Site Monitoring	0	0
2.1	Intensive Outpatient	2	3
1 WM	Ambulatory Withdrawal Management without Extended On-Site Monitoring	0	0
1	Outpatient	2	3
Other	Specify	0	0

*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?

Staff report/SCA EHR system

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
7	4	4	3

*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?
   SCA EHR system

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	3	0	0
4	3	0	0
3.7 WM	14	0	1
3.7	5	0	5
3.5	21	1	6
3.1	11	0	0
2.5	5	0	0
2 WM	0	0	0
2.1	6	1	0
1 WM	0	0	0
1	7	2	0
Other	2	1	

a. What is the source of the data reported in the table above?
   SCA Excel Worksheet for Contracts

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:

Transportation is the biggest need in Armstrong County so that people can access treatment and recovery services. Armstrong County does have an MATP Program for in-plan treatment services, however clients need transportation to recovery services, such as support group meetings and to

attend groups and activities at the local recovery centers. They also need transportation to employment-related appointments and back and forth to work. Non-MA eligible clients struggle with transportation and the SCA tries to provide ride services for them. Clients also need transportation to and from other appointments, such as probation, work, and obtaining signatures for required forms for services.

Safe and sober housing is also another need in Armstrong County. The SCA is working with ARC Manor to establish licensed Recovery Houses through reinvestment funds, but we need more recovery housing and affordable housing for those that don't want to live in Recovery Houses. Many clients still use medical marijuana and may not be accepted into Recovery Houses.

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

As far as expansion or enhancement plans, there are currently no plans in place in Armstrong County for additional treatment services at this time. The SCA continues to work with the Armstrong Center for Medicine and Health to re-open their hospital detox program. The detox program was shut down during the pandemic due to staffing issues with nurses.

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

The reinvestment plans in use in Armstrong County include 1) Recovery Houses for men and women; 2) SDOH plan for funds for MA eligible clients who have emergent needs; and 3) rent for licensed recovery housing.

1) ARC Manor currently has a reinvestment plan to purchase, renovate, and furnish a men's recovery house and a women's recovery house. The men's house opened in 2026 and is almost full at this time. The women's house has been purchased but ARC Manor is having difficulty in finding someone to renovate the house. We are trying to get two more bids. Construction companies do not like working with the prevailing wage requirements.
2) The SCA has a plan to fund Social Determinants of Health for MA eligible clients that have emergent needs for such things as housing, transportation, food, clothing, childcare, etc. This plan has been very successful in helping people in our County.
3) The SCA has a plan to pay for rent for licensed recovery housing. There is only one licensed men's recovery house in the County, but we have accessed those funds.

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 Armstrong-Indiana-Clarion Drug and Alcohol Commission (AICDAC) was the Central Coordinating Entity (CCE) for the training and distribution of Narcan for Armstrong County and continues to be in that role through the Partner program with DOH. All Police Departments, Fire Departments, EMS Agencies, Treatment Providers, School Districts, County Jail, County Agencies and Human Service Agencies have access to Narcan if they choose. The general public also has access to Narcan through AICDAC as well.

AICDAC has collaborated with the following agencies in Armstrong County to provide Narcan training and distribution: ARC Manor, Armstrong Agency on Aging, Armstrong County District Attorney, Children and Youth Services, Armstrong County Jail, ACMH, Department of Human Services, Probation, various Fire Departments, and all School Districts.

AICDAC offers on-site training to all area first responders and other groups that may request a formal group training. Each of AICDAC's four offices have staff that can do an individual training, if needed. Upon request, AICDAC will give anyone a free box of Narcan. People can stop in at any of the offices for their free Narcan kit. We will also mail kits to people with no transportation.

Through a federal grant from the Health Resources and Services Administration (HRSA), AICDAC has purchased and installed over 200 naloxone boxes in the three counties. Naloxone boxes look similar to AED boxes and provide space for 4 Narcan doses, gloves, and mouth guards. Anyone experiencing an overdose can access the boxes for free Narcan kits. The naloxone boxes have been installed in hotels, school buildings, county buildings, stores, malls, etc. where the public can easily access them.

Through a grant with PCCD, AICDAC has purchased 8 outdoor vending machines and has placed them in areas such as outside the Emergency Department at Armstrong and Indiana hospitals, recovery centers, FQHCs, etc. Indoor vending machines have also been purchased and are located at the SCA offices, jails, provider agencies, etc. The vending machines are free of charge and contain Narcan, Drug testing strips, and wound care kits.

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.

The SCA's Addiction Recovery Mobile Outreach Team (ARMOT) consists of a Case Manager and Certified Recovery Specialist who provide warm hand-off services through Armstrong Center for Medicine and Health (ACMH) Hospital and community partners. Individuals identified with a substance use disorder are offered an immediate connection to the ARMOT Team. Based on the individual's needs, services can include screening, level of care assessments, case coordination, recovery support, direct referrals to treatment, and connections to community resources for various needs. When emergent care needs are identified, staff coordinate timely referrals and admission whenever possible.

The program also includes a 24/7 Warmline when ARMOT staff are not onsite. Warmline provides hospitals, first responders, and community partners with direct access to on-call staff who connect individuals to appropriate services in a timely manner. Our program successes include increased referrals from additional hospital units beyond the Emergency Department, strengthened partnerships with hospitals, first responders, and community providers. We have also expanded education and collaboration with healthcare providers to improve substance use disorder identification.

Program challenges include limited availability of Emergency Department and providers prescribing medications for opioid and alcohol use disorder (MOUD/MAUD). This can delay treatment or increase risk of individual initiated discharges. Another challenge is medetomidine in the drug supply, which makes withdrawal management and medical stabilization more complex.

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

# of Individuals Contacted	# of Individuals who Entered Treatment	# of Individuals who Completed Treatment
162	140	85

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

INTELLECTUAL DISABILITY SERVICES

Armstrong Indiana Behavioral and Developmental Health Program remains committed to enabling individuals with an intellectual disability and autism the opportunity to live rich and fulfilling lives in our community (this includes children with complex medical issues and developmental disabilities). We strive to help the individuals we serve achieve their vision of an Everyday Life.

AI-BDHP offers a broad array of services and supports to meet the needs of county residents with intellectual disabilities and autism. There are currently 793 open cases between the two counties. Of these individuals, 609 are receiving services in a waiver. 300 are receiving services funded through Consolidated Waiver, 180 are receiving services through Person/Family Directed Support (P/FDS) Waiver, and 129 are receiving services through the Community Living Waiver. There are also currently 20 vacant Person/Family Directed Supports (P/FDS) Waiver slots available for upcoming graduates and emergencies. The remaining 184 consumers are receiving services through Base funding or are waiting for additional services and support.

Of the 184 individuals who have open cases with base funded services, 149 of those individuals receive only Supports Coordination Services and 35 individuals receive Supports Coordination, Transportation, CPS, Companion and/or Home and Community Based Services.

Listed below are services available, offered or received by individuals through Base funding. Individuals avoid significantly higher-level costs by utilization of Base funds. Most of the families who have their family members reside with them would be forced to place their family members in an institution if these services were not made available to them. Some individuals, who reside in an apartment by themselves, would be unable to maintain their current living arrangement without the services and support made available by these Base funds.

- Family Aide - Provides in-home help to individuals/families, doctor visits, etc.
- In Home and Community Supports- provides opportunities and support for community inclusion and builds interest in and developing skills and potential for competitive integrated employment.
- Companion Service Provides supervision or assistance to ensure the individual's health, safety, and welfare, or to perform activities of daily living for individuals age 18 and older.
- Life Sharing- Provides residential services to individuals in the private home of a host family, or the primary residence of the individual.
- Residential Habilitation- Provides licensed and unlicensed housing services to individuals in a residential home in an inclusive community setting.

- Community Participation Supports- Provides opportunities and support for community inclusion and building interest in and developing skills and potential for competitive integrated employment.
- Small Group Employment - Supports participants in transitioning to competitive integrated employment through work that occurs in a location other than a licensed facility.
- Supported Employment- Provides services in a variety of community settings for the purpose of supporting participants in obtaining and sustaining full or part-time competitive integrated employment at minimum wage or higher.
- Transportation - Provides transportation to services and activities specified in the individuals approved service plan.
- Behavioral Support - Provides services that include a comprehensive assessment, the development of strategies to support the participant based upon the assessment, and the provision of interventions and training to participants, staff, parents, and caregivers.
- Home Accessibility Adaptations- Consists of modifications to the private home of individuals to ensure health, safety, and accessibility for the individual which allows the individual to function with greater independence in the home.
- Vehicle Accessibility Adaptations- Consists of adaptations for the installation, repair, and/or maintenance of the vehicle that the individual uses as his/her primary means of transportation to meet his/her needs.
- Respite- These are services that are provided to supervise and support individuals living in private homes on a short-term basis for planned or emergency situations, giving the person(s) normally providing care a period of relief that may be scheduled or due to an emergency.

**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 receive services in more than one category.*

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	0	0	3	1%
Pre-Vocational/SGE	1	<1%	4	<1%
Community participation	18	2%	24	3%
Base-Funded Supports Coordination	91	11%	95	12%

Residential (6400)/unlicensed	3	<1%	4	<1%
Lifesharing (6500)/unlicensed	0	0	1	<1%
PDS/AWC	1	<1%	1	<1%
PDS/VF	0	0	1	<1%
Family Driven Family Support Services	15	2%	20	3%
Assistive Technology	0	<1%	2	<1%
Remote Supports	1	<1%	2	<1%
Behavior Support	4	<1%	4	<1%
Transportation	1	<1%	1	<1%

Supported Employment:

Armstrong and Indiana Counties have two long-standing, established providers who are very well respected and active in the communities in which they operate. The Progressive Workshop of Armstrong County (PWAC) has been in existence since 1968 and ICW Vocational Services, Inc. (ICW) has been operating since 1971. Although each agency is unique in its approach to employment services and what is available to the individuals they serve, both offer a variety of employment experiences including, community participation supports, small group employment, and supported employment. During recent years, we have seen the growth of both agencies as they strive to help individuals obtain employment.

Indiana County Workshop (ICW)

- ICW supports 6 individuals through Supported Employment, 34 through Small Group Employment and 64 individuals through Community Participation Supports.
- ICW utilizes 17 community Small Group Employment sites to place individuals one or two days per week, for a period of eight to twelve weeks. Small Group Employment gives ICW Employment Services staff the opportunity to evaluate work abilities in a less “threatening” and permanent manner. ICW Small Group Employment work includes janitorial services, clerical services, outside work, folding pizza boxes, bussing tables, labeling, setting up dining room/wrapping silverware, and litter pickup.
- ICW supports 12 individuals through Small Group Employment Mobile Work. ICW contracts with a local business to occupy a workstation within its location. Teams of individuals, supervised by a Job Coach, perform small parts assembly in this integrated setting. This opportunity provides employment skills training necessary to find and maintain competitive integrated employment and is provided in a manner that promotes engagement in the workplace and interaction between individuals and people without disabilities.
- ICW operates the Steps to Success Day program. This program is specially designed to provide employment education to those individuals who have graduated or are preparing to graduate and are working toward the goal of employment. The Vocational/Employment consists of class-based

training (Workplace Readiness Training) and community integrated training (Paid Work Experience). Workplace Readiness Training provides individuals with knowledge needed to find and maintain competitive integrated employment. Curriculum includes interview skills, job readiness, job-seeking skills, HR practices, and other skills needed to become "workplace ready." It also includes measurable performance objectives and lesson plans. Paid Work Experience in a community integrated setting provides individuals with experiences in various areas of interest in integrated community businesses or settings. Individuals are provided with several Paid Work Experiences to fully experience a variety of career opportunities. Upon completion of each experience, the Transition Services Director, Job Developer, and/or Job Coach will complete an evaluation of the individual to be reviewed by the Team. Currently 19 individuals attend the Steps to Success program.

- ICW supports 18 individuals through In-Home and Community Support. ICW's In-Home and Community Support is tailored to each participant. Program services are offered in the home, in the community, or a combination of both to assist individuals in acquiring, maintaining, and improving the skills necessary to live in the community, to live more independently, and to participate meaningfully in community life. ICW individuals and their families are the decision makers regarding where and how they receive services to best fit their goals and needs. Individuals are paired with a trained direct support professional, who assists in developing skills necessary for everyday living. This team approach allows for access to community resources that foster enhanced socialization and independence. This service is built on the principle that every individual has the capacity to engage in lifelong learning.

Progressive Workshop of Armstrong County (PWAC)

- PWAC currently has 13 individuals receiving Supported Employment Services with a job coach. The job coach works with individuals until they are fully trained, and they need less assistance to complete their assigned job duties at their competitively integrated employment position. As individuals become more independent in completing their job tasks the on-site supports of a job coach will be reduced and then the job coach will occasionally check in with the individual and their employer to ensure all job expectations are being met. PWAC also offers Job Finding/Job Development services. This is a service where along with a Job Coach they find jobs of interest, apply for those jobs, interview, and build interviewing/job finding skills.
- PWAC currently employs 66 individuals in Small Group Employment Services. They are paid above minimum wage. They have 6 Cleaning Crews (Progressive Commercial Cleaning) that clean at different community sites Monday thru Friday and they include: Ford Memorial Church, Manor Township VFD, Quality Life Services, Apollo Elks, Kiski Township VFD, Hetrick's Manufacturing, United Way, Lutheran Church, Ford Cliff VFD, Armstrong Care Incorporated, MK Bridal Shop, Butler Office Klingensmith's, Pulflex Manufacturing, Coherent, Outdoor Discovery Center, Crooked Creek Horse Park, Glad Run Lutheran, Edward Jones, RC Men's Club, Anchor, Marconi Club, Lighthouse Foundation, Manor Township VFD, and Kittanning TWP VFD, Living Water, SGK/Collide, KEC, United Way, Armstrong Community Action, Plumville Presbyterian Church, Cook Medical and St. Johns Church. There are 3 Lawn Crews (Progressive Lawn and Landscaping) that work Monday through Friday and they have 50 contracts. All Small Group Employment crews also work on PWAC shredding contracts (Progressive Document Destruction)
- At PWAC Oak Location, they have a professional woodshop (Progressive Woodworks), and they employ individuals who earn above minimum wage. They make a variety of items that are ordered via phone and online through our Progressive Woodworks site. They also have an ongoing contract to make stakes that survey companies order and purchase.
- PWAC currently has 58 individuals receiving Community Participation Supports at the Oak location. Community activities occur daily ensuring individuals' likes, interests, and desires are

considered. Progressive Productions at the Oak location have on site sub-contract jobs that are piece rate jobs or above minimum wage jobs. They primarily specialize in light assembly jobs for various companies such as: Cook Medical, Sloan Brothers, Belleflex and Coherant, Snyder Brothers and Butler Technologies. They also have individuals training in the kitchen doing various meal prep jobs/coffee & snack bar duties. They also have individuals training to complete various janitorial jobs tasks. While working on learning important job skills the individuals also learn soft skills related to working in the community. This varies from group discussions regarding job skills; activities focused on skill building and socialization opportunities.

- PWAC has two established day programs-The Adult Achievement Center (one is in Kittanning and one is in Leechburg)- to address the needs of adults with developmental disabilities such as socialization opportunities, skills that will help them relate to others, achieve independent living and/ or employment skills. The program creates a positive environment where individuals have opportunities to build their knowledge utilizing various curriculums, plus hands-on activities and experiences to reinforce newly learned skills (this occurs at the facility and through community integrated activities). This enables individuals to build upon their current competencies in Life Achievement Skills and Educational Achievement Skills. There are currently 16 unique individuals who attend the Adult Achievement Center in Kittanning and 13 at the Leechburg location.

Other Employment Information:

- Armstrong-Indiana counties also work with many other employment providers including Career Habilitation Building Services, CCABH, Community Options Inc, Goodwill, Kaleidoscope, Lifesteps, Lifestyles, Mainstay, MCAR, Merakey, Passavant, Valley Advantages, VTDC, Wesley Family Services and Bayada.
- Project Search Update: During this past FY, the committee hasn't met because OVR placed a hold on all new Project Search funding opportunities. However, we were recently made aware that the OVR hold was lifted. We have contacted the new OVR Administrator Drue Flora to restart our committee meetings. We have a commitment from Armstrong County Memorial Hospital and need to have more discussions with local school districts to ensure we have their support for this project.
- The Armstrong Indiana Employment Coalition has continued to meet quarterly and discuss updates to employment services, initiatives occurring with providers and local businesses and events that we are planning for our individuals, caregivers and community.
- Looking ahead, the Armstrong-Indiana Employment Coalition is committed to continuing its work by exploring more employment-related topics, bringing in new speakers, and planning future events. This ongoing effort will further support individuals with disabilities in finding meaningful employment opportunities and achieving their full potential.
- As part of the Armstrong-Indiana Quality Management plan, employment continues to be a focus area. We are looking to increase competitive integrated employment (CIE) amongst our individuals. We currently have 1 of 4(our goal) individuals successfully transitioned to CIE.

Supports Coordination:

The AE utilizes 5 Supports Coordination Organizations (SCO) which provides individuals with a choice of providers: the Community Guidance Center, Family Counseling Center, Family Links, Center for Community Resources, and Bradford Sullivan Counties MH-MR Program.

Engaging individuals/families to explore the communities of practice using the life course tools:

- Our Family Liaison and Intake Coordinator are now both official Life Course Ambassadors! Our AE (by way of the intake coordinator and family liaison) use the tools to connect individuals and families to their communities, resources, and peers. The Life Course Tools are being utilized to help the support coordinators, individuals and families plan and connect to provide an everyday life and ensure they are thriving within their home and community. At intake, we make sure the Life Course

Framework is a focus. We review the individual's age and where they are in their lifespan to determine what tools to complete with the individual/family. This helps everyone become more familiar with the tools at the front door. This also allows the SC to make the initial individual support plan (ISP). The tools provide starting point to focus on what is important to the individual. The Family Liaison attends ongoing ISP and team meetings and goes more in-depth with the Life Course Tools to support SCs, individuals, families, and the broader community. Together, they are working to create a meaningful and positive impact during the intake process and throughout the individual and family members' lifespan. Our Communities of Practice partnership meetings (2 meetings a year in both counties) always include the SCs and supervisors.

- At monthly meetings with our SCO supervisors, we discuss new community supports they have found, and we share this information. On an ongoing basis the AE reviews ISPs for inclusion of natural support. AE staff participate in monthly team meetings in person or via phone conference to discuss services and support with individuals, families, and provider agency administration and staff.

<u>Engaging SCOs with wait list planning:</u>

- Monthly, the AE meets with the SCO supervisors and Intake Coordinator to discuss vacant waiver slots, review current individuals in the queue, review the Emergency PUNS list and discuss Priority Lists. Prior to the meeting, the SCO Supervisors meet with their staff to determine a priority list using the PUNS to be presented to the waiver capacity meeting (WCM). These priority lists are compiled from the information known about individuals aging out of CYS, EPSDT services, jail, and probation services, graduating seniors, elderly caregivers, individuals at the PFDS and Community Living cap, and individuals who need county base funds. This transparent process allows for an open and fair practice for determining utilization of available waiver capacity. The AE and Waiver Capacity Management Team continue to review PUNS at least monthly in preparation to fill vacant waiver slots, plan for EPSDT and RTF age outs, and work through Emergency crisis situations of the individuals that we serve and support. We also review Unfinalized PUNS reports and PUNS reviewed within 365 days of reports monthly.
  AI BDHP continues to use the Multi Year Program Growth Strategy within the Waiver Capacity Management process. We have created 2 consolidated waiver slots since last year.

<u>Promoting Self Direction:</u>

- To serve individuals post high school, our Family Liaison has joined up with Team Friends, SCOs, providers and families to successfully establish and provide social and philanthropical opportunities to individuals and their caregivers monthly. Our Self-Advocacy group has also seen success, thanks to a partnership with the HCQU, offering informative and engaging trainings for participants. We feel with more information about how individuals can determine their own interests, they will be more willing to explore services and supports they can self-direct. Within the last year, the self-advocates and SCOs had vision board parties.

Lifesharing and Supported Living:

- Evergreen Homes is currently serving two individuals in their private apartments and are taking referrals for expansion into Indiana County. Community Options is also qualified for Supported Living Services and is looking to expand into Armstrong/Indiana counties as well. We have seen an increased interested and referrals for the Supported Living Program. Community Options presents their Supported Living Program at Open Houses in Indiana County periodically.
- Life sharing has expanded to include individuals with Medical Complex Care Needs. There is only 1 life sharing service, but different provider qualifications, rates, and specialty codes for providers of life sharing services. Armstrong/Indiana has one individual in Life sharing with Medical Complex Needs.

- Both the AE and SCOs meet monthly for Waiver Capacity Management meetings. During these meetings the Emergency PUNS wait list and service request forms are reviewed with the committee. Life sharing and Supported Living are offered and discussed for all individuals seeking residential placement. In FY 25-26 we did have one new family interested in providing Life Sharing services, but we did not have an individual who was a match with the family.
- We are seeing an increase in aging life sharing individuals and caregivers. In FY25-26 (5) individuals received alternate placements due to the death or serious illness of Life Sharer.
- Limited transportation options in our rural communities hinder the individuals from using the bus, trains, UBER, Lyft, carpools, causing them to solely rely on the Life sharing providers for all transportation. Lifesharing families have often requested transportation as a discrete service. Currently, life sharing families are responsible for all transportation to activities related to health, community involvement, and individual specific programs and activities as identified within their ISP.
- There has not been a Life sharing initiative for a while. The AE could benefit from additional waiver slots which would help to expand the Life sharing program specifically.
- AE continues to look at Life Sharing as an option for individuals in Emergency situations and documents reasons why Life Sharing was or was not chosen for the individual. Often the medical or behavioral needs of the individual are greater than what a life sharer is willing and able to provide.
- The AE has organized Life Sharing meetings with our Qualified Life Sharing Providers to discuss challenges, concerns, and creative ways to expand the program. These meetings will be ongoing. We will also be expanding into Supportive living.
- As part of the Program Growth Strategy, the AE reviews funding quarterly and is interested in expanding life sharing or supported living for a minimum of (2) individuals in FY 26-27.
- The AE shared Life Sharing and Life Course information with the community in April 2026 during our Carnival of Opportunities event. There were over 250 people in attendance.
- AE continues to participate in the Western Region and Statewide Regional Life Sharing Coalition meetings and is scheduled to attend the Regional Life Sharing Conference in Fall 2026.
- The AE has (2) Providers who are now qualified to offer housing Transition and Tenancy Sustaining services. In FY 25-26 (4) individuals were authorized to receive this service. This is an area that the AE would like to see growth in this area as apartment seeking and supported living coincide with each other.

Cross-Systems Communications and Training:

<u>Increase Capacity for Individuals with Multiple System Needs/Complex Medical Needs</u>

- Merakey continues to provide the Dual Diagnosis Treatment Team (DDTT) services in Armstrong and Indiana Counties. The DDTT consists of a team that includes a Psychiatrist, Pharmacist Consultant, Behavioral Specialist, Program Director, Registered Nurse, and Recovery Coordinator. Eligibility criteria for the DDTT consists of being over the age of 18; be an Armstrong or Indiana County resident; have an MH and ID/Autism diagnosis; frequent hospitalizations/crisis involvement; or require step down, transitional services to the community from a higher level of care. We are seeing more referrals being made for individuals with Autism and under the age of 18.
- Within the last year, we've held training for our program staff on the Merakey ACT program and the Merakey DDTT program. Understanding the differences between the programs is very helpful when we are making referrals. Knowing the individual and the best service that will fit their needs in a timely manner leads to better outcomes.
- We collaborate with the HCQU and the Milestone Pediatric Resource Center West.
- The Resource Center helps families and caregivers navigate the non-medical aspects of caring for children with complex medical needs. They are family-centered and emphasize fostering communication, providing education, and connecting families to community resources. Pediatric

Coaches and Family Facilitators are becoming more prevalent in our counties as we serve children with complex medical needs. Their guidance helps families/teams to make sure the child is receiving all the support available.
- The HCQU continues to be a valuable resource for providers, self-advocates and families to receive the most up to date and relevant training possible.

Collaboration with Schools

- AI-BDHP works with our local ARIN Intermediate Unit (IU) and attends the Transition Council meetings and Local Task Force meetings.
- The AE is collaborating with OVR and School Districts to ensure all transition aged children are educated on OVR and ID employment services.
- Flexibility is available for the intake worker to directly work with the schools. The intake worker has been attending IEP's when requested and other events at the schools such as the Family Outreach Fairs and the Back to School Nights.
- The ID Director and Intake Coordinator periodically meets with school psychologists to review necessary documentation and eligibility requirements for individuals who are interested in Intellectual Disability and Autism services with our AE. Specifically, we are reviewing autism and medically complex children's requirements of our program to school professionals.
- The ARC of Indiana County provides an Educational Advocacy Program. This program offers free advocacy services to individuals with intellectual disabilities and their families, ensuring that students receive the appropriate education mandated by law. As an independent educational and community advocate, the Arc of Indiana County supports individuals of all ages. These cases range from assisting with the IEP process to addressing behavioral disruptions, concerns about cyber or charter schooling, homeschooling, expulsions, detentions, or suspensions, and supporting compensatory and extended school year needs. Each case involves research, correspondence with all parties, meetings with parents and caregivers, attendance at school or team meetings, and collaboration with parents, school districts, and service providers. During the 2025-2026 school year, the advocacy program received 64 case referrals and advocacy calls, assisting families across all 11 school districts in Indiana and Armstrong County.
- We've worked with OVR, local school districts and Indiana University of Pa to hold our 2nd event for individual with autism to spend the day on campus and see if college is right for them. This is a fun and well received day for the students.
- Indiana University of PA plans to begin their "Crimson Hawk Bridge" Program this Fall 2026. The Crimson Hawk Bridge Program is designed specifically for students with an Intellectual Disability (ID) diagnosis. The Crimson Hawk Bridge will provide students with an inclusive 2-year college experience, ending with a certificate of completion. Students will engage in career exploration, campus involvement, and independent living skills. We are very excited to watch this program get started!

Collaboration with CYS / Aging / Mental Health

- **CYS**- We continue to work to find ways to fill the void for lack of placements options for individuals with ID/autism and possibly involved with CYS services. Over the past few years, we have been meeting quarterly with both CYS offices to discuss joint complex cases. These meetings help the ID, MH and EI systems all stay in touch with each other.
- **Aging Services and Nursing Home referrals** – AI-BDHP works closely with the Area Agency on Aging offices in both Armstrong and Indiana Counties on OBRA cases or other cases that require a joint effort. Recently, our office has started attending the Indiana County Elder Abuse MDT quarterly meetings. Community Health Choices has been a barrier to services for individuals living in the community and in nursing homes. We are using base funding to assist nursing homes with

behavior support and community habilitation. ODP could be helpful in this area by providing clearer expectations on services through CHC and our ID Waivers/base funding.

- **Mental Health Services –** As indicated previously, the DDTT is available to assist with individuals that are dually diagnosed and have frequent inpatient hospitalizations. The ACT team is also available to some of our individuals' receiving services. In addition, our AE works very closely with the base service units (BSUs) and local emergency rooms when individuals who are dually diagnosed present in their facilities. We attend multiple meetings with mental health providers and have unique program positions to assist us with collaboration.
    - **Dually Diagnosed (MH/IDA) Clinical Care Manager position (DDCM)**The dually Diagnosed Clinical Care Manager has been in place since January 2022. This position works with individuals who have both mental health and intellectual disability or autism diagnoses. This position is a liaison between the mental health and intellectual disabilities systems for the MH and ID providers, insurers, Supports Coordination units, families, and counties. During a crisis, the DDCM is the point person and responsible for the development of a care management plan for the individual. The plan addresses the behavioral health needs of the individuals related to psychiatric care, behavioral supports, and crisis planning. This position keeps a very detailed spreadsheet to help us collect data for the Quality Management Plan and other areas where we rely on information to produce better outcomes for the people in our program.
    - **Clinical Care Managers**–AI-BDHP employs a Clinical Care Manager and Case Manger that work on coordinating care for individuals that have complex mental health needs. They primarily work with individuals that have multiple inpatient hospitalizations and are getting discharged from a state hospital. They work with the DDCM, and our departments have meetings every month to discuss cases.
    - **Hospitals-** In June 2025 the Indiana Regional Medical Center (IRMC) opened a new 44 bed behavioral health inpatient facility. The facility can serve 12 geriatric, 24 adult and 8 adolescent patients. Indiana Regional Medical Center employs Psychiatric Assessment Liaisons in the Emergency Room and the ID department has frequent collaboration and communication with the liaisons. It has been extremely helpful to have a contact person to manage individuals in the emergency room as we have a difficult time finding them inpatient treatment options. We also attend the Joint Hospital meetings as needed for collaboration.
    - **Education**-We continue to use all formats to meet with families, such as in person, Zoom and Teams at various times of the day that work best for the families. The PA Family network hosts trainings for families, and we ensure that information is filtered to individuals, families and providers. The Indiana County ARC has an eagerness to plan new and innovative programs and training and is a great resource for families that provide information, education, support, and networking. We hold monthly self-advocacy Groups with education always being a focal point. During the intake process the individuals and families can discuss their needs and questions with the intake worker who can then provide them with informational brochures, referral assistance and contacts. Our AE mails quarterly newsletters to our individuals to share community resources and events. This year we held an Incident Management Training for individuals, families and caregivers.

Emergency Supports:

- Generally, for an ID individual identified as being in a non-medical emergency situation, their needs would be assessed by a support coordinator, the Waiver Capacity Committee, or the AE ID Director. Then, depending on their current emergent need and their existing living status a determination would be made as to what action would be taken.
- If the individual does not have a safe place to go and no waiver capacity is available, we would Base fund the individual at a respite site to protect their health and safety. A respite placement

might be at a provider operated residential home, Lifesharing and/or a personal care home. Some additional options for this scenario are possibly a homeless shelter with support; or in certain circumstances a domestic violence shelter such as HAVIN or The Alice Paul House could be utilized.

- If the individual lives in their own home, apartment or family home and health and safety are assured, we could support them through either initiating or increasing home and community habilitation, companion or community participation supports services if a residential placement or respite was not available. We could also utilize services such as increased Supports Coordination monitoring and non-paid natural/community support.
- When warranted ODP will be notified of the emergency need.
- We would base fund the individual at a respite site or temporarily increase in home and community support, if appropriate, to protect the individual's health and safety. If no emergency Waiver capacity is available, the AE would continue to use Base funding to provide services to keep the individual safe.

Emergency Response Plan

- In the event an emergency occurs outside the normal work hours, the following protocols are followed depending on the type of emergency.
    - Any medical emergency would be addressed in the nearest Emergency Room, 7 days a week, 24 hours a day. We work very closely with the ERs in both counties. If needed they contact the on-call SCOs 24 hours a day, 7 days a week. If additional assistance is needed, they contact the AE ID Director.
    - In the event an emergency happens after hours and there are no identified medical needs, 911 emergency centers would contact our 24 hour on-call Supports Coordinator available for each county. If the problem cannot be resolved or if further authorization is needed the AE ID Director is contacted.
    - If there is a community member in need of emergent services outside the normal work hours there is a 24/7 telephone and mobile Crisis services available. The Crisis workers are trained to direct the caller to an appropriate contact or if appropriate dispatch mobile crisis to the setting where the individual is located.
    - Individuals have Crisis Support plans written within their ISPs.
- In the event an emergency occurs during normal working hours:
    - Any medical emergency can be addressed at the nearest Emergency Room. We work very closely with the ERs in both counties. If needed the appropriate SCOs or AE ID Director may be contacted.
    - If there is no identified medical need the provider agency, family or any community member is educated to contact the consumer's Supports Coordinator to discuss their concerns. If the problem cannot be resolved, or if further authorization is needed, the AE ID Director or a member of the AE ID staff may be contacted.
    - If appropriate, an emergency team meeting would be organized to develop a plan to address the individual's needs and/or the Waiver Capacity Committee could be convened via conference call to make a placement determination.
    - For behavioral health emergencies 24/7 telephone and mobile crisis services can be accessed in Armstrong and Indiana County. The Crisis workers are trained to direct the

caller to an appropriate contact or if necessary, dispatch mobile crisis to the setting where the individual is located. Walk in Crisis Services are also available in both Armstrong and Indiana Counties. In June 2026 the Open Door opened a Walk in Crisis Center on the campus of IRMC. The current hours of operation are 8:00 AM to 8:00 PM daily. In Armstrong County Walk in Crisis services are available 8:00 AM – 4:00 PM Monday – Friday. After hours protocols are identified in the first Emergency Response Plan bullet point.

24/7 Telephone and Mobile Crisis services are available.

- As indicated in the previously listed procedures, Armstrong-Indiana County Crisis offers 24/7 telephone and mobile crisis services, as well as a 24/7 text line.
- Mobile Crisis Staff receive ongoing individual internal, external, and group trainings. Skills for working with and understanding the etiology of individuals who are identified as ID or ASD are covered in ongoing training. Trainings include:
    - The seven-stage crisis intervention model developed by Roberts. It can be applied in situations where an individual is diagnosed as ID or Autistic and its interface with the American Association for Emergency Psychiatry Project BETA De-escalation workgroup.
    - The use of non-coercive methods and the negative impacts of restraining.
    - Public trainings and workshops related to mental health, substance use, ID/D and ASD that are shared by community partners are attended by staff members on a voluntary basis, and staff are encouraged to attend 40 hours of training per year.
    - 24/7 access to a free web-based training platform, ASERT, providing an Autism Resource Guide and readily available trainings for supplemental knowledge.
- The crisis team is currently made up of 22 crisis workers from an array of full-time, part-time, and substitute positions, which include 1 department director and 3 crisis team supervisors. The workers reflect an eclectic background in treatment which includes ID, SUD, and Autistic experience. This experience includes work as a group home worker for individuals diagnosed with ID, employment experience working with children diagnosed with ASD, as well as several school-based substance use professionals cross-trained to provide crisis intervention services in the school setting. Several employees are involved with the Suicide Task Force of Indiana County and each employee partakes in training for Suicide Risk Assessment as well as various Crisis Intervention Team trainings offered throughout the year to improve skills for assessing and working with various populations, especially those diagnosed with ID/DD. The crisis intervention supervisor has extensive experience working with various populations including those involved with mental health and drug & alcohol services, individuals in ID services and settings, as well as children and adults diagnosed or undergoing testing for ASD. The CI Director has worked in outpatient mental health settings as an outreach case manager, as well as intake clinician and forensic liaison, becoming familiar with numerous diagnoses, diagnostic interviewing methods, and treatment options in the Indiana and surrounding areas. The newly appointed crisis team lead has numerous years' experience working among the community to offer outreach services for crisis and engages in regular treatment meetings with various providers and partners to coordinate care and provide service updates.
- As noted above, all staff are trained on an ongoing basis and exposed to new research methods and practices as they become available.

The AE and Waiver Capacity Management Team continue to review PUNS monthly in preparation to fill vacant waiver slots, plan for EPSDT and RTF age outs, and work through emergency crisis situations of the individuals that we serve and support.

Administrative Funding:

- **PA Family Network**: PA Family Network brochures and information are included in all of our Welcome Packets, and their flyers and brochures are available in our office display rack for individuals and families visiting our office. We will continue to support and promote any training and resources they make available.

- **Regional/Local Collaborative**: Our Local Collaborative has been busy this year. One of the collaborative highlights was the Carnival of Opportunities, which is now a much-anticipated annual event. With more than 20 collaborative members participating as vendors, the event welcomed community members and individuals with intellectual disabilities and autism for a day of food trucks, carnival games, and fun activities while learning about valuable services and resources available in the area. Armstrong/Indiana also strengthened regional collaborative efforts through the Move Your Way Initiative, in partnership with Beaver, Butler, and Lawrence Counties. Family Liaisons from each county worked together to plan and promote a series of health and wellness activities that were open to self-advocates across all participating counties. The initiative included a line dancing class, Zumba class, and hip-hop class, providing opportunities for participants to engage in physical activity while building friendships with individuals from neighboring counties. In addition to promoting healthy lifestyles, these events encouraged community connection and expanded social opportunities beyond participants' local areas. As part of our regional collaborative efforts, Armstrong/Indiana and Butler Counties also organized a Speed Friending Series, giving self-advocates the opportunity to meet new people, build meaningful friendships, and practice conversational and social skills in a welcoming, supportive environment. These collaborative initiatives reflect our shared commitment to promoting health, wellness, inclusion, and meaningful community connections for individuals with intellectual disabilities and autism.

- **Family Liaison** – Our Family Liaison has continued to expand opportunities and supports for individuals with intellectual disabilities and autism, their families, and caregivers. In addition to becoming a certified LifeCourse Ambassador, she has earned the LifeCourse Good Life Groups, Meeting Facilitator, and Presenter badges, further enhancing her ability to facilitate person-centered planning and education throughout our communities. She creates LifeCourse Portfolios for individuals navigating key life transitions and hosts vision board parties utilizing the Charting the Lifecourse framework for both individuals and professionals. The Family Liaison works closely with the Intake Coordinator, who has also recently become a Lifecourse Ambassador, to provide guardianship and transition resources, emergency preparedness information, and comprehensive welcome packets to individuals and families at intake. To improve accessibility for working families, digital office hours have been offered during evenings and weekends, providing additional opportunities for families to connect, ask questions, and access resources at times that best fit their schedules. Community engagement continues to be a primary focus. The Family Liaison maintains a quarterly newsletter, a growing email distribution list, and an enhanced social media presence to keep families informed of available resources, events, and opportunities. An online digital padlet with up-to-date events and resources is also maintained and utilized within the counties to help participants stay informed and connected. Efforts have also focused on expanding local and regional collaborative partnerships, including initiatives that promote health and wellness through healthy eating education and partnerships with local CrossFit organizations and the YMCA. Throughout the year, the Family Liaison coordinated a variety of free, inclusive events and support opportunities, including Night at the Library, Carnival of Opportunities, the annual Meet 'n Greet,

Coffee Club, parent support groups, LifeCourse vision board workshops, and community craft activities. Coffee Club has provided a welcoming space for individuals and families to socialize, build connections, and access valuable community resources, while the vision board workshops have utilized the LifeCourse framework to help participants identify and plan for their vision of a good life.

- **HCQU** – The Health Care Quality Unit (HCQU) continues to be a valuable partner by providing regular educational trainings for our self-advocates on a variety of important topics, including personal hygiene, oral hygiene, healthy eating, portion control, boundaries, and other health and wellness subjects. These interactive training courses promote increased independence, self-advocacy, and healthy lifestyle choices. In addition to these educational opportunities, information about HCQU resources, upcoming training, and available supports are regularly shared through our quarterly newsletters to ensure individuals, families, and providers remain informed of valuable services and educational opportunities. Our providers frequently utilize nursing and behavioral support, the in-home and online training, sexual behaviors assessments, and possible medication interaction reviews that are available. The HCQU assists providers navigate Health Risk screening tools, complete ITA's, and have a lending iPad program. The Clinical supervisor is a member of our Human Rights Committee. She offers a medical component to our reviews. The HCQU also provides us with data on the Fatal 5, ITA referrals, medication information, etc., and we use this information to help us plan our Quality Management Plan.
- **Team Friends**- Team Friends support individuals beyond high school so they can continue to thrive. It is one of our most popular and impactful programs, serving adults with intellectual disabilities and autism post-high school. With 100–150 participants (including family and caregivers) attending each monthly gathering, this group offers meaningful opportunities for social connection, community engagement, and philanthropy. From themed parties and outings to Kennywood and the Pittsburgh Pirates games, to volunteer activities, Team Friends provides a welcoming space where friendships grow between caretakers, staff, and individuals in attendance and in the community.
- **The Self-Advocacy Group** has also continued to meet monthly through its partnership with the HCQU, offering engaging educational sessions that promote self-determination, skill development, and meaningful community participation.
- **Annual Meet and Greet-** Our Annual Meet 'n Greet with First Responders brings together individuals with disabilities, caregivers, and all types of first responders in a non-emergency setting. With an upwards of 150 attendees, the Meet 'n Greet has become a much anticipated and successful annual event. In addition, we developed Emergency Preparedness Folders that can be used year-round. These folders include information on the PA Yellow Dot Program, tips and trainings for first responders working with individuals with disabilities, PA State Police state-recognized autism printables, communication tools, and other helpful resources to enhance emergency planning and response. This year, the Arc of Indiana started their own Meet and Greet in Indiana County. We will continue the event in Armstrong, meaning individuals will have 2 opportunities to attend the Meet and Greet each year. We are reaching more first responders in both counties, and the feedback is always very positive. We have first responders volunteer to attend these events.
- **Intake**-The Intake Coordinator serves as the initial point of contact for individuals seeking eligibility for the Intellectual Disability (ID) and Autism program. All intakes for Armstrong-Indiana Behavioral and Developmental Health Program (AI-BDHP) are conducted by an independent, conflict-free agency (Alliance for Non-Profit Resources). Our mobile intake model allows assessments to be completed in the individual's home or community, removing barriers for families unable to travel. In addition to completing intake paperwork, the intake worker also provides community outreach at schools and events on behalf of the ID department, administers the Adaptive Behavior Assessment

System (ABAS) when appropriate, and coordinates with an independent psychologist to support accurate eligibility determinations. As part of the intake process, “Welcome Packets” are distributed that include valuable information on resources such as PA Family Network, PA Gold Book, The Arc, special needs trusts, Parent to Parent, mental health supports, local community events, and more. This standardized and accessible intake process has proven to be highly beneficial for individuals and families, offering flexibility, consistency, and meaningful support from the very first interaction. The Intake Coordinator also provides guardianship resources, emergency preparedness resources, utilizes Lifecourse tools on a regular basis with individuals at the front door, plays an active role at scheduled community outreach and events, assists in the growth and functions of the local and regional collaboratives, and continues to foster healthy relationships with the school districts and in the community. If a referral does not meet the criteria for the ID/Autism program, the coordinator ensures that the individual, family, or agency is connected to the appropriate resources or services that can assist them. The intake coordinator is also a new LifeCourse Ambassador.

Intakes by number for the past 12 months:

- Total Intake Referrals: 109
- Total Case Openings: 41 (23 ID, 18 ASD)
- Active Referrals: 36 (average)
- Referred To Testing: 73
- No Follow Through: 15
- Out of County: 7 Transfer
- CHC/Nursing Home: 2
- Compass Referrals: 42
- Ineligible: 5

- **IM4Q**- The Arc of Indiana County is our IM4Q provider. We have a close working relationship with them that has allowed us to develop a streamlined process for getting feedback from the questionnaires completed. The Arc is very supportive of ‘AE suggested’ additional questions to the IM4Q surveys to get/ collect data for us. We use our ‘additional questions’ data to help support our Quality Management plan. The IM4Q always provides the AE with urgent requests and general individual information. The use of technology is freeing up time and giving the workers more time with individuals and we are receiving clear and concise reports. At the closure of the IM4Q FY cycle, reports are generated showing the consideration themes. When there is a theme that is predominate across the considerations, we look at what the theme is and see if there is a quality management outcome that can be developed from the requests that are being made within that consideration. If there is a consideration theme that is already part of a quality management outcome, we look at what each of those consideration requests were and add them to the QM outcome to track and follow up on.

- **Quality Management:**
  - Our Quality Management Coordinator, Incident Management Coordinator and waiver coordinators work together closely to monitor our QM Plan.
  - We have an active Human Rights Committee in our AE to fulfill ODPs Operating agreement. We review restrictive support plans quarterly. We evaluate the quality and results of the plans. We will also use this time to review all the restraints that occurred in the past quarter.

- We provide Quality Management/incident management/risk management data to our Advisory Board members annually. We also provide this information to providers and stakeholders at various other meetings and forums.

Quality Management Plan 25-28 focus areas:

1. *Medical/behavioral needs are being addressed* by using Health Risk Screening Tool and ensuring accurate information is included in the ISP. We currently have 30 people with Health Care Level (HCL) 6. We review the HRST assessments and see if medical/behavioral concerns are listed in the current ISP. We can also track to see if HCQU referral has been made or should be made to support the individual. Our data shows progress as we initially indicated 30 Individuals with HCL 6 at the beginning of this plan year. By the end of the plan year, the number of individuals was reduced by 10 to 20 individuals with HCL 6. This represents 3 who passed away and 7 changed in HCL from 6 to 5 as of 6/18/26. Our focus will be on the remaining 20 HCL 6. Over this past year we have gained knowledge and understanding of the HRST process and the correspondence between residential providers and clinical reviewers. This review is reflective of individuals fluctuating healthcare needs and/or the provider's thorough completion of the HRST assessment. During the present year, Eight (8) moved to an HCL 6 which shows fluctuation occurs. The Support Coordinator will ensure that the risks identified by the team as a result of the most recent HRST are captured in the Health and Safety Focus Area Section of the ISP and that a plan to mitigate the risk is identified. The SC and team are encouraged to use the Considerations when developing risk mitigation plans.
2. *Providing individuals/families with information they want* by evaluating how we are getting information out to our community. This will include data from the family liaison, surveys, turnouts to events, and feedback. Our data reflects Team Friend events in October, November, and December 2025 were popular and will continue. Surveys for information created and sent to SCs were completed. Individuals want physical paper with information regarding events. We will continue to use paper mailing for newsletters. We also have a QR code for individuals and families that prefer electronic communication.
3. *Moving individuals into competitive employment* from supportive employment or small group employment. Armstrong Indiana had a baseline completed for small group employment on our previous QM plan. Our plan is to move 4 individuals from small group employment into competitive integrated employment. 1 individual has made the move to CIE. We will continue to track and monitor. Barriers for the other individuals include staying focused, completing work accurately and being independent. We are working with PWAC and ICW quarterly to review activities and progress.
4. *Diverting individuals from hospitalizations or higher levels of care*. We will be looking at new people coming into the program, people phasing out of the services and who needs short periods of support to maintain their current level of care. Progress is being made by the activities, interventions, and treatment offered to individuals in crisis by the Dual Diagnosis/Clinical Care manager (DD/CCM). Quality Management Coordinator (QMC) + DD/CCM meet monthly and discuss the data from the spreadsheet. Reviewing High, Active, Inactive, and Archive at the END of each quarter. The data shows stabilization.

- **Increase Provider Competency** – Because of the rural nature of our counties and of the number of tight knit communities in which our families and providers live, we are a very interactive AE that works very closely with our SC's & Providers. As a result, we can act relatively quickly in getting necessary resources to support individuals with higher level needs. Our Dually Diagnosed Clinical Care Manager attended the Capacity Building Institute this year and shares the information and resources he learned about with the multiple providers he meets with weekly. He also presented

information on “Let’s Talk About Stress” with various provider staff and at other training events. Other examples of resources shared recently include: Community of Practice and Life Course Framework for natural supports/ Social capital, Intensive Technical Assistance (ITAs), Health Risk Screening Tools (HRST), Human Rights Committee (HRC) to ensure restrictive plans follow ODPs regulations, Work with Area Agency on Aging Offices, Work with several County Assistance Offices, Provider specific Technical Assistance, Education on Waiver Regulation changes, Education on employment and OVR services, Education on EPSDT services and processes, Education on Special Needs Trusts, Education on Guardianship/Power of Attorney, Education on Sexual and Behavioral Risk Assessments, Experienced Forensic Interviewers through the HAVIN’s Kay’s Cottage program, referral to the Dually Diagnosed Treatment Team (DDTT)

- **Risk Management-** We utilize an Incident Management Coordinator, Waiver Coordinators, and Quality Management Coordinator who work closely with each other on risk management and prevention. This includes trend analysis of incidents. When trends are identified, we work with the provider and SCO to mitigate the risk. We have expanded our ability to review incident reports, service notes, progress notes and ISPs to mitigate risk. We continue to complete the Provider Risk assessment process each year. There were 72 county investigations for this fiscal year which was 1 more than last fiscal year 2024-2025 with 71. We continue to meet with ANR (CI Provider) quarterly and implement extra quality assessments to ensure contracted Certified Investigators are meeting requirements and quality standards. We had a total of 1039 providers/county investigations for fiscal year 2025-2026. This year we completed an EIM educational training in June with families, caregivers, DSPs, and individuals during our self-advocacy group to explain further what the incident coordinator does and how incident management works. Individuals were able to ask questions information packets were shared and identifying and discussing how to be safe were also included in the training.

- **Housing**- When housing issues arise the SC contacts the housing authorities for assistance on placement or for problem resolution. Both county community action programs offer assistance for determining eligibility for housing programs and assistance with homelessness. Community Health Workers (CHW’s) are available to work with individuals to develop individualized housing plans when appropriate. A-I BDHP continues to identify housing as an ongoing priority for our counties. Currently Armstrong, Indiana and Westmoreland are working on a joint plan to make available additional personal care home beds in Armstrong County.

- **Emergency Preparedness Plan** –Currently all existing providers have emergency preparedness plans developed. These plans are reviewed at provider monitoring. We also offer Emergency Preparedness education to any individual or family who requests it through the IM4Q surveys. The Family Liaison has updated the information we are handing out to include QR codes where we can update information immediately.

Participant Directed Services (PDS):

The AE has recognized that this is a needed service that gives families and individuals more control over their services and staff. The Waiver Coordinator attends regional AWC meetings which include ODP, SCOs and providers. This meeting is extremely educational, and a lot of information is shared. The AE mails Information on Self-Direction to everyone in the queue who will be enrolled into a waiver program. Quarterly meetings are held with ANR and SCO Directors to discussion service utilization, concerns, and solutions to any issues that may occur. At registration, information is given to everyone who is in the Intake Process. Currently, we have 89 individuals receiving services through Agency with Choice. This has been an increase of 12 in the past year. SCs continue to offer the option of self-direction to everyone yearly during the Annual ISP. We also provide AWC education to families and

professionals at various meetings. In FY 25-26 14 individuals were authorized for Participant Directed Goods and Services. Of the 14 (7) or 50% received support for pest control in their home. This has been an identified increasing concern in our counties. Due to provider policies, some individuals have been unable to receive CPS or employment services in Facilities because they need written documentation that their home is pest free to return to the facility. It may take months for the individual to be able to return. The goal is to have the individual return as quickly as possible, but in many cases the homes are reinfected due to lack of education or knowledge of health and hygiene. The AE has scheduled educational trainings on health and hygiene for individuals. The AE may also consider educational training on Pest Control with a focus on bed bugs in the future to increase awareness and mitigate spread. It is detrimental to all individuals who receive services in a facility as they would also lose program for several days if the facility itself requires extermination. This is also very costly to the provider agency. ODP could assist providers by offering funding for equipment such as bed bug boxes; heat chambers that kill bed bugs in luggage and belongings or other comparable mitigation devices.

Community for All:

- Armstrong and Indiana Counties have under 20 individuals who reside in private and state ICF/ID facilities and nursing homes. SC's monitor and assess the needs of these individuals. Families are also involved in this process. We continue to provide specialty services in Nursing Homes as needed/recommended. Anyone in a State Center is offered the choice to return to the community at any point. We currently have 1 individual pending admission to a State Center from Jail. We are assisting with the transition and plan to be very involved to return the individual back into the community when right provider match can be found.

Technology:

AIBDHP supports the use of assistive technology and remote support for individuals to achieve their goals and live more independently.

- We are seeing an increase in individuals who no longer wish to live in a residential group setting and want to live and be successful in their own apartments.
- The AE continues to see growth in this area as (8) individuals utilized Remote Support/Technology Equipment in FY 25-26.
- The AE supports assistive technology that will increase independence for individuals according to the goals listed in their Individual Support Plans. The AE receives multiple requests for approval throughout the fiscal year. We currently have 2 providers in our area that offer Remote Support: Safe in Home and Lifesteps. We have two qualified providers who offer Specialty Telehealth Services to individuals in our area: Station MD and Senacare. We have seen an increase in authorizations for this service for individuals with unique medical and behavioral challenges. In FY 25-26 (33) individuals were authorized to receive this service. This service offers 24-hour per day medical support and guidance and eliminates the need for individuals to sit in a waiting room. This service is available during evening and weekend hours when traditional physician offices are closed.
- The Family Liaison is using QR codes to modernize the information we are giving out through our quarterly Newsletters. The family liaison has also purchased and distributed both stickers and magnets containing the QR code for easy access. The family liaison updates community training and events monthly so that the information is most current at any time the individual scans the QR code.
- The AE continues to learn about Remote Supports and Assistive Technology by attending periodic training offered through Safe in Home, meeting virtually with Tech Owl to explore their services and support, and by attending training with Lifesteps to learn more about their Smart Home offerings. Information from these providers has been shared at our Local Collaborative meetings.

- The AE and Family Liaison have discussed having hands-on training in FY 26-27 in which individuals and caregivers can sample different types of technology. Additional resources would also be provided on how to research and access different forms of equipment such as 3D printed spoon holders, Alexa, use of smart devices and much more.

HOMELESS ASSISTANCE PROGRAM SERVICES

Homeless individuals and families can be found throughout Armstrong County just as they may be found in any other community. These unfortunate situations can occur with people living on the streets, in cars, and in vacant buildings. People who have temporarily been taken in by a friend or family member (offering short-term assistance) are also considered homeless. Fortunately, funding through the Homeless Assistance Program (HAP) allows assistance to be given to these people who have suffered the misfortune of losing their housing and have been forced to find themselves in unfortunate situations. Most Federal funding governed by the HEARTH Act does not allow assistance to be given to the homeless who are in "doubled up" situations. Below is a brief description of the present Continuum of Homeless Programs in Armstrong County.

Armstrong County has various programs that serve the homeless and near homeless populations of the county. The Armstrong County Community Action Partnership (ACCAP) has spearheaded the response to many of the issues facing the homeless, as well as serving as a point source for coordination of all homeless programs. ACCAP is a voting member of the Western Pennsylvania Continuum of Care (COC) and attends the meetings on a regular basis. Locally, there is a Housing Advisory Board that meets quarterly to discuss issues of housing and homelessness. This group is analogous to a Local Housing Options Team (LHOT) that is an important part of any Continuum of Care. This group assists in assessing the needs of the homeless, as well as assisting in problem resolution. Many groups are represented on this advisory board including a formerly homeless participant, representatives from the Armstrong County Housing Authority, Armstrong County Planning and Development, Armstrong/Indiana Behavioral and Developmental Health Program, Armstrong /Indiana Drug and Alcohol, ARC Manor, Area Agency on Aging, Mechling-Shakely Veterans Center, HAVIN, Children and Youth Services, Habitat for Humanity, Salvation Army, ARIN Intermediate Unit, the Armstrong County Board of Assistance, among others.

Emergency Shelters

The county has a number of emergency shelter programs available which assist the homeless. HAVIN is an emergency shelter for abused victims centrally located in Kittanning, PA. In addition to this shelter, the Mechling-Shakely Veterans Center is an emergency homeless shelter for single male veterans. Armstrong County also has scattered site rental units that can house homeless families or individuals. These units are the direct result of a collaborative effort among the Armstrong County Community Action Partnership, Armstrong County Children and Youth Services, Armstrong-Indiana Behavioral and Developmental Health, Armstrong-Indiana-Clarion Drug and Alcohol Commission, and the Armstrong County Jail and Probation. The heads of these agencies planned a Pennsylvania Housing Affordability and Rehabilitation Enhancement Fund (PHARE) grant application. The plan was approved by the Pennsylvania Housing Finance Agency and is presently being operated by the Armstrong County Community Action Partnership. Presently nine units are being used to house the homeless in emergency situations. Each of the planning agencies, with the exception of the Area Agency on Aging, has a unit dedicated to housing homeless participants in their categorical programs.

The Pennsylvania Homeless Assistance Program (HAP) plays a key role with housing the homeless through motel stays. More importantly, HAP acts as the cement that holds many of the housing programs together through the case management funding it provides.

In addition to the HAP, the Armstrong County Community Action Partnership received funding to provide rapid rehousing of homeless individuals and families through the Emergency Solutions Grant Programs.

Additionally, our county is included in a regional grant operated by the Lawrence County Community Action Agency (LCCAP) for assisting homeless Veterans. ACCAP operates the Supportive Services for Veteran Families (SSVF), and it is funded by the Veterans Administration. This grant provides case management for veterans and their families, as well as short-term housing assistance, transportation assistance, car repairs, household placement items, and other supportive items and services. Rapid rehousing is one of the important short-term activities that can be paid for through this grant.

Homeless Prevention
This type of assistance has been the most prevalently used in past efforts to prevent Armstrong County citizens from becoming homeless. A number of funding streams have assisted in these efforts. The Homeless Assistance Program funding under this plan is used for paying rent and utilities of clients who are in near homeless situations. Funding can also be found for participants utilizing the Emergency Solutions Grant or, if they are a veteran and they are eligible, the SSVF Program may be able to assist them.

The Emergency Solutions Grant funding is used by Armstrong County to assist participants in homeless prevention. The Armstrong County Community Action Partnership uses both the rapid rehousing component (mentioned above) and the homeless prevention component to assist local participants. Both short and medium-term rental assistance is used, as well as limited utility assistance. The program can also pay for arrearages incurred by the participants if the payment will stay an eviction.

The Armstrong County Community Action Partnership also uses the private fuel fund of Dollar Energy to assist with emergency heating situations that go beyond the assistance provided by the Armstrong County Board of Assistance's Low Income Home Energy Assistance Program (LIHEAP).

Rapid Re-Housing
Lately, the concentration of resources seems to be in the area of rapid rehousing instead of transitional housing. This program is for participants who meet the Federal definition of homelessness, and who are able and willing to work. This is a scattered site rental assistance program that allows the participants to remain in the program for up to two years. Case management and a comprehensive array of supportive services are provided to the participants. The Agency also partners with Fayette County Community Action (FCCA) in another Rapid Re-Housing Program. This program is designed to help families only (not individuals) and is a scattered site rental assistance program.

Permanent Housing
The primary purpose for all homeless programs is to move the participant into permanent housing as quickly as possible. The Armstrong County Community Action Partnership operates a Permanent Supportive Housing Program also funded through the HUD sponsored Supported Housing Programs (SHP) funding stream. Under this program, all participants must have come to ACCAP as homeless (meeting the Federal definition for homeless) and be permanently disabled. Once again, this program is a scattered site leasing program. Participants can be housed in this program indefinitely.

Under the program found above, supportive services provide an integral part of successfully transitioning a participant from homelessness to permanent housing. Participants and Housing Case Managers work together to ensure that all County mainstream resources are utilized to assist the participants in becoming self-sufficient. ACCAP provides case management assistance to help participants prepare a service plan

designed to help them overcome barriers and provide the necessary assistance to support the participant in becoming self-sufficient.

Programs to be Funded Under the Homeless Assistance Program:

Case Management
Integral for the success of all homeless programs is the Case Management component. For this reason, the County of Armstrong would like to budget **$152,009 into this category** with **$24,948 of this amount going towards program administration**. This should allow us to see an estimated **400 persons** who are either homeless, or are close to being homeless. This funding is extremely important, not only for the participants seen under this HAP funding, but also because it is used as a match for the other federal programs. We are expecting to see many more households than normal seeking assistance after the funding from the Emergency Rental Assistance Program concludes. Last program year we were able to serve **345 persons** with case management services. This program serves as the glue that binds the many programs that the county has at its disposal to assist the homeless, as well as the supportive services needed to keep the homeless from future episodes of homelessness.

All homeless participants are provided case management services. Each participant meets with the case manager during the intake process. The case manager performs a ***needs assessment*** for the participant with regard to housing needs, personal budgeting needs and housing affordability. Each participant is connected to main stream resources through the ACCAP Resource Center and, if needed, emergency shelters. If a participant is eligible for federally funded housing options, the case manager will make the necessary referrals to those programs.

Our agency has implemented a “Housing First” approach for delivery of homeless services and implements Coordinated Entry. Coordinated Entry ensures that those homeless individuals with the highest acuity will be given priority to be housed first. We identified a gap in providing tenant education services, and we filled that gap by training our entire housing department in ***PREP: Prepared Renters Education Program***. Now, every participant who comes into our agency can take advantage of this voluntary training if desired. The truest and best method of evaluating case management services is by reviewing the placement rates of new participants as it pertains to permanent housing.

Rental Assistance
It is always difficult to determine whether to budget additional funding for Rental Assistance or Emergency Shelter activities. Something can be said for either activity as being important, but with funding cuts happening in all social service programs, including ones for the homeless, it seems natural to ensure that if homelessness occurs, there will be funding available to assist them.

With this in mind, and with emergency shelter participants increasing each year, as well as the cost of motel voucher stays increasing each year, we wish to budget **$48,745 to Rental Assistance**. This will allow us to help approximately **100 persons** in the form of assisting in the payment of arrearages, first month’s rent, or security deposits.

The efficacy of rental assistance is determined by the number of people helped in avoiding homelessness and the number of homeless individuals placed into permanent housing. Rental assistance prevents homelessness. Rental assistance also places homeless persons into permanent housing. We helped **80 individuals prevent homelessness or end homelessness** during the year ending June 30, 2026.

Emergency Shelter

We are proposing budgeting **$48,745 for Emergency Shelter services** this year. This will allow us to provide assistance to a targeted **150 persons** in need. In the previous year, we were able to help 131 individuals. We were able to provide **868 days** of emergency shelter to our participants.

Our evaluation of the efficacy of the emergency housing program must factor in the unmet needs present because of the lack of a true shelter. However, we look for every opportunity to divert participants to other resources within the community, which includes staying with family and friends until a permanent housing solution can be found. We propose no changes to the emergency shelter service at this juncture; however, we continue to seek funding opportunities for a homeless shelter.

Other Housing Supports and Bridge Housing
At this time, the county does not have a need to allocate funding out of HAP funds for other housing supports or Bridge Housing. Other programs are providing for all housing support services that we have found necessary.

HMIS AND COORDINATED ENTRY
The Housing Department staff of the Armstrong County Community Action Partnership is quite familiar with the Homelessness Management Information System (HMIS) as they perform all the requirements of data entry into the HMIS system. As a member of the Western Pennsylvania Continuum of Care, and as a recipient for McKinney Vento funding through HUD, the ACCAP is required to report all homeless activities for these funding streams into a Homeless Management Information System. This system is an internet accessed system set up by the Department of Community and Economic Development (DCED) for all Balance of State Continuum's of Care throughout the state of Pennsylvania. All homeless individuals and families are able to be tracked through the HMIS. In addition, a reporting function is built into the system so that time sensitive data can be accessed and gathered for periodic reporting to the funding source. Participant destination data upon exit is also recorded and tracked by the HMIS in Pennsylvania and in Armstrong County.

ACCAP is also the county assessment center for the Western Pennsylvania Continuum of Care's Coordinated Entry System. All homeless individuals who call or walk through our doors are offered the opportunity to be added onto the Coordinated Entry System. This System scores and ranks the individuals on a prioritization list that allows the participants to be selected for homeless programs for which they are eligible throughout the counties of the Continuum of Care.

Homeless Assistance Services Summary:

	Individuals served in FY 25-26	Projected Individuals to be served in FY 26-27
Case Management	345	400
Rental Assistance	80	100
Emergency Shelter	131	150
Days of Emergency Shelter Provided	868	700

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: Life Skills Education
Description of Services: Provides adults with the practical education, skills, and training needed to safely perform the activities of daily living. Service is provided in the client's home, office, or community as part of an overall service plan formulated by a case manager of the agency's Base Service Unit. Examples include training in budgeting, meal preparation, and parenting. In conjunction with the client's case manager, the Adult Services Block Grant Aide helps determine and coordinate the services needed for each client.
Service Category: Life Skills Education - Provides to persons the practical education and training in skills needed to perform safely the activities of daily living. The term does not include job readiness training, instruction in a language, or remedial education.

Generic Services: Please provide the following:
Program Name: Information and Referral
Description of Services: Clients are provided with detailed information and referrals tailored to the individual or family's specific needs. ACCAP's trained staff carefully assesses each caller's situation to ensure they receive guidance on the most relevant resources available. Referrals may include connections to appropriate county human service agencies, such as those offering financial aid, housing support, food assistance, and healthcare services. Additionally, ACCAP directs individuals to private organizations and non-profit agencies that provide similar services, ensuring residents have access to a broad network of support within the community. By offering these referrals, ACCAP helps individuals navigate the often complex landscape of available services, ensuring residents receive the help they need as efficiently and effectively as possible. The goal is to empower individuals by linking them to the right resources and enhancing their ability to overcome challenges, thus improving their overall quality of life.

Service Category: Information & Referral - The direct provision of information about social and other human services, to all persons requesting it, before intake procedures are initiated. The term also includes referrals to other community resources and follow-up.
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:
Program Name: Children's Program
Description of Services: Through therapeutic individualized counseling, victimized children will have the opportunity to gain a sense of self and empowerment through a safe and secure outlet to express their concerns about themselves, family relationships, social interaction, and their school environment. This consists of play and art therapy so that the child is able to express him/herself freely. Tutoring is also a component to help improve academic success and reduce truancy and dropout rates by improving self-esteem and empowerment through this individualized counseling. This grant money is intended to target families who are low-to-mid income level and do not have the means to get their children individualized help.

Service Category: Counseling/Intervention - Activities directed at preventing or alleviating conditions which present a risk to the safety or well-being of the child, by improving problem-solving and coping skills, interpersonal functioning, and the stability of the family.

Specialized Services: Please provide the following:
Program Name: Transportation
Description of Services: Provide transportation to social and medical service providers and community facilities, as well as promote independent living. Examples include transportation to doctor's appointments when no other means of transportation are 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.

Specialized Services: Please provide the following: (Limit 1 paragraph per service description)
Program Name: Day Treatment Aftercare & Mentoring Program
Description of Services: This mentoring program is offered to both dependent and delinquent youth who are transitioning from the Day Treatment Program serving school truant youth and who are returning to the traditional school setting. A county-wide day treatment program accepts students from all school districts serving Armstrong County residents.

Specialized Services: Please provide the following: (Limit 1 paragraph per service description)
Program Name: ARC Manor
Description of Services: Outpatient counseling services are available to both adults and adolescents who are struggling with drug and alcohol abuse, as well as to family members who are affected by their loved ones' substance use. These services are designed to provide comprehensive support through both individual and group counseling sessions tailored to meet the unique needs of each client.

Specialized Services: Please provide the following: (Limit 1 paragraph per service description)
Program Name: Project TIPS Program
Description of Services: Project TIPS will enable incarcerated females in Armstrong County to develop skills in parenting and in the use of positive discipline and guidance techniques thus increasing the mother's sense of self-worth and ability to deal with stressful child-rearing situations. The parenting sessions will strengthen the parent-child bond and heighten the degree of communication between parent and child. A Parent Educator will meet with every incarcerated female individually to explain the program and encourage participation.

Specialized Services: Please provide the following: (Limit 1 paragraph per service description)
Program Name: Prison Counseling at the Armstrong County Jail
Description of Services: Provides counseling to inmates of the Armstrong County Jail. Individual and group counseling will be performed to prevent possible suicide, change behavior and attitudes, assist in adjusting to incarceration, and help inmate's growth and preparation for eventual release back to society. General Counseling, Group Counseling, & Drug and Alcohol Counseling may also be provided as well as coordination with treatment providers to ensure continuity of care. This service is provided by Family A.C.T.S. and not by the prison staff.

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.

The funds allocated are specifically used to supplement the salary of a dedicated staff member who is responsible for overseeing the coordination of several critical programs listed below. This role is central to the success of our Interagency Coordination efforts, which are designed to enhance the overall effectiveness and efficiency of collaboration among local agencies, private organizations, non-profits, and advocacy groups within the community.
The staff person ensures that these diverse entities work together seamlessly by fostering open and ongoing communication, which is essential for addressing the multifaceted needs of the community. By bridging gaps among these organizations, the Interagency Coordination initiative helps to prevent duplication of services, identify and address service gaps, and streamline the delivery of support to those who need it most.
Additionally, this coordination allows for the sharing of resources, expertise, and information, which enhances the capacity of all involved agencies to serve the community more effectively. The staff member plays a pivotal role in planning, reporting, and coordinating services between categorical programs on behalf of the County, ensuring that each program operates in harmony with the others to maximize their collective impact.
Through strategic collaboration, the Interagency Coordination initiative not only strengthens the relationships among these organizations but also creates a more cohesive and supportive network that can respond more agilely to the evolving needs of the community. This, in turn, leads to better outcomes for the individuals and families who rely on these services, as well as a more resilient and integrated community support system.

Other HSDF Expenditures – <u>Non-Block Grant Counties Only</u>

If the county plans to utilize HSDF funds for Mental Health, Intellectual Disabilities, Homeless Assistance, or Substance Use Disorder services, please provide a brief description of the use and complete the chart below.

Only HSDF-allowable cost centers are included in the dropdowns.

Category	Allowable Cost Center Utilized	
Mental Health		
Intellectual Disabilities		
Homeless Assistance		
Substance Use Disorder		

Note: Please refer to Planned Expenditures directions at the top of Appendix C-2 for reporting instructions (applicable t