

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES

REQUEST FOR PROPOSALS

**SERVICES FOR SUBSTANCE ABUSE PREVENTION
HUNTERDON COUNTY**

Funding Opportunity – Community-Based Services

Priority: Prescription Drug Abuse

April 20, 2015

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Division of Mental Health and Addiction Services

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I. Purpose and Intent

The Department of Human Services (DHS) Division of Mental Health and Addiction Services (DMHAS) is issuing this Request for Proposals (RFP) for Services for Substance Abuse Prevention in Hunterdon County, New Jersey. The guidelines and requirements specified in this document were developed by DMHAS in accordance with and support of the DMHAS Substance Abuse Prevention Strategic Plan. This RFP contains funding opportunities for community-based services for prevention of prescription drug abuse in Hunterdon County. Funding for all services will be provided by the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant and administered by DMHAS. **Total annualized funding availability, subject to appropriations, is \$50,000.** DMHAS anticipates making up to one award.

Eligible bidders are encouraged to carefully review the RFP to determine the goals that can best be achieved that address risk and protective factors for the target population(s) that it proposes to serve. Bidders should pay special attention to the “Standards for Agencies Providing Substance Abuse Prevention Services for the Department of Human Services/Division of Mental Health and Addiction Services (DHS/DMHAS),” attached to this RFP. Only those bidders that have the capacity to uphold these operational and programmatic standards should consider applying for funds.

Cost sharing is not required. Actual funding levels will depend on the availability of funds. This RFP will provide funding for substance abuse prevention services for a five (5) year period, 2015-2019. Annual continuation and renewal are subject to availability of funds, satisfactory performance, as well as compliance and completion of all required/requested data collection and reporting.

The following summarizes the RFP schedule:

April 20, 2015	Notice of Funding Availability
May 11, 2015	Deadline for receipt of proposals - no later than 5:00 p.m.
June 5, 2015	Preliminary award announcement
June 12, 2015	Appeal deadline
June 19, 2015	Final award announcement
August 1, 2015	Award start date

II. Background and Population to be Served

In late 2010, DMHAS began a strategic prevention planning process to guide the development and implementation of new programming, and to evaluate its prevention goals as a means of guiding the organization’s actions and decision-making with respect to prevention activities. There are numerous and often competing issues of concern to the community. In order to reflect its commitment to inclusiveness and collaboration in statewide planning, the Division sought the counsel of stakeholders to determine priority areas.

Through a competitive application process, 15 community members were selected to serve on the Planning Committee. Thirty applications were received, and applications were scored based on criteria such as the bidder's experience in/familiarity with prevention, and experience participating in planning workgroups. In addition, DMHAS reached out to all state departments and divisions that provide prevention programming to their service population and requested they provide a representative to serve on the Planning Committee.

Beginning in October 2010, the Planning Committee met monthly to complete the first three (3) of five (5) sections of the plan. Workgroups met more frequently based upon a schedule determined by workgroup members. The group reconvened in the fall of 2012 to complete the final two (2) sections of the plan.

DMHAS PREVENTION GOALS

DMHAS has identified four (4) goals to achieve in meeting its mission related to substance abuse prevention, which are:

1. New Jersey's citizens have access to the prevention services they need, which are identified by means of an intensive data-driven needs assessment process;
2. Substance abuse and its harmful consequences are prevented;
3. Services and programs are cost-effective and resources are maximized; and
4. Partnerships with communities are created and sustained to assess, develop, implement, and advocate for prevention policies, programs, and services.

PURPOSES OF THE PLAN

Acting upon its commitment to prevent substance abuse and its harmful consequences, and as specified in DMHAS' Strategic Planning Project Charter, DMHAS sought to:

1. Develop a data-driven five-year Addiction Prevention Strategic Plan that will become a roadmap for DMHAS-funded statewide prevention activities and funding decisions;
2. Address the Center for Substance Abuse Prevention's (CSAP) recommendation that New Jersey develop a unified strategic plan for prevention services;
3. Align primary stakeholder groups' prevention efforts and resources with the identified priority areas;
4. Use the Addiction Prevention Strategic Plan to guide prevention decision making and policy development at the State, County, and provider levels; and
5. Create an infrastructure to guide the continued development of DMHAS' Prevention Outcomes Management System (POMS) to collect environmental, outcome, and performance indicator data.

Further, DMHAS determined that the Addiction Prevention Strategic Plan would:

1. Be developed jointly by DMHAS staff and stakeholders who participated in the Planning Committee and/or its work groups;
2. Utilize data to determine the substance abuse prevention needs in New Jersey;

3. Indicate the types of prevention services to be offered in New Jersey;
4. Estimate New Jersey's capacity to provide these services and specify capacity gaps, where identified;
5. Identify planning principles that will be used in this planning process;
6. Offer an implementation strategy to realize the recommendations in the Plan; and
7. Include the intention to evaluate the effectiveness of DMHAS in meeting its goals, objectives, activities, key products, and outcomes.

DMHAS PREVENTION FRAMEWORK

DMHAS seeks to institutionalize a systematic approach to prevention that synthesizes and strengthens knowledge from multiple disciplines and addresses substance abuse and its related societal concerns based upon the following tenets:

- Health is more than healthcare or the absence of injury or disease;
- The environment in which we live profoundly shapes our health and well-being;
- Prevention requires commitment and dedication; and
- Prevention offers hope by saving lives and money.

Additionally, DMHAS seeks to fund programs and strategies that:

- Apply a comprehensive strategy across diverse disciplines, populations, and issues;
- Respond to and address national priorities and directives as identified by Federal funders;
- Advance changes in social norms and systems;
- Advocate for solutions that concurrently impact multiple problems;
- Research, synthesize, and disseminate information that builds upon successes;
- Inspire a broad vision and fresh approach that incorporates a variety of strategies;
- Are responsive to, and reflective of, community needs including culturally diverse communities and individuals with special needs;
- Acknowledge the importance of a comprehensive approach to prevention that includes both individual and family-focused evidence based curricula as well as environmental approaches;
- Integrate a community and policy orientation into prevention practice that utilizes a multi-dimensional approach to risk and protective factors in order to impact multiple problems and communities; and
- Expand the field by encouraging new participants, dialogue, and explorations.

UTILIZING A PUBLIC HEALTH APPROACH TO PREVENTION

Both DMHAS and the Planning Committee acknowledge the importance and utility of a public health approach to substance abuse prevention that is based on the following six (6) key principles:

1. Prevention is an ordered set of steps along a continuum to promote individual, family, and community health, prevent behavioral disorders, support resilience and recovery, and prevent relapse;
2. "Prevention is prevention is prevention." That is, the common components of effective prevention for the individual, family or community within a public health model are the same;
3. Common risk and protective factors exist for many substance abuse and mental health problems. Good prevention focuses on these common risk factors that can be altered. Risk and protective factors exist in the individual, the family, the community and the broader environment;
4. Resilience is built by developing assets in individuals, families, and communities through evidence-based health promotion and prevention strategies;
5. Systems of prevention services work better than service silos. Implementing these strategies within a broader system of services increases the likelihood of successful, sustained prevention activities. Collaborative partnerships enable communities to leverage scarce resources and make prevention everyone's business; and
6. Baseline data, common assessment tools, and outcomes shared across service systems can promote accountability and effectiveness of prevention efforts.

This framework represents a foundation that, if integrated into the structure and function of the community system, can potentially impact and prevent alcohol and substance abuse, while reducing violence, teenage pregnancy, crime, absenteeism, school drop-out, delinquency and other social problems throughout the lifespan. As such, DMHAS seeks to ensure that all funded programs and strategies offer the potential to effectuate lasting change by ultimately improving the capacity of the prevention system to work with many sectors to improve the health status of all people in a community.

Terms used in this RFP that have specific meanings related to substance abuse prevention programs are defined in the Attachment "*Standards for Agencies Providing Substance Abuse Prevention Services for the DHS/DMHAS.*"

III. Who Can Apply?

To be eligible for consideration for this RFP, the bidder must satisfy the following requirements:

- The bidder must be a non-profit or governmental entity;
- For a bidder that has a contract with DMHAS in place when this RFP is issued, that bidder must have all outstanding Plans of Correction (PoC) for deficiencies submitted to DMHAS for approval prior to submission;
- The bidder must be fiscally viable based upon an assessment of the bidder's audited financial statements;
- The bidder must not appear on the State of New Jersey Consolidated Debarment Report at <http://www.state.nj.us/treasury/debarred/debarsearch.htm> or be suspended or debarred by any other State or Federal entity from receiving funds;

- The bidder shall not employ a member of the Board of Directors in a consultant capacity;
- Pursuant to N.J.S.A. 52:32-44, a for-profit bidder and each proposed subcontractor must have a valid Business Registration Certificate on file with the Division of Revenue, i.e., this statutory requirement does not apply to non-profit organizations, private colleges and universities, or state and municipal agencies; and
- The bidder must comply with the terms and conditions of DHS' contracting rules and regulations as set forth in the Standard Language Document, the Contract Reimbursement Manual (CRM) and the Contract Policy and Information Manual (CPIM). These documents are available on the web at: <http://www.state.nj.us/humanservices/ocpm/home/resources/manuals>.

IV. Contract Scope of Work

DMHAS defines prevention as a proactive, evidence-based process that focuses on increasing protective factors and decreasing risk factors that are associated with alcohol and drug abuse in individuals, families, and communities. DMHAS' approach to alcohol and substance abuse prevention and the conceptual framework that supports it has continuously evolved over time. It is based on emerging national research findings and the State's experience in program development, implementation and evaluation. Current research regarding prevention continues to prove that effective substance abuse prevention must include evidence-based strategies for addressing risk and protective factors across multiple domains. In addition, these strategies must be implemented at appropriate levels of intensity and in appropriate settings such as schools, workplaces, homes and community venues. Community Anti-Drug Coalitions of America (CADCA) has developed the following effective strategies that are essential components of lasting community change (the first three (3) are of particular relevance to the types of programs this RFP will fund):

1. Providing Information - Educational presentations, workshops or seminars or other presentations of data (e.g., public announcements, brochures, dissemination, billboards, community meetings, forums, web-based communication);
2. Enhancing Skills - Workshops, seminars or other activities designed to increase the skills of participants, members and staff needed to achieve population level outcomes (e.g., training, technical assistance, distance learning, strategic planning retreats, curricula development);
3. Providing Support - Creating opportunities to support people to participate in activities that reduce risk or enhance protection (e.g., providing alternative activities, mentoring, referrals, support groups or clubs);
4. Enhancing Access/Reducing Barriers - Improving systems and processes to increase the ease, ability and opportunity to utilize those systems and services (e.g., ensuring healthcare, childcare, transportation, housing, justice, education, safety, special needs, cultural and language sensitivity);

5. Changing Consequences (Incentives/Disincentives) - Increasing or decreasing the probability of a specific behavior that reduces risk or enhances protection by altering the consequences for performing that behavior (e.g., increasing public recognition for desired behavior, individual and business rewards, taxes, citations, fines, revocations/loss of privileges);
6. Physical Design - Changing the physical design or structure of the environment to reduce risk or enhance protection (e.g., parks, landscapes, signage, lighting, outlet density); and
7. Modifying/Changing Policies - Formal change in written procedures, by-laws, proclamations, rules or laws with written documentation and/or voting procedures (e.g., workplace initiatives, law enforcement procedures and practices, public policy actions, systems change within government, communities and organizations).

The risk and protection-focused prevention framework that DMHAS has historically endorsed is based on the work of Hawkins and Catalano and recognizes specific research-based risk and protective factors that are present in four (4) domains or broad areas of life: Individual/Peer Relationships; Family Relationships; School Environment; and Community Environment. The most effective prevention programs incorporate strategies that address risk factors across more than one (1) of these domains.

DMHAS defines prevention as a process that not only addresses the reduction of risk factors, but also seeks to enhance or increase protective factors. Risk factors tell us what to focus on to reduce unhealthy behaviors such as substance abuse. Protective factors are those characteristics and processes that have been shown by research to mediate the negative effects of exposure to risk factors by young people. Information regarding risk and protective factors can be found online at: <http://www.state.nj.us/humanservices/das/prevention/factors/>.

When using this framework, it is important to remember that:

- Individuals face alcohol and substance abuse risk factors in several domains;
- Different risk factors are related to different periods of development;
- The more risk factors that are present, the greater the risk for alcohol and substance abuse;
- When many risk factors are present, multiple protective factors have a buffering effect on risk, reducing the likelihood of substance abuse;
- Risk and protective factors show consistency over time and across different races, cultures and classes;
- While focusing on the multiple risks that individuals face, it is equally important to increase protective factors; and
- Prevention programs that strengthen the individual's protective factors by providing opportunities, skills and rewards and by developing consistent norms and standards for behavior across families, school, communities and peer groups are more likely to be effective.

This framework represents a foundation that, if integrated into the structure and function of the community system, can potentially impact and prevent not only alcohol and substance abuse, but assist in preventing violence, teenage pregnancy, crime, absenteeism, school drop-out, delinquency and other social problems throughout the lifespan. As such, DMHAS seeks to not merely fund the delivery of prevention programs, but to ensure that funded programs offer the potential to effectuate lasting change by ultimately improving the capacity of the prevention system to work with many sectors to improve the health status of all people in a community.

Hunterdon County has been assigned a priority-based funding allocation based on its relative need. This allocation is determined based on the presence and intensity of social indicators, past 30-day use rates, treatment admission rates, as well as need and risk factors in Hunterdon County.

Bidders are required to utilize evidence-based programs developed for use with individuals and families. Environmental-type programs such as Community Trials Intervention and Communities Mobilizing for Change will not be funded.

DMHAS highly recommends, though does not require, that bidders have an office or administrative presence in Hunterdon County. Services are required to be delivered in Hunterdon County to residents of Hunterdon County.

Bidders will be required to address the risk and protective factors specific to the prevention priority identified in this RFP as well as the population (e.g. families, middle or high school students, older adults, workplaces, etc.) that they propose to serve. Bidders must provide quantitative data to substantiate the need for the substance abuse prevention services within the community and population they intend to target. Many of these data are available at <http://www.state.nj.us/humanservices/das/news/reports/>.

Additionally, helpful information provided by the Robert Wood Johnson Foundation and the University of Wisconsin is available online at <http://www.countyhealthrankings.org/app/new-jersey/2014/overview>.

In identifying the most appropriate prevention program(s) to address the risk and protective factors of the target population and priority, it would be very worthwhile to consider the prevention priorities identified by the Municipal Alliances that are funded by the Governor's Council on Alcoholism and Drug Abuse (GCADA) and coordinate prevention efforts with those of the Municipal Alliance(s) in the community. A list of Municipal Alliance priorities can be found here: <http://www.state.nj.us/humanservices/das/prevention/resources/>.

The goals of this project are meant to address the prevention priorities identified by DMHAS' Prevention Strategic Planning Committee and to complement and reflect the first of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Eight (8) Strategic Initiatives.

The DMHAS Strategic Planning committee formed needs assessment, capacity, and planning sub-committees to analyze existing data on addictions in the state population and current prevention resources. These data provided the foundation for identifying and selecting the following prevention priority for Hunterdon County:

1. Reduce prescription medication misuse across the lifespan.

Opioids and Medication Misuse: Mortality data associated with prescription drug/opioid use have demonstrated a steady increase in deaths for all but one age group (35-44 years of age). From 2004 to 2011, there was a 41% increase in deaths associated with prescription drug/opioid involvement (325 to 458). The percentage of deaths for persons 24 years of age and under increased from 9.8% of the total deaths in 2004 to 14% of the total deaths in 2011. The total deaths for persons 24 years of age and under increased by 100% during this eight year period (32 to 64).

New Jersey State Prescription Opioid-Involved Deaths by Age*

Age	2007	2008	2009	2010	2011	2012	2013
Under 18	8	4	3	4	10	11	14
19-24	43	55	53	52	54	68	78
25-34	115	87	105	111	102	166	207
35-44	168	102	116	125	104	112	142
45-54	116	113	123	115	128	140	151
55-64	32	31	26	35	56	55	67
65 +	1	6	8	7	4	7	8
Total	483	398	434	449	458	559	667

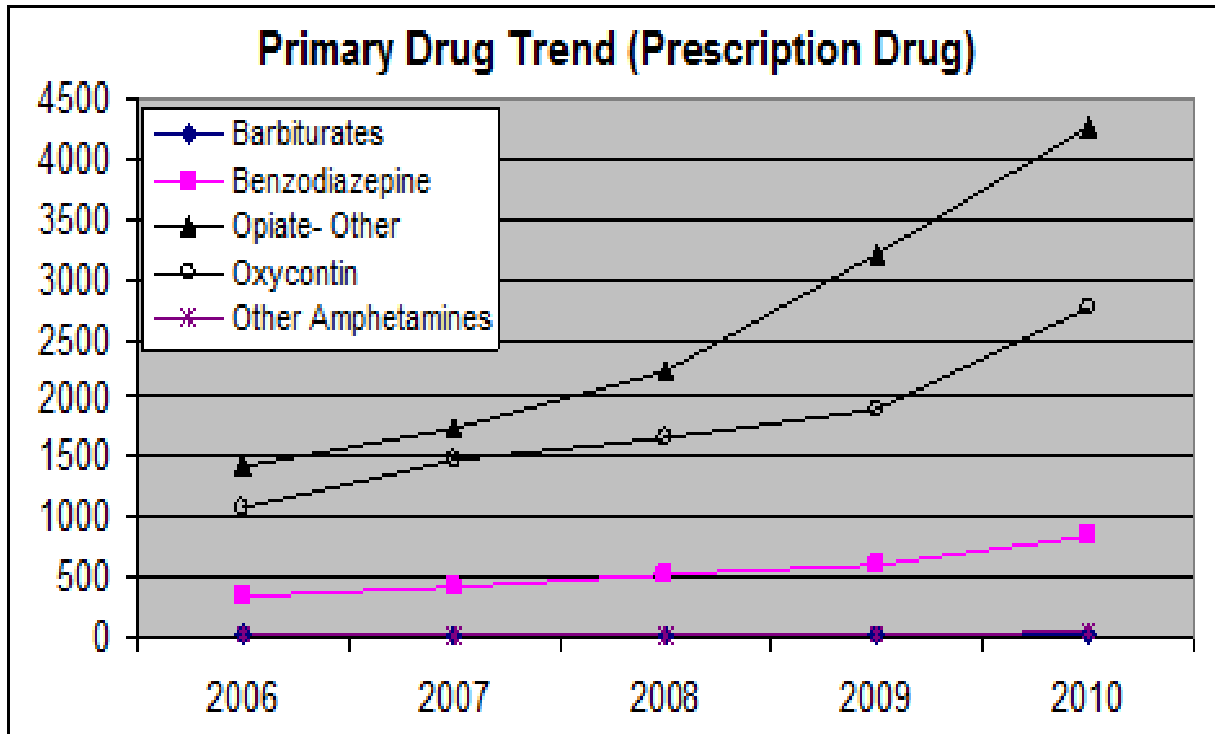
*New York/New Jersey High Intensity Drug Trafficking Area 2012 Drug Abuse Assessment Report (via the New Jersey State Medical Examiner's Office)

NJ SAMS Treatment Admissions 2009-2012

Year	Age	Alcohol	Heroin	Other Opiates*
2009	<18	565	138	71
	18-25	3480	5875	2016
	60+	758	239	42
2010	<18	422	112	79
	18-25	3861	5566	3133
	60+	950	220	49
2011	<18	389	76	92
	18-25	4160	6370	3571
	60+	826	223	85
2012	<18	411	118	99
	18-25	3933	7337	2993
	60+	891	346	88
Change 2009-2012	<18	-27%	-15%	39%
	18-25	13%	25%	49%

	60+	18%	45%	110%
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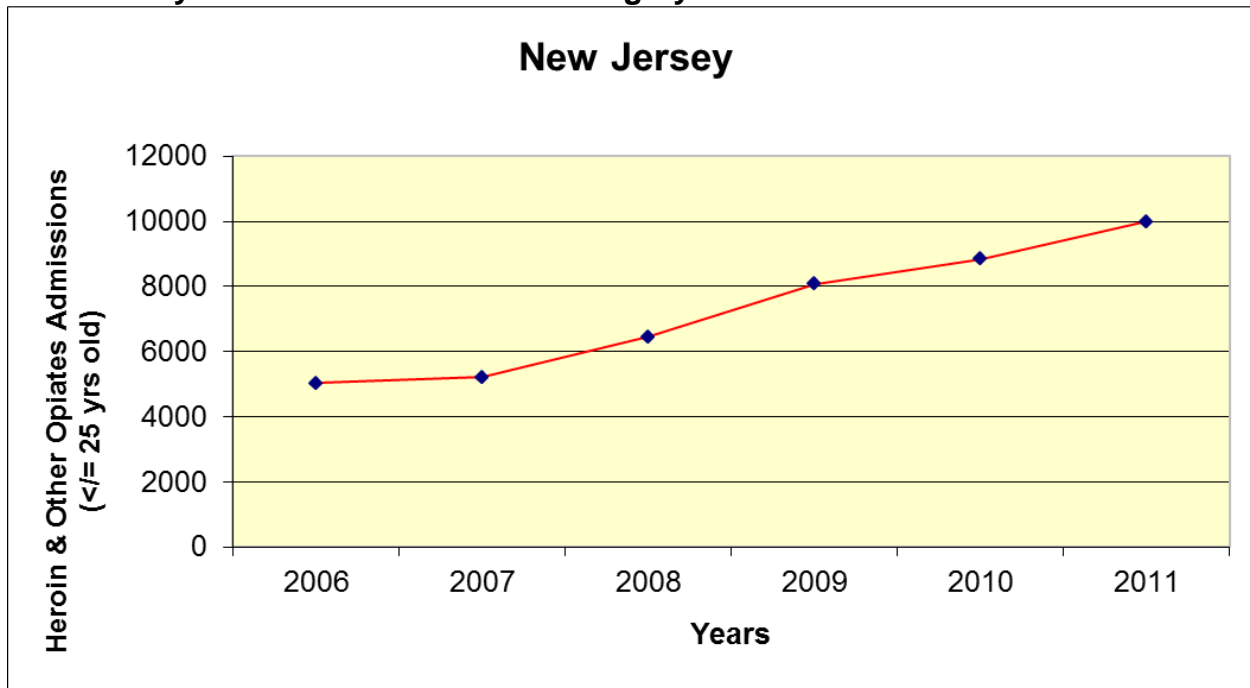
*Other opiates: Methadone (non-prescription use), Oxycontin, and Opiate Other



High School Risk & Protective Factor Survey - Prevalence of Prescription Drug Use by Subgroups

	<u>Lifetime %</u>	<u>Past Year %</u>
NJ High School Students	15	12
<i>Grade</i>		
9 th /10 th	13	10
11 th /12 th	17	14
<i>Gender/Sex</i>		
Male	13	10
Female	17	14
<i>Race/Ethnicity</i>		
White	17	15
African-American	8	5
Hispanic	14	10
Other	12	8.7

New Jersey Substance Abuse Monitoring System Data on Treatment Admissions



- Statewide Annual Increase between 2006-2011 = 99%
- Annual admissions for Heroin & Other Opiates have nearly doubled from 2006 to 2011 (99.01%)
- Counties annual admissions increases split around state increase: 10 counties > 99%; 11 counties < 99%
- There was an increase of nearly 5,000 total annual admissions from '06-'11 (4976): 35% attributable to persons from Ocean and Monmouth Counties seeking treatment (1754)
- For most years, admissions for Ocean and Monmouth Counties combined have exceeded 25% of total state admissions
- One regional pattern: three (3) counties with highest increases are shore counties (Cape May, Ocean, Monmouth)

SAMHSA has identified eight (8) strategic initiatives to focus its resources on areas of urgency and opportunity. The initiatives also will enable SAMHSA to respond to national, state, territorial, tribal, and local trends and support implementation of the Affordable Care Act and the Mental Health Parity and Addictions Equity Act.

SAMHSA's Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness

This entails creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the likelihood of mental illness, substance abuse including tobacco, and suicide. This Initiative will include a focus on the Nation's high-risk youth, youth in Tribal communities, and military families.

The promotion of positive mental health and the prevention of substance abuse and mental illness have been key components of SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. The evidence base in this area continues to grow and was summarized by the 2009 Institute of Medicine (IOM) report, *Preventing Mental, Emotional, and Behavioral Disorders among Young People*. The Affordable Care Act places emphasis on prevention and promotion activities at the community, State, Territorial, and Tribal levels. By means of this Federal Initiative, SAMHSA is working to take advantage of the opportunities presented by the Affordable Care Act and the growing evidence base behind prevention to achieve the following goals:

Goal 1.1: With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.

Goal 1.2: Prevent or reduce consequences of underage drinking and adult problem drinking.

Goal 1.3: Prevent suicides and attempted suicides among populations at high risk, especially military families, LGBTQ youth, and American Indians and Alaska Natives.

Goal 1.4: Reduce prescription drug misuse and abuse.

Additionally, the "National Prevention and Health Promotion Strategy", which was introduced on June 16, 2011, includes actions that public and private partners can take to help Americans stay healthy and fit. It helps move the nation away from a health care system focused on sickness and disease to one focused on wellness and prevention. Two (2) of the seven (7) priority areas identified in the National Prevention and Health Promotion Strategy are of particular relevance to the goals this RFP seeks to achieve: 1) preventing drug abuse and excessive alcohol use and 2) mental and emotional well-being.

Effective January 1, 2015, all DHMAS-funded prevention providers will be required to employ a staff member who has earned the Certified Prevention Specialist (CPS) credential. Providers who do not meet this requirement on January 1, 2015 will have until December 31, 2016 to hire a staff person with a CPS, or provide CPS training for an existing staff member. Credentials or degrees that will be accepted in lieu of the CPS are the Certified Health Education Specialist (CHES), Masters in Public Health (MPH), or a Doctoral degree in the medical, health, or behavioral sciences. This requirement is described in the "Standards for Agencies Providing Substance Abuse Prevention Services for the DHS/DMHAS."

Awardees must adhere to all applicable State and Federal cost principles. Budgets should be reasonable and reflect the scope of responsibilities in order to accomplish the goals of this project.

If the contract(s) resulting from this RFP includes drug treatment services, then the contract awardee must have in place established, facility-wide policies that prohibit discrimination against consumers of prevention, treatment and recovery support services assisted in their prevention, treatment and/or recovery with legitimately prescribed medication(s). These policies must be in writing in a visible, legible and clear posting at a common location accessible to all who enter the facility.

Moreover, no consumer admitted into a treatment facility, or a recipient of or participant in any prevention, treatment or recovery support services, shall be denied full access to, participation in and enjoyment of that program, service or activity, available or offered to others, due to the use of legitimately prescribed medications.

Capacity to accommodate consumers who present or are referred with legitimately prescribed medications can be accomplished either through direct provision of services associated with the provision or dispensing of medications and/or via development of viable networks/referrals/consultants/sub-contracting with those who are licensed and otherwise qualified to provide medications.

V. General Contracting Information

All bidders will be notified in writing of the State's intent to award a contract. All proposals are considered public information and as such will be made available for a defined period after announcement of the contract awardees and prior to final award, as well as through the State Open Public Records Act process at the conclusion of the RFP process.

The contract awarded as a result of this RFP may be annually renewable at DMHAS' sole discretion with the agreement of the awardee. Funds may only be used to support services that are specific to this award; hence, this funding may not be used to supplant or duplicate existing funding streams. Actual funding levels will depend on the availability of funds and satisfactory performance.

In accordance with DHS Policy P1.12 available on the web at www.state.nj.us/humanservices/ocpm/home/resources/manuals/index.html, programs awarded pursuant to this RFP will be separately clustered until the DMHAS determines, in its sole discretion, that the program is stable in terms of service provision, expenditures, and applicable revenue generation.

Should service provision be delayed through no fault of the provider, funding continuation will be considered on a case-by-case basis based upon the circumstances creating the delay. In no case shall the DMHAS continue funding when service commencement commitments are not met, and in no case shall funding be provided for a period of non-service provision in excess of three (3) months. In the event that the timeframe will be longer than three (3) months, DMHAS must be notified so the circumstances resulting in the anticipated delay may be reviewed and addressed.

Should services not be rendered, funds provided pursuant to this agreement shall be returned to the Division.

The bidder must comply with all rules and regulations for any DMHAS program element of service proposed by the bidder. Awardees must uphold all programmatic standards outlined in the “Standards for Agencies Providing Substance Abuse Prevention Services for DHS/DMHAS,” attached to the RFP. These standards are intended to ensure that prevention programs funded by DMHAS achieve their desired outcomes. A site visit may be conducted to bidders before a contract is awarded. The site visit will determine the applicant’s capacity to maintain these standards.

VI. Written Intent to Apply and Contact for Further Information

Bidders are requested to email RFP.submissions@dhs.state.nj.us indicating their organization’s intent to submit a proposal. Submitting a notice of intent to apply does not obligate an organization to submit a proposal.

Any questions regarding this RFP should be directed via email to RFP.submissions@dhs.state.nj.us no later than April 27, 2015. All questions and responses will be compiled and emailed to all those who provided a notice of intent to apply on or before May 4, 2015. Bidders are guided to rely upon the information in this RFP and the responses to questions that were submitted by email to develop their proposals. **Specific guidance, however, will not be provided to individual applicants at any time.**

VII. Required Proposal Content

Proposals must address the following topics, and be submitted according to the following sections:

Funding Proposal Cover Sheet (RFP Attachment A)

Bidder History and Recent Experience/Performance (10 points)

1. A brief narrative describing the bidder’s history and mission, its primary purpose, current licenses and modalities, target population and the number of years’ experience working with the target population.
2. The bidder’s experience in providing the history and record of accomplishment in providing substance abuse prevention services within the specific domain identified by the county in this RFP.
3. Include any information on how the agency has achieved desired outcomes in the past (i.e., an increase in protective factors and a reduction in risk factors within the domain). Include data to support these results.

4. Attach an organizational chart and identify where the program will fit into the existing structure.
5. The bidder's plan to bring the initiative to a conclusion at the end of the contract.
6. The bidder's current status and history relative to debarment by any State, Federal or local government agency. If there is debarment activity, it must be explained with supporting documentation as an appendix to the bidder's proposal.
7. Description of all active litigation in which the bidder is involved, including pending litigation of which the bidder has received notice.
8. Description of the bidder's ability to provide culturally competent services.
9. Describe if the bidder is currently meeting contract commitments in regard to level of service.

Needs and Resource Assessment (20 points)

Bidders should identify data sources when responding to the questions below.

1. Which risk factors in the community are related to the prevention priority the bidder has chosen to address? Include social indicator data to demonstrate how prevalent these risk factors are.
2. How prevalent are these problems/issues among the population proposed to serve?
3. How important are these problems/issues to different sectors of the community (e.g., parents, youth, service providers, the faith community, policymakers, etc.)?
4. What factors in the community, families, or individuals protect people from these problems/issues?
5. Which resources already exist in the community to address the targeted problem, either through reducing risk factors or strengthening protective factors?

Bidders are directed to use the following processes in conducting their needs assessment related to the identified prevention priorities.

- a. Consider the priorities according to:
 - Consequences and social costs in Hunterdon County;
 - Consumption levels and prevalence of use; and
 - Causal factors (i.e., risk and protective factors) that predict population prevalence.
- b. Also use the following criteria to further refine the selection of prevention strategies:
 - Substances most commonly used/abused that impact the greatest numbers residents in Hunterdon County; and

- Substances that lead to the most severe consequences for the greatest numbers of residents in Hunterdon County.

Goals (10 points)

Prepare and present a five (5) year goal statement that the program will adopt based on the Needs and Resource Assessment.

Goals should be identified for all services that the program participants will receive from the beginning until the end of the program. Goals are broad statements that describe the desired long-term impact of what the bidder wants to accomplish. The bidder's goal statement should be the driving force behind the prevention programming it intends to implement. The goal statement should be the touchstone against which everything done on the project is measured. A good project goal statement is SMART (Specific, Measurable, Agreed-upon, Realistic and Time-framed).

- *Specific* - The goal should state exactly what the organization plans to accomplish. It should be phrased using action words (such as "design," "build," "implement," etc.). It should be limited to those essential elements of the project that communicate the purpose of the project and the outcome expected.
- *Measurable* - If you can't measure it, you can't manage it. In the broadest sense, the whole goal statement is a measure for your project; if the goal is accomplished, the project is a success. However, there are usually several short-term or small measurements that can be built into the goal. Caution: Watch for words that can be misinterpreted such as improve, increase, and reduce (by how much?). If you must include them, be sure to include how they will be measured.
- *Agreed-upon* - Those individuals in the organization who control the resources necessary to complete the project need to agree that it is important. In addition, those who will be impacted by the project should agree that it needs to be done (and this is a key aspect of your needs assessment).
- *Realistic* - This is not a synonym for "easy." Realistic, in this case, means "doable." It means that the learning curve is not a vertical slope; that the skills needed to do the work are available; that the project fits with the overall strategy and goals of the organization. A realistic project may push the skills and knowledge of the people working on it but it shouldn't break them. This consideration is related to the "capacity" of the bidder to undertake the project.
- *Time-framed* - Probably one of the easiest parts of the goal to establish the deadline. Very little is ever accomplished without a deadline. Building the deadline into the project goal keeps it in front of the team and lets the organization know when they can expect to see the results. The deadline can specify when the project or program will begin, when it will achieve certain milestones, and when it will end.

Objectives (Outcome Statements) (10 points)

Describe the specific changes in attitude, knowledge and behavior of the program's participants or changes in the environment that will occur as a result of the program. Objectives should be identified for all services that the program participants will receive from the beginning until the end of the program.

Objectives (Outcome Statements) are changes that occur as a result of specific programs. Typically, objectives are related to changes in the following.

- *Knowledge* - What people learn or know about a topic (e.g., warning signs of marijuana use, effective ways for setting limits with adolescents).
- *Attitudes* - How people feel toward a topic (e.g., attitudes toward substance abuse, merchants' attitudes toward selling alcohol to minors).
- *Behaviors* - Changes in behavior (e.g., reduced use of alcohol among middle school youth, increased frequency in "carding" underage youth attempting to buy cigarettes).
- *Skills* - The development of skills to prevent substance abuse (e.g., peer refusal skills, parental supervision skills).

In order to be quantified and measurable, objectives must include the following information:

- Who or what is to change?
- In what direction will the changes occur (increase/decrease)?
- How much change (percentage) is anticipated?
- What is the projected time frame for change to occur?

Methods (20 points)

Methods describe the services to be conducted to achieve the desired objectives. Bidders are required to use multiple strategies in multiple settings to work toward a common goal.

Bidders must choose evidence-based programs from one (1) of the registries listed below. Identify reasons the selected curriculum is appropriate to the risk and protective factors that have been selected and the goals and objectives of the proposed program.

Describe how the bidder will incorporate all curriculum components in order to ensure program fidelity.

Provide a narrative depicting the services that individuals and/or families will receive when they participate in the program. The narrative should describe how participants will be identified and the frequency with which services will be provided. A description

of ancillary services that will support education services (i.e., mentoring, recreational and cultural activities, and community service) should be also be provided.

Describe the setting(s) or location(s) used for program implementation (i.e., school, church, or housing site). Note: the same settings may be used for more than one (1) program/strategy.

Describe how the proposed program/strategy fits with other community prevention activities that address the needs of the population to be served.

Describe when each proposed prevention activity will begin and end, and the expected program achievements for each.

Describe how the organization will collaborate with and coordinate its efforts with those of the local DMHAS-funded Regional Coalition.

Awardees must utilize evidence-based programming. Bidders should select programs that target the risk and protective factors related to the priority they will be addressing. Programs must be listed on one (1) of the following registries:

1. Blueprints for Healthy Youth Development (select programs identified as “Model”): <http://www.blueprintsprograms.com/>.
2. US Office of Juvenile Justice and Delinquency Prevention – Model Programs Guide (select programs identified as “Effective”) <http://www.ojjdp.gov/mpg/Program>.
3. SAMHSA’s National Registry of Evidence-Based Programs and Practices (NREPP) – does not provide information regarding the risk and protective factors targeted by the program, so bidders will need to find that information elsewhere <http://nrepp.samhsa.gov/>.
4. Find Youth Info (select programs identified as “Effective”) <http://www.findyouthinfo.gov/program-directory>.
5. Effective Interventions (focused on HIV prevention, but includes numerous programs that concurrently focus on substance abuse prevention): <http://www.effectiveinterventions.org/en/Home.aspx>.

Staffing (10 points)

1. Staffing (FTE numbers) required to provide intended services. Describe proposed staff qualifications, i.e., professional licensing and related experience. An indication as to proposed staff who are currently on-board or must be hired, with an indication of all staff who are bilingual.
2. Resumes – limited to two (2) pages each – for all proposed staff are required in an appendix to the bidder's proposal. Each resume shall include job descriptions for key personnel with oversight and involvement in completing the responsibilities of the contract. Provide resumes of current staff and job descriptions, including credential requirements of future staff, and consultant agreements, where

applicable. Please provide copies of staff CPS certificates or evidence of advanced degree and experience.

3. The number of work hours per week that constitute each FTE and PTE in the bidder's proposal.
4. The composition and skill set of the proposed program team, including staff qualifications.
5. The proposed organizational structure, including an organizational chart in an appendix to the bidder's proposal.
6. The bidder's hiring policies, including background and credential checks, as well handling of prior criminal convictions.
7. The approach for supervision of clinical staff, if applicable.
8. A list of the bidder's board members, including each member's professional licensure and organizational affiliation(s). The bidder's proposal must identify each board member who is also an employee of the bidder or an affiliate of the bidder. The proposal shall indicate if the Board of Directors votes on contract-related matters.
9. A list of names of consultants the bidder intends to utilize for the contract resulting from this RFP, including each consultant's professional licensure and organizational affiliation(s). Each consultant must be further described as to whether they are also a board member and, if so, whether they are a voting member. The bidder must identify all reimbursement the consultant received as a board member over the last twelve (12) months.

Budget Note: According to Budget criteria, staff working on this contract must spend a minimum of 60% of their time providing direct services.

Community Linkages (10 points)

1. Describe how the bidder will provide or create access to services and resources that support the proposed program.
2. Include copies of signed Memoranda of Agreement (MOAs) and contracts detailing how parties will work together to offer more comprehensive services. These should be included as an appendix to the proposal(s). (Signed MOAs **must** be included if the bidder is proposing to do a program with a particular school district or agency.)

Budget (10 points)

1. A detailed budget using the Annex B standard budget categories for expenses and revenues: A. Personnel, B. Consultants and Professionals, C. Materials & Supplies, D. Facilities Costs, E. Specific Assistance to Clients, F. Other, General and Administrative Distribution, and Revenues including Client Generated Fees, Public & Private Grants and Other Agency Funds. Utilize the Excel budget template which will be emailed to all registered applicants. The budget must be presented in two (2) clearly labeled separate columns:
 - a. One column detailing the full annualized operating costs and revenues excluding one-time costs; and
 - b. One column detailing the one-time costs.

2. Budget Notes that may be useful to help explain costs and assumptions made for certain non-salary expenses and the calculations behind various revenue estimates. The State's proposal reviewers need to fully understand the bidder's budget projections from the information presented in its proposal. Failure to provide adequate information could result in lower ranking of the proposal. Budget Notes, to the extent possible, should be displayed on the budget template file itself.
3. The name and address of each organization – other than third-party payers – providing support and/or money to help fund the program for which the proposal is being made.
4. For personnel line items, staff position titles, i.e., not staff names, and hours per workweek.
5. The number of hours per clinical consultant such that cost/hour may be evaluated.
6. Staff fringe benefit expenses, which may be presented as a percentage factor of total salary costs, should be consistent with the bidder's current fringe benefit percentage.
7. If applicable, General & Administrative (G&A) expenses, otherwise known as indirect or overhead costs, should be included if attributable and allocable to the proposed program. Since administrative costs for existing DMHAS programs reallocated to a new program do not require new DMHAS resources, a bidder that currently contracts with DMHAS should limit its G&A expense projection to “new” G&A only by showing the full amount of G&A as an expense and the off-set savings from other programs’ G&A in the revenue section.
8. Written assurance that if the bidder receives an award pursuant to this RFP, it will pursue all available sources of revenue and support upon award and in future contracts, including agreement to obtain approval as a Medicaid-eligible provider.

Appendices

The following items must be included as appendices with the bidder's proposal, limiting appendices to a total of 100 pages:

1. Bidder mission statement;
2. Organizational chart;
3. Job descriptions of key personnel;
4. Resumes of key personnel if on staff, limited to two (2) pages each;
5. A description of all pending and in-progress audits, the requestor, the firm's name and telephone number, and the audit type;
6. List of the board of directors, officers and terms of office of each;
7. Documentation of the bidder's charitable registration status;
8. Original and/or copies of letters of commitment/support;
9. Department of Human Services Statement of Assurances (RFP Attachment C);
10. Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions (RFP Attachment D);
11. Disclosure of Investment in Iran (www.nj.gov/treasury/purchase/forms.shtml); and
12. Statement of Bidder/Vendor Ownership Disclosure (www.nj.gov/treasury/purchase/forms.shtml).

The documents listed below are required with the proposal, **unless the bidder has a current contract with DMHAS and these documents are already on file with DMHAS.**

1. Most recent single audit report (A133) or certified statements (submit only hard two copies); and
2. Any other audits performed in the last two (2) years (submit only two [2] hard copies).

VIII. Submission of Proposals

DMHAS assumes no responsibility and bears no liability for costs incurred by the bidder in the preparation and submittal of a proposal in response to this RFP. The narrative portion should be single-spaced with one (1") inch margins, no smaller than twelve (12) point Arial, Courier New or Times New Roman font, and not exceed 20 pages in length. For example, if the bidder's narrative starts on page 3 and ends on page 23 it is 21 pages long, not 20 pages. DMHAS will not consider any information submitted beyond the page limit for scoring purposes. Budget detail and appendix items do not count towards the narrative page limit. Proposals must be submitted no later than 5:00 p.m. Eastern Standard Time on **May 11, 2015**. Five (5) copies and one (1) original of the proposal narrative, budget and appendices (six [6] total proposal packages) must be submitted to the following address:

For U.S. Postal Service delivery:

Helen Staton
Division of Mental Health and Addiction Services
PO Box 700
Trenton, NJ 08625-0700

OR

For private delivery vendor such as UPS or FedEx:

Helen Staton
Division of Mental Health and Addiction Services
222 South Warren Street, 4th Floor
Trenton, NJ 08608

The bidder may mail or hand deliver its proposal, however, DMHAS is not responsible for items mailed but not received by the due date. Note that U.S. Postal Service two-day priority mail delivery to the post office box listed above may result in the bidder's proposal not arriving timely and, therefore, being deemed ineligible for contract award. The bidder will not be notified that its proposal has been received. The State will not accept facsimile transmission of proposals.

In addition to the required hard copies, the bidder must also submit its proposal in a PDF formatted file via email to RFP.submissions@dhs.state.nj.us. The email "subject" should include the bidder's name and the proposal name.

The bidder must also submit the completed budget template file as an excel attachment to RFP.submissions@dhs.state.nj.us.

IX. Review of Proposals

Proposals received after the due date and time will not be evaluated. There will be a review process for all timely submitted proposals. DMHAS will convene a review committee of public employees to conduct a review of each proposal accepted for review.

The bidder must obtain a minimum score of 70 points out of 100 points in order to be considered eligible for funding, as well as meet the threshold score for budget and scope of work sections. Criteria scores and thresholds will become available when proposals become available for public inspection.

Award decisions will be based on such factors as the proposal scope, quality and appropriateness, as well as budget reasonableness. The review committee will look for evidence of cultural competence in each section of the narrative. The review committee may choose to visit a bidder's existing program(s) and/or review any programmatic or fiscal documents in the possession of DMHAS. The bidder is advised that contract award may be conditional upon contract negotiation. The requested changes, along with their requested implementation dates, will be communicated to the prospective awardees prior to final award.

DMHAS reserves the right to reject any and all proposals when circumstances indicate that it is in its best interest to do so. DMHAS' best interests in this context include, but are not limited to, loss of funding, inability of the bidder(s) to provide adequate services, an indication of misrepresentation of information and/or non-compliance with State and federal laws and regulations, existing DHS contracts, and procedures set forth in DHS Policy Circular P1.04 (<http://www.state.nj.us/humanservices/ocpm/home/resources/manuals/index.html>).

DMHAS will notify all bidders of awards, contingent upon the satisfactory final negotiation of a contract, by June 5, 2015.

X. Appeal of Award Decisions

An appeal of any award decision may be made only by a respondent to this RFP. All appeals must be made in writing and received by DMHAS at the address below no later than 5:00 p.m. Eastern Standard Time on June 12, 2015. The written request must clearly set forth the basis for the appeal.

Appeal correspondence should be addressed to:

Lynn A. Kovich, Assistant Commissioner
Division of Mental Health & Addiction Services
222 South Warren Street, 3rd Floor
PO Box 700
Trenton, NJ 08625-0700

Please note that all costs incurred in connection with appeals of DMHAS decisions are considered unallowable cost for the purpose of DMHAS contract funding.

DMHAS will review all appeals and render a final decision by June 19, 2015. Contract award(s) will not be considered final until all timely appeals have been reviewed and final decisions rendered.

XI. Post Award Required Documentation

Upon award announcement, the successful bidder(s) must be prepared to submit, at a minimum, one (1) copy of the following documentation (if not already submitted with the proposal) in order to process the contract in a timely manner, as well as any other documents required by DMHAS.

1. Most recent IRS Form 990/IRS Form 1120, and Pension Form 5500 (if applicable) (submit only hard two [2] copies);
2. Copy of the Annual Report-Charitable Organization (for information visit: http://www.state.nj.us/treasury/revenue/dcr/programs/ann_rpt.shtml);
3. A list of all current contracts and grants as well as those for which the bidder has applied for from any Federal, state, local government or private agency during the contract term proposed herein, including awarding agency name, amount, period of performance, and purpose of the contract/grant, as well as a contact name for each award and the phone number;
4. Proof of insurance naming the State of New Jersey, Department of Human Services, Division of Mental Health and Addiction Services, PO Box 700, Trenton, NJ 08625-0700 as an additional insured;
5. Board Resolution authorizing who is approved for entering into a contract and signing related contract documents;
6. Current Agency By-laws;
7. Current Personnel Manual or Employee Handbook;
8. Copy of Lease or Mortgage;
9. Certificate of Incorporation;
10. Co-occurring policies and procedures;
11. Policies regarding the use of medications, if applicable;
12. Policies regarding Recovery Support, specifically peer support services;
13. Conflict of Interest Policy;
14. Affirmative Action Policy;
15. Affirmative Action Certificate of Employee Information Report, newly completed AA

302 form, or a copy of Federal Letter of Approval verifying operation under a federally approved or sanctioned Affirmative Action program. (AA Certificate must be submitted within 60 days of submitting completed AA302 form to Office of Contract Compliance);

16. A copy of all applicable licenses;
17. Local Certificates of Occupancy;
18. Current State of New Jersey Business Registration;
19. Procurement Policy;
20. Current Equipment inventory of items purchased with DHS funds (Note: the inventory shall include: a description of the item, a State identifying number or code, original date of purchase, date of receipt, location at the Provider Agency, person(s) assigned to the equipment, etc.);
21. All subcontracts or consultant agreements, related to the DHS Contracts, signed and dated by both parties;
22. Business Associate Agreement (BAA) for Health Insurance Portability Accountability Act of 1996 compliance, if applicable, signed and dated;
23. Updated single audit report (A133) or certified statements, if differs from one submitted with proposal;
24. Business Registration (online inquiry to obtain copy at https://www1.state.nj.us/TYTR_BRC/jsp/BRCLoginJsp.jsp; for an entity doing business with the State for the first time, it may register at <http://www.nj.gov/treasury/revenue>);
25. Source Disclosure (EO129) (www.nj.gov/treasury/purchase/forms.shtml); and
26. Chapter 51 Pay-to-Play Certification (www.nj.gov/treasury/purchase/forms.shtml).

XII. Attachments

Attachment A – Proposal Cover Sheet

_____ Date Received

**STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES**
Division of Mental Health and Addiction Services
Proposal Cover Sheet

Name of RFP _____

Incorporated Name of Bidder: _____

Type: Public _____ Profit _____ Non-Profit _____ Hospital-Based _____

Federal ID Number: _____ Charities Reg. Number (if applicable) _____

Address of Bidder: _____

Contact Person Name and Title: _____

Phone No.: _____ Email Address: _____

Total dollar amount requested: _____ Fiscal Year End: _____

Funding Period: From _____ to _____

Total number of unduplicated consumers to be served: _____

County in which services are to be provided: _____

Brief description of services by program name and level of service to be provided:

Authorization: Chief Executive Officer (printed name): _____

Signature: _____ Date: _____

Attachment B – Addendum to RFP for Social Service and Training Contracts

STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES

ADDENDUM TO REQUEST FOR PROPOSAL FOR SOCIAL SERVICE AND TRAINING CONTRACTS

Executive Order No. 189 establishes the expected standard of responsibility for all parties that enter into a contract with the State of New Jersey. All such parties must meet a standard of responsibility that assures the State and its citizens that such parties will compete and perform honestly in their dealings with the State and avoid conflicts of interest.

As used in this document, "provider agency" or "provider" means any person, firm, corporation, or other entity or representative or employee thereof that offers or proposes to provide goods or services to or performs any contract for the Department of Human Services.

In compliance with Paragraph 3 of Executive Order No. 189, no provider agency shall pay, offer to pay, or agree to pay, either directly or indirectly, any fee, commission, compensation, gift, gratuity, or other thing of value of any kind to any State officer or employee or special State officer or employee, as defined by N.J.S.A. 52:13D-13b and e, in the Department of the Treasury or any other agency with which such provider agency transacts or offers or proposes to transact business, or to any member of the immediate family, as defined by N.J.S.A. 52:13D-13i, of any such officer or employee, or any partnership, firm, or corporation with which they are employed or associated, or in which such officer or employee has an interest within the meaning of N.J.S.A. 52:13D-13g.

The solicitation of any fee, commission, compensation, gift, gratuity or other thing of value by any State officer or employee or special State officer or employee from any provider agency shall be reported in writing forthwith by the provider agency to the Attorney General and the Executive Commission on Ethical Standards.

No provider agency may, directly or indirectly, undertake any private business, commercial or entrepreneurial relationship with, whether or not pursuant to employment, contract or other agreement, express or implied, or sell any interest in such provider agency to, any State officer or employee or special State officer or employee having any duties or responsibilities in connection with the purchase, acquisition or sale of any property or services by or to any State agency or any instrumentality thereof, or with any person, firm or entity with which he is employed or associated or in which he has an interest within the meaning of N.J.S.A. 52:13D-13g. Any relationships subject to this provision shall be reported in writing forthwith to the Executive Commission on Ethical Standards, which may grant a waiver of this restriction upon application of the State officer or employee or special State officer or employee upon a finding that the present or proposed relationship does not present the potential, actuality or appearance of a conflict of interest.

No provider agency shall influence, or attempt to influence or cause to be influenced, any State officer or employee or special State officer or employee in his official capacity in any manner which might tend to impair the objectivity or independence of judgment of said officer or employee.

No provider agency shall cause or influence, or attempt to cause or influence, any State officer or employee or special State officer or employee to use, or attempt to use, his official position to secure unwarranted privileges or advantages for the provider agency or any other person.

The provisions cited above shall not be construed to prohibit a State officer or employee or special State officer or employee from receiving gifts from or contracting with provider agencies under the same terms and conditions as are offered or made available to members of the general public subject to any guidelines the Executive Commission on Ethical Standards may promulgate.

Attachment C – Statement of Assurances

Department of Human Services Statement of Assurances

As the duly authorized Chief Executive Officer/Administrator, I am aware that submission to the Department of Human Services of the accompanying application constitutes the creation of a public document that may be made available upon request at the completion of the RFP process. This may include the application, budget, and list of applicants (bidder's list). In addition, I certify that the applicant:

- Has legal authority to apply for the funds made available under the requirements of the RFP, and has the institutional, managerial and financial capacity (including funds sufficient to pay the non-Federal/State share of project costs, as appropriate) to ensure proper planning, management and completion of the project described in this application.
- Will give the New Jersey Department of Human Services, or its authorized representatives, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with Generally Accepted Accounting Principles (GAAP). Will give proper notice to the independent auditor that DHS will rely upon the fiscal year end audit report to demonstrate compliance with the terms of the contract.
- Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain. This means that the applicant did not have any involvement in the preparation of the RFI, including development of specifications, requirements, statement of works, or the evaluation of the RFI applications/bids.
- Will comply with all federal and State statutes and regulations relating to non-discrimination. These include but are not limited to: 1) Title VI of the Civil Rights Act of 1964 (P.L. 88-352; 34 CFR Part 100) which prohibits discrimination based on race, color or national origin; 2) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794; 34 CFR Part 104), which prohibits discrimination based on handicaps and the Americans with Disabilities Act (ADA), 42 U.S.C. 12101 et seq.; 3) Age Discrimination Act of 1975, as amended (42 U.S.C. 6101 et. seq.; 45 CFR part 90), which prohibits discrimination on the basis of age; 4) P.L. 2975, Chapter 127, of the State of New Jersey (N.J.S.A. 10:5-31 et. seq.) and associated executive orders pertaining to affirmative action and non-discrimination on public contracts; 5) federal Equal Employment Opportunities Act; and 6) Affirmative Action Requirements of PL 1975 c. 127 (NJAC 17:27).
- Will comply with all applicable federal and State laws and regulations.
- Will comply with the Davis-Bacon Act, 40 U.S.C. 276a-276a-5 (29 CFR 5.5) and the New Jersey Prevailing Wage Act, N.J.S.A. 34:11-56.27 et seq. and all regulations pertaining thereto.
- Is in compliance, for all contracts in excess of \$100,000, with the Byrd Anti-Lobbying amendment, incorporated at Title 31 U.S.C. 1352. This certification extends to all lower tier subcontracts as well.

- Has included a statement of explanation regarding any and all involvement in any litigation, criminal or civil.
- Has signed the certification in compliance with federal Executive Orders 12549 and 12689 and State Executive Order 34 and is not presently debarred, proposed for debarment, declared ineligible, or voluntarily excluded. The applicant will have signed certifications on file for all subcontracted funds.
- Understands that this provider agency is an independent, private employer with all the rights and obligations of such, and is not a political subdivision of the Department of Human Services.
- Understands that unresolved monies owed the Department and/or the State of New Jersey may preclude the receipt of this award.

Applicant Organization

Signature: CEO or equivalent

Date

Typed Name and Title

6/97

Attachment D - Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions

READ THE ATTACHED INSTRUCTIONS BEFORE SIGNING THIS CERTIFICATION. THE INSTRUCTIONS ARE AN INTEGRAL PART OF THE CERTIFICATION.

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions

1. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by an Federal department or agency.
2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Name and Title of Authorized Representative

Signature

Date

This certification is required by the regulations implementing Executive order 12549, Debarment and Suspension, 29 CFR Part 98, Section 98.510.

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions

Instructions for Certification

1. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.
2. The certification in this clause is a material representation of facts upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.
3. The prospective lower tier participant shall provide immediate written notice to the person to whom this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.
4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.
5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.
6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion-- Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Non-Procurement Programs.
8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

Attachment E - Prevention Classification Definitions

Universal prevention: The mission of universal prevention is to deter the onset of drug abuse by providing all individuals in a population with the information and skills necessary to prevent the problem. All members of the population share the same general risk for drug abuse, although the risk may vary greatly among individuals. Universal prevention programs are delivered to large groups without any prior screening for drug abuse risk status of the individual program recipients. The entire population is assumed at-risk for substance abuse. *Examples: Substance abuse education in schools, media and public awareness (i.e., Red Ribbon Week, Alcohol Awareness Month).*

Selective prevention strategies: Selective prevention targets specific subgroups of the population that are believed to be at greater risk than others. Age, gender, family history, place of residence (i.e., high drug use, or low-income neighborhoods) and victimization, or physical and/or sexual abuse may define the targeted subgroups. ***Selective prevention targets the entire subgroup regardless of the degree of risk of any individual within the group.*** One individual in the subgroup may not be at personal risk for substance abuse, whereas another individual in the same subgroup may be abusing substances. The selective prevention program is presented to the entire subgroup because the subgroup as a whole is at higher risk for substance abuse than the general population. An individual's personal risk is not specifically assessed or identified and is based solely on a presumption given in his or her membership in the at-risk subgroup. *Examples: Skills training for groups affected by environmental influences like high crime rate, unemployment and community disorganization.*

Indicated prevention strategies: Indicated prevention approaches are used for individuals who may or may not exhibit early signs of substance abuse but exhibit risk factors. Examples of risk factors include school failure, interpersonal social problems, delinquency, and other anti-social behaviors and psychological problems such as depression and suicidal behavior that increase their chances of developing a substance abuse problem. ***Indicated prevention programs typically address risk factors associated with the individual,*** such as conduct disorders and alienation from parents, schools, and positive peer groups. The aim of indicated prevention programs is not just the reduction in first time substance abuse but also reduction in the length of time the signs continue, delay of onset of substance abuse, and/or reduction in the severity of substance abuse. Individuals can be referred to indicated prevention programs by parents, teachers, school counselors, school nurses, youth workers, friends or the courts. *Examples: Youth already engaged in substance abuse and/or negative behaviors, such as truancy, early anti-social behavior, Children of Substance Abusers.*

Reference: *Drug Abuse Prevention: What Works*, National Institute of Drug Abuse, NIH Publication No. 97-45110

Attachment F - Definition of Indicated Prevention Strategies

Indicated Prevention Strategies

- Indicated prevention strategies identify individuals who are experiencing early signs of substance abuse and other related problem behaviors associated with substance abuse and target them with special programs.
- The individuals identified at this stage, though showing signs of early substance abuse, have not reached the point where a clinical diagnosis of substance abuse can be made.
- Indicated prevention strategies are used for individuals who may or may not be abusing substances, but exhibit risk factors such as:
 - school failure;
 - interpersonal social problems;
 - delinquency and other antisocial behaviors;
 - psychological problems such as depression; and
 - suicidal behavior that increases their chances of developing a drug abuse problem
- Indicated prevention strategies require a precise assessment of an individual's personal risk and level of related problem behaviors, rather than relying on the person's membership in an at-risk group as in the selected approach.
- Programs are frequently extensive and highly intensive; they typically operate for longer periods of time, at a greater frequency of contact and require greater effort on the part of participants than do selective or universal programs.
- Programs require highly skilled staff who have clinical training, counseling and other skills. In the field of substance abuse, an indicated prevention intervention would be a substance abuse program for high school students who are experiencing a number of problem behaviors, including truancy, failing academic grades, juvenile depression, suicidal ideation, and early signs of substance abuse.

Source: *"Reducing Risks for Mental Health Disorders: Frontiers for Preventive Intervention Research."* National Institute of Medicine

Attachment G – Standards for Agencies Providing Substance Abuse Prevention Services for DHS/DMHAS

**STANDARDS FOR AGENCIES PROVIDING SUBSTANCE ABUSE PREVENTION SERVICES
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES (DHS/DMHAS)**

Revised September 2014

FORWARD

This document outlines program requirements for agencies providing substance abuse prevention services for the Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS), Office of Prevention and Early Intervention. This document supplements requirements specified in each contractees "State of New Jersey Department of Human Services Standard Language Document for Social Service and Training Contracts".

The Office of Prevention and Early Intervention is a unit of DMHAS within DHS. It is responsible for the administration of the prevention set-aside portion of the Substance Abuse Prevention and Treatment (SAPT) Federal Block Grant. This office maintains a staff of Program Managers who interact with and monitor all contractees to ensure their compliance with all program requirements.

Questions regarding the content of this document may be directed to:

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SECTION I - PURPOSE

The purpose of this document is to outline the operational requirements for all agencies that receive DMHAS Provider Service Contracts for substance abuse prevention. These formal statements are the minimum standards to which the providers must adhere in order to provide quality prevention services to their clients and to meet their contract requirements.

Prevention contracts are intended to promote efforts which increase protective and resiliency factors to prevent the illegal use or abuse of alcohol, tobacco, and other substances by New Jersey's citizens of all ages.

NOTE: For purposes of this document, the words "guidelines" and "standards" are interchangeable.

SECTION II - FACILITY and OPERATIONAL REQUIREMENTS

A. Location

Every prevention program must have an identifiable physical location/facility, evidenced by a street address, from which client and/or administrative services are provided. This is required regardless of whether it is a free-standing program or a program within a multi-purpose organization. The name of the agency must be on a sign or directory visible to the public from outside the building or within a public access reception area.

B. Legal Status

The agency must be county or other local government, a hospital, free standing clinic, or a public or incorporated non-profit organization which meets the Internal Revenue Service Code Section 501(c) 3.

C. Hours of Operation/Telephone

Each prevention agency must establish and post in a visible public place, and in the agency, the agency's regular hours of operation as well as communicate this availability to the community in its promotional literature. The agency must be available by phone during these hours. All contracts are to operate throughout the year. Closure of the operation for "breaks" is not permitted.

D. Accessibility

Each program should be accessible to persons with disabilities and must comply with the requirements of The Americans with Disabilities Act (ADA).

E. Adherence to Codes

Each program must adhere to local and state health and safety codes. If the facility is not a licensed health care facility, it must meet or exceed all fire, building and safety codes of the municipality in which it is situated. Current and valid certificates from the local government shall be on file and available for inspection.

F. Supplies

Appropriate and adequate supplies and equipment should be available to the staff to carry out the mission of the agency.

SECTION III - STAFFING AND RELATED PERSONNEL POLICIES

A. Office of the Director

Every prevention program must have one (1) person identified as the Director who has at least a Bachelor's degree from an approved institution, in a health, education, psychology, science, or human service field, and two (2) years of experience in program administration.

B. Prevention Specialist Qualifications

Effective January 1, 2015, all DHMAS-funded prevention providers will be required to employ a staff member who has earned the Certified Prevention Specialist (CPS) credential. Providers who do not meet this requirement on January 1, 2015 will have until December 31, 2016 to hire a staff person or provide CPS training for an existing staff member. Credentials or degrees that will be accepted in lieu of the CPS are the Certified Health Education Specialist (CHES), Masters in Public Health (MPH), or a Doctoral degree in the medical, health, or behavioral sciences. This requirement is described in the "Standards for Agencies Providing Substance Abuse Prevention Services for the DHS/DMHAS." Please provide copies of staff certificates or evidence of advanced degree and experience.

C. Administrative Support

A prevention program must have a staff which devotes adequate time to ensure full competency in all administrative requirements of the program. At a minimum, the administrative staffing pattern should include a Program Director and an Accountant/Bookkeeper.

A Bookkeeper must have a High School Diploma and formal training in bookkeeping and accounting principles and/or successful experience as a bookkeeper. Successful experience will be determined by DMHAS.

D. Table of Organization/Job Descriptions

Each prevention agency must have on file a table of organization which reflects how the agency is structured to deliver its services and lines of authority among its staff

members. Written descriptions of duties, responsibilities and credentials are required for all jobs.

According to budget criteria, staff working on substance abuse prevention contracts must spend a minimum of 60% of their time providing direct services.

E. Staff Development Plan and Continuing Education

Every prevention program must have in place a staff development plan to ensure that each staff member has knowledge and skills in the prevention field. The agency shall have written policies regarding a plan for continuing education of its staff. Such policies shall include support for attendance at conferences and symposia and similar activities which foster obtaining or maintaining prevention credentials.

F. Personnel Policies and Procedures

Each agency shall have on file a policy and procedure manual that includes but is not limited to the following items:

- staff hiring procedures
- orientation protocols
- sick and vacation time policies
- staff evaluation procedures
- determination procedures
- fiscal controls
- conflict of interest policies
- hiring of consultants
- confidentiality of records assurance (see Attachment 3: Confidentiality of Drug and Alcohol Patient Information 42 U.S.C. 290dd-2, 42 C.F.R. Part 2)

SECTION IV - ADMINISTRATIVE REQUIREMENTS

A. Administration

The administration of the agency shall provide the staff with facilities, equipment and supplies needed to implement the prevention program in an efficient, economical and effective manner.

B. Administrative Policies and Procedures

Every program shall have written policies and procedures on file for the use of vehicles, which documents mileage, purpose and driver; purchase of equipment; leasing of equipment and facilities; rentals; inventory controls; fees for services; and medical emergencies. Policies and procedures are required to address justification of expenditures and the personnel authorized to approve both programmatic and fiscal needs.

C. Criteria for Board of Directors

The facility shall have a Board of Directors which shall assume legal responsibility for the management, operation, and financial viability of the agency. The Board of Directors shall be responsible for, but not limited to, the following:

1. Services provided and the quality of care rendered to participants.
2. Provision of a safe physical plant, equipped and staffed to maintain the agency and services.
3. Adoption and documented review of written by-laws, or their equivalent, in accordance with a schedule established by the Board of Directors.
4. Ensuring development and review of all policies and procedures in accordance with a schedule established by the Board of Directors.
5. Determination of the frequency of meetings of the Board of Directors and its committees, or equivalent; conducting such meetings, and documenting them through minutes.
6. Delineation of the duties of the officers of any committees, or equivalent, of the Board of Directors. When the governing authority establishes committees, their purpose, structure, responsibilities, and authority, and the relationship of the committee to other entities within the facility, shall be documented.
7. Establishment of the qualifications of members and officers of the Board of Directors, the procedures for electing and appointing officers, and the terms of service for members, officers, and committee chairpersons or equivalent.

D. Administrative Records

Each program shall maintain files that include but are not limited to: service grants and/or contracts for services from any source; insurance policies; certificates of need where applicable; rental agreements; and personnel records.

E. Property

Accurate property records, inventory control and maintenance for equipment and for all other non-expendable (non-consumable) personal property acquired under the contract must be maintained. Property records must provide a description of the property, identification number, date of acquisition, cost, present location and/or disposition of property. A physical inventory of non-expendable personal property must be taken and the results reconciled with the property records at least once every two (2) years to verify the existence, current utilization and continued need for the property. A control system must be in effect to ensure adequate safeguards to prevent loss. Damage or theft must be investigated and fully documented.

F. Client and Programmatic Records

Each program shall maintain records that document the delivery of services including the place, date, number of participants, the risk factors being addressed that pertain to the population being served, the prevention strategies and activities that were utilized, and outcome related comments. When appropriate, (i.e., in events that employ

strategies other than pure information in large events such as assemblies), the program shall also maintain records indicating the names of the participants, their ages, attendance records and other pertinent information.

G. Confidentiality

The program must have and enforce procedures protecting the confidentiality of participant information.

H. Smoke-Free Environment

1. In accordance with the Synar Amendment (P.L.102, Section 321), programs shall:
 - ensure that all prevention activities will be conducted in a smoke-free environment; and
 - ensure that individuals under 18 years of age are not permitted to smoke in any part of the agency or its premises.
2. In accordance with the Pro-Children's Act of 1994 (P.L. 103-227), no smoking will be permitted in any portion of any indoor facility owned, leased, or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services for children under eighteen (18) years of age.

I. Lavatory Facilities

Lavatory facilities with sinks shall be available on premises.

J. Insurance

The agency is required to have sufficient fire and theft insurance to cover the fair market value of the equipment and building occupied by the agency.

K. Affirmative Action

The agency is required to have a formal non-discrimination policy and to have and enforce an affirmative action plan.

L. Fiscal Control

The agency has adequate internal controls, management and administrative procedures and qualified personnel to assure the appropriate use and accounting for all the resources of the agency. Further, the agency must have not less than one (1) annual audit by an approved public accountant, as required in the DHS Contract Manual, Terms and Conditions, and Federal Office of Management and Budget, Cost Principals.

M. Other General State Requirements

1. Political Activity - Federal funds cannot be used for partisan political activity of any kind by any person or organization involved in the administration of federally-assisted programs. Hatch Act (5 U.S.C. 1501-1508) and Intergovernmental Personnel Act of 1970 as amended by Title VI of Civil Service Reform Act (P.L. 95-454 Section 4728).
2. Davis-Bacon Act - When required by the Federal grant program legislation, all laborers and mechanics employed by contractors or subcontractors to work on construction projects financed by Federal assistance must be paid wages not less than those established for the locality of the project by the Secretary of Labor (40 Stat. 1494, Mar. 3, 1921, Chap. 411, 40 U.S.C. 276 A-5).
3. Civil Rights - No person shall, on the ground of sex, race, color, national origin, age, or disability, be excluded from participation in or be subjected to discrimination in any program or activity funded, in whole or in part, by Federal funds. Discrimination on the basis of sex or religion is also prohibited in some Federal programs. (Age-42 U.S.C. 6101, et. seq.; Race-42 U.S.C. 2000d; Handicap-29 U.S.C. 794).

SECTION V- PROGRAMMATIC REQUIREMENTS

A. Mission Statement

Each agency that provides substance abuse prevention services must have a written mission statement on file, as well as a summary of its overall goals and services to fulfill this mission.

B. Cultural and Linguistic Competence

Culture and language have considerable impact on how clients access and respond to prevention services. All prevention contractees will be required to adhere to the standards and procedures listed below:

1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with clients and each other in a culturally competent work environment.
2. Have a comprehensive management strategy to address culturally and linguistically appropriate prevention services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.
3. Develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent prevention staff that are trained and qualified to address the needs of the racial, ethnic, and other minority communities being served.
4. Require and arrange for ongoing education and training for prevention staff in culturally and linguistically competent service delivery.
5. Provide all clients with limited English proficiency (LEP) access to bilingual prevention staff or interpretation services.
6. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to

receive no-cost interpreter services.

7. Translate and make available signage and commonly-used written client educational material and other materials for members of the predominant language groups in service areas.
8. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.