INTEGRATED Services of Kalamazoo

Community • Independence • Empowerment

Administrative Services
610 South Burdick Street
Kalamazoo, MI 49007
www.iskzoo.org
(269) 553-8000

24-HOUR CRISIS HOTLINE or NON-EMERGENCY CLINICAL SERVICES: (269) 373-6000

AGENDA

November 23, 2026

Name: INTEGRATED Services of Kalamazoo Board of Directors
Commencement Time: 4:30PM
Location: 610 South Burdick Street/Kalamazoo, MI., 2nd Floor
ISK Boardroom #220

I. CALL TO ORDER – CITY & COUNTY DECLARATION
II. AGENDA
III. CITIZEN TIME

IV. RECIPIENT RIGHTS
  a. ORR Recipient Rights Monthly Report

V. PROGRAM SERVICE REPORT
  a. JETT - Justice, Equity, & Trauma Team/*Dusty Jepkema & Cheryl Nebedum*

VI. CONSENT CALENDAR/VERBAL MOTION
  a. Minutes *November 2, 2026*
  b. Communication and Counsel to the Board V.06 (Policy)
  c. Governing Style II.02 (Policy)
  d. Endowment Fund VI.03 (Policy & Report)
  e. Corporate Compliance & Risk Management V.11 (Policy & Report)
  f. Compliance & Risk; FY Annual Plan (Report)

VII. MONITORING REPORTS/ VERBAL MOTION
  a. Compliance & Risk; FY26 Year-End Summary & FY27 Goals/*Ashley Esterline*
  b. Emergency Executive Succession V.05 (Policy)

VIII. FINANCIAL REPORTS
  a. Financial Condition Report
  b. *September & October* 2026 Disbursement/MOTION

IX. ACTION ITEM
  a. FY26-27 ISK Benefit Enrollment (PA152)/MOTION & RESOLUTION

X. ACTION ITEMS REVISITED - Consent Calendar November 2, 2026/MOTION
  a. Minutes *September 28, 2026*
  b. Board Purpose and Business Description (II.01)(Policy)
  c. Board Business Description (II.03)(Policy)
  d. Treatment of Persons Served w/Substantiated Complaints (V.01)(Policy & Report)
  e. Guidelines For Board Member Appointments (I.03)(Policy)
  f. Annual Customer Advisory Council (CAC) & Customer Service(Reports)
  g. Annual Family Support Advisory Council (FSAC)(Report)

INTEGRATED
Services of Kalamazoo

Community • Independence • Empowerment

Administrative Services
610 South Burdick Street
Kalamazoo, MI 49007
www.iskzoo.org
(269) 553-8000

XI. CHIEF EXECUTIVE OFFICER VERBAL REPORT
   a. CLOSED SESSION/MOTION

XII. CITIZEN TIME

XIII. ACKNOWLEDGEMENT of MERITORIOUS STATUS

XIV. BOARD MEMBER TIME
   a. SWMBH (Southwest Michigan Behavioral Health) Updates/Michael Seals
   b. Decision to have Monday, December 28, 2026, ISK/BoD Meeting

XV. ADJOURNMENT

IV.a.

Office of Recipient Rights
Report to the Mental Health Board
On Complaints/Allegations
Closed in: October 2026

Office of Recipient Rights Report to the Mental Health Board
Complaints/Allegations Closed in October 2026

	October 2026	FY 26-27	October 2025	FY 25-26
Total # of Complaints Closed	**43**	**49**	**49**	**49**
Total # of Allegations Closed	**63**	**63**	**71**	**71**
Total # of Allegations Substantiated	**23**	**23**	**20**	**20**

The data below represents the total number of closed allegations and substantiations for the following categories: **Consumer Safety, Dignity/Respect of Consumer, Treatment Issues, and Abuse/Neglect.**

ALLEGATIONS	**October 2026**		**October 2025**	
Category	**TOTAL**	**SUBSTANTIATED**	**TOTAL**	**SUBSTANTIATED**
Consumer Safety	7	1	7	1
Dignity/Respect of Consumer	4	1	17	3
Treatment Issues/Suitable Services (Including Person Centered Planning)	18	3	14	3
Abuse I	0	0	2	0
Abuse II	1	1	5	2
Abuse III	7	3	2	0
Neglect I	0	0	0	0
Neglect II	2	2	2	0
Neglect III	10	8	7	7
	49	**19**	**56**	**16**

APPEALS	**October 2026**	**FY 26-27**	**October 2025**	**FY 25-26**
Uphold Investigative Findings & Plan of Action	0	0	1	1
Return Investigation to ORR; Reopen or Reinvestigate	0	0	0	0
Uphold Investigative Findings but Recommend Respondent Take Additional or Different Action to Remedy the Violation	0	0	0	0
Request an External Investigation by the State ORR	0	0	0	0

ABUSE AND NEGLECT DEFINITIONS – SUMMARIZED

Abuse Class I means serious injury to the recipient by staff. Also, sexual contact between a staff and a recipient.
Abuse Class II means non-serious injury or exploitation to the recipient by staff and includes using unreasonable force, even if no injury results.
Abuse Class III means communication by staff to a recipient that is threatening or degrading. (such as; putting down, making fun of, insulting)
Neglect Class I means a serious injury occurred because a staff person DID NOT do something he or she should have done (an omission). It also includes failure to report apparent or suspected abuse I or neglect I of a recipient.
Neglect Class II means a non-serious injury occurred to a recipient because a staff person DID NOT do something he or she should have done (an omission). It also includes failure to report apparent or suspected abuse II or neglect II of a recipient
Neglect Class III means a recipient was put at risk of physical harm or sexual abuse because a staff person DID NOT do something he or she should have done per rule or guideline. It also includes failure to report apparent or suspected abuse III or neglect III of a recipient.

ORR ADDENDUM TO MH BOARD REPORT
November 2026

Re: October 2026 Abuse/Neglect Violations

October
Abuse Violations

- There was one substantiated Abuse II violation in October 2026.
  - The remedial actions for this violation were Pending(1).
- There were four substantiated Abuse III violations in October 2026.
  - The remedial actions for this violation were Employment Termination (1), Written Reprimand (1), Written Counseling (1), Training (3), and Pending (1).

    The 4 violations occurred at 4 different agencies.

Neglect Violations

- There were two substantiated Neglect II violations in October 2026.
  - The remedial actions for these violations were Employment Termination (1), Written Reprimand (1), Training (2).

    The 2 violations occurred at the same agency, but different program sites.
- There were eight substantiated Neglect III violations in October 2026. Three of the eight were Neglect III, Failure to Report.
  - The remedial actions for these violations were Employment Termination (1), Employment Left Agency but Substantiated (1), Verbal Counseling (1), Written Reprimand (5), Training (7), and Pending (1).

    The 8 violations occurred at 5 different agencies. Two of the 5 agencies had 2 violations at the same program site. For both of those agencies one of the violations was a Failure to Report.

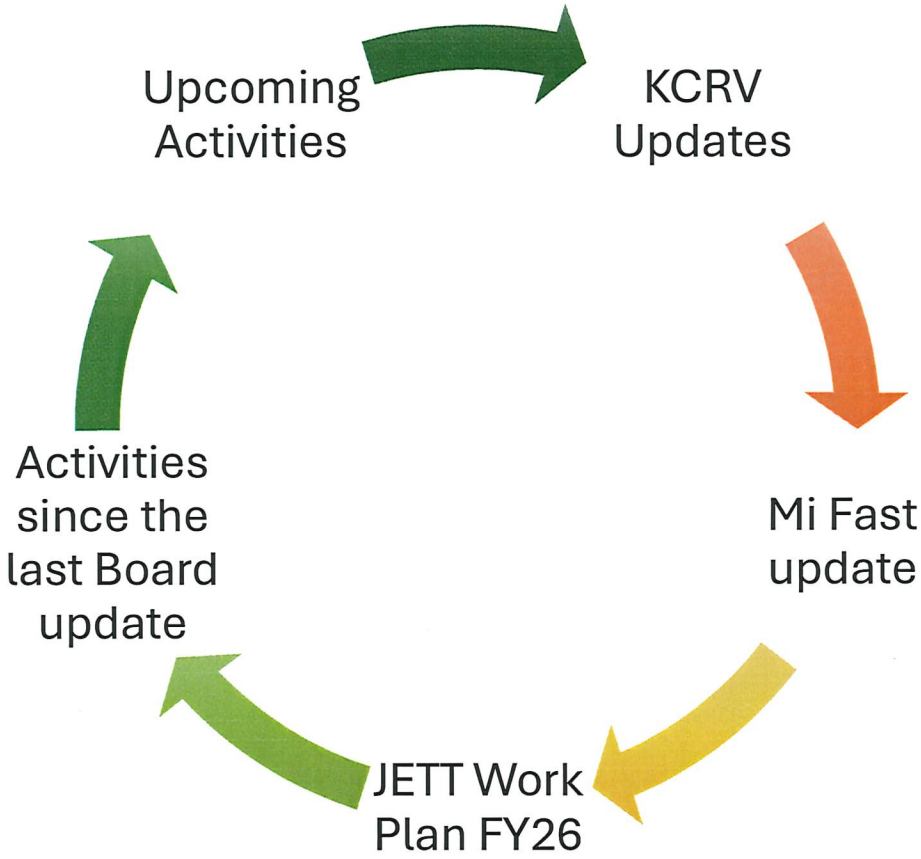
Justice Equity Trauma Team (JETT)
ISK Board Updates
November 23, 2026

Dusty Jepkema
and
Cheryl Nebedum

Co-Facilitators

V.a.

Topics for Board Update





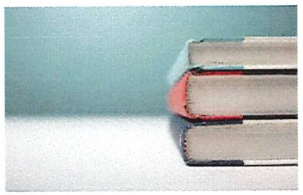
SOLIDARITY

We have a common interest in assuring that Kalamazoo County, our communities and the organizations in which we serve remain committed to all individuals and groups being treated with respect and value.



MUTUAL GOALS AND OBJECTIVES

We create mutual goals and objectives to support each other, provide focus and advance the culture of respect and value for all in our county.



EDUCATION

Continuous growth and learning assures that our organizations and county remains focused on a humanitarian culture. We learn with each other, We teach each other and grow collectively.

IMPACT

Our activities and time invested will be focused toward creating an impact within our organizations, communities and county. We don't want to just have meetings, we want deliverables.



CAMARADERIE

We will find time to have fun and fellowship

4 Cs

Community

Compassion

Collective

Coaction

Kalamazoo Collective for Respect and Value

MIFAST

TRAUMA INFORMED REVIEW PROCESS

1



PREPARE FOR SITE REVIEW

At the end of 2025 into the beginning of 2026 the trauma Informed Subcommittee of JETT collected policies, practices, and other show proofs for the state MIFST team to demonstrate the Trauma Informed work we are doing

2



SITE REVIEW

On February 17, 2026, the state MIFAST team came to ISK and completed an on-site review which included touring locations, interviewing staff and individuals served, and reviewing records to find evidence of our Trauma Informed work.

3



REPORT PREPARATION

The state MIFAST team reviewed their site notes and well as the documentation we previously submitted to create a report which highlights the work we are doing, what we are doing well and opportunities for growth.

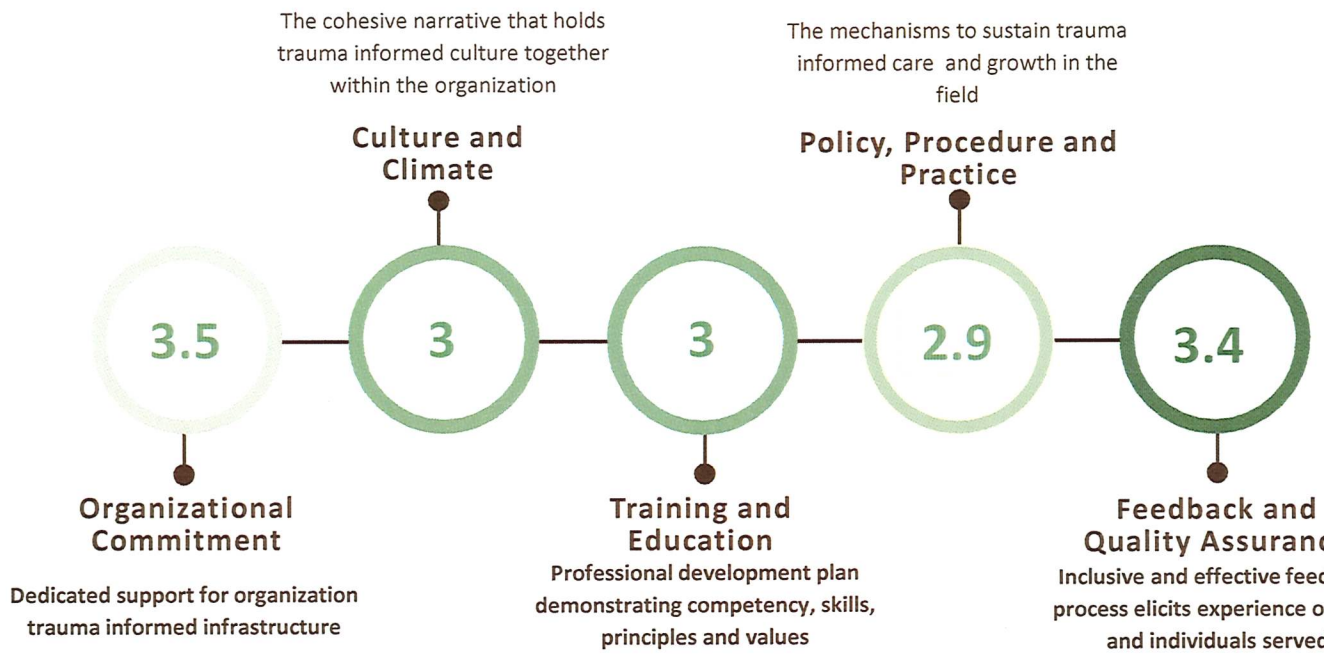
4



REPORT REVIEW AND WORKPLAN CREATION

JETT and the Trauma Informed subcommittee will review the report and identify actionable steps that the agency can take to create a more Trauma Informed environment for community members and staff.

REVIEW RESULTS - 5 ELMENTS OF TRAUMA INFORMED CARE REVIEW



Strengths and Opportunities

Teamwork

Many teams are working hard to provide Trauma Informed services: UCAC, Peers, Recovery Coaches, Engagement Team, Zero Suicide team, Bilingual staff, Trauma Coaches, DBT, KIT, HR

Vision

There is a strong and evident agency commitment to trauma informed work

Client Focus

Interviews with individuals served indicated that there is a strong sense of psychological safety, rapport and trust in sessions.

Feedback

Additional strengths in the areas of collecting feedback, particularly through customer surveys as well as the Citizen Advisory Council



Consistency

A lot of great work is happening across agency, but it is not systematic of consistent across all departments

Policy reviews

Better application of trauma informed lens on policies and practices with inclusion of JETT in these reviews. Formalized protocols surrounding traumatic events that may occur

Staff support

Recommendations for improved trauma informed supervision as well as trauma informed staff review and feedback processes

Communication

Improved communication to staff as well as the community and individuals served surrounding trauma informed principles and the work being done within ISK

JETT Workplan

FY 2025-2026

- Accomplishments
  - MIFAST Review
  - Restructuring of Equity Review
  - Additional Opportunities for staff to meet cultural Diversity Credit
  - KCRV participation

FY 2026-2027

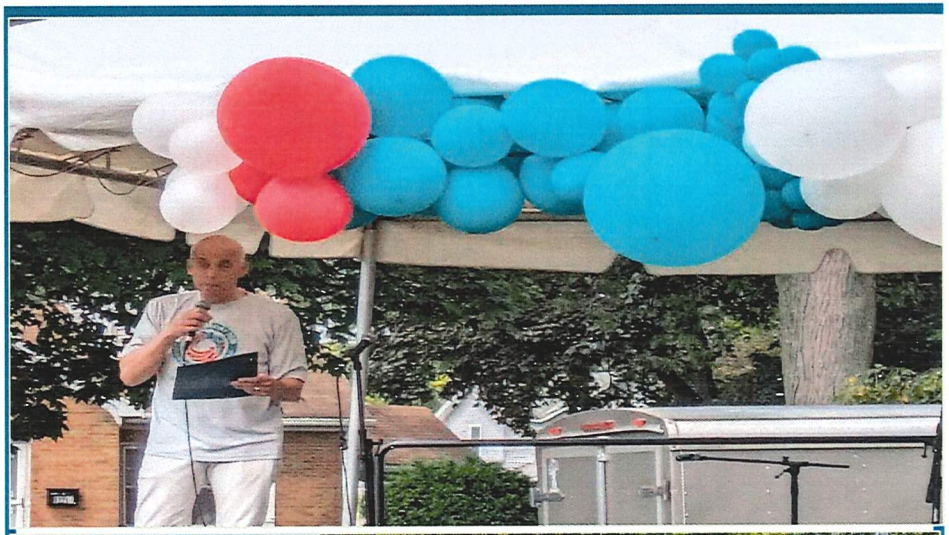
- What's next?
  - Continue to align with the agency's strategic plan
  - Coordinate with other departments for alignment of goals i.e. training, HR
  - Consolidate workplan into strong actionable items for the group to focus on
  - Participate and support diverse events in our community

JETT Activities



Northside Day 2026





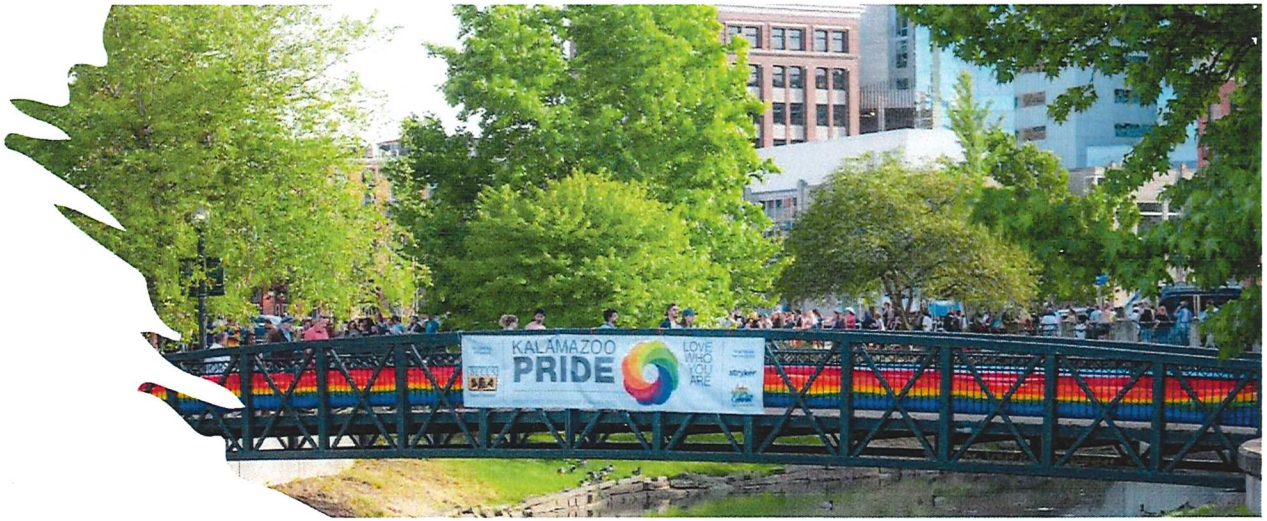






Kalamazoo Pride Festival 2026







Upcoming Activities for JETT

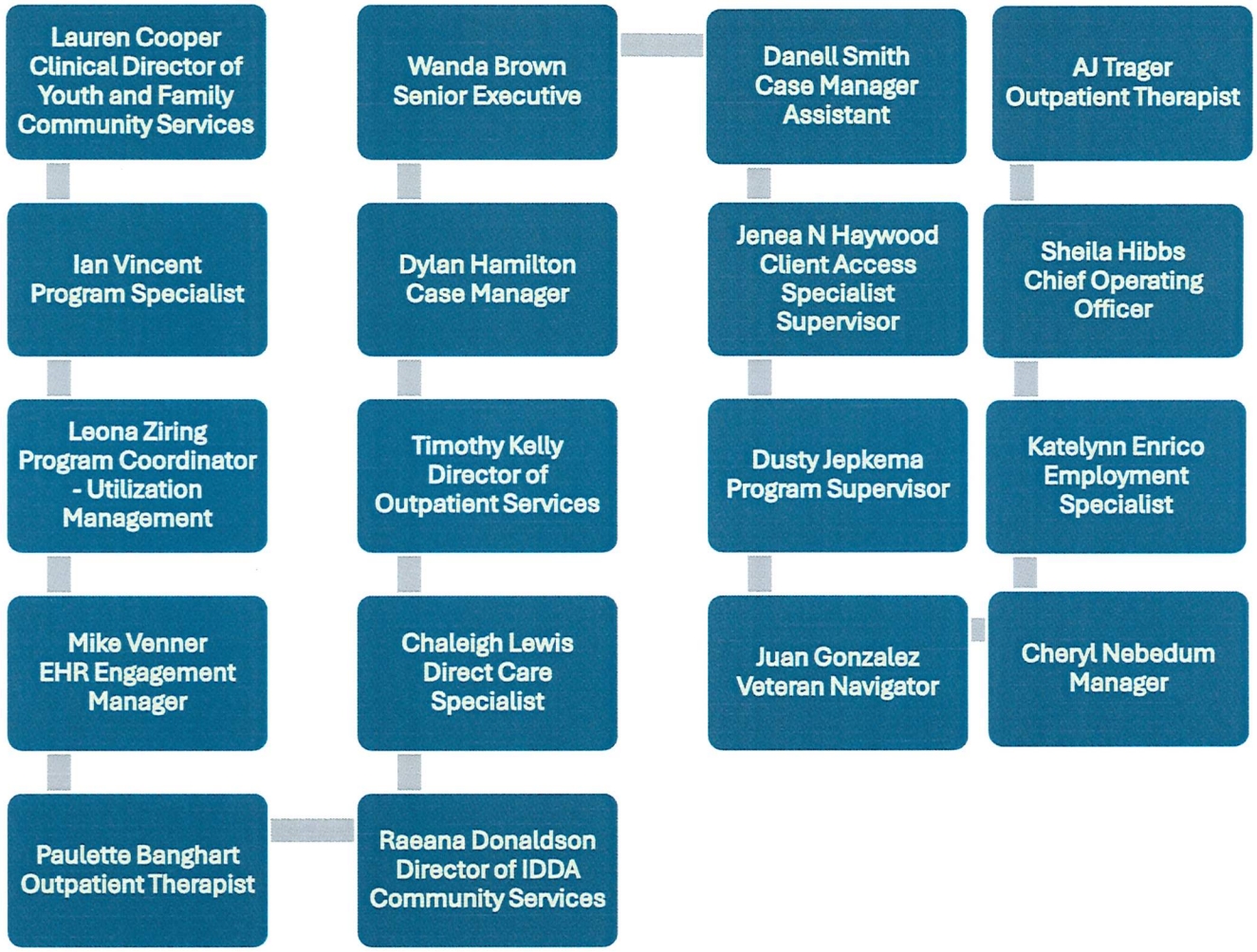
Hannukah Celebration and Education

- Do you have an interest in learning about different cultural holiday traditions? Or you just really like fried potatoes and donuts. 😊 Well, now is your chance to learn more about the Jewish tradition of Hannukah!
- CulturAlly, one of the affinity groups here at ISK, is sponsoring a Hannukah holiday celebration this year.

December 4, 2026

1:00pm




Lauren Cooper
Clinical Director of Youth and Family Community Services
Ian Vincent
Program Specialist
Leona Ziring
Program Coordinator - Utilization Management
Mike Venner
EHR Engagement Manager
Paulette Banghart
Outpatient Therapist
Wanda Brown
Senior Executive
Dylan Hamilton
Case Manager
Timothy Kelly
Director of Outpatient Services
Chaleigh Lewis
Direct Care Specialist
Raeana Donaldson
Director of IDDA Community Services
Danell Smith
Case Manager Assistant
Jenea N Haywood
Client Access Specialist Supervisor
Dusty Jepkema
Program Supervisor
Juan Gonzalez
Veteran Navigator
AJ Trager
Outpatient Therapist
Sheila Hibbs
Chief Operating Officer
Katelynn Enrico
Employment Specialist
Cheryl Nebedum
Manager

J
E
T
T

Thank you, ISK Leadership, and Board for the opportunity to share!

Questions or comments?

INTEGRATED Services of Kalamazoo

Community • Independence • Empowerment

INTEGRATED Services of Kalamazoo (*ISK*) Board of Director's Meeting

INTEGRATED Services of Kalamazoo
610 South Burdick Street
Kalamazoo MI 49007

November 2, 2026 VI.a.

ISK Board Member	Board Members PRESENT	Declaration of Location City/County	Board Members ABSENT
Karen Longanecker, *CHAIR*	X	Kalamazoo/Kalamazoo	
Michael Seals, *VICE CHAIR*	X	Kalamazoo/Kalamazoo	
Nkenge Bergan			
Patrick Dolly			X
Ramona Lumpkin			X
Sharon Price			X
Michael Raphelson			X
Jackie Schut	X	Kalamazoo/Kalamazoo	
Caelynn Uhlmann			X
Melissa Woosley			X
Abigail Wheeler, *COMMISSIONER*			X

ISK - Staff Present:
Beth Ann Meints, *CEO*
Sheila Hibbs
Dianne Shaffer
Michael Schlack, *Corporate Counsel*
Charlotte Bowser
Chantel Graham
Lisa Smith
Amy Rottman
Ed Sova
Alecia Pollard
Demeta Wallace, *Board Liaison*

Guests Present:
Fiorella Spalvieri, CEO/CLO
Sean Harris, CEO/Recovery Institute
Dr. Shenetta Coleman, CEO/ROI
Diane Marquess, CEO/FCS
Theresa Bell, Community Member
Dave Bergman, Community Member
Rebecca Bergman, Community Member
Kyle Fevig, Community Member
Zachary Lassiter, Community Member

Call to Order

The Board of Directors (Integrated Services of Kalamazoo) met to hold their meeting on Monday, November 2, 2026 @ 4:31PM. It was scheduled to be presided over by the Chair, *Karen Longanecker.*

Absence of a Quorum

Due to the lack of a quorum, the ISK Board of Directors meeting on November 2, 2026, was adjourned until their next meeting on November 23, 2026 @ 4:30p.m.

All meeting materials will be brought back for review and approval at the next meeting on Monday, November 23, 2026.

Meeting adjourned at 4:48PM.

MOTION PASSED

Demeta J. Wallace
Board Liaison
Office of the CEO
Integrated Services of Kalamazoo Board of Directors

INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY V.06

AREA:	Governance		
SECTION:	Board Governance Process	PAGE:	1 of 2
SUBJECT:	**COMMUNICATION AND COUNSEL TO THE BOARD**	SUPERSEDES:	01/24/2012
		REVISED:	10/29/2018

PURPOSE/EXPLANATION

To establish limitations of means regarding the Chief Executive Officer's (CEO) communication and counsel to the Board.

POLICY

I. With respect to providing information and counsel to the Board, the CEO may not permit the Board to be uninformed. Accordingly, they may not:

A. Neglect to submit monitoring data required by the Board (see policy on Monitoring Executive Performance) in a timely, accurate and understandable fashion, directly addressing provisions of the Board policies being monitored.

B. Let the Board be unaware of relevant trends, anticipated adverse media coverage, material external and internal changes, particularly changes in the assumptions upon which any Board policy has previously been established.

C. Fail to advise the Board if, in the CEO's opinion, the Board is not in compliance with its own policies on Governance Process and Board-Staff Relationship, particularly in the case of Board behavior which is detrimental to the work relationship between the Board and the CEO.

D. Fail to use a process that utilizes as many internal and external points of view, issues and options as needed for fully informed Board choices.

E. Present information in unnecessarily complex or lengthy form.

F. Fail to provide a mechanism for official Board, officer or committee communications.

G. Fail to deal with the Board as a whole except when (a) fulfilling individual requests for information or (b) responding to officers or committees duly charged by the Board.

H. Fail to report in a timely manner any actual or anticipated non-compliance with any policy of the Board.

II. This policy will be monitored through internal mechanisms on an annual basis.

CHIEF EXECUTIVE OFFICER

Jeff Patton
Chief Executive Officer

APPROVED

Erik Krogh
Board Chair

INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY II.02

AREA:	Governance		
SECTION:	Board Governance Process	PAGE:	1 of 2
SUBJECT:	**GOVERNING STYLE**	SUPERSEDES:	01/23/2012
		REVISED:	10/29/2018

PURPOSE/EXPLANATION

To establish the Board's governing style.

POLICY

The Board will govern with an emphasis on outward vision as well as an awareness of internal operations, encouragement of diversity in viewpoints, strategic leadership more than administrative detail, clear distinction of Board and Chief Executive roles, collective rather than individual decisions, future rather than past or present, and pro-activity rather than reactivity.

The Board will:

A. Cultivate a sense of group responsibility. The Board, not the staff, will be responsible for governance. The Board will be an initiator of policy, not merely a reactor to staff initiatives. The Board will use the expertise of individual members to enhance the ability of the Board as a body, rather than to substitute the individual judgements for the Board's values.

B. Direct, control, and inspire the organization through the careful establishment of broad written policies reflecting the Board's values and perspectives. The Board's major focus will be to establish policy that is aimed at having a positive long-term impact on the community.

C. Enforce upon itself whatever discipline is needed to govern with excellence. Discipline will apply to matters such as attendance, preparation for meetings, policy-making principles, respect of roles, and ensuring the continuity of governance capability. Continual Board development will include orientation of new members in the Board's governance process and periodic Board discussion of process improvement. The Board will allow no officer, individual or committee of the Board to hinder or be an excuse for not fulfilling its commitments.

CHIEF EXECUTIVE OFFICER

Jeff Patton
Chief Executive Officer

APPROVED

Erik Krogh
Board Chair

INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY VI.03 / ORGANIZATIONAL POLICY 08.10

AREA:	*(Board)* Governance		
APPLICATION:	*(Organizational)* ISK Staff & Contract Providers		
SECTION:	*(Board)* System Governance *(Organizational)* Financial Management	PAGE:	1 of 4
SUBJECT:	**ENDOWMENT FUND**	SUPERSEDES: REVISED:	11/27/2023 11/24/2025

PURPOSE/EXPLANATION

The Integrated Services of Kalamazoo (ISK) Endowment Fund was established in response to the very real needs faced by people. The purpose of the fund is to coordinate grant opportunities for persons who receive services through ISK, when other means of increasing and/or sustaining independence have been exhausted. Fund dollars are not to be utilized for services and/or supports provided through the community mental health service system.

DEFINITIONS

Dollars Available to Grant
This amount is determined by the Kalamazoo Community Foundation (KCF) and is derived from endowment fund earnings and earmarked donations made to KCF on behalf of ISK.

Yearly Grant Allocation
Through a yearly award process these funds will be made available to Providers and ISK direct operated programs for persons who receive services through ISK. All expenditures must fall within the specific intent of the grant award. A maximum of $5,000, excluding emergency grant awards, can be granted to any Provider or ISK direct operated program. Whenever grant funds are applied for and utilized, it is anticipated that the applicant/awarded provider/program will coordinate with other CMH programs to ensure that fund dollars are not inadvertently spent when other resources are also available. Each Fiscal year for ISK runs October 1 – September 30.

Contingent Grant Award
Through an "as needed award process" contingent grants will be awarded for specific requests for an individual's emergency needs that had been previously unknown and cannot be provided for through any other means. Contingent Grant Awards are limited to a maximum of $800 per individual per each fiscal year. If the Grant if for more than 1 individual, the total for each individual still cannot exceed $800 per fiscal year.

Individual.
For this policy, Individual is the identifying term for a consumer/customer/person-served by ISK. To be considered for funding, any individual must have a Case # within the ISK Electronic Health Record (EHR) system linking to them.

POLICY

A. Through the ISK Endowment Fund we are committed to combating the stigma of mental illness, developmental disabilities, and substance use disorders, and to prioritize our grant giving in key areas, which will assist persons served by ISK in taking positive steps toward independence and integration in the community.

Those areas of emphasis for grant giving will be, but not limited to:

1. Assistance with setting up and maintaining Independent Residence
2. Assistance with clothing, transportation, or other needs related to supporting vocational pursuits related to Competitive Employment
3. Assistance with crucial Health Care Needs necessary to make community living feasible and not otherwise funded by insurance benefits or other means
4. Assistance with costs related to supporting Educational Pursuits - including books, tuition/fees, equipment
5. Support for Community Events that promote education of mental health-related matters, and/or celebrate customer successes, and/or integration of customers in the community and are promoting the reduction of stigma

B. Of the total dollars available to grant, 90% will be made available for expenditure during the ISK fiscal year through a Yearly Grant allocation award process. A maximum of $5,000 can be awarded to any Provider or ISK direct operated program for the following purposes:

1. Independent Living Arrangements
2. Competitive Employment Assistance
3. Community Living / Health Care Needs
4. Educational Support
5. Community Events (not to exceed $1000)

The Yearly Grant Allocation process will begin at approximately two months before the start of the fiscal year. The Fund applications due date is to allow for fund dollars to be available at beginning of the fiscal year for agencies/departments that receive an award.

Of the total dollars available to grant 10% will be made available for expenditure during the ISK fiscal year through a contingent/discretionary determination by the Endowment Fund Committee. Applications will be accepted throughout the fiscal year. Contingent The Endowment Committee will evaluate each request for Contingent Grant within 10 calendar days of receipt of the application.

Award Limits

Grant awards cannot exceed $800.00 per individual per fiscal year. Grant allocations for Community Events promoting integration are limited to $1,000 per event.

C. The Endowment Fund Committee will consist of seven members and will include at least one Board member (appointed by the Board chair), one individual served by ISK, the Customer Services Manager and service provider. Any member of the committee will abstain from any voting in which the program/department or organization they specifically represent within ISK has a funding application. Any necessary voting by the committee will be determined by a simple majority to consider an application approved or declined.

The Customer Services Manager will notify the ISK CEO of appointments to the committee and the CEO will notify the Board of Directors.

D. In selecting grant recipients from among the deserving applications, the Endowment Fund Committee will use the Board recommended characteristics for a successful grant proposal:
   1. Shows evidence of potential impact of the grant on the life of the person served by ISK
   2. Shows evidence of how the grant would enable an individual to become more independent
   3. Shows evidence of how the grant would improve the quality of life
   4. Shows evidence of how the grant would improve community integrated living

E. The ISK Board of Directors is committed to the wise allocation of its charitable resources. Accordingly, all grantees will be asked to complete a brief summary report of grant activities and outcome. This report will be completed in a format prescribed by ISK and due dates will be told to awardees with the letter explaining their award. Reporting is required for both Annual Award allocations and Contingent Awards. Each Program/Department/Agency who receives dollars from the ISK Endowment Fund will be provided with the tools to report spending. Unexpended funds will be allowed to carry over for one fiscal year. Any remaining unexpended funds after this period will be returned to ISK.

F. ISK Board of Directors will also establish an Oversight Committee for the specific purpose of making emergency grants from the principal funds in the Community Mental Health Endowment Fund held by the Kalamazoo Community Foundation.

   The Oversight Committee will determine whether emergency circumstances exist to make grants from principal funds where allowed by the endowment stipulations.

   Oversight Committee Composition

   The Oversight Committee will consist of the ISK Board Chair, Board Finance & Compliance Committee Chair, Chief Executive Officer, Administrator of Operations & Administrator of Clinical Services.

G. This policy will be monitored through internal mechanisms on an annual basis.

EXHIBITS

A. Endowment Fund Application (Emergency)
B. Endowment Fund Application (Full-Year)

CHIEF EXECUTIVE OFFICER

Jeff Patton
Chief Executive Officer

BOARD CHAIR

Karen Longanecker
Board Chair

ENDOWMENT FUND
EMERGENCY SPENDING APPLICATION

FOR USE BY ORGANIZATIONS WITHIN THE ISK SERVICE NETWORK
TO ADDRESS OTHERWISE UNMET AND UNFUNDED NEEDS

APPLICANT ORGANIZATION /ISK DEPARTMENT INFORMATION

Name of Organization / ISK Department: _____

Street Address: _____

City: _____ Zip Code: _____ Phone: _____

Name of staff Applicant: _____

Email address: _____

Name of person **authorizing** this application: _____

Email address: _____

Financial Report(s) will be due within 60 calendar days of approval of this application and the due date will be indicated on the approval letter.

Name of the person who will be completing the Financial Report for this application: _____

Applicant? ☐ YES ☐ NO Authorizer? ☐ YES ☐ Other: _____

Email address: _____

PROPOSAL

1) Emergency Spending Application
EMERGENCY SPENDING IS LIMITED TO A MAXIMUM OF $500 PER ANY INDIVIDUAL CUSTOMER OF ISK SERVICES PER AN FISCAL YEAR.

Areas the funds will be utilized to assist the customer(s):

☐ Setting up or maintaining ***Independent Residence***

☐ Needs related to ***Competitive Employment Assistance***

☐ Crucial ***Healthcare Needs*** to enhance ***Community Living***

☐ ***Educational Support***

2) Awarded funds are anticipated to support:

☐ One Customer Case #: _____

☐ Two or more Customers Number of customers anticipated: _____

ISK Case #s will be required as part of the Fund Expenditure Report

3) Written summary of the emergency situation:

4) How much money is being requested from the Endowment fund? _____ *(up to $500 / individual)*

ENDOWMENT FUND
EMERGENCY SPENDING APPLICATION

FOR USE BY ORGANIZATIONS WITHIN THE ISK SERVICE NETWORK
TO ADDRESS OTHERWISE UNMET AND UNFUNDED NEEDS

5) Have you attempted to access other resources for funds? ☐ Yes ☐ No
(such as HRI, Deacon's Conference, Loaves & Fishes)

Have you confirmed that no other available Endowment Funds are available to meet this request? ☐ Yes ☐ No

Applicant Agency/ISK Department has **no ($0)** Fund dollars available. ☐ Yes ☐ No

Agency/ISK Department providing Primary services has **no ($0)** dollars available. ☐ Yes ☐ No

IS this request being partially funded by another current Endowment Fund Award? ☐ Yes ☐ No

Fund Award number being utilized for partial funding? # _____

Award dollars accessed for this request? $ _____ ☐ N/A

Please list all other resources you have contacted below: ☐ N/A

6) Why was money from other resources not available - - or not able to cover all costs?

7) Describe how Endowment funds will support customers of ISK: (*please comment on all that apply in this situation*):

(A) Positively impact the life of the individual(s) served:

(B) Enable individual(s) to become more independent:

(C) Improve the quality of life for the individual(s):

(D) Improve the individual(s) integration into the community:

8) Please add any other information you feel is pertinent to this Endowment Funds application:

ENDOWMENT FUND
EMERGENCY SPENDING APPLICATION

FOR USE BY ORGANIZATIONS WITHIN THE ISK SERVICE NETWORK
TO ADDRESS OTHERWISE UNMET AND UNFUNDED NEEDS

CERTIFICATION

I certify that I am authorized to sign on behalf of the ISK contract organization / ISK Department that is making this application and that this is an accurate statement of anticipated expenditures from the ISK Endowment Fund to address otherwise unmet and unfunded needs.

Authorized Signature: _____ Date: _____

Please submit application to:

ISK Endowment Fund / Customer Services
610 S Burdick Street
Kalamazoo MI 49007-5221

OR

email to communityrelations@iskzoo.org

if you have questions, please call (269) 364-6990

Date received: _____ Initials: _____ Application #: _____

ENDOWMENT FUND FULL FISCAL YEAR APPLICATION

For the use by organizations within the ISK Service Network

For Fiscal Year: _____

APPLICANT ORGANIZATION / DEPARTMENT INFORMATION

Name of Organization/ISK Department Applicant: _____

Street Address: _____

City: _____ Zip Code: _____ Phone: _____

Name of staff Applicant: _____

Email address _____

Name of person **authorizing** this application: _____

Email address: _____

Financial Report(s) will be due at the end of this fiscal year.
Details will be included with the approval letter as appropriate.

Name of the person who will be completing the Financial Report for this application: _____

Applicant? ☐ YES ☐ NO Authorizer? ☐ YES ☐ NO Other: _____

Email address: _____

PROPOSAL

1) What is being requested?
EACH APPROVED APPLICATION FOR A YEARLY GRANT ALLOTMENT IS MAXIMIZED AT $8000 PER YEAR, PER AGENCY OR ISK DEPARTMENT

Please check all of the categories for which you intend to spend dollars awarded through his application. Each application may be for any/all of the listed categories. Additionally, while the dollars may be used for a variety of supports for individuals served by ISK, Endowment Funds are to be requested and used for situations in which no other funding is currently available. And, not to cover ISK service costs or replace any insurance coverage or community resource. *Please note any individual customer may receive up to $800 in assistance from the funds of this application.*

☐ Setting up or maintaining ***Independent Residence***

☐ Needs related to ***Competitive Employment Assistance***

☐ Crucial ***Healthcare Needs*** to enhance ***Community Living***

☐ ***Educational Support***

☐ ***Community Event*** ($1000 or the $5000 awarded can be spent to supports the costs of an event

2) Number of customers anticipated to be served by this award: _____
ISK Case #(s) will be required as part of the Fund Expenditure Report

INTEGRATED Services of Kalamazoo

ENDOWMENT FUND FULL FISCAL YEAR APPLICATION

For the use by organizations within the ISK Service Network

3) Written summary of the request and how the Endowment Funds will be used to meet identified needs:

4) **How much money is being requested from the Endowment fund?** _____

5) Describe how Endowment funds dollars will support customers of ISK (*please comment on all that apply in this situation*):

(A) Positively impact the life of the individual(s) served:

(B) Enable individual(s) to become more independent:

(C) Improve the quality of life for the individual(s):

(D) Improve the individual(s) integration into the community:

6) Please add any other information you feel is pertinent to this Endowment Funds application:

ENDOWMENT FUND FULL FISCAL YEAR APPLICATION

For the use by organizations within the ISK Service Network

CERTIFICATION

I certify that I am authorized to sign on behalf of the ISK-contract organization / ISK Department that is making this application and that this is an accurate statement of anticipated expenditures from the ISK Endowment Fund to address otherwise unmet and unfunded needs.

Authorized Signature: _____ Date: _____

Please submit application to:
ISK Endowment Fund / Customer Services
610 Burdick Street
Kalamazoo MI 49007-5221
OR
email to communityrelations@iskzoo.org

Date received: _____ Initials: _____ Application #: _____

INTEGRATED
Services of Kalamazoo

Community • Independence • Empowerment

Beth Ann Meints
Chief Executive Officer
www.iskzoo.org
(269) 553-8000
Administrative Services:
610 South Burdick Street,
Kalamazoo, MI 49007

August 10, 2026

Greetings ISK Staff and Service Providers:

I am pleased to announce that ISK is opening the Endowment Fund for applications for project funding for fiscal year 2026-2027. These dollars are available via application made by an ISK network provider agency/organization or direct-operated department to assist customers with costs they have that are not associated with payment for ISK services/supports or covered through insurance benefits or other community resources.

Full Fiscal-Year Awards:
If you are considering applying for any funding for the new 2026-2027 fiscal year, now is the time.

Important: The annual award per provider agency/ISK Department remains $5000. This level of available funding will allow us to continue to have funds available for as many individuals as possible. Thank you for your continued understanding.

Please remember the focus of the Fund dollars is to assist customers with needs in categories such as: *Independent Residence, Competitive Employment, Healthcare Needs, and Educational/Vocational Support.* Agencies/Departments may spend their $5000 in ways that will provide support to customers within these same titles/categories, and we are asking for indication of anticipated categories on the application.

Reminder: if your agency/department is planning to use any funding to support "Community Events", that spending continues to be capped at $1000 of the $5000 possible full year award.

Full 2026-2027 Year Applications are due by 5:00 pm on Friday August 28, 2025

Email address to send applications: communityrelations@iskzoo.org

****Past Year Award Reporting****
Please note, if your agency/department has had pervious Endowment Fund awards:

A. Any full year awards distributed within FY 25-26 that have an unspent balance - those dollars can be rolled over and used into FY 25-26. These awards are titled as 26_xx.
B. Any unspent dollars from any award granted in FY 24-25 needs to be returned to ISK and will become part of the fund pool once again. These awards are titled as 25_xx.

Requests for dollars in the new fiscal year may not be released to you until ISK has received your reporting for the previous awards – including any outstanding reports of contingent award spending for fy 25-26. We need to account for previously awarded dollars before additional dollars can be distributed from the Fund. Agencies/departments that are overdue in reporting for past awards will receive separate communication about the information that is outstanding and when that information is "due" back to ISK.

As a reminder, the expenditure reports for full year awards from FY 25-26 are due on or before November 15, 2026.

INTEGRATED
Services of Kalamazoo
Community • Independence • Empowerment

Beth Ann Meints
Chief Executive Officer
www.iskzoo.org
(269) 553-8000
Administrative Services:
610 South Burdick Street,
Kalamazoo, MI 49007

Contingent Awards in FY 26-27:

Important: Contingent/Emergency Awards will be available again. And applications for funding to support individuals who are at risk of losing their housing or who have significant healthcare needs that cannot be supported by other resources will be the priority for dollars to be awarded.

Reminder, before any Contingent awards will be made, we will be asking the applicant to confirm that their agency/ISK department has no other Endowment Funds dollars available to meet this same need. We cannot award new dollars if there are other Endowment Fund dollars already awarded/available to the same agency/department to meet this same need. Any Contingent Application received without indication of other resources approached, will be returned to sender before processing.

And please remember, it is difficult to process the application and make funds available in any shorter time than 10 business days from date the application is received.

All Awards:
All Full-Year and Contingent applications continue to have a place to identify the "Authorized Signature" to be included. Applications received without authorized signature, will be returned to sender before review and processing.

For any fund dollars that are awarded, instructions for reporting the use of the dollars will be sent with the award notification.

The total available Endowment Fund dollars for any individual served by ISK remains $800 per fiscal year.

While these dollars can be used to assist with many needs, these caveats remain unchanged:

- dollars are not to be given directly to the individual(s) served
- dollars cannot be used toward expenses or payments that could potentially be returned to the customer. So that includes costs such as housing deposits. Dollars can be used for first month rent and other expenses related to securing housing but not for deposits.

For ISK Staff: Please continue to process applications through the identified Office Managers ONLY. Thank you to all who were part of the change in recent years – it has helped to reduce some confusion and duplicate processing of applications.

As we started in fy 23-24, for purpose of Endowment Fund Applications, ISK Departments are identified as: **MIA-A and MIA-B and MIA-C, IDDA, YOUTH, HOUSING, CORRECTIONS**. Please make sure that all applications are funneled through the appropriate Office Manager. If your department at ISK is outside of one of these we have named here, please contact me before sending in your application.

If you have any questions about the Endowment Fund, please contact me.

INTEGRATED
Services of Kalamazoo
Community • Independence • Empowerment

Beth Ann Meints
Chief Executive Officer
www.iskzoo.org
(269) 553-8000
Administrative Services:
610 South Burdick Street,
Kalamazoo, MI 49007

A copy of the full fiscal year application was sent along with this memo. You can find the policy supporting the E Fund within *ISK Board Policy VI.03 Endowment Fund* if you need it in the future. The Contingent Fund Application will also be available within the ISK policy manual on the portal. *If/when you need a copy of the contingent application, I can also help you to secure one. The previous versions of both applications are obsolete and should* ***not*** *be used.*

Thank you all for your participation in past application cycles. The Endowment Fund has been a positive support for many of our customers to meet needs related to independent living, healthcare, employment, education, and to celebrate successes they have had.

Endowment Fund spending snapshot:

Fiscal Year	Number of Full year awards	Dollars in Full year Awards	Number of Contingent Awards	Dollars in Contingent Awards	Total Dollars Awarded for the year
22-23	6	$38.000	15	$10,390	**$48.390**
23-24	12	$72,240	17	$14,540	**$86,780**
24-25	13	$90,000	12	$4,718	**$94,718**
25-26	12	$56.000	2 ytd	$700	**$56,700**

Thank you.

Teresa Lewis, LBSW
ISK Customer Services Manager
610 S Burdick Street | Kalamazoo, MI 49007-5221
Office line: 269-364-6990

ISK Endowment Fund
Report to the Board of Directors
November 2026

VI.d.

Fiscal Year 2026-2027:

Annual Award Application Summary. Dollars to be spent October 1, 2026 through September 30, 2027

Number	Agency/Department	Request $$	Approved $$
27_01	ISK – MIA A for UCAC_Program	5000.00	5000.00
27_02	ISK – MIA_B for Programs WHI/ZS/CM -CTT and MBHIT/CHW/CC/OORP	5000.00	5000.00
27_03	ISK - MIA_C for Programs Sup Employ/PSY only/OPT/Navigate/ACT	5000.00	5000.00
27_04	ASK Family Services	5000.00	5000.00
27_05	Milestone Senior Services	5000.00	5000.00
27_06	Family and Children Services	5000.00	5000.00
27_07	ISK Youth and Families Services	2500.00	2500.00
27_08	Community Living Options (CLO)	5000.00	5000.00
27_09	MRC Industries BridgeWays Program	5000.00	5000.00
27_10	MRC Industries Community Employment Program	4000.00	4000.00
27_11	ISK IDDA Department	5000.00	5000.00
27_12	Community Healing Centers (CHC)	5000.00	5000.00
27_13	ISK Housing Resource Center	2500.00	2500.00
27_14	ISK Justice Department	1000.00	1000.00
	TOTAL	**$60,000.00**	**$60,000.00**

Fiscal Year 2025-2026:

Dollars to be spent October 1 2025 through September 30, 2026. Annual awards dollars unspent allowed to roll-over into spending for 2026-2027. Four (4) Contingent/Emergency awards were granted. Spending reports due back 11/15/26.

Number	Agency/Department	Request $$	Approved $$
26_01	ISK MIA_B: WHI/ZS/CM -CTT and MBHIT/CHW/CC/OORP	5000.00	5000.00
26_02	ISK MIA_C: Sup Employ/PSY only/OPT/Navigate/ACT	5000.00	5000.00
26_03	Family & Children Services	5000.00	5000.00
26_04	ISK IDDA	5000.00	5000.00
26_05	Community Healing Center	5000.00	5000.00
26_06	Milestone Senior Services	5000.00	5000.00
26_07	ISK Youth and Families	5000.00	5000.00
26_08	ISK Justice Dept	5000.00	5000.00
26_09	MRC Community Employment	4000.00	3000.00
26_10	MRC Bridgeways	5000.00	5000.00
26_11	ISK Housing Resource Center	5000.00	5000.00
26_12	Community Living Options	5000.00	3000.00
	Total Annual awards	59,000.00	56,000.00
26_13	Community Healing Centers	800.00	300.00
26_14	ISK – Whole Health Initiative program	400.00	400.00
26_15	ISK – Community Health Worker team	450.00	450.00
26_16	ISK – Adult Case Management team for MIA individuals	740.00	740.00
	TOTAL with contingent/emergency awards included	**$61,390.00**	**$57,890.00**

tl. 11/10/26

INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY V.11

AREA:	Governance		
SECTION:	Board Governance Process	PAGE:	1 of 4
SUBJECT:	**CORPORATE COMPLIANCE AND RISK MANAGEMENT**	SUPERSEDES: REVISED:	10/29/2019 11/27/2023

PURPOSE/EXPLANATION

Integrated Services of Kalamazoo (ISK) is committed to identifying and complying with local, state and federal laws and regulations as they apply to health care delivery managed by ISK. The purpose of this policy is to authorize the establishment of a comprehensive Corporate Compliance Program, including an annual Risk Assessment and a Compliance Plan, designed to minimize risks associated with operational activities and service delivery.

DEFINITIONS

Corporate Compliance
The mechanisms, including the written Compliance Program and Policies, training efforts, resources and activities that are collectively intended to prevent and detect unethical and/or illegal business practices and violations of law.

Corporate Compliance Program
The specific compliance principles, components and activities of ISK and its provider network. These include activities ISK performs both for itself as a healthcare management entity and as a service provider as well as for its provider network.

Risk Assessment
The US Sentencing Guidelines of 2021, section §8B2.1. - Effective Compliance and Ethics Program, identifies elements of an "effective compliance program" and includes promotion of ethics and a commitment to compliance with ongoing risk assessment as part of the program. Annual Risk Assessment information will include input from ISK leadership. The objectives of the annual ISK Risk Assessment are as follows:

1. Enhance ISK's compliance and ethics program to meet internal and external requirements and "best practices".
2. Identify and prioritize risks/gaps and monitor/review performance against requirements.
3. Meet US Sentencing Guidelines for "risk assessment" and adhere to other requirements
4. Inform the Annual Corporate Compliance Plan.

Corporate Compliance Plan
The Annual Corporate Compliance Plan include goals and objectives based on current themes gleaned from the Annual Risk Assessment. It is presented to the Board each year for approval with progress reported at least every six months.

Seven Elements of an Effective Compliance Program
In accordance with the US Sentencing Guidelines of 2021 and the Office of Inspector General (OIG), ISK shall be in compliance with seven elements of an effective compliance programs, which have become the benchmark of corporate compliance. The seven elements are as follows:

1. Implementing written policies, procedures, and standards of conduct
2. Governance & Oversight: Designating a compliance officer and compliance committee
3. Conducting effective training and education
4. Developing effective lines of communication
5. Conducting internal monitoring and auditing
6. Enforcing standards and disciplinary action through consistent, well-publicized guidelines
7. Responding promptly to detected offenses and undertaking corrective action

POLICY

I. ISK is dedicated to the delivery of behavioral health services in an environment characterized by strict conformance with the highest standards of accountability for administrative, business, clinical, financial and marketing management.

II. The leadership of ISK shall be fully:

A. Aware of and committed to the need to prevent and detect fraud, waste, abuse, fiscal mismanagement and misappropriation of funds and to the strict adherence of all federal and state laws, rules and regulations through the development and implementation of a formal Corporate Compliance Program that addresses all required elements promulgated by the Michigan Department of Health and Human Services/Office of Inspector General (MDHHS/OIG) for an effective Compliance Program.

B. Committed to the development and implementation of comprehensive policies, procedures and other corporate compliance measures to provide regular monitoring and conformance with all legal and regulatory requirements.

III. All persons who provide services within, or are formally affiliated with ISK (e.g., officers/board members, employees, consultants, volunteers, students, internal contractors, agents, etc.) must sign an attestation agreeing to conduct themselves in a manner that promotes the ISK Mission/Vision and Code of Ethics. All are expected to abide by the ISK Compliance Program and immediately report suspected compliance issues to the ISK Compliance Officer.

IV. With respect to the delivery of services to those affected with mental illness, emotional disturbance, co-occurring substance use disorder and developmental disabilities, the Chief Executive Officer shall not cause or allow conditions which are not in strict conformance with laws and regulations governing administrative, business, clinical, financial and marketing practices. The Chief Executive Officer shall not fail to create and implement a comprehensive Corporate Compliance Program and a Risk Management Plan that includes ongoing risk assessment activities.

V. Accordingly, they shall not fail to:

A. Reduce the agency's likelihood of exposure to identified risks.

B. Comply with the mandated federal and state regulations

C. Prevent and detect fraud, abuse, fiscal mismanagement and misappropriation of funds (corporate compliance program).

D. Respond to events that could pose a risk to the ISK.

VI. The ISK Board of Directors shall delegate, by formal resolution or policy, the overall responsibility for ISK Compliance Program to its Chief Executive Officer (CEO). The CEO shall ensure the retainment of a Compliance Officer (CO) capable of managing the functions of the Compliance Office as contained in this policy guideline and other ISK operating policies.

VII. The ISK Board of Directors shall be notified in writing prior to any change in the Compliance Officer's role, capacity or employment status.

VIII. Implementation and effectiveness of the corporate compliance and risk management strategies shall be monitored internally at a minimum, quarterly by the Compliance Committee. Additionally, necessary recommendations for actions shall be made to the Chief Executive Officer and/or the Board Members.

REFERENCES

- Federal Laws
  a. Deficit Reduction Act, United States Code, Vol. 42, Sec. 1396a (a)(68) (Section 6032 of the Deficit Reduction Act of 2005)
  b. False Claims Act, United States Code, Vol. 31, Secs. 3729-3733
  c. Program Fraud and Civil Remedies Act, United States Code, Vol. 31, Secs. 3801-3812 (Program Fraud Civil Remedies Act of 1986)
  d. Anti-Kickback Statute
  e. United States Organizational Sentencing Guidelines (1991)
  f. Stark Laws I (1989) and Stark Laws II (1993)
  g. Health Insurance Portability and Accountability Act of 1996 (HIPAA)

h. Balance Budget Act of 1997 (BBA)
i. Social Security Act, specifically 1903(m)(95)(i)
j. Affordable Care Act (Public Law 111-148; 111-152 of 2010)
k. Whistleblowers Protection Act of 1980
l. HITECH Act of 2009
m. 42 CFR, Parts 400 and 438 (Balanced Budget Act)
n. 45 CFR Part 164 (Health Information Portability and Accountability Act)

- Michigan Laws
  a. Medicaid False Claims Act, Michigan Compiled Laws, Annotated Sections 400.601-613
  b. HIPAA Privacy Rule Preemption Analysis Matrix for the Michigan Medical Records Access Act, Public Act 47 of 2004 (revised 11/04)
  c. Michigan Mental Health Code, PA 258, as amended
  d. Michigan Public Health Code, PA 368, as amended

- Michigan Department of Health and Human Services (MDHHS)
  a. MDHHS/PIHP Medicaid Managed Specialty Supports and Services Contract – Section 6.9 Regulatory Management
  b. MSA-Medicaid Provider Manual
  c. MDHHS: Application for Participation, Section 4.0

- PIHP
  a. Southwest Michigan Behavioral Health Compliance Program
  b. Southwest Michigan Behavioral Health Policy
     i. 10.2 (Compliance Policy Development)
     ii. 10.3 (Code of Conduct Distribution and Training)
     iii. 10.4 (Compliance Oversight Committee)
     iv. 10.5 (Compliance Education and Training)
     v. 10.6 (Compliance Reporting and Responsibilities)
     vi. 10.7 (Compliance Auditing and Monitoring)
     vii. 10.8 (Compliance Reviews and Investigations for Reporting)
     viii. 10.9 (Compliance Enforcement and Discipline)
     ix. 10.11 (Fraud and Abuse)

CHIEF EXECUTIVE OFFICER

Jeff Patton
Chief Executive Officer

APPROVED

Karen Longanecker
Board Chair

INTEGRATED
Services of Kalamazoo

Community • Independence • Empowerment

FY27 Corporate Compliance Program

Ashley Esterline, LMSW, CHC
ISK Director of Network Compliance/Corporate Compliance Officer

EXECUTIVE SUMMARY

The Integrated Services of Kalamazoo (ISK) Corporate Compliance Program establishes the organizational framework for promoting ethical conduct, ensuring regulatory compliance, preventing and detecting fraud, waste, and abuse, and mitigating organizational risk. The Program outlines the structure, authority, responsibilities, and essential functions necessary to maintain effective compliance oversight across ISK's direct-operated services and Provider Network.

Through ongoing monitoring, auditing, education, investigation, and corrective action, the Compliance Program supports organizational accountability, regulatory integrity, and the consistent application of compliance expectations across ISK and its Provider Network.

PROGRAM PURPOSE

The ISK Compliance Program establishes and maintains safeguards to promote compliance with applicable federal and state laws, regulations, contractual requirements, and organizational policies, including those related to fraud, waste, and abuse. The program advances a culture of compliance and upholds the standards necessary for responsible stewardship of public healthcare dollars.

The primary purposes of the Corporate Compliance Program are to:

- **Prevent** noncompliance with applicable laws, regulations, and organizational policies, whether accidental or intentional;
- **Detect** instances of noncompliance through monitoring, auditing, reporting mechanisms, and proactive oversight;
- **Enforce** appropriate disciplinary measures for individuals or entities involved in noncompliance, including sanctions or exclusion from participation in federal healthcare programs, as applicable; and
- **Prevent recurrence** of noncompliance through corrective action plans, education, training, and continuous quality improvement.

The scope of the Compliance Program extends to ISK's organizational operations and activities, including those supported by federal and state healthcare funding. All Board Members, Officers, employees, Providers, contractors, subcontractors and/or agents operating within the Provider Network are required, as part of their employment or contractual relationship, to adhere to ISK compliance standards and participate in compliance activities.

PROGRAM DESIGN

The ISK Compliance Program is structured in alignment with technical guidance from the Michigan Department of Health and Human Services (MDHHS), the Office of Inspector General (OIG), and the Department of Justice (DOJ). Core program oversight and strategic direction are centralized within the ISK Compliance Committee.

Key personnel and structural components of the Compliance Program are as follows:

- **Director of Network Compliance/Corporate Compliance Officer (CCO)**
  The Director of Network Compliance/Corporate Compliance Officer (CCO) operates under the authority of the ISK Board of Directors and maintains unobstructed access to the Chief Executive Officer (CEO). The CCO additionally has direct access to the Board of Directors and may report compliance concerns to the Board independently when circumstances warrant. The CCO is responsible for the design, implementation, and oversight of the Compliance Program, oversight and coordination of compliance inquiries and investigations, oversight of financial remediation, and development and delivery of compliance-related training for staff and network stakeholders.

- **Manager of Health Information and Risk Oversight**
  The Manager of Health Information and Risk Oversight supports the CCO in carrying out activities related to the Corporate Compliance Program and the annual Corporate Compliance Plan. The Manager oversees the operations of ISK Medical Records, including the integrity, accuracy, completeness, and appropriate

maintenance of health information and medical records, and conducts inquiries and investigations in collaboration with the CCO.

- **Compliance & Risk Mitigation Coordinator**
  The Compliance & Risk Mitigation Coordinator assists the CCO by implementing components of the Compliance Program and the annual Corporate Compliance Plan. The Compliance & Risk Mitigation Coordinator completes inquiries and investigations alongside the Manager of Health Information and Risk Oversight, supports the Risk Management Program, supports the development and implementation of risk-based monitoring activities, and contributes to the development, monitoring, and evaluation of the annual Risk Management Plan.

- **Compliance Committee**
  The Compliance Committee includes representatives from all major agency departments such as Finance, Clinical Services, Quality, Information Technology, the Office of Recipient Rights, and Administration. The Committee meets no less than quarterly and receives reports regarding investigations, monitoring, identified risks, corrective actions, regulatory developments, and progress toward the Annual Compliance Plan. The Committee provides oversight and cross-functional coordination of compliance-related activities, assists in identifying emerging organizational risks, supports corrective action efforts, and promotes ethical conduct and accountability across ISK and the Provider Network.

- **Annual Plan**
  The Annual Compliance Plan, reviewed and approved by the ISK Board of Directors, establishes the Compliance Program's priorities for the fiscal year. It identifies key risk areas and outlines planned monitoring and auditing activities, regulatory implementation priorities, education and training initiatives, corrective action activities, and opportunities for program improvement. The Annual Compliance Plan is informed by ongoing risk assessments, audit and investigation findings, regulatory developments, and organizational needs.

- **Semi-Annual Compliance Program Evaluation**
  The Semi-Annual Compliance Program Evaluation assesses the effectiveness of the Compliance Program during the first six months of the fiscal year. It includes a review of inquiries and investigations, progress toward annual goals and planned activities, risk monitoring and audit results, corrective action efforts, and developments affecting the Program's effectiveness and priorities.

PROGRAM ELEMENTS

To maintain an effective and responsive Compliance Program, ISK engages in the following core compliance functions on a continuous basis. These functions reflect elements of an effective compliance and ethics program, including principles articulated in the U.S. Sentencing Guidelines.

- **Assessment of Risk and Establishing Audit Priorities**
  The CCO ensures that ISK and its Provider Network engage in compliant and ethical practices that minimize the risk of fraud, waste, and abuse. Ongoing risk assessments inform audit priorities and direct monitoring activities to the areas of highest vulnerability.

- **Monitoring, Audits, and Investigations**
  The CCO, with support from the Compliance Committee, oversees and monitors audit, monitoring, and investigative activities involving both ISK's direct-operated services and the Provider Network. These activities may include internal reviews, external audit results, targeted compliance reviews, and risk-based monitoring informed by operational data and other available tools. Findings are evaluated to identify emerging or recurring risks, assess compliance with applicable requirements, and determine appropriate follow-up, corrective action, or additional monitoring.

- **Policy and Procedure Review, Revision, and Development**
  Policies and procedures undergo regular assessment to ensure ongoing alignment with regulatory requirements and operational needs. High-risk areas are reviewed and revised by the CCO, with input from

the Compliance Committee and other subject-matter experts. Robust policies, procedures, and protocols are essential for identifying, detecting, and preventing fraud, waste, and abuse both internally and across the Provider Network.

- **Prevention Activities: Training and Effective Communication**
  The Compliance & Risk Mitigation Coordinator supports the delivery and coordination of initial compliance orientation and ongoing education for ISK staff and Providers, in collaboration with the CCO and appropriate subject-matter experts. Education is provided periodically and as needed to address regulatory and policy changes, identified risks, audit and investigation findings, documentation and billing requirements, and other compliance priorities. Ongoing communication and targeted training reinforce individual responsibilities, promote consistent practices, and support a culture of ethical conduct and accountability.

- **Detection Activities**
  ISK maintains processes for applicable exclusion, sanction, licensure, credentialing, and eligibility monitoring consistent with federal, state, contractual, and organizational requirements. ISK's detection framework includes two key components:

  1. **Auditing and monitoring** of ISK's direct-operated services and the Provider Network, including risk-based reviews of service delivery, documentation, claims, billing practices, and compliance with applicable requirements; and
  2. **Confidential reporting mechanisms** that enable employees, Providers, contractors, and other agents to raise concerns or report suspected violations, fraud, waste, or abuse, through established hotline and anonymous reporting options.

  All staff are expected to promptly report suspected or actual noncompliance. Reports and other identified concerns are reviewed and, when warranted, investigated under the oversight of the CCO. Reports are handled confidentially to the extent permitted by law and organizational policy, and individuals who report concerns in good faith are protected from retaliation. The Department of Network Compliance maintains accessible reporting channels, including the Compliance Hotline, anonymous reporting options, and direct access to the CCO. Information obtained through reporting, monitoring, audits, and other sources is evaluated to identify potential compliance issues and determine appropriate follow-up.

- **Investigation, Disciplinary Action, and Disclosure Activities**
  When a concern or potential violation is identified through a report, audit, monitoring activity, referral, or other source, the Department of Network Compliance conducts or coordinates an appropriate preliminary review and, when warranted, oversees a thorough and objective investigation. Investigative activities are documented and may include collaboration with relevant departments, subject-matter experts, Providers, and external oversight agencies, as appropriate. When noncompliance is substantiated, the CCO coordinates appropriate corrective action, which may include education, process or policy changes, enhanced monitoring, financial remediation, and/or disciplinary action, consistent with applicable policies and requirements. Required disclosures or referrals to regulatory or law enforcement authorities are made when indicated. Follow-up monitoring is used, as appropriate, to assess implementation and effectiveness of corrective actions and reduce the risk of recurrence.

- **Assessment and Evaluation**
  The Compliance Program is evaluated at least semi-annually, with ongoing assessment throughout the year, to determine whether its core elements are implemented and functioning effectively. The evaluation considers information from risk assessments, monitoring and audit results, investigations, reporting activity, corrective actions, training, regulatory developments, and feedback from organizational stakeholders. Results are used to assess progress toward the Annual Corporate Compliance Plan's priorities, identify gaps or emerging risks, and establish opportunities to strengthen program operations and effectiveness.

INTEGRATED
Services of Kalamazoo

Community • Independence • Empowerment

Corporate Compliance
Audit and Monitoring Work Plan
FY27

Ashley Esterline, LMSW, CHC
ISK Director of Network Compliance/Corporate Compliance Officer

PURPOSE

Integrated Services of Kalamazoo (ISK) is committed to ethical conduct, regulatory integrity, responsible stewardship of public healthcare dollars, and compliance with applicable federal and state laws, regulations, contractual requirements, and organizational policies. The Department of Network Compliance implements safeguards across ISK's direct-operated services and Provider Network to prevent and detect fraud, waste, abuse, and other noncompliance, reduce organizational risk, and promote consistent accountability.

The purposes of the Corporate Compliance Program and Department are as follows:

- Prevent noncompliance with applicable laws, regulations, contractual requirements, and organizational policies, whether accidental or intentional;
- Detect noncompliance through monitoring, auditing, reporting mechanisms, and proactive oversight;
- Enforce appropriate disciplinary measures for individuals or entities involved in noncompliance, including sanctions or exclusion from federal healthcare programs when applicable; and
- Prevent recurrence through corrective action, education, training, follow-up monitoring, and continuous improvement.

ISK COMPLIANCE PROGRAM & PLAN

The FY27 Corporate Compliance Program establishes the structure, authority, responsibilities, and core functions for compliance oversight. It is aligned with guidance from MDHHS, OIG, and DOJ and is carried out through ongoing risk assessment, monitoring, auditing, education, reporting, investigation, corrective action, and program evaluation. The Annual Corporate Compliance Plan, reviewed and approved by the ISK Board of Directors, identifies the fiscal year's priorities and is informed by regulatory developments, organizational needs, external audit activity, and findings from monitoring and investigations.

ANNUAL AUDIT AND MONITORING WORK PLAN

The FY27 Audit and Monitoring Work Plan operationalizes the Annual Corporate Compliance Plan's priorities. It emphasizes risk-based claims and documentation oversight, high-risk services, including CLS, OHSS, and waiver services, unsigned and incomplete documentation, regulatory and operational readiness, fraud, waste, and abuse prevention and detection, external audit readiness, and sustainable corrective action. The work plan is dynamic and may be reprioritized when emerging risks, regulatory changes, investigation findings, external audit results, or operational needs warrant a change in planned activity.

DEVELOPMENT OF THE WORK PLAN

The CCO, with the Compliance Committee, develops the work plan using the organizational risk assessment, FY26 year-end results, external audit activity, regulatory developments, and identified documentation and billing vulnerabilities. FY26 investigations identified

continuing risk involving CLS billing, code and modifier accuracy, documentation sufficiency, unsupported services, and potential systemic financial exposure. These findings support FY27 priorities for risk-ranked claims monitoring, integration with QMR processes, centralized tracking of findings and corrective actions, and follow-up review of corrective-action effectiveness.

Activities may be added, modified, deferred, or discontinued based on risk, changes in federal or state requirements, duplication with other oversight activities, available data, and Department of Network Compliance capacity. Material changes require CCO approval and review through the Compliance Committee; significant changes will be communicated to appropriate leadership, the Board of Directors, and affected stakeholders.

Adjustments to the work plan, including additions, deletions, deferrals, or substantive edits, will be documented and communicated to applicable stakeholders, ISK leadership, the Board of Directors, and the Compliance Committee as appropriate to the significance of the change.

AUDIT AND MONITORING METHODS

The Department of Network Compliance uses risk-based, data-informed methods appropriate to the question under review. Methods may include random, targeted, judgmental, or stratified sampling; concurrent and retrospective record-to-claim review; exception and aging reports; trend and recurrence analysis; dashboards and analytics; validation of service delivery, authorization, medical necessity, person-centered plan alignment, coding, modifiers, and supporting documentation; interviews and document requests; and follow-up testing of corrective-action effectiveness.

Methodology and performance measures are selected based on the identified risk, available data, population size, prior findings, and intended assurance level. Results will be analyzed for trends, recurring deficiencies, financial impact, and the need for corrective action or broader systemic improvement.

1. Sampling and Targeted Selection - random, judgmental, stratified, exception-based, or risk-ranked selection of records or claims.
2. Data Monitoring and Analytics - dashboards, exception reports, and trend analysis to identify utilization, billing, documentation, and recurrence risks.
3. Record and Service-Delivery Review - examination of clinical records, authorizations, person-centered plans, medical necessity, documentation completion, and evidence that billed services were delivered.
4. Claims and Billing Audit - testing coding, modifiers, units, dates, payor requirements, duplicate or unsupported claims, and consistency between documentation and claims.

CORRECTIVE ACTION AND RESOLUTION

The CCO or designee will document the scope, methodology, results, risk rating, financial impact, disclosure or referral determination, and required corrective action for completed activities. Substantiated findings requiring action will be entered into a centralized tracking process with an assigned owner and due date. Financial remediation will be reconciled and

tracked through completion. High-risk matters and overdue corrective actions will be escalated promptly.

Corrective actions may include education, policy or process changes, claims correction, repayment or recoupment, disciplinary action, enhanced monitoring, or external disclosure or referral when required. Follow-up monitoring will evaluate implementation, sustainability, and recurrence risk. High-risk corrective action plans will generally receive a documented effectiveness review within 90-180 days, based on risk. Progress will be reported through the Compliance Committee and summarized in the semi-annual and year-end Compliance Program evaluations.

ATTACHMENT
FY27 Compliance Audit and Monitoring Work Plan

INTEGRATED SERVICES OF KALAMAZOO
FY27 Compliance Audit and Monitoring Work Plan

Title	Risk / Scope / Purpose	Activity	Reporting	Status	Responsibility	Methodology / Performance Measure	Findings Reported To	Start	End / Follow-up
Risk-Based Claims and Documentation Monitoring Framework	Establish a documented, risk-ranked monitoring schedule aligned with QMR processes and informed by FY26 investigation, audit, claims, and documentation findings.	Monitoring	Quarterly results; annual schedule	New / FY27 priority	CCO; Compliance & Risk Mitigation Coordinator; Quality; Finance; operational subject-matter experts	Complete risk-ranking methodology and annual schedule by end of Q2. Track scheduled high-risk reviews, substantiated findings, recurrence, and corrective actions in a centralized process.	Compliance Committee; Executive Operations Committee; Board, as warranted	FY27 Q1	Framework by Q2; monitoring ongoing through Q4
High-Risk Service Claims and Documentation Reviews CLS, OHSS, waiver services, and other emerging high-risk areas	Address continuing risk involving unsupported services, medical necessity, coding and modifier accuracy, documentation sufficiency, and billing integrity.	Audit and monitoring	At least quarterly; prompt escalation of high-risk findings	Continuing /expanded	CCO; Compliance & Risk Mitigation Coordinator; Manager of Health Information and Risk Oversight; Quality; Finance	Risk-based and targeted samples; retroactive and concurrent record-to-claim review; trend analysis; validation of service delivery, authorization, person-centered plan alignment, coding, modifiers, and supporting documentation.	Compliance Committee; Executive Operations Committee; Board; affected Providers; SWMBH/MDHHS when required/warranted	FY27 Q1	Ongoing; year-end evaluation Q4
Unsigned and Incomplete Documentation Oversight	Reduce billing, revenue, and record-integrity risk across direct-operated programs and DCOs through timely completion, signing, escalation, and resolution.	Monitoring	Monthly tracking; quarterly summary	Continuing /expanded	Compliance & Risk Mitigation Coordinator; Health Information; program leadership; DCO contacts	Exception reporting and analysis; track open items through resolution; identify recurring deficiencies and escalate when established risk or recurrence	Compliance Committee; Executive Operations Committee; affected departments and DCOs, as warranted	FY27 Q1	Ongoing through Q4

INTEGRATED SERVICES OF KALAMAZOO
FY27 Compliance Audit and Monitoring Work Plan

Title	Risk / Scope / Purpose	Activity	Reporting	Status	Responsibility	Methodology / Performance Measure	Findings Reported To	Start	End / Follow-up
						thresholds are met.			
External Audit Readiness and Corrective Action Oversight MDHHS, SWMBH, waiver, CCBHC, and other applicable reviews	Maintain readiness, coordinate submissions, and ensure findings and corrective actions are implemented, sustained, and incorporated into future monitoring.	Monitoring and audit response	Tracker maintained throughout FY27; CAP status at least quarterly	Continuing	CCO; Compliance & Risk Mitigation Coordinator; responsible operational owners; Quality	Centralized tracker for requests, submissions, findings, owners, milestones, and due dates. Escalate overdue or high-risk items promptly and perform effectiveness review based on risk.	Compliance Committee; Executive Operations Committee; Board; applicable external oversight entity, as warranted	FY27 Q1	Ongoing; high-risk CAP effectiveness generally within 90-180 days
Fraud, Waste, and Abuse Investigations and Remediation	Detect and respond to questionable billing, unsupported services, inappropriate coding, falsified or deficient documentation, and other suspected noncompliance.	Investigation and targeted audit	Quarterly aggregate reporting; immediate escalation as warranted	Continuing	CCO; Manager of Health Information and Risk Oversight; Compliance & Risk Mitigation Coordinator; Finance and subject-matter support as needed	Documented risk triage and disposition; reconcile financial remediation; document disclosure/referral determination; assign corrective actions with owners and due dates; conduct risk-based follow-up monitoring.	Compliance Committee; CEO; Board; affected Providers; SWMBH, MDHHS, OIG, or law enforcement when required	As identified	Tracked through closure; effectiveness review generally within 90-180 days for high-risk CAPs
Regulatory Change and Operational Readiness Monitoring	Support timely, consistent implementation of Medicaid, CCBHC, HCBS, waiver, coding, modifier, service-delivery, funding,	Monitoring	Ongoing review; quarterly status	Continuing / dynamic	CCO; Compliance & Risk Mitigation Coordinator; cross-functional implementation owners	Log and assess material changes; assign owners; communicate affected requirements; develop implementation plans; document education and	Compliance Committee; Executive Operations Committee; affected departments and Provider Network, as warranted	FY27 Q1	Material assessment within 30 days when practicable; urgent changes escalated upon identification

INTEGRATED SERVICES OF KALAMAZOO
FY27 Compliance Audit and Monitoring Work Plan

Title	Risk / Scope / Purpose	Activity	Reporting	Status	Responsibility	Methodology / Performance Measure	Findings Reported To	Start	End / Follow-up
	reimbursement, and oversight changes.					technical assistance; track open risks and decisions to closure or formal acceptance.			

Corporate Compliance & Risk Management
FY26 Year-End Summary Report

Prepared by: Ashley Esterline, LMSW, CHC
Director of Network Compliance/Corporate Compliance Officer

Executive Overview

Fiscal Year 2026 was marked by significant regulatory change, expanded compliance oversight, and continued development of a proactive, risk-based approach to identifying and mitigating organizational and Provider Network risks. Throughout the year, the Compliance Department strengthened monitoring activities across ISK's direct-operated services and Provider Network, supported implementation of evolving federal and state requirements, and expanded oversight of documentation, billing practices, and service delivery.

Key areas of focus included implementation and oversight of the CCBHC direct-billing model, coordination of MDHHS waiver audit activities, targeted monitoring of high-risk services, and continued efforts to prevent and identify fraud, waste, and abuse. The Department of Network Compliance also expanded its monitoring capacity through the addition of a Compliance and Risk Mitigation Coordinator and began developing a more integrated approach to claims and documentation oversight in coordination with existing processes.

Collaboration with organizational leadership, operational departments, the Provider Network, SWMBH, and MDHHS remained central to these efforts. Findings from audits, investigations, and monitoring activities informed provider education, corrective action, financial remediation, and planning for continued improvements in FY27.

FY26 Compliance at a Glance

Indicator	FY26 Result
Compliance Investigations Completed	3
Financial Remediation/Recoupment	$312,638.57
Investigations Rated High Risk	3 of 3
FY26 MDHHS Waiver Audit	Completed; final results pending
Primary Risk Themes	CLS billing; code/modifiers; documentation sufficiency; unsupported services
Monitoring Capacity	Compliance & Risk Mitigation Coordinator added

Major Achievements

Regulatory Compliance & Policy Implementation

- Supported implementation and ongoing oversight of the CCBHC direct-billing model, including continued coordination with leadership, cross-functional workgroups, and MDHHS.
- Collaborated with Customer Services to develop and implement a standardized CCBHC Recipient Handbook, supporting consistent communication and application of CCBHC requirements across ISK and its Designated Collaborating Organizations (DCOs).
- Worked with the State CCBHC team to review and clarify requirements associated with the October 1, 2026 CCBHC Handbook, including the intersection of CCBHC services with Habilitation Supports Waiver (HSW), Serious Emotional Disturbance Waiver (SEDW), and Children's Waiver Program (CWP) services.
- Partnered with MDHHS, Southwest Michigan Behavioral Health (SWMBH), internal ISK departments, and the Provider Network on implementation activities associated with the return of Community Living Supports (CLS) and Overnight Health and Safety Supports (OHSS) per diem codes.

- Monitored the evolving Michigan Mental Health Framework initiative and assessed potential implications for the behavioral health system, maintaining organizational awareness and readiness as State direction and implementation timelines evolved.

Provider Network & Service Oversight

- Maintained focused monitoring of Community Living Supports (CLS) across the Provider Network and self-determined arrangements, evaluating service delivery, alignment with individual person-centered plans, supporting documentation, and billing practices to identify and address potential compliance concerns.
- Provided targeted technical assistance, education, and corrective action support to internal ISK staff and Providers when concerns were identified through reviews and investigations.
- Continued targeted oversight of Electronic Visit Verification (EVV) requirements, including Provider education and monitoring to support compliance with MDHHS expectations.
- Enhanced monitoring tools and oversight processes to support ongoing alignment with CARF, SWMBH, CCBHC, and MDHHS requirements.

Waiver & HCBS Compliance

- Successfully concluded activities associated with the FY25 MDHHS Waiver Audit, including acceptance of ISK's corrective action plans and positive feedback regarding implementation efforts.
- Coordinated ISK's response to the FY26 MDHHS Waiver Audit. This included an increased emphasis on Home and Community-Based Services (HCBS) requirements and review of individuals receiving services through multiple waiver programs. Final audit results were pending at fiscal year-end. Any findings received subsequent to fiscal year-end will be incorporated into FY27 Compliance Plan monitoring and corrective action oversight.
- Initiated planning to incorporate FY26 MDHHS Waiver Audit findings and corrective actions into FY27 claims monitoring and Quality Monitoring Review (QMR) activities.
- Continued education and technical support to operational areas to promote systemic remediation and sustained compliance with Medicaid, Waiver, CCBHC, and HCBS requirements.

Compliance & Risk Mitigation Initiatives

Expanded Monitoring & Claims Oversight

- Expanded the Compliance Department's monitoring capacity through the addition and integration of a Compliance and Risk Mitigation Coordinator, increasing resources available for risk-based monitoring, documentation review, investigations, and compliance oversight across direct-operated services and the Provider Network.
- Developed and implemented enhanced monitoring of unsigned documentation across direct-operated services and Designated Collaborating Organizations (DCOs), establishing a structured oversight process to improve timely completion and signing of clinical documentation, mitigate billing risks, and support accurate capture of services and associated revenue.
- Identified priorities for FY27 claims oversight and auditing activities designed to integrate Compliance monitoring with existing Quality Monitoring Review (QMR) processes, strengthen identification of documentation and billing deficiencies, and promote systemic corrective action.

Fraud, Waste, and Abuse

- Continued focused investigations and monitoring of high-risk billing and documentation practices, with Community Living Supports representing a significant area of review throughout FY26.
- Investigated claims involving unsupported services, inappropriate coding, and documentation deficiencies. Findings resulted in provider education, corrective action plans, enhanced monitoring, and financial remediation where appropriate.
- Utilized findings from investigations and targeted reviews to identify recurring vulnerabilities and opportunities for broader improvements in provider education, documentation standards, billing practices, and compliance oversight.
- Advanced development of a proactive auditing and monitoring framework for FY27, with an emphasis on identifying emerging risks, detecting questionable billing practices, and mitigating potential regulatory and financial exposure.

Organizational Readiness & Strategic Planning

- Maintained a dynamic, risk-based approach to compliance oversight throughout FY26, adjusting monitoring priorities in response to emerging operational, regulatory, billing, and service-delivery risks.
- Established and participated in cross-functional workgroups to assess regulatory changes, clarify requirements, and support translation of State and Federal expectations into operational practices.
- Strengthened the connection between audit and investigation findings and organizational improvement efforts through targeted education, corrective action, and ongoing monitoring.
- Established priorities for FY27 focused on expanded claims and documentation oversight, integration with QMR processes, implementation of corrective actions resulting from external audits, and continued readiness for evolving CCBHC, Medicaid, waiver, and coding requirements.

During FY26, the Compliance Department completed three investigations involving potential billing irregularities, unsupported services, and falsified service documentation. These investigations resulted in financial remediation totaling $312,638.57.

FY26 Continuing Risk & Lessons Learned

FY26 monitoring and investigation activity identified documentation integrity, coding and modifier accuracy, and sufficient support for billed services as continuing areas of compliance risk. Investigation results also demonstrated that systemic billing issues may create significant financial exposure even when individual claim-level discrepancies appear limited. These findings have informed FY27 priorities emphasizing risk-based claims monitoring, documentation oversight, corrective-action effectiveness, and integration of Compliance monitoring with existing processes.

FY26 Year End Recoupment and Reallocation Report

Summary	Source	Risk	Corrective Action/Education/Monitoring	Recoupment/Reallocation (if applicable)	External Reporting/Disclosure Required?
FY26 Investigations Completed					
Provider's staff falsified reported and submitted documentation for dates of service not rendered	Provider	High	Provider ensured continued education and training of staff. Heightened oversight and monitoring of timesheets and documentation standards now implemented.	Recoupment/Reallocation completed: $1,082.88	No, based on Compliance review
Provider submitted claims for Community Living Supports (CLS) that appeared to be up-coded.	ISK Specialized Residential Team	High	ISK Compliance investigation completed. Provider education on code/modifier reporting and appropriateness of documentation discussed. CAP received from Provider.	Recoupment/Reallocation completed: $307,697.33	No, based on Compliance review
Identified potential billing discrepancies from a Provider. Discrepancies included claims submitted for services lacking adequate documentation to support delivery.	ISK Office of Recipient Rights	High	ISK Compliance investigation completed. Reviewed 116 dates of service (DOS). 14 DOS did not have documentation to support the submitted claim. Provider education rendered. Corrective action plan received.	Recoupment/Reallocation completed: $3,858.36	No, based on Compliance review

INTEGRATED SERVICES OF KALAMAZOO

FY27 COMPLIANCE PLAN: GOALS, OBJECTIVES & PERFORMANCE MEASURES

Fiscal Year 2027 | Corporate Compliance & Risk Management

BASIS FOR FY27 PRIORITIES

FY27 priorities are informed by FY26 investigations and monitoring findings, external audit activity, regulatory developments, identified documentation and billing vulnerabilities, and ISK's ongoing compliance risk assessment. Emphasis will be placed on claims integrity, documentation sufficiency, high-risk services, corrective-action effectiveness, and emerging Medicaid and CCBHC requirements.

GOAL	KEY OBJECTIVES / ACTION STEPS	PERFORMANCE MEASURES	TARGET / REPORTING
1. Risk-Based Claims & Documentation Oversight	• Implement a risk-based claims and documentation monitoring framework aligned with existing QMR processes. • Conduct targeted reviews of CLS, OHSS, waiver services, medical necessity, documentation completion, coding, and billing accuracy. • Monitor unsigned and incomplete documentation across direct-operated programs and DCOs, including escalation and resolution. • Analyze trends and recurring deficiencies and translate findings into corrective action and systemic improvement.	• Documented risk-ranking methodology and annual monitoring schedule established. • Scheduled high-risk reviews completed and findings reported. • Unsigned/incomplete documentation trends tracked through resolution. • Substantiated findings requiring corrective action entered into a centralized tracking process. • Recurring deficiencies elevated when established risk or recurrence thresholds are met.	• Framework and schedule: by end of Q2 • Monitoring results: at least quarterly • Documentation exceptions: monthly tracking; quarterly summary • High-risk findings: prompt escalation as warranted

GOAL	KEY OBJECTIVES / ACTION STEPS	PERFORMANCE MEASURES	TARGET / REPORTING
2. Regulatory Compliance & Operational Readiness	• Monitor Medicaid, CCBHC, HCBS, waiver, coding, modifier, and service-delivery requirements. • Coordinate with internal departments, MDHHS, SWMBH, and the Provider Network to support consistent interpretation and implementation. • Provide implementation guidance and technical assistance when requirements affect service delivery, documentation, billing, or reporting. • Maintain readiness for changes in program structures, funding, reimbursement, and State or regional oversight.	• Material regulatory changes logged, assessed, assigned, and communicated to affected stakeholders. • Implementation plans developed for changes requiring operational action. • Education or technical assistance documented for material changes. • Open implementation risks and decisions tracked to closure or formal acceptance.	• Regulatory review: ongoing • Material change assessment: within 30 days when practicable • Status reporting: quarterly • Urgent changes: escalated upon identification
3. Fraud, Waste & Abuse Prevention and Detection	• Conduct targeted audits and investigations involving questionable billing, unsupported services, inappropriate coding, and documentation deficiencies. • Evaluate patterns from claims reviews, investigations, provider monitoring, and reporting channels for systemic vulnerabilities. • Coordinate financial remediation, education, corrective action, and required disclosure or referral when noncompliance is substantiated. • Perform follow-up monitoring to evaluate corrective-action effectiveness and recurrence risk.	• Matters triaged using documented risk criteria and disposition recorded. • Financial remediation reconciled and tracked to completion when applicable. • Required disclosure/referral determination documented for substantiated matters. • Corrective actions assigned with responsible party and due date. • High-risk CAPs receive documented effectiveness review, generally within 90-180 days based on risk.	• Investigation status: quarterly aggregate reporting • High-risk matters: prompt escalation • Remediation: tracked through completion • CAP effectiveness: risk-based, generally 90-180 days

GOAL	KEY OBJECTIVES / ACTION STEPS	PERFORMANCE MEASURES	TARGET / REPORTING
4. Audit Readiness & Sustainable Corrective Action	• Coordinate responses to MDHHS, SWMBH, and other applicable external audits and reviews. • Monitor corrective action plans arising from external audits, investigations, and internal monitoring. • Incorporate audit findings and identified risks into monitoring activities. • Provide targeted education and technical assistance to reinforce accountability and sustain improvement.	• Audit requests, submissions, findings, owners, and due dates maintained in a centralized tracker. • CAP milestones completed by approved due dates or formally escalated. • Relevant findings incorporated into future monitoring, education, or policy review.	• Audit tracker: maintained throughout FY27 • CAP status: at least quarterly • Overdue/high-risk items: escalated promptly

Governance and year-end evaluation: Progress will be reviewed through the Compliance Committee and summarized in the semi-annual and year-end Compliance Program evaluations. Results will inform reprioritization when emerging risks warrant a change in planned activity.

~~KALAMAZOO COMMUNITY MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES~~INTEGRATED SERVICES OF KALAMAZOO

BOARD POLICY V.05

AREA:	Governance		
SECTION:	Executive Limitations	PAGE:	1 of 1
SUBJECT:	**EMERGENCY EXECUTIVE SUCCESSION**	SUPERSEDES:	11/27/2023
		REVISED:	~~11/28/2016~~11/23/2026

PURPOSE/EXPLANATION

To establish limitations of means regarding emergency executive succession.

POLICY

I. In order to protect the Board from sudden loss of Chief Executive Officer (CEO) services, the C~~hief E~~~~xecutive O~~~~fficer~~ may not have fewer than two other executives familiar with board and C~~hief E~~~~xecutive O~~~~fficer~~ issues and processes.

II. The order of succession in an emergency is as follows:

A. Chief Executive Officer

~~A.~~B. Chief Operating Officer

~~B.~~C. Chief Clinical Officer

D. Chief Medical Officer

~~C. Chief Executive Officer~~

~~B. Deputy Director Program Services~~

~~C. Deputy Director Administrative Services~~

~~D. Chief Medical Officer~~

III. This policy will be monitored through internal mechanisms on an annual basis.

CHIEF EXECUTIVE OFFICER

Beth Ann Meints
Chief Executive Officer

APPROVED

Karen Longanecker
Board Chair

INTEGRATED SERVICES OF KALAMAZOO

INTEGRATED
Services of Kalamazoo

October 2026

Monthly Finance Report

This financial report is for internal use only. It has not been audited, and no assurance is provided.

INTEGRATED SERVICES OF KALAMAZOO

Statement of Revenue, Expenditures and Change in Net Position

Budget to Actual - October 1, 2026 through October 31, 2026

Percent of Year is 8.33%

	Original 2027 Budget	YTD Actual	Remaining Budget	Percent of Budget - YTD
Operating revenue				
Medicaid:				
Traditional Capitation	$ 92,224,152	$ 7,348,192	$ 84,875,960	7.97%
Healthy Michigan Capitation	6,134,500	569,995	5,564,505	9.29%
State General Fund:				
Formula Fundings	3,900,516	325,043	3,575,473	8.33%
CCBHC Demonstration	35,620,053	2,968,338	32,651,715	8.33%
CCBHC Quality Bonus	1,326,190	-	1,326,190	0.00%
County Allocation	1,550,400	129,200	1,421,200	8.33%
Client Fees	619,418	51,618	567,800	8.33%
Other grant revenue	5,180,770	426,031	4,754,739	8.22%
Other earned contracts	1,520,355	108,547	1,411,808	7.14%
Interest	143,620	11,968	131,652	8.33%
Local revenue	508,606	-	508,606	0.00%
Total operating revenue	$ 148,728,580	$ 11,938,932	$ 136,789,648	8.03%
Operating expenses				
Salaries and wages	$ 30,190,229	$ 2,515,852	$ 27,674,377	8.33%
Employee benefits	11,316,975	940,189	10,376,786	8.31%
Staff development	285,550	23,646	261,904	8.28%
Payments to providers	96,842,228	7,817,790	89,024,438	8.07%
Administrative contracts	8,571,309	774,973	7,796,336	9.04%
IT software and equipment	913,454	77,246	836,208	8.46%
Client transportation	61,170	4,898	56,273	8.01%
Staff travel	410,390	32,424	377,966	7.90%
Office expenses	717,407	56,418	660,989	7.86%
Insurance expense	206,797	17,233	189,564	8.33%
Depreciation expense	697,049	73,351	623,698	10.52%
Utilities	384,082	31,932	352,150	8.31%
Facilities	58,552	4,050	54,502	6.92%
Local match	305,108	25,426	279,682	8.33%
Total operating expenses	$ 150,960,300	$ 12,395,428	$ 138,564,872	8.21%
Change in net position	(2,231,720)	(456,496)	(1,775,224)	
Beginning net position	-	-		
Ending net position	$ (2,231,720)	$ (456,496)		

This financial report is for internal use only. It has not been audited, and no assurance is provided.

INTEGRATED SERVICES OF KALAMAZOO

Statement of Revenue, Expenses and Change in Net Position
October 1, 2026 through October 31, 2026
Percent of Year is 8.33%

	Specialty Services		Healthy Michigan		SUD Block Grant		Totals		
	YTD Budget	YTD Totals 10/31/26	YTD Budget	YTD Totals 10/31/26	YTD Budget	YTD Totals 10/31/26	YTD Budget	YTD Totals 10/31/26	Variance
Operating revenue									
Medicaid:									
Traditional Capitation	$ 7,685,346	$ 7,484,067	$ -	$ -	$ -	$ -	$ 7,685,346	$ 7,484,067	$ (201,279)
Healthy Michigan Capitation	-		511,209	606,095	-	-	511,209	606,095	94,886
Settlement Estimate	-	(135,875)	-	(36,100)	-	254	-	(171,721)	(171,721)
Client Fees	-	-	-	-	-	-	-	-	-
Total operating revenue	$ 7,685,346	$ 7,348,192	$ 511,209	$ 569,995	$ -	$ 254	$ 8,196,555	$ 7,918,441	$ (278,114)
Operating expenses									
Internal services	$ 188,865	$ 130,269	$ 1,356	$ 447	$ -	$ -	$ 190,220	$ 130,715	(59,505)
External services	6,553,978	6,461,619	447,161	467,949	-	-	7,001,139	6,929,568	(71,571)
Delegated managed care	942,503	756,304	62,693	101,599	-	254	1,005,196	858,157	(147,039)
Total operating expenses	$ 7,685,346	$ 7,348,192	$ 511,209	$ 569,995	$ -	$ 254	$ 8,196,555	$ 7,918,440	$ (278,115)
Change in net position	$ -	$ 0	$ 0	$ (0)	$ -	$ 0	$ 0	$ -	$ -

INTEGRATED SERVICES OF KALAMAZOO

Statement of Revenue, Expenses and Change in Net Position
October 1, 2026 through October 31, 2026
Percent of Year is 8.33%

	State General Fund		CCBHC		Other Funding Sources		Totals		
	YTD Budget	YTD Totals 10/31/26	YTD Budget	YTD Totals 10/31/26	YTD Budget	YTD Totals 10/31/26	YTD Budget	YTD Totals 10/31/26	Variance
Operating revenue									
General Fund	$ 325,043	$ 325,043	$ -	$ -	$ -	$ -	$ 325,043	$ 325,043	$ -
CCBHC Demonstration	-	-	3,130,472	2,968,338	-	-	3,130,472	2,968,338	(162,134)
Other Federal and State Grants	-	-	-	-	431,731	426,031	431,731	426,031	(5,700)
Earned Revenue	-	-	-	-	31,590	109,183	31,590	109,183	77,593
Client Fees	-	-	-	51,618	-	-	-	51,618	51,618
COFR Revenue	-	-	-	-	-	-	11,968	-	(11,968)
Interest	-	-	-	-	11,968	11,968	129,200	11,968	(117,232)
County Allocation	-	-	-	-	129,200	129,200	42,384	129,200	86,816
Local Revenue	-	-	-	-	42,384	-	-	-	-
Transfer from GF		-	21,016	65,500	-	-	21,016	65,500	44,484
Total operating revenue	$ 325,043	$ 325,043	$ 3,151,488	$ 3,085,456	$ 646,873	$ 676,382	$ 4,123,404	$ 4,086,881	$ (36,523)
Operating expenses									
Internal Programs	$ 57,317	$ 40,636	$ 3,333,734	$ 3,423,068	$ 199	$ -	$ 3,391,251	$ 3,463,703	$ 72,453
External Programs	209,425	169,863	-	-	89,360	94,069	298,785	263,932	(34,853)
Other Federal and State Grants	-	-	-	-	366,936	430,565	366,936	430,565	63,629
HUD Grants	-	-	-	-	130,499	115,962	130,499	115,962	(14,537)
Managed Care Administration	37,285	49,045	-	-	-	-	37,285	49,045	11,760
Homeless Shelter	-	-	-	-	33,474	35,161	33,474	35,161	1,687
Transfer from GF	-	65,500	-	-	-	-	-	65,500	65,500
Local match expense	21,016	-	-	-	25,426	25,426	46,442	25,426	(21,016)
Non-DCH Activity Expenditures	-	-	-	-	4,709	94,083	4,709	94,083	89,374
Total operating expenses	$ 325,043	$ 325,043	$ 3,333,734	$ 3,423,068	$ 650,603	$ 795,266	$ 4,309,381	$ 4,543,377	$ 233,996
Change in net position	$ -	$ 0	$ (182,246)	$ (337,612)	$ (3,731)	$ (118,884)	$ (185,977)	$ (456,496)	$ (270,519)

INTEGRATED SERVICES OF KALAMAZOO

CCBHC

October 1, 2026 through October 31, 2026
Percent of Year is 8.33%

	CCBHC Medicaid	CCBHC Healthy MI	CCBHC Non-Medicaid	CCBHC YTD Totals
Operating revenue				
CCBHC revenue	$ 2,304,216	$ 664,122	$ -	$ 2,968,338
CCBHC Quality Bonus	-	-	-	-
FFS Revenue	51,618	-	-	51,618
CCBHC SAMSHA Grant	-	-	-	-
Total CCBHC Revenue (PPS-1 of $311.21 x encounters)	$ 2,355,834	$ 664,122	$ -	$ 3,019,956
Operating expenses				
Internal services	$ 1,666,889	$ 674,327	$ 401,690	$ 2,742,906
DCO Contracts	533,951	99,810	46,401	680,161
Total operating expenses	$ 2,200,840	$ 774,137	$ 448,091	$ 3,423,068
Operating change in net position	154,994	(110,015)	(448,091)	(403,112)
General Fund Reclassification to cover Non-Medicaid	-	-	65,500	65,500
Total change in net position	$ 154,994	$ (110,015)	$ (382,591)	$ (337,612)

CCBHC Cost per daily visit

	FY 2024	FY 2025	FY 2026	10/31/26
Total CCBHC Cost	$ 31,777,786	$ 35,393,270	$ 40,585,665	$ 3,423,068
Daily Visits	110,326	125,458	128,663	10,261
Cost per daily visit	$ 288.04	$ 282.11	$ 315.44	$ 333.60

Community • Independence • Empowerment

Integrated Services of Kalamazoo
MOTION

Subject:	September & October 2026 Disbursements	
Meeting Date:	**November 23, 2026**	**Approval Date:**
Prepared by:	Charlotte Bowser	**November 23, 2026**

Recommended Motion:

"Based on the Board Finance and Compliance meeting review, I move that ISK approve the September 2026 vendor disbursements of $14,793,397.57 and the October 2026 vendor disbursements of $11,190.948.04."

Summary of Request:

As per the September 2026 Vendor Check Register Report dated 10/13/2026 that includes checks issued from 09/01/2026 to 09/30/2026 and the October 2026 Vendor Check Register Report dated 11/10/2026 that includes checks issued from 10/1/2026 to 10/31/2026.

I affirm that all payments identified in the monthly summary above are for previously appropriated amounts.

Staff: **C. Bowser, Director of Finance**

Date of Board Consideration:

November 23, 2026

INTEGRATED
Services of Kalamazoo

Community • Independence • Empowerment

Integrated Services of Kalamazoo

MOTION

Subject:	2027 Medical Plan Coverage Year	
Meeting Date:	November 23, 2026	Approval Date:
Prepared by:	Chantel Graham	November 23, 2026

RECOMMENDED MOTION:

"I move that the ISK BOARD elects to comply with the requirements of 2011 Public Act 152, the Publicly Funded Health Insurance Contribution Act, by adopting the annual Exemption option for the medical benefit plan coverage year January 1, 2027, through December 31, 2027."

SUMMARY OF REQUEST:

During annual benefit planning, ISK reviews the PA 152 hard cap and overall health insurance costs to determine the appropriate employer and employee premium contributions. For 2027, the PA 152 hard cap increased by 3%.

ISK plans to increase its employer contribution toward employee health insurance premiums by approximately 14.2% above the 2027 PA 152 hard cap amount. This increase is intended to keep employee healthcare premium costs per pay period relatively stable for 2027, particularly in light of employees not receiving salary increases in December 2026. ISK has also implemented plan design and vendor changes to help maintain the organization's overall healthcare costs at approximately 2026 levels.

In order to still comply with PA 152, the Board may elect the "Exemption" Option- and exempt itself from the requirements of the Act by an annual 2/3 vote.

Budget: FY27
Staff: C. Graham

Date of Board
Consideration: November 23, 2026

BOARD OF Directors **OF**

Integrated Services of Kalamazoo

(the "Public Entity")

RESOLUTION AUTHORIZING PUBLIC ENTITY MEMBERSHIP IN THE WEST MICHIGAN HEALTH INSURANCE POOL ("WMHIP") FOR A MINIMUM THREE-YEAR PERIOD

PREMISES

A. The Western Michigan Health Insurance Pool ("WMHIP") is a Public Employer Pooled Plan ("PEPP") that provides pooled self-funded health insurance coverage, as authorized by the Public Employees Health Benefit Act, Act 106 of 2007.

B. WMHIP has received from the Michigan Department of Insurance and Financial Services ("DIFS") a certificate of registration authorizing establishment of the PEPP.

C. The Board has had opportunity to consider the obligations of the Public Entity to WMHIP and PEPP plans, and services available to the Public Entity by WMHIP, and has carefully reviewed the WMHIP Amended Trust Agreement and Bylaws.

D. The Board desires to authorize membership of the Public Entity in the WMHIP for a minimum period of three years.

NOW, THEREFORE, the Board of the Public Entity hereby resolves:

1. The Board approves the WMHIP Amended Trust Agreement and bylaws, and accepts WMHIP provision of Public Entity self-funded, pooled health insurance coverage under the PEPP plan.

2. The Superintendent, Manager, or CFO of the Public Entity or, with their approval, the person appointed by the Board as WMHIP Trustee or Alternate Trustee, is hereby authorized to

execute all documents necessary for the Public Entity to become a Member in the WMHIP PEPP plan.

3. The Board hereby confirms its appointment of the following persons as Trustee and Alternate Trustee to serve as Trustee when the initial Trustee is not available or in attendance to carry out the Trustee's duties:

Chantel Graham

[Insert Trustee's Name]

Amy Rottman

[Insert Alternate Trustee's Name]

As required by law, neither the Trustee nor the Alternate Trustee is an owner, officer, or employee of any third-party administrator or any other third party providing services to WMHIP. The Trustee and Alternate Trustee shall serve until replaced by action of the Board. Once appointments are made known to the WMHIP, the persons appointed shall remain in office until the WMHIP receives evidence of appointment of other persons. Evidence of proper appointment of the Trustee and Alternate Trustee shall be a certified copy of the resolution passed by the Board, indicating the names of the designated Trustee and/or Alternate Trustee. Failure of the Public Entity to designate a Trustee, or the failure of that Trustee/Alternate Trustee to participate on the Board of Trustees, shall not affect the responsibilities or duties of the Public Entity under the Amended Trust Agreement.

4. The Public Entity shall continue participation in the WMHIP for a minimum of three full years under its PEPP plan.

5. All resolutions and parts of resolutions insofar as they conflict with the provisions of this Resolution be and the same are hereby rescinded.

CERTIFICATE

I hereby certify that the foregoing is a true and complete copy of a resolution adopted by the Board of Directors of the Integrated Services of Kalamazoo Public Entity, Kalamazoo County(ies), State of Michigan, at a Public Meeting meeting held on November 23, 2026, and that this meeting was conducted and public notice of this meeting was given pursuant to and in full compliance with the Open Meetings Act, being Act 267, Public Acts of Michigan, 1976, and that the minutes of this meeting were kept and will be or have been made available as required by this Act.

I further certify that the following Members were present at this meeting:

_____ and that the following Members were absent _____.

I further certify that the foregoing resolution was moved by Member _____ and seconded by Member _____.

I further certify that the following Members voted for adoption of the foregoing resolution:

_____ and that the following Members voted against adoption of this resolution:

_____.

_____
Secretary

w:\wdsystem\wddocs\cliedoc\3293\3\01046548.doc

INTEGRATED Services of Kalamazoo

Community • Independence • Empowerment

X.a.-g.

INTEGRATED SERVICES OF KALAMAZOO

MOTION

Subject:	Consent Calendar DEFERRED	Administration Department
Meeting Date:	November 23, 2026	Approval Date:
Prepared by:	Beth Ann Meints	November 23, 2026

Recommended Motion:

"I MOVE TO APPROVE THE CONSENT CALENDAR ITEMS DEFERRED FROM THE NOVEMBER 2, 2026, BOARD MEETING DUE TO THE LACK OF A QUORUM."

Summary of Request:

a. Minutes *September 28, 2026*
b. Board Purpose and Business Description (II.01)(Policy)
c. Board Business Description (II.03)(Policy)
d. Treatment of Persons Served w/Substantiated Complaints (V.01)(Policy & Report)
e. Guidelines For Board Member Appointments (I.03)(Policy)
f. Annual Customer Advisory Council (CAC) & Customer Service(Reports)
g. Annual Family Support Advisory Council (FSAC)(Report)

Budget:	FY2026/2027	Date of Board
Staff:	B. Meints	Consideration: November 23, 2026

STRAW VOTE

THE RESULTS ARE IN!

November 12, 2026

Per Board policy, Integrated Services of Kalamazoo (ISK) conducts a straw poll every 5 years to gauge employee support for continuing outside the Social Security system. ISK held the most recent poll on November 12, 2026. Michael D. Schlack, Corporate Counsel, counted the ballots and certified the results. Employees who voted overwhelmingly supported keeping ISK's current status in the Money Purchase Pension Plan 401(a) with 15 votes cast against it.

Thank you,
Chantel Graham
ISK/Chief Human Resources Officer

Beth Ann Meints
ISK/Chief Executive Officer

Cc: Michael D. Schlack
ISK/Corporate Counsel



INTEGRATED
Services of Kalamazoo

Community • Independence • Empowerment

Administration
610 South Burdick Street
Kalamazoo, MI 49007

www.iskzoo.org
(269) 553-8000

24-HOUR CRISIS HOTLINE or NON-EMERGENCY CLINICAL SERVICES: (269) 373-6000

Board Report from the CEO

Beth Ann Meints November 23, 2026

RE: Chief Medical Director and Psychiatrist Recruitment & Interviews

ISK Board of Directors,

The recruitment process for the positions of Chief Medical Director and Psychiatrist has been successful.

Dr. Bihn Dinh will be our new Chief Medical Director starting on November 30, 2026. Dr. Dinh is a board-certified psychiatrist and Fellow of the American Psychiatric Association with more than 15 years of experience in clinical psychiatry, behavioral health leadership, medical education, and program development.

We have also successfully hired 3 additional psychiatrists. Dr. Herrington has already started working within Integrated Health Clinic. While Dr. Nanyes and Dr. Meza will start late summer of 2027 after completion of their residency.

On behalf of our Compliance Officer, Ashley Esterline, I would like to inform the Board that Ashley will be contacting each Board member by phone during the month of November, prior to the Board meeting, to complete the required Conflict of Interest Disclosure and Ownership and Control Disclosure forms. Thank you in advance for your time and cooperation in fulfilling these important compliance requirements.

Ashley will be available to assist you with completing both documents and answer any questions you may have. Each Board member must complete both documents, even if you have no conflicts of interest or ownership and control interests to disclose.

These disclosures are an important part of our compliance and governance responsibilities. They document that potential conflicts of interest and

INTEGRATED
Services of Kalamazoo

Community • Independence • Empowerment

Administration
610 South Burdick Street
Kalamazoo, MI 49007

www.iskzoo.org
(269) 553-8000

ownership or controlling interests have been reviewed and appropriately disclosed, including when there is nothing to report.

Please expect to hear directly from Ashley this month and thank you in advance for your cooperation.

That concludes my report.

With appreciation,

Beth Ann Meints
Chief Executive Officer

INTEGRATED
Services of Kalamazoo

Community • Independence • Empowerment

Integrated Services of Kalamazoo

MOTION

Subject:	CLOSED SESSION	
Meeting Date:	November 23, 2026	Approval Date:
Prepared by:	*Beth Ann Meints*	November 23, 2026

RECOMMENDED MOTION:

"I MOVE THAT THE ISK BOARD OF DIRECTORS GO INTO CLOSED SESSION PURSUANT TO Section 8(1)(a) OF THE OPEN MEETINGS ACT TO CONSIDER A COMPLAINT SUBMITTED BY AN INDIVIDUAL SERVED BY ISK."

SUMMARY OF REQUEST:

ROLL-CALL:	Yes	No
Karen Longanecker	____	____
Michael Seals	____	____
Nkenge Bergan	____	____
Patrick Dolly	____	____
Ramona Lumpkin	____	____
Melissa Woosley	____	____
Michael Raphelson	____	____
Abigail Wheeler	____	____
Caelynn Uhlmann	____	____
Sharon Price	____	____
Jackie Schut	____	____
MOTION PASSED:	____	____

Budget:_____
Staff:_____

Date of Board
Consideration: November 23, 2026