HEALTH FIRST
KOSCIUSKO

Memorandum of Understanding

THIS AGREEMENT made between the **KOSCIUSKO COUNTY COMMISSIONERS ON BEHALF OF THE KOSCIUSKO COUNTY HEALTH DEPARTMENT,** Kosciusko County, Indiana, ("County") and Fellowship Missions, ("*Grantee*").

SECTION 1.

RECITALS

1.1 The County desires to obtain from the Grantee the core public health related services outlined in Exhibit "A" attached hereto and the Memorandum of Understanding.

1.2 The Grantee desires to provide to the County the core public health related services described in Exhibit "A" and the Memorandum of Understanding for the sum of fifteen thousand dollars ($15,000) which is provided through the Health First Kosciusko fund.

SECTION 2.

CONSIDERATION

2.1 The consideration for this agreement is the providing of services by the Grantee and the payment to the Grantee by the County of the sum of fifteen thousand dollars ($15,000).

SECTION 3.

TERMS

3.1 The County shall pay half of the total sum within 60 days of the execution of this agreement and the completion of the 30 day public notice period only if the Grantee has provided, to Health First Kosciusko, written confirmation and evidence that the nurse practitioner is or will be working under a certified collaborating physician.

3.2 The Grantee shall provide monthly data, success stories, and summary reports in a timely manner. A data, success story, and summary report schedule (attached) will be provided to the Grantee which shall list the dates these items shall be due. Data shall be due monthly. The date the data collection begins shall be determined by the funding period start date. The funding period shall be from the time the Health First Indiana money is dispersed from the Kosciusko County Health Department to the Grantee until the date the agreement is no longer in effect. Success stories and reports shall be due quarterly until the date the agreement is no longer in effect.

3.3 The Grantee agrees to attend a quarterly meeting scheduled by the Health First Kosciusko Coordinator. The purpose of the quarterly meeting is to provide progress updates. A meeting schedule will be provided.

3.4 The second half of the total sum shall only be paid if the Health First Kosciusko Coordinator approves the Grantee has met Health First Kosciusko requirements. This will be executed by the Health First Kosciusko Coordinator analyzing the submission of the Grantee's monthly data, success stories, and second summary report, and determining if the remaining Health First Indiana money is needed to fulfill the requirements listed in Exhibit "A" and the Memorandum of Understanding. If the submission and work does not meet the requirements, the second half of the total sum shall not be distributed to the Grantee. If a portion or full amount of the remaining money is not needed, an addendum listing the change in disbursement, will be created which shall be signed by both the Kosciusko County Health Department Administrator and the Grantee. If the submission and work does meet the requirements and the full amount of the remaining money is needed, the County shall pay the second half of the total sum after the second summary report is approved. The work outlined should include but is not limited to:

- Number of pregnancy tests provided
- Number of women referred to prenatal care

- Number of women provided prenatal services:
    - Vitamins
    - Syphilis testing
    - HIV testing
    - Hepatitis C testing
    - Chlamydia testing
    - Gonorrhea testing
    - Nutrition education
    - Nutrition support
    - Mental health/substance use disorder services
    - Clinical care (from a healthcare provider, such as a physician, nurse practitioner, clinic, midwife)
    - Immunizations, such as RSV, Tdap, flu
- Number of women referred to My Healthy Baby
- Number of women provided mental health/substance use disorder services
- Number of women referred to health/substance use disorder services
- Number of women referred to postpartum care
- Number of women provided mental health/substance use disorder services
- Number of women referred to mental health/substance use disorder services
- Number of women provided breastfeeding education or support
- Number of women referred to breastfeeding education or support
- Number of families referred to pediatric care
- Number of people provided with parenting classes/education
- Number of families referred to childcare assistance (such as Child Care and Development Fund "CCDF" program)
- Number of people referred to substance use disorder treatment/support
- Number of people provided contraceptive education
- Number of women tested for STIs/HIV
- Number of women referred for STI/HIV treatment
- Number of women treated for STIs/HIV
- Number of women referred to WIC
- Number of families referred or connected to local food pantries
- Number of children tested for blood lead level

  - Number of children identified with an elevated blood lead level (EBLL) above 3.5 ug/dL
- Number of families provided lead education
- Number of outbreaks (or suspected outbreaks) that were investigated
  - Number of outbreaks (or suspected outbreaks) in which the pathogen responsible for the outbreak was identified if known
- Number of vaccinations given due to disease investigation interviews (e.g., hepatitis A, hepatitis B)
- Number of people provided HIV testing
  - Number identified
- Number of people provided hepatitis C testing
  - Number identified
- Number of people provided syphilis testing
  - Number identified
- Number of people provided chlamydia testing
  - Number identified
- Number of people provided gonorrhea testing
  - Number identified
- Number of referrals to counseling
  - HIV
  - Hepatitis B
  - Hepatitis C
  - Syphilis
  - Chlamydia
  - Gonorrhea
- Number of referrals to care
  - HIV
  - Hepatitis B
  - Hepatitis C
  - Syphilis
  - Chlamydia
  - Gonorrhea
- Number of individuals treated for HCV/HIV/STI (not including syphilis)

- Number of individuals treated for syphilis
- Number of people educated on HIV/HCV/STI
- Number of pediatric referrals for clinical care
    - Obesity/overweight
    - Substance use disorder
    - Mental health services
    - General (Please list the services)
- Number of adult referrals for clinical care
    - Hypertension
    - Diabetes
    - Obesity
    - HIV
    - Hepatitis B
    - Hepatitis C
    - Syphilis
    - Chlamydia
    - Gonorrhea
    - Substance use disorder
    - Mental health services
    - General (Please list the services)
- Number of individuals referred to insurance navigation or Medicaid/Medicare
- Number of people provided TB testing (IGRA or TST)
- Number of people screened for high blood pressure through local health department or partners
    - Number of people identified with undiagnosed high blood pressure through LHD or partners
- Number of people screened with a hemoglobin A1c through LHD or partners
    - Number of people identified with elevated hemoglobin A1c
- Number of people screened for diabetes risk factors through LHD or partners
    - Number of people referred to or enrolled in a diabetes prevention program
    - Number of people referred to or enrolled in a diabetes self-management education support program
- Number of people screened for high cholesterol through LHD or partners

  - Number of people identified with high cholesterol
- Number of people screened for cancer through LHD activity (breast, colon cancer, etc)

- Number of people screened for BMI
  - Number of people referred to a weight treatment or obesity prevention program
  - Number of people identified as having a BMI over 30
- Number of individuals with asthma who receive and in-home trigger assessment
- Number of people referred for chronic disease preventative care
- Number of people referred for cancer screening
- Number of people provided for cancer screening
- Number of people screening positive for food insecurity:
  - Number of people referred to a food assistance program
- Number of people referred to the IDOH Breast and Cervical Cancer Program
- Number of adults participating in nutrition and physical activity education programming
- Number of seniors participating in nutrition and physical activity education programming
- Number of cancer risk reduction and prevention programs provided by the LHD
- Number of cancer survivorship related services provided (smoking cessation resources, cancer support groups, respite opportunities for caregivers)
- Other services provided
- Success stories and/or testimonials
- Budget Summary: Detailed list of expenditures to date and detailed list of future expenditures. Include the total amount of Health First Indiana money claimed and to be claimed.

The activity trackers listed are subject to change.

3.5 No later than January 8, 2027 , the Grantee shall provide to the Health First Kosciusko Coordinator, remaining data for December 14, 2026 through December 31, 2026.

3.6 The Grantee agrees to expend all monies in the areas specified in the budget plan within the funding period and agrees to refund all unspent monies to the Kosciusko County Health Department.

3.7 As a condition of the partnership with Health First Kosciusko, the Grantee shall incorporate either the Health First Kosciusko logo or name in all correspondence, advertisements, or communications regarding Health First Indiana money or Health First Kosciusko support. All correspondence, advertisements, or communications regarding Health First Indiana money or Health First Kosciusko support must be approved by the Health First Kosciusko Coordinator before publication. Statement to include in all correspondence: "Funding provided by the Kosciusko County Health Department via Health First Indiana, learn more at https://www.in.gov/healthfirstindiana/".

3.8 If Health First Indiana funding should stop being provided to Kosciusko County during the term of the Memorandum of Understanding, the Memorandum of Understanding shall be terminated without cause.

The Grantee agrees to explain to any staff hired using Health First Indiana monies that the staff position may be terminated at any time due to budget cuts or elimination of Health First Indiana funding to the County.

3.9 To the fullest extent permitted by law, the Grantee agrees to indemnify, defend, and hold the Kosciusko County Commissioners and Kosciusko County Council, harmless from and against any and all claims, damages, losses and expenses. This clause shall survive the expiration or earlier termination of this agreement.

3.10 This agreement may be changed or modified only in writing signed by both the Kosciusko County Health Department Administrator and the Grantee.

3.11 By providing a signature below, the Grantee agrees to abide by the conditions set forth in this agreement until the date the agreement is no longer in effect.

3.12 This Agreement shall be in effect through December 31, 2026 (month/day/year).

Fellowship Missions

"Grantee"

Authorized Representative Signature

Eric Lane, Exec. Director

Printed Name & Title

Nov. 13, 2025

Date

Kosciusko County Health Department

Authorized Representative Signature

Robert Weaver, Administrator

Printed Name & Title

11-18-25

Date

Kosciusko County Commissioner

Cary Groninger

Commissioner Printed Name

Kosciusko County Commissioner

11-18-2025

Commissioner Signature and Date

The Parties have executed this agreement this 18th day of November, 20 25. (Date provided by the County Commissioner or Health Department Administrator)

HFK0007

$15,000

Fellowship missions

Health First Kosciusko County Request

Mission and Fellowship Missions

Fellowship Missions has served vulnerable individuals and families since 2010, offering shelter, recovery, and life-skills support rooted in the love and hope of Jesus Christ. What began as an emergency shelter has grown into a comprehensive care model that includes addiction recovery, mental health services, and life-skills programming—all designed to help residents achieve long-term self-sufficiency.

To further this mission, we propose adding on-site Nurse Practitioner (NP) support. This initiative will allow us to address health concerns early, reduce ER visits, and break the stigma around seeking care. By providing trusted, compassionate healthcare within our shelter, we can strengthen our wraparound support and help residents move forward with dignity and hope.

Proposal: On-Site Nurse Practitioner Support at Fellowship Missions

To launch this vital initiative, Fellowship Missions is seeking ***$75,000*** in startup funding. This investment will support:

- The hiring of one full-time and one part-time Nurse Practitioner (NP) to provide consistent, compassionate, on-site healthcare for our residents.
- The purchase of essential medical, office equipment, and operational cost needed to onboard Nurse Practitioners to our team.

This funding will allow us to take a critical step forward in expanding our wraparound care model—ensuring that every individual we serve has access to the physical and mental healthcare they need to move forward with dignity, stability, and hope.

Primary Goals:

- Reduce unnecessary emergency room visits by providing timely, on-site care for non-emergency issues.
- Support residents who are hesitant or unable to visit a doctor by offering accessible, trusted healthcare within the shelter.
- Improve continuity of care and enable early intervention for chronic or emerging health concerns.
- Enhance recovery support through on-site administration and management of Vivitrol, a medication used to prevent relapse in opioid and alcohol dependence. Having a Nurse Practitioner (NP) on staff ensures residents receive this treatment safely and consistently, removing barriers to access and improving outcomes.

Fellowship missions

- Proactively address healthcare needs before they escalate. Many residents at Fellowship Missions face significant barriers to accessing care, including past trauma, mistrust of medical institutions, and the stigma associated with seeking help. By embedding a healthcare advocate within the shelter, we can meet residents where they are, both physically and emotionally. This approach builds trust over time, normalizes conversations around health, and helps identify concerns early—before they become crises.
- Break the stigma around seeking care. For many individuals experiencing homelessness, asking for medical help can feel overwhelming or shameful. A compassionate, consistent healthcare presence within the shelter helps humanize care and shift perceptions. The NP not only provides treatment but also serves as a trusted ally—someone who listens without judgment, explains options clearly, and walks alongside residents on their health journey. This advocacy is essential to fostering a culture where seeking care is seen as a strength, not a weakness.
- Decrease staff stress by shifting medical responsibilities to trained healthcare professionals.
- Increase staff satisfaction and retention by creating a more supported and efficient care environment.
- Advance our mission of providing compassionate, holistic support to residents within Fellowship Missions.

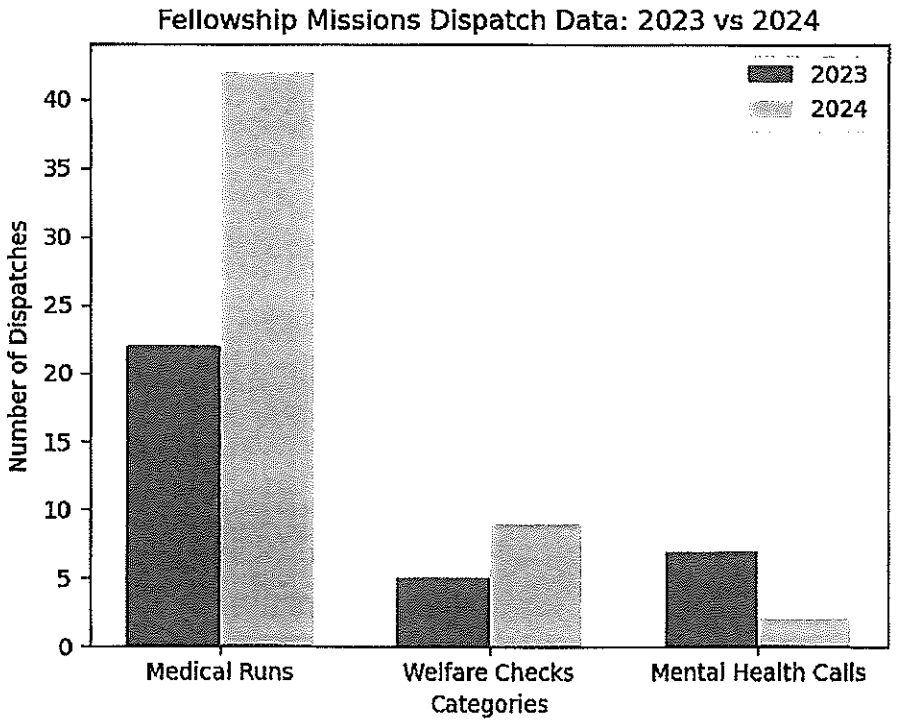
Fellowship missions

Local Dispatch Trends

Recent dispatch data from Fellowship Missions highlights a growing need for on-site medical care:

- Medical Runs increased from 22 in 2023 to 42 in 2024—a 91% rise—indicating a growing number of health-related incidents, some of which may be non-emergency in nature and could be effectively addressed by an on-site Nurse Practitioner, reducing the need for external dispatches and improving timely care.
- Welfare Checks rose from 5 to 9, reflecting more frequent concerns about residents' well-being.
- Mental Health-related calls decreased from 7 to 2, which may correlate with the positive impact of having an on-site mental health therapist.

These trends underscore the importance of embedding qualified medical personnel within the shelter to proactively address health concerns and reduce reliance on emergency services.



Fellowship missions

Benefits to Fellowship Missions and our Community

Since 2010, Fellowship Missions has been a place of refuge and renewal for individuals and families in crisis. Rooted in the love and hope of Jesus Christ, our mission has always been to walk alongside those we serve—offering not just shelter, but a path to healing, recovery, and long-term self-sufficiency.

This proposal to add on-site Nurse Practitioner support is a vital extension of our wraparound care model. By embedding trusted healthcare professionals within our shelter, we can proactively address medical and mental health needs, reduce unnecessary emergency room visits, and break the stigma that often prevents vulnerable individuals from seeking care. This initiative ensures that every resident receives compassionate, consistent support across all areas of life—physical, emotional, and spiritual.

With your support, we can take this important step forward—building a stronger, healthier community where lives are not only protected, but truly transformed through comprehensive, wraparound care.

Attached is the budget for the Nurse Practitioner Proposal and the KPI activity tracker. Please note that the activity trackers are subject to change based on the hiring of the Nurse Practitioner and the funding available to be able to provide the services needed to track the specific KPI's.

Fellowship missions

Fellowship Missions – Nurse Practitioner Program Budget

1. Personnel Costs

Role	Details	Annual Cost
Full-Time Nurse Practitioner	Salary (adjusted to request)	$75,000
Part-Time Nurse Practitioner	20 hours/week	$37,500
Total Personnel Costs		**$112,500**

2. Equipment Costs

Category	Item	Cost
Examination Equipment & Diagnostic Tools	Basic clinical tools and diagnostic supplies	$25,000
Office Setup & Miscellaneous	Computer, printer, software	$10,000
Total Equipment Costs		**$35,000**

3. Operational Costs

Category	Description	Annual Cost
Training & Onboarding	Orientation, EMR training	$6,000
Medical Expense	Subsidy	$10,000
Facility Expenses	Utilities/maintenance	$3,000
Insurance	Insurance	$3,000
Total Operational Costs		**$22,000**

Grand Total $169,500

Health First Funding Request: $75,000

Maternal and Child Health

Prenatal Services (up to time of delivery)

- Number of pregnancy tests provided: ✓
- Number of women referred to prenatal care: ✓
- Number of women provided prenatal services: ✓
  - vitamins: ✓
  - syphilis testing: ✓
  - HIV testing: ✓
  - hepatitis C testing: ✓
  - chlamydia testing: ✓
  - gonorrhea testing: ✓
  - nutrition education: ✓
  - nutrition support: ✓
  - mental health/substance use disorder services: ✓
  - clinical care (from a healthcare provider, such as physician, nurse practitioner, clinic, midwife): ✓
  - immunizations, such as RSV, Tdap, flu: ✓
  - other prenatal services: _____
- Number of women referred to My Healthy Baby: ✓
- Number of women provided mental health/substance use disorder services: ✓
- Number of women referred to health/substance use disorder services: ✓

Postpartum Services (following delivery)

- Number of women referred to postpartum care: ✓
- Number of women provided postpartum services: _____
  - clinical care (state what services): _____
- Number of women provided mental health/substance use disorder services: ✓
- Number of women referred to health/substance use disorder services: ✓
- Number of women provided breastfeeding education or support: _____

- Number of women referred to breastfeeding education or support: _____
- Number of families referred to pediatric care: ✓
- Number of people provided with parenting classes/education: ✓
- Number of families referred to childcare assistance (such as Child Care and Development Fund "CCDF" program): ✓

Health and Safety Services

- Number of people receiving child car safety seats: _____
    - Number of child car safety seats provided: _____
    - Number of car safety seat inspections provided: _____
- Number of people provided safe sleep education: _____
    - Number of people receiving sleep sacks: _____
- Number of cribs provided by LHD or partner: _____
- Number of handle-with-care alerts issued: _____
- Number of women and children referred for active domestic violence assistance: _____
- Number of women and children provided safe, anonymous transport to shelter for victims of domestic violence and interim care/assistance provided: _____
- Number of women and children referred for assistance with physical and mental health recovery from domestic violence: _____
- Number of menstrual period products distributed: _____

Community Assistance

- Number of people referred to substance use disorder treatment/support: ✓
- Number of people referred to/provided care through Mobile Integrated Health: _____
- Number of referrals to housing supports or resources: _____
- Number of families provided with utility/rent assistance: _____
- Number of families screened or referred to developmental services, such as First Steps: _____
- Number of people receiving life skills courses: _____

- Number of families receiving home visiting services, such as a home visiting program: _____
- Number of families referred to home visiting services, such as a home visiting program: _____
- Number of youth and parent cafés hosted: _____
- Number of families referred to an insurance navigator or Medicaid: _____

Contraception/STIs

- ☒ Number of people provided contraceptive education
- ☒ Number of women tested for STIs/HIV
- ☒ Number of women referred for STI/HIV treatment
- ☒ Number of women treated for STIs/HIV

Food and Nutrition

- ☐ Number of women referred to WIC
- ☐ Number of families referred or connected to local food pantries

Other:_____

Childhood Lead Screening and Case Management

Testing

- Number of children tested for blood lead level: ✓
  - Number of children identified with an elevated blood lead level (EBLL) above 3.5 µg/dL: ✓
  - Number of children identified with an EBLL for whom case management was started: _____
- Number of children with an EBLL who were referred to developmental resource services (Head Start, etc.): ✓

Home Services

- Number of homes of children with EBLLs at which the LHD was able to conduct a risk assessment: _____
  - Number of children identified with an EBLL whose homes had an identified lead hazard: _____
- Number of individuals connected with financial assistance for home lead remediation services: _____
- Number of families provided lead cleaning supplies: _____
- Number of families assisted with in-home lead remediation services: _____

Education

- Number of families provided lead education: _____
- Number of health care providers or early childhood providers given lead testing/lead reduction education: _____

❑

Other:_____

Infectious Disease Prevention and Control

Disease Prevention and Control

- Number of outbreaks (or suspected outbreaks) that were investigated: _____
  - Number of outbreaks (or suspected outbreaks) in which the pathogen responsible for the outbreak was identified if known: ✓
- Number of vaccinations given due to disease investigation interviews (e.g., hepatitis A, hepatitis B): ✓

Testing

- Number of people provided HIV testing: ✓
  - Number identified: _____
- Number of people provided hepatitis C testing: ✓
  - Number identified: _____
- Number of people provided syphilis testing: ✓
  - Number identified: _____
- Number of people provided chlamydia testing: ✓
  - Number identified: _____
- Number of people provided gonorrhea testing: ✓
  - Number identified: _____

Referrals and Treatment

- Number of referrals to counseling and/or care for: _____
  - HIV: ✓
  - hepatitis: X
  - syphilis: X
  - chlamydia: X
  - gonorrhea: X
- Number of individuals treated for HCV/HIV/STI (not including syphilis): ✓
- Number of individuals treated for syphilis: ✓

Community Outreach

- Number of people educated on HIV/HCV/STI: ✓
- **Other:** _____

Referrals to Clinical Care

- Number of pediatric referrals for clinical care: ✓
  - obesity/overweight: ✓
  - substance use disorder: ✓
  - mental health services: ✓
  - general: ✓
- Number of adult referrals for clinical care: _____
  - hypertension: ✓
  - diabetes: ✓
  - obesity: ✓
  - HIV: ✓
  - hepatitis: ✓
  - syphilis: ✓
  - chlamydia: ✓
  - gonorrhea: ✓
  - substance use disorder: ✓
  - mental health services: ✓
  - general: ✓
- Number of individuals referred to insurance navigation or Medicaid/Medicare: _____

Other:_____

Tuberculosis (TB) Prevention and Case Management

- Number of people provided TB testing (IGRA or TST): ✓
- Number of people provided treatment for latent TB infection (LTBI): _____
- Number of people provided treatment for TB disease: _____
- Number of Directly Observed Therapy (DOT) services provided: _____
- Number of people supported with food/housing assistance: _____
- Number of people educated on TB: _____
- Number of B1 immigration reviews: _____
- Number of referrals to wraparound services: _____

Chronic Disease Prevention

Screening and Referrals

- Number of people screened for high blood pressure through local health department or partners: ✓
    - Number of people identified with undiagnosed high blood pressure through local health department or partners: ✓
- Number of people screened with a hemoglobin A1c through local health department or partners: ✓
    - Number of people identified with elevated hemoglobin A1c: ✓
- Number of people screened for diabetes risk factors through local health department or partners: ✓
    - Number of people referred to or enrolled in a diabetes prevention program: ✓
    - Number of people referred to or enrolled in a diabetes self-management education support program: ✓
- Number of people screened for high cholesterol through local health department or partners: ✓
    - Number of people identified with high cholesterol: ✓
- Number of people screened for cancer through local health department activity (breast, colon cancer, etc.): ✓
- Number of people screened for BMI: ✓
    - Number of people referred to a weight treatment or obesity prevention program: ✓
    - Number of people identified as having a BMI over 30: ✓
- Number of individuals with asthma who receive an in-home trigger assessment: ✓
- Number of people referred for chronic disease preventative care: ✓
- Number of people referred for cancer screening: ✓
- Number of people provided for cancer screening: ✓
- Number of people screening positive for food insecurity: ✓
    - Number of people referred to a food assistance program: ✓

- Number of people referred to the IDOH Breast and Cervical Cancer Program: ✓

Programming

- Number of adults participating in nutrition and physical activity education programming: ✓
- Number of seniors participating in nutrition and physical activity education programming: ✓
- Number of cancer risk reduction and prevention programs provided by the LHD: ✓
- Number of cancer survivorship related services provided (smoking cessation resources, cancer support groups, respite opportunities for caregivers): ✓

Other:

Access and Linkage to Clinical Care

Screening and Referrals

- Number of people screened for high blood pressure through local health department or partners: ✓
    - Number of people identified with undiagnosed high blood pressure through local health department or partners: ✓
- Number of people screened with a hemoglobin A1c through local health department or partners: ✓
    - Number of people identified with elevated hemoglobin A1c: ✓
- Number of people screened for diabetes risk factors through local health department or partners: ✓
    - Number of people referred to or enrolled in a diabetes prevention program: ✓
    - Number of people referred to or enrolled in a diabetes self-management education support program: ✓
- Number of people screened for high cholesterol through local health department or partners: ✓
    - Number of people identified with high cholesterol: ✓
- Number of people screened for cancer through local health department activity (breast, colon cancer, etc.): ✓
- Number of people screened for BMI: ✓
    - Number of people referred to a weight treatment or obesity prevention program: ✓
    - Number of people identified as having a BMI over 30: ✓
- Number of individuals with asthma who receive an in-home trigger assessment: ✓
- Number of people referred for chronic disease preventative care: ✓
- Number of people referred for cancer screening: ✓
- Number of people provided for cancer screening: ✓
- Number of people screening positive for food insecurity: ✓
    - Number of people referred to a food assistance program: ✓

- Number of people referred to the IDOH Breast and Cervical Cancer Program: ✓

Programming

- Number of adults participating in nutrition and physical activity education programming: ✓
- Number of seniors participating in nutrition and physical activity education programming: ✓
- Number of cancer risk reduction and prevention programs provided by the LHD: ✓
- Number of cancer survivorship related services provided (smoking cessation resources, cancer support groups, respite opportunities for caregivers): ✓

Other:_____