NJ DEPARTMENT OF
CommunityAffairs

Governor
Mikie Sherrill

Commissioner
Jacquelyn Suárez

OFFICE OF HOMELESSNESS PREVENTION:

NJ FamilyCare Hospital and Housing Supports Services Integration Grant Program

REQUEST FOR PROPOSALS - SFY26

RFP Due Completed in DCA SAGE: No later than 11:59pm on 10/9/2026

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I. Name of the grant program

NJ FamilyCare Hospital and Housing Supports Services Integration Grant Program

II. DCA contact information

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III. Context on Housing Supports Program

On July 1, 2025, the New Jersey Division of Medical Assistance and Health Services (DMAHS) launched a new NJ FamilyCare Medicaid benefit known as Housing Supports Program (HSP). The Housing Supports benefit is designed to assist eligible NJ FamilyCare members who have both a clinical risk factor (e.g., a chronic health condition) and a social risk factor (e.g., risk of homelessness) by providing supportive services that help members obtain and maintain stable housing. The Housing Supports benefit does not fund rent payments or housing development activities.

Please see the figure below for more details.

Figure 1: Overview of NJ FamilyCare Housing Supports Program

IV. Purpose of the grant program

As part of the implementation and ongoing operation of the NJ FamilyCare Housing Supports Program, DMAHS, in partnership with DCA's Office of Homelessness Prevention (DCA OHP), is launching **two related but distinct Requests for Proposals (RFPs)** to support hospital–housing integration efforts for high-need NJ FamilyCare members.

NJ FamilyCare members experiencing housing instability frequently present in acute care settings — including emergency departments, inpatient units, and other hospital-based care settings — at disproportionate rates compared to the broader Medicaid population. These encounters represent a critical but often missed opportunity: members are physically present, engaged with the healthcare system, and in a moment where they may be more receptive to support than at any other point in their lives. Yet without structured, in-person engagement and meaningful relationship-building before they leave the care setting, these members typically return to the same unstable housing conditions that contributed to their acute care need in the first place.

The consequences are cyclical and compounding. Unaddressed housing instability drives repeat acute care utilization — and each discharge without a warm, supported transition to housing-focused services makes the next engagement harder. Without structured connection to Housing Supports services during or immediately following a hospital encounter, many members experience fragmented transitions back into unstable housing situations and community settings that may lack sufficient housing stabilization supports. Housing instability, competing immediate needs, limited access to resources, and disruptions in communication following discharge can make continuity of engagement and successful connection to services difficult to sustain without coordinated, in-person transition support prior to discharge.

This pilot is designed to address that gap directly — by creating structured, in-person connections between members and Housing Supports Program providers at the point of care, before discharge, when the opportunity for engagement and service initiation is greatest. As such, these two RFPs are intended to advance coordination between healthcare and housing systems while testing and learning from different operational approaches. These two RFPs both serve a separate purpose and will result in distinct awards.

1. **Hospital and Housing Supports Services Integration Pilot**

*(Issued under **this** RFP)*

Through this RFP, DMAHS and DCA will award grants to a limited number of hospital and Housing Supports provider partnerships to participate in the **Hospital and Housing Supports Services Integration Pilot**. These pilots are designed to improve care coordination for complex NJ FamilyCare members by integrating Housing Supports Program services and hospital care delivery settings. As a note, hospital and acute care settings are the primary focus of this RFP. However, broader health system care settings that interact with eligible members (e.g., federally qualified health centers (FQHCs), semi-acute facilities, medical outreach teams, and mobile clinics) may also be considered. For simplicity and consistency, this RFP refers to all such settings collectively as "hospital."

The hospital pilots will support collaboration between hospitals and Housing Supports Program providers to identify and engage eligible members who present in healthcare settings and to deliver ongoing, longitudinal housing case management services consistent with the core components of the Housing Supports Program. Ultimately, the pilot aims to improve outcomes for members with complex housing needs by ensuring they receive timely, coordinated support that addresses the social determinants driving repeated healthcare utilization. An additional objective of the pilot is to test and assess different models of hospital–housing integration, generating evidence on implementation approaches and operational feasibility to inform development of a scalable, replicable framework for broader adoption across the State.

2. **Hospital and Housing Integration Technical Assistance Grant Program**

(Issued under a separate RFP – NOT this solicitation)

To support the successful design, implementation, and learning objectives of the Hospital and Housing Supports Services Integration Pilot, DMAHS is issuing a separate RFP for the **Hospital and Housing Integration Technical Assistance Grant Program**.

The Technical Assistance Grant Program will fund a qualified organization to provide technical assistance to pilot participants and to support the State in assessing the quality of these pilots. The selected technical assistance provider will serve two core functions:

a. **Pilot implementation support**, including assisting with the launch and ongoing operations of the pilot, supporting hospital–provider partnerships, developing training material on best practices, facilitating shared learning across pilot sites, and communicating with DCA/DMAHS on pilot progress. Further enumeration of the support that the TA organization will provide to awarded pilot participants will be enumerated in Section V; and

b. **Pilot mixed-methods assessment**, including conducting analysis of pilot implementation — such as interviews with participating hospitals, Housing Supports Program providers, and other relevant stakeholders and descriptive data analysis — and producing a written synthesis of implementation experiences, effective practices, challenges encountered, and key lessons learned to inform future program design and potential scale.

This RFP is solely for the direct service delivery and pilot participation by hospitals and Housing Supports Program providers and does not fund the selection or operation of the technical assistance provider.

V. Description of Responsibilities

The intent of this RFP is to allow both existing and proposed partnership models that advance the goals described above to be responsive to this solicitation and to support innovative approaches to improving care for NJ FamilyCare members eligible for the Housing Supports Program. The State recognizes that healthcare providers and Housing Supports providers are best positioned to understand how these goals can be achieved in practice. Accordingly, this RFP is intentionally open-ended where possible, while being structured around fixed requirements to clearly define the parameters and expectations for proposed partnerships.

If an applicant has a proposed approach that aligns with the goals and requirements described in this RFP but is unsure whether it is allowable, applicants are encouraged to contact DCA for clarification. In general, proposals that clearly advance the program goals described below are likely to be considered responsive.

1. **Definition of Success for the Hospital and Housing Supports Services Integration Pilot**

A successful Hospital and Housing Supports Services Integration Pilot is one that both **establishes effective, replicable care processes** and **demonstrates meaningful benefits for participating members and the broader system.** Success is defined across two complementary dimensions: **process success** and **outcomes success.**

a. **Process-Based Definition of Success:** A successful pilot demonstrates that hospitals and Housing Supports Program providers can work together in a coordinated, sustainable manner to implement integrated care models within hospital and/or other healthcare settings. Process success includes the following:

   i. **Effective operational integration:** Participating hospitals and Housing Supports Program providers establish and maintain clear, functional workflows for referral, engagement, communication, and service delivery in healthcare delivery settings. Roles and responsibilities are clearly defined and consistently executed across partners. Where appropriate, workflows also support coordination with external community-based resources to promote housing stability and continuity of care.

   ii. **Improved care coordination and reliable service connection:** Eligible NJ FamilyCare members are consistently identified within participating healthcare settings and experience, timely transitions from acute care to community-based Housing Supports Program services are communicated (as relevant), reducing fragmentation and gaps in service delivery and ensuring services are delivered in alignment with program requirements and best practices.

   iii. **Sustained and adaptive partnership collaboration:** Hospital and Housing Supports Program provider partnerships remain engaged throughout the pilot period, address implementation challenges collaboratively, and demonstrate the ability to adapt workflows, staffing models, and practices as conditions evolve.

b. **Outcomes-Based Definition of Success:** A successful pilot demonstrates that integrated hospital–housing approaches can improve how eligible members are identified, engaged, and supported in longitudinal housing case management services, with the potential to improve member experiences and reduce avoidable strain on the healthcare system. Outcomes success includes:

   i. **Improved health outcomes:** The pilot demonstrates the potential for improved overall health and well-being among participating NJ FamilyCare members as a result of more stable housing connections and better-aligned support services.

   ii. **Improved access to Housing Supports Program services:** The pilot increases the number of eligible NJ FamilyCare members who are identified and engaged in Housing Supports services compared to what would have occurred absent hospital–housing integration.

   iii. **Potential to reduce avoidable acute care utilization:** By addressing housing-related needs that contribute to repeated hospital use, the pilot demonstrates pathways that may reduce avoidable emergency department visits or other acute care utilization over time.

   iv. **Informing future policy and scale decisions:** The pilot generates clear, well-documented, outcome-oriented insights regarding implementation feasibility, operational challenges, and promising practices, enabling the State to assess whether and how integrated hospital–housing models should be continued, refined, or expanded.

2. **Fixed Requirements Applicable to All Applications**

All proposals submitted under this RFP must meet the following requirements, regardless of the operating model proposed:

a. **Purpose:** All proposed models must advance the goals of this pilot, as outlined in Section V

   i. **Participation in Technical Assistance Activities:** All pilot participants are required to actively participate in Technical Assistance activities for the duration of the grant period. This includes attending required trainings, convenings, and coordination meetings facilitated by the State-selected TA provider; responding to requests for information, data, or feedback from the TA provider in a timely manner; and cooperating with evaluation-related activities including interviews, site visits, and data collection requests. The TA provider plays a critical role in supporting pilot implementation and generating the evidence base that justifies this investment, and as such, meaningful participation from all pilot sites is essential to the success of the program as a whole. Continued or repeated failure to engage with TA activities, including unresponsiveness to information requests or absence from required convenings without prior notice, may be considered a material breach of grant conditions and could result in suspension of funding or removal from the program.

b. **Duration**: The anticipated grant period is 1.5 years, with possibility for extensions.

i. Extensions beyond the initial grant period may be made available at the State's discretion. Extension may be accompanied by additional funding, the amount of which will be determined by the State based on the scope of continued activities proposed. Grantees seeking an extension will be required to submit a written application that addresses, at a minimum: the rationale for continuing the pilot beyond the initial grant period; a summary of progress and outcomes to date, including evidence of meaningful member engagement and service delivery; any proposed revisions to service delivery workflows based on experiences and outcomes from initial pilot period; and whether the grantee intends to expand capacity — either at the existing pilot site or by adding new hospital or HSP provider partners — and if so, how.

ii. Any extension of the grant period, including associated additional funding, is subject to alignment with the terms of New Jersey's 1115 Medicaid demonstration waiver and applicable Special Terms and Conditions (STCs) as agreed upon with CMS.

c. **Allowable Use of Funds**: All proposed operating models and budgets must align with the allowable uses of funds described in Section X, *Eligible Activities*. Proposals that include activities or expenditures outside those parameters will not be considered allowable.

d. **Eligibility and Threshold Requirements**: Hospitals, healthcare providers, and Housing Supports Program providers must meet the eligibility and threshold requirements described in Section VIII, *Eligible Entities*.

e. **Billing Requirements**: The Housing Supports Program provider must serve as the billing entity for Housing Supports services delivered under the pilot and will retain any associated service revenue generated during the pilot period.

3. **Pilot Operating Model**

a. **Applicant responsibilities:** As part of the narrative response in XV.1., applicants will propose a pilot operating model. Applicants may propose a wide range of hospital–Housing Supports Program partnership models, provided that the proposed approach aligns with the fixed requirements described above. Applicants are encouraged to propose approaches that reflect their local context, operational capacity, and experience serving complex NJ FamilyCare members.

i. A core component of each application will be a clear description of how the proposed operating model will function in practice, as outlined in Section XIV. This should include, as applicable, how partners will coordinate, how members will be identified and engaged, how services will be delivered, and how continuity of care will be maintained between hospital and community-based settings.

ii. An illustrative operating model is described below for reference. Applicants are **not required** to adopt this model and may propose alternative or innovative approaches that better meet the goals of this pilot (e.g., utilizing medical outreach teams, mobile clinics, FQHCs).

iii. Note: the Technical Assistance provider will be able to support applicants in further enumerating responsibilities and workflows as part of the start-up of the pilot, as articulated in V.4. below.

b. **Illustrative operating model:**

i. **Overview:** Housing Supports Program (HSP) care managers are physically present in a hospital Emergency Department on a regular, structured basis to identify eligible NJ FamilyCare members and initiate Housing Supports engagement in person. This model features face-to-face engagement at the point of care, with flexible staffing configurations reflecting the operational context and volume of the participating hospital:

- The specific HSP care manager embedding model can be flexible and should reflect the operational context, referral volume, and capacity of the participating partnership. At one end of the spectrum, HSP care managers may be fully embedded at the hospital on a daily basis, working alongside hospital care teams as an integrated part of operations. At the other end, care managers may operate on a regularly scheduled onsite cadence — coming in several times per week — combined with an on-call protocol that allows them to respond in person when a member is identified or in need of support. In any case, the HSP care manager must be available to engage members in person before discharge.

ii. **High-level Theory of Change *(Illustrative)***

NJ FamilyCare members experiencing housing instability are frequently discharged from acute care settings without the infrastructure needed to successfully connect to housing and care management services. Gaps in discharge planning, limited access to housing stabilization and transition resources, and the absence of coordinated warm handoff processes mean that even members who are identified as having housing-related needs often leave the care setting without a clear, supported path forward. This pilot addresses those structural and operational gaps directly — by embedding or placing HSP care managers in the care setting before discharge, creating the coordination infrastructure, relationships, and momentum necessary to connect members to Housing Supports services while they are still present and reachable.

iii. **Envisioned Workflow:** The following workflow illustrates how this operating model may function in practice:

- Members present to the emergency department through normal hospital intake and clinical workflows.
- During routine clinical interactions, hospital clinicians or care team members screen patients for health-related social needs (HRSNs), including housing instability, using existing screening tools or workflows.
- Members who screen positive for a housing-related need and potential eligibility for HSP are flagged within hospital workflows so that the onsite or on-call HSP housing care manager is notified for engagement. Absent such live engagement and access

to housing stabilization resources prior to discharge, there may not be sufficient support for a successful transition out of acute care.

- During this initial in-person meeting, the HSP care manager conducts the Housing Supports Program initial engagement, which includes:
  - Explaining Housing Supports Program services to the member;
  - Confirming whether the member or anyone in their household is already connected an HSP provider;
  - Completing and submitting the required prior authorization documentation for Housing Supports services (the Initial Assessment Tool);
  - Identifying potential options for non-hospital placements for member to be safely discharged, based on their clinical and housing-related needs; and
  - Informing the member of how and when staff from the HSP provider organization will follow up after discharge.
  - *Optional:* At the hospital's discretion, HSP care managers may be trained to assess additional health-related social needs beyond housing and to coordinate with hospital staff to support those needs as appropriate.
- Enhanced engagement for complex members:
  - Recognizing that such complex NJ FamilyCare members who frequently present in hospital settings may require intensive, high-touch follow-up to successfully engage in Housing Supports services, grant resources may be used to support enhanced engagement strategies where necessary.
  - This may include, as appropriate additional care manager time for outreach or in-person follow-up, or other supports needed to locate, engage, and sustain contact with members who are difficult to reach (given these activities align to the allowable spend categories defined in Section X)
- Where a member is clinically ready for discharge but lacks a safe or stable place to go, the HSP care manager — drawing on their knowledge of community-based housing resources — can assist hospital discharge planning staff in identifying appropriate non-hospital placement options, such as emergency shelter, medical respite, or transitional housing, to support a safe discharge and reduce the likelihood of the member returning to the ED without having been connected to stable housing supports. Example HSP care manager activities may include:
  - Coordination with **medical respite or recuperative care providers** to support members who are medically stable for discharge but lack a safe place to recover; or
  - Engagement of **emergency shelters or short-term housing partners** to support safe discharge and immediate housing stabilization following hospital

encounters, including through specialized partnerships designed to address common access barriers such as curfews, substance use policies, or limited bed availability that members presenting at a hospital may face

- Partnerships with **County Social Service Agencies (CSSAs**) to identify potential resources to support the member's safe discharge, such as utilization of Emergency Assistance

- Prior to the member's discharge or departure from the hospital, the HSP housing care manager meets with the member in the emergency department, inpatient bed, or another designated location within the hospital
- Following discharge, the HSP provider assumes responsibility for ongoing, longitudinal Housing Supports services in the community while the member remains eligible for HSP, including housing case management, care coordination, and all required documentation and billing for Housing Supports Program services.

c. **Note:** Grant funds awarded under this RFP may only be used to support Housing Supports Program–related enabling activities or direct Housing Supports services. Funding may be used to support hospital or Housing Supports Program provider activities that facilitate member engagement, coordination, or delivery of Housing Supports services. However, grant funds may **not** be used to directly pay for services that fall outside the Housing Supports Program or for services provided by non–Housing Supports entities.

Applicants proposing enhanced or creative partnership models should plan to use non-financial incentives, operational coordination, or other allowable mechanisms to support participation by additional partners, rather than direct payment for non–Housing Supports services.

4. **Role of the State-Selected Technical Assistance Provider**

As applicants consider the responsibilities associated with participating in this pilot, they should be aware that the TA provider described in Section V will be a hands-on, day-to-day partner throughout this process. Applicants are not expected to have all workflows, partnership structures, and implementation details fully resolved at the time of application; rather, the TA provider is expressly designed to support pilot participants in developing and refining these elements from the earliest stages of the pilot. The TA provider will support pilot participants across the following areas:

a. **Pre-Launch and Partnership Formation Support.** The TA provider will conduct a structured partnership readiness assessment for each awarded pilot to evaluate whether participating hospital and Housing Supports Program provider partnerships have the foundational capacity, roles, and workflows in place to begin operations. The TA provider will also assist hospital and HSP provider partnerships in establishing formal partnership agreements (e.g., memoranda of agreement), and will provide a playbook to support

hospitals and HSP providers in establishing effective partnerships, including milestone timelines for activities to be completed within the first week, month, and beyond.

b. **Workflow Design and Co-Development.** The TA provider will work collaboratively with each pilot site to refine hospital–housing workflows informed by best practices and aligned with both hospital operations and Housing Supports Program requirements. This includes workflows related to member identification, referral, engagement, care coordination, information sharing, and service delivery within hospital settings. As such, a more detailed and refined version of the operating model proposed in this RFP in Section XIV will be developed collaboratively with the TA provider during the pre-launch period and will be submitted to DMAHS and DCA as a condition of receiving payment for Milestone 2.

c. **Training and Capacity Building.** The TA provider will design and host targeted trainings for participating hospitals and HSP providers focused on effective execution of the pilot model. Training topics will cover both general best practices — such as managing cross-organizational communication, and navigating hospital policies and norms — and reactive supports as real-world challenges arise during pilot operations.

d. **One-on-One Technical Assistance.** The TA provider will provide individualized, ongoing technical assistance to each participating hospital and HSP provider. This includes guidance on care coordination expectations and cross-organizational communication, as well as dissemination of practical tools, templates, guidance documents, and implementation resources to support consistent pilot execution across sites.

e. **Shared Learning and Peer Convenings**. The TA provider will convene participating hospitals and HSP providers on a regular basis to facilitate peer learning, shared problem-solving, and exchange of implementation experiences across pilot sites. Convenings will focus on cross-site themes, including common operational challenges, workflow adaptations, and emerging effective practices.

f. **Pilot Assessment and Evaluation.** The TA provider will conduct a mixed-methods assessment of the pilot throughout and following the grant period. This will include qualitative engagement, such as interviews, site visits, and structured feedback sessions, with hospital staff, HSP provider staff, participating members, and oversight staff, as well as descriptive quantitative analysis of pilot implementation and outcomes. Pilot participants will be expected to cooperate with evaluation activities, including timely responses to information requests, participation in interviews and site visits, and collection and sharing of de-identified member-level data consistent with the methodology established by the TA provider.

g. ***Note:*** Pilot participants should view the TA provider as a critical operational resource and are expected to engage in good faith throughout the duration of the pilot. The TA provider does not have decision-making authority over grant funding or program policy; escalation of policy questions or structural issues will be directed to DCA and DMAHS.

VI. RFP Due Date:

***RFP Due Completed in SAGE*:** No later than 11:59pm on 10/9/2026

***Award Notification Date*:** On or about 11/23/2026

VII. Maximum amount of single award:

$500,000.00 per pilot site unless an exception is made by DCA OHP as defined previously

1. Funding amounts under this RFP are also intentionally open-ended and are expected to reflect the operating model proposed by the applicant.
    a. Applicants must submit a proposed budget (as outlined in Section XIV.3.a) based on their partnership structure and implementation plan, rather than selecting from pre-defined funding levels. Proposed budgets must:
        i. Be clearly tied to the proposed operating model and planned activities;
        ii. Reflect reasonable and necessary costs to support pilot implementation; and
        iii. Be aligned to the eligible activities outlined in Section X; and
        iv. Not exceed **$500,000** per pilot. Applicants who believe a funding request above this amount is necessary **may submit a written justification explaining the rationale** for the higher investment. Such requests are not guaranteed to be approved. Applicants are strongly encouraged to also submit an alternative, scaled version of their operating model and budget that falls within the $500,000 funding cap
    b. Applications must clearly identify the proposed allocation of funds, organizational roles, and fiscal responsibilities across all participating pilot partners, including the hospital/healthcare entity and Housing Supports provider.
2. This approach is intended to allow applicants to request funding that reflects actual anticipated need and operational requirements, rather than estimates driven by a predetermined model. Applicants should clearly justify how requested funds support the goals of the pilot and represent an effective use of resources, in responses to Section XIV.3.a.
    a. Proposed budgets should demonstrate a reasonable allocation of resources across participating entities and provide sufficient support for both the healthcare entity and the Housing Supports provider to carry out their respective responsibilities under the pilot.

VIII. Eligible entities

Eligible Applicant Structures:

1. The application at the time of submission must represent a **partnership** between a New Jersey hospital or healthcare provider and one or more enrolled Housing Supports Program providers submitting a joint application. Applicants are not required to have a fully executed partnership agreement at the time of application.
    a. **The Housing Supports Program provider will be the "primary" applicant on the application within the SAGE portal.** For partnerships that include more than one Housing Supports Program provider, either provider may serve as the "primary" applicant. The "primary" applicant will be responsible for:
        i. Serving as the sole point of contact with DCA for all fiscal and administrative matters related to the grant, including submission of all required financial status reports, milestone documentation, and supporting materials through the SAGE portal. This includes collecting and consolidating any required reporting, supporting documentation, or expenditure records from the sub-recipient(s) and submitting that information to DCA as part of the primary applicant's regular reporting obligations;
        ii. Receiving all advance and reimbursement payments from DCA under the grant and transferring funds to the partner organization(s) in a timely manner, consistent with the allocation of funds agreed upon between the parties and as reflected in the approved budget. The terms and timing of any such inter-organizational fund transfers must be documented in the formal partnership agreement executed between the partners (e.g., memorandum of agreement); and
        iii. Ensuring that the partner organization(s), as sub-recipient(s) of grant funds, adheres to all requirements governing allowable expenditures and eligible activities as described in this RFP. The primary applicant is responsible for the fiscal integrity of the full award, including funds transferred to and expended by the sub-recipient(s).
    b. The sub-recipient organization(s) will be responsible for:
        i. Adhering to all requirements governing allowable expenditures and eligible activities described in this RFP, to the same extent as the primary applicant. Receipt of transferred grant funds does not exempt the sub-recipient(s) from compliance with any applicable grant conditions, fiscal requirements, or programmatic obligations;
        ii. Providing the primary applicant with timely, accurate, and complete financial records, expense documentation, and programmatic reporting materials on a schedule sufficient to allow the primary applicant to meet all DCA reporting and milestone documentation deadlines;

2. **Not allowed:**
    a. Applications submitted solely by a Housing Supports Program provider without a partner healthcare entity
    b. Applications submitted solely by a hospital or healthcare provider without an identified Housing Supports Program provider

Applicants that are participating in an application must meet the following requirements, at the time of application:

1. Healthcare Entity

The healthcare entity must:

a. Be a healthcare provider operating in New Jersey, as demonstrated by possession of a valid National Provider Identifier (NPI); and

b. **Not** be an enrolled Housing Supports Program provider (i.e., the organization's Medicaid ID is not associated with the Housing Supports Program). Although hospitals and other healthcare entities are generally eligible to enroll as Housing Supports Program providers, that structure does not align with the partnership-focused intent of this grant program.

c. Organizational Capacity and Commitment: Please attach to your application a staffing plan indicating:
    i. Allocation of sufficient clinical or other relevant staff to actively participate in the pilot and actively support care coordination
    ii. Allocation of sufficient administrative staff to manage oversight for pilot logistics and coordination

d. **Demonstrations of Commitment:**
    i. Descriptions of Housing First and Persons with Lived Experience and Expertise (PWLEE) principles are described in section 2.c. below.
    ii. Participating healthcare entities are not required to have existing organizational policies or frameworks formally adopting Housing First or Persons with Lived Experience and Expertise (PWLEE) principles at the time of application. However, as a condition of participation in this pilot, healthcare entities must affirm a commitment to:
        - Supporting and operationally aligning with the Housing First and PWLEE-informed approaches of their Housing Supports Program provider partner throughout the pilot period, including ensuring that hospital workflows, referral processes, and staff interactions with members are consistent with and respectful of those principles;
        - Attending Housing First and PWLEE-related trainings as part of pilot implementation and cross-system partnership development; and
        - Making a good faith effort to incorporate Housing First and PWLEE principles into relevant hospital operations and staff practices over the course of the pilot, with the understanding that this pilot represents an opportunity to build cross-sector fluency between healthcare and housing systems.

iii. Attestation of this commitment must be included as part of the application using the template provided in Appendix B.

2. **Housing Supports Program Provider(s)**

a. Participating Housing Supports Program provider(s) must demonstrate significant participation in and operational readiness for the Housing Supports Program as of the RFP due date, including **all** of the following:

i. Be a nonprofit organization;

ii. **Program Participation Thresholds**

- Currently enrolled and in-network as a Housing Supports Program provider with all five **(5) Managed Care Organizations (MCOs)**
  - Note: It is permissible for an HSP provider applicant to be in-network with 3+ MCOs and in-process of contracting and credentialing with the remaining 2 MCOs at the time of application. However, the expectation is that by the time of pilot launch, the HSP provider should be in network with all 5 MCOs
- Approval of at least twenty-five (25) Housing Supports Initial Assessment Tools (IATs)
- Approval of at least twenty (20) Housing Supports claims
- Consistent adherence to program HMIS documentation requirements

b. **Organizational Capacity and Commitment.** Please attach to your application a staffing plan indicating:

i. Allocation of sufficient housing care manager staff – or plan to hire new staff - to actively participate in the pilot, expand services, and serve additional members

- As part of staffing plan, organizations should include estimated care manager caseloads and staffing ratios, to substantiate the capacity that they anticipate serving as part of the pilot

ii. Allocation of sufficient administrative staff to manage oversight for pilot logistics and coordination

iii. Sufficient administrative capacity to manage an anticipated increase in authorizations, MCO coordination and documentation review, and claims volume resulting from pilot participation

c. Provide the following demonstrations of commitment:

i. **Commitment to Housing First:**

- Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing **without preconditions and barriers to entry**, which include but are not limited to:

- Ensuring low-barrier, easily accessible assistance to all people, including, but not limited to, people with no income or income history, and people with active substance abuse or mental health issues;
- Helping participants quickly identify and resolve barriers to obtaining and maintaining housing;
- Seeking to quickly resolve the housing crisis before focusing on other non-housing related services;
- Allowing participants to choose the services and housing that meets their needs, within practical and funding limitations;
- Connecting participants to appropriate support and services available in the community that foster long-term housing stability.

- Attestation of this commitment must be included as part of the application using the template provided in Appendix C.

ii. **Commitment to the Inclusion of & Incorporation of Feedback from Persons with Lived Experience & Expertise (PWLEE):**

- OHP is committed to incorporating the perspectives and insights of persons with lived experience and expertise (PWLEE) of homelessness and housing instability in feedback and program evaluation processes.
- OHP regularly receives this feedback through the DCA Statewide PWLEE Advisory Board, which meets on a monthly basis with OHP and a quarterly basis with DHCR and DCA leadership.
- As this feedback is critical to promoting inclusion, equity, diversity, and access in the homelessness prevention and services ecosystem (HPSE), all OHP grantees must affirm and provide proof of organizational alignment with (or the good faith effort of development of alignment with) the following key principles for ensuring the inclusion of PWLEE in feedback in their programs and organization:
  - Centering the voices of PWLEE: PWLEE have a unique perspective on the experience of homelessness and offer valuable insights into the challenges and barriers they face. It is essential to center their voices in feedback processes to ensure that their experiences and needs are accurately represented.
  - Creation of a safe and supportive environment: PWLEE may have experienced trauma or marginalization related to their experiences of homelessness. It is important to create a safe and supportive environment for them to share their feedback, where they feel heard and respected.
  - Using inclusive language and communication: Feedback processes should use language and communication that is inclusive and accessible to all. This includes using plain language, avoiding jargon or technical terms, and ensuring that all communication is available in formats that are accessible to individuals with disabilities.

- Providing opportunities for meaningful engagement: PWLEE should have opportunities to provide feedback in ways that are meaningful and accessible to them. This may include one-on-one conversations, focus groups, surveys, or other methods of engagement that suit their preferences and needs.
- Recognition of power imbalances: Power imbalances can and often do exist between PWLEE and those collecting feedback, which can lead to a lack of representation or influence. It is important to recognize and address these imbalances to ensure that the perspectives and experiences of PWLEE are fully represented and considered in feedback processes.

- Applicants for OHP funding are required to **document affirmation of the principles through completion of the template in Appendix C, including submission of at least one (1) of the following supplementary materials submitted as addenda to their application.** Acceptable materials indicating affirmation include, but are not limited to:
  - Centering PWLEE Voices: This could be proven through agency protocols highlighting how PWLEE's perspectives are prioritized, or instances where their insights have influenced changes in the program.
  - Creating Safe Environments: Evidence of this could include policies or guidelines about creating respectful and supportive spaces for PWLEE, and possibly testimonials from PWLEE on their experience participating in feedback processes.
  - Inclusive Language and Communication: Applicants may share their guidelines or examples of accessible, jargon-free communication materials, including different formats for individuals with disabilities.
  - Opportunities for Meaningful Engagement: This could be shown through the variety of feedback methods employed to suit different preferences and needs of PWLEE, and how this feedback has been utilized by applicant.
  - Recognition of Power Imbalances: Applicant could provide evidence of their strategies to identify and address power imbalances, such as policies for equitable treatment, or practices promoting shared decision- making.
  - Active Pursuit of Inclusion, Equity, Diversity, and Access: Applicant may share the organization's policies, training programs, and examples of actions taken to uphold these values.
  - Evidence of Good Faith Effort: For organizations still developing alignment with these principles, they should provide a detailed plan showcasing their understanding of these principles and their steps towards incorporating them. This can include timelines, measurable goals, and designated personnel responsible for each step.

IX. Ineligible entities

All Entities:

1. Entities listed on the State Debarment list, located at: https://www.nj.gov/treasury/revenue/debarment/

For Housing Support Program Providers Only:

1. Municipal governments, counties, and other local governmental agencies or units of local government are not eligible to apply for funding under this program.
2. Entities listed on the DCA list of High-Risk grantees and, as applicable, the current audit submission is not overdue.
3. Entities whose annual information update has not been completed in DCA SAGE.

X. Eligible Activities

All grant-funded activities and expenditures under this program must fall within one of the following categories:

1. Technology
2. Development of business or operational practices
3. Workforce development
4. Outreach, education, and stakeholder convening

All proposed activities and uses of funds must directly support and advance the goals and objectives of this RFP. Activities or expenditures that do not clearly align with the purpose of the grant program will not be considered allowable. If an applicant has a question about eligible activities, applicants are encouraged to contact DCA for clarification.

Applicants should submit a budget for each of the partner organizations, as shown in the example budget in Appendix A. The total requested budget for the application should reflect the sum of these individual organization budgets. Note that if a hospital applicant has not yet secured a partnership with a housing supports provider, they should include an estimated budget that based on the anticipated activities of the housing supports provider.

1. Technology:

Technology is a critical enabler of effective hospital–Housing Supports Program integration. Under this pilot, grant funds may be used to support technology and data systems that enable hospitals and Housing Supports Program providers to coordinate more effectively, securely share information, manage referrals, document services, and support billing and reporting requirements.

For **Housing Supports Program providers**, allowable technology costs may include systems or tools needed to manage increased referral volume, improve documentation of service delivery, and

submit authorizations and claims. Allowable technology costs may also include mobile or field-based technology needed to support bedside engagement, documentation, care coordination, and community-based follow-up activities, such as laptops, tablets, secure mobile devices, or related equipment necessary for service delivery and communication across settings. Allowable costs may also include tools that support coordination of care across hospital and community-based settings, including integration with or modification of existing electronic health record systems or other platforms to enable secure communication with partner organizations. Costs associated with onboarding consulting staff, and training staff on new, modified, or existing systems are also allowable.

For **hospitals or other healthcare entities**, allowable technology costs may include modifications to existing electronic health record systems, referral platforms, or communication tools needed to collaborate with HSP providers and support real-time or near-real-time coordination, including tools required to enable virtual engagement between HSP providers and hospitals where applicable. As with HSP providers, consulting and staff training costs associated with onboarding to new or modified systems are allowable.

2. Development of business or operational practices

Participation in this pilot will require both hospitals and Housing Supports Program providers to adapt and refine existing business and operational practices to function effectively in a more integrated, higher-volume, cross-sector environment. Grant funds under this category are intended to support the design, implementation, and refinement of new or modified workflows, policies, and partnership structures necessary for hospital–HSP collaboration.

Note that the State-selected Technical Assistance provider will support pilot participants in designing and refining workflows, policies, and partnership structures during the pre-launch period. Accordingly, grant costs in this category are expected to be oriented primarily toward the operationalization of those workflows — such as the administrative tools, staffing capacity, and infrastructure necessary to carry them out — rather than toward workflow design itself.

For **Housing Supports Program providers**, allowable activities may include work to modify intake and engagement workflows for hospital-referred members; expand administrative capacity to manage increased referrals and billing; operationalize new internal processes for coordinating with hospital partners; and support legal or operational work needed to formalize partnerships (e.g., memoranda of agreement).

For **hospitals or healthcare entities**, allowable activities may include adapting clinical or care management workflows to incorporate Housing Supports screening and referral; developing procedures to support onsite, near-site, or virtual HSP engagement; dedicating or modifying space for HSP staff when applicable; and supporting legal, compliance, or administrative work necessary to establish and maintain partnerships.

3. Workforce development

Successful implementation of the Hospital and Housing Supports Services Integration Pilot requires a workforce prepared to operate across hospital and community-based environments. Grant funds under this category may be used to support workforce development activities that enable participating organizations to absorb increased demand, operate within new settings, and deliver services consistent with Housing Supports Program requirements.

For **Housing Supports Program providers**, workforce development costs may include hiring or onboarding additional care managers or administrative staff to manage increased member volume; training staff to operate within hospital environments; and supporting certifications or specialized training (e.g., treatment of other HRSNs, privacy requirements) necessary for effective service delivery.

For **hospitals or healthcare entities**, allowable activities may include training hospital staff to understand Housing Supports Program requirements, referral workflows, and coordination expectations, as well as training HSP staff on hospital protocols, safety requirements, and care team norms where applicable.

Note that costs associated with salary and fringe for personnel who will have a direct role in overseeing, designing, implementing, and/or executing responsibilities as part of this pilot are **time limited** to a period of up to 18 months. While this grant may fund salaries and staffing costs during the implementation period, agencies should focus on building long-term sustainability through Medicaid reimbursement revenue to support program staffing beyond the grant term. Program staff supporting Housing Supports services should not be viewed solely as grant-funded positions. Agencies are encouraged to incorporate Medicaid revenue into workforce sustainability planning throughout the grant period. DCA anticipates that in most cases, personnel costs charged to this grant will reflect a partial allocation of staff time, recognizing that employees supporting this pilot will likely carry responsibilities across this program and other organizational activities.

OHP supports the payment of a fair living wage with appropriate benefits for professionals serving as Housing Case Managers or in similar direct service roles providing pre-tenancy and tenancy sustaining services. Agencies awarded this grant are strongly encouraged to ensure Housing Case Managers are compensated at a salary of at least $65,000 annually, regardless of whether the position is partially or fully funded through the grant

4. Outreach, education and stakeholder convening

While the Technical Assistance (TA) provider selected under a separate RFP will lead most convening, training, and shared learning activities related to the day-to-day operation of the Hospital and Housing Supports Services Integration Pilot, grant funds under this category may be used by participating hospitals and Housing Supports Program providers for complementary outreach, education, and engagement activities that support broader system awareness and effective implementation.

For **hospitals or healthcare entities**, allowable activities may include educating additional parts of the health system—such as clinical departments, care management teams, discharge planning

staff, or affiliated providers—about the Housing Supports Program and referral pathways, in order to support consistent identification and appropriate referral of eligible members.

For **Housing Supports Program providers**, allowable activities may include education or engagement efforts that support coordination with healthcare partners, community-based organizations, or other stakeholders whose involvement is necessary to facilitate member engagement and continuity of care.

Both hospitals and HSP providers may use funds under this category to support targeted outreach or engagement with **third-party organizations** (e.g., community-based partners, shelters, or other enabling entities), where such activities directly support Housing Supports Program engagement or coordination. Grant funds may not be used to pay for non–Housing Supports services delivered by third-party entities.

XI. Ineligible activities

Activities not specifically approved through this application or subsequently approved in writing by DCA or DMAHS.

Grant funds may not be used to pay for direct client assistance, including financial or material assistance to clients or program participants (e.g., rental assistance, security deposits, utility payments, gift cards, transportation, application fees, etc.). However, organizations may provide direct client assistance using their own resources, outside of this grant, as appropriate.

Direct client services (e.g., pre-tenancy and tenancy-sustaining services) provided to Medicaid members through the Housing Supports Program may only be billed through the Medicaid claims process. No grant funding may be used to provide those direct client services.

XII. Funding Distribution

Payments under this grant program will be made through a combination of an initial advance and subsequent milestone-based reimbursement caps. In the event the grant term is extended, milestone schedules, deliverables, and associated disbursements may be revised as necessary to align with the updated grant period.

1. **Thirty percent (30%)** of the total award will be issued as a cash advance upon grant selection, prior to the completion of any milestones.
2. **Up to 50% of total grant award** is eligible for reimbursement upon execution of a formal partnership agreement between the hospital and Housing Supports Program provider (e.g., Memorandum of Agreement or similar instrument) and approval of the following by DMAHS and DCA, reflecting any refinements made in collaboration with the TA provider during the pre-launch period:

a. A resubmission of the "Narrative" requirements drafted as part of Section XIV, including a budget in the template of Appendix A, with more detail and refinement to reflect any changes from the initial application.

   i. Note: The revised **implementation plan** should also include additional detail such as: a sequenced list of pre-launch activities with estimated timelines for completion across both partners (covering staffing deployment and onboarding, required trainings, and technology procurement and configuration); identified operational risks and specific mitigation strategies for each; and a description of the cadence and structure by which partners will meet to monitor performance, identify challenges, and make workflow adjustments once the pilot is live.

   ii. Revised **budget** should include any material changes from the original application noted and explained. Budgets cannot be revised to exceed the original award amount, unless otherwise expressly approved by DCA and DMAHS.

b. **Note:** Formal partnership agreement (e.g., Memorandum of Agreement or similar instrument) should indicate that organizations must have agreed upon terms for funds transfers and reporting of expenses

c. **Note:** The 50% reimbursement cap is **inclusive** of the initial 30% advance. Expenses reported are first subtracted from "Cash on Hand" from advance prior to reimbursement.

3. **Up to 60% of total grant award** is eligible for reimbursement upon demonstration of readiness to serve members in pilot, as determined by DCA OHP and DMAHS, which includes completion of the following foundational activities:

   a. Implementation of jointly agreed-upon operational workflows (e.g., referral, engagement, and follow-up processes) to prepare for operationalization;

   b. Completion of required staff training for hospital and Housing Supports Program provider staff participating in the pilot; and

   c. Demonstration that required technology or data-sharing processes are live and functional (e.g., referral mechanisms operational).

4. **Up to 90% of total grant award** is eligible for reimbursement one (1) year following the official launch of the Hospital and Housing Supports Services Integration Pilot, contingent upon:

   a. DCA OHP determining that the organization is demonstrating a good-faith effort to implement and participate in the pilot, examples of behaviors that may demonstrate a lack of good-faith participation include, but are not limited to:

      i. Failure to comply with the terms of the executed hospital–Housing Supports Program partnership agreement;

      ii. Poor collaboration with the Technical Assistance provider, including failure to participate in required coordination or learning activities or share data with TA provider;

iii. Repeated unresponsiveness to communications or requests from TA Provider, DCA, or DMAHS;

iv. Failure to make reasonable, documented efforts to address operational challenges or adapt workflows as issues arise; and

v. Minimal service delivery through the pilot, defined as serving fewer than twenty (25) members per year with Housing Supports Program services through this partnership model, absent a documented and State-approved justification.

b. Completion of a mid-term review with the Technical Assistance provider, which includes structured reflection on pilot progress to date, identification of implementation challenges, success stories, and development of an improvement or refinement plan for the second year of the pilot.

5. **Final ten percent (10%)** of the total award will be disbursed at the conclusion of the of the pilot implementation, contingent upon same standards of demonstration of good faith effort as shown above.

Primary grantee will **share documentation** proving completion of milestones with DCA.

Grantee will have **approximately 1.5 years** from the official launch of all pilot sites under the Hospital and Housing Supports Services Integration Pilot as defined above to **complete activities** and earn funding (unless extension given).

Note: *All grant disbursements will be directed by DCA to the primary grantee, as outlined in Section VIII. The primary grantee will be responsible for transferring funds to the sub-grantee partner organization(s) as applicable, consistent with the terms documented in a formal memorandum executed between the pilot participants. The primary grantee is solely responsible for submitting all required fiscal and programmatic documentation to DCA through SAGE, including collecting and consolidating relevant expenditure records, milestone documentation, and supporting materials from the sub-grantee(s) in advance of submission. Sub-grantees must provide timely and accurate documentation to the primary grantee sufficient to meet all DCA reporting deadlines. All fund transfers between pilot participants must be documented and align with the approved budget and eligible activities described in this RFP.*

XIII. Grant term

December 1st, 2026 – June 30th, 2028

XIV. Application process - Narrative

The proposal must be submitted electronically via SAGE as an application attachment. All applicants must submit in SAGE a written narrative that describes the following:

1. **Proposed Partnership Model (Maximum length - 3 Pages, non-inclusive of attachments)**

   Note: Throughout the early stages of pilot launch, if applicant is selected, pilot participants will be supported by TA provider in further enumerating responsibilities of all parties and determining workflows. A revised and more detailed version of the operating model will be submitted to DCA and DMAHS as part of the activities needed to receive payment for milestone 2.

   a. **Description of Proposed Operating Model**

      Applicants must describe the proposed hospital–Housing Supports Program partnership model. Describe the proposed member journey from initial point of contact through longitudinal Housing Supports service delivery. Please include delineation of roles and responsibilities across these steps in the operating model.

      In this application, at minimum, include:

      i. **Member intake point:** Identify the specific clinical care setting(s) where members are engaged (e.g., emergency department, inpatient unit, outpatient clinic).

      ii. **Screening for housing need:** Describe how and when members will be screened for housing instability (and, if applicable, other health-related social needs). Responses must identify who conducts the screening, at what point during the clinical encounter the screening occurs, and how screening results are operationalized. Applicants must clearly explain how screening triggers the next step in the workflow, including how the member is transitioned into HSP provider's engagement and care.

      iii. **HSP engagement:** Specify what level of Housing Supports engagement occurs as part of the workflow and how it may vary depending on context (e.g., whether HSP provider is routinely on-site vs. on-call). Clearly describe:

         - When in the clinical care experience this engagement occurs and whether repeat engagement is expected;
         - What the scope of engagement is expected to contain (e.g., evaluation of needs, discussion of eligibility for potential emergency housing options, working to connect member to emergency housing), including whether HSP authorization forms (e.g., IAT) are expected to be completed;
         - Where the engagement physically takes place (e.g., bedside in the ED, designated consultation space, virtual connection facilitated onsite);

- Which staff are involved.

iv. **Transition to longitudinal care:** Describe the mechanism by which members are connected to the HSP provider community engagement care managers and transitioned to ongoing HSP services after discharge. Staying in contact with members to support them in their housing journey over time, even after discharge, is anticipated to be challenging in many instances. Include any required technology, referral platforms, or data-sharing processes needed to operationalize this transition and follow-up with the member

2. Please note any expected longitudinal engagement between the HSP provider and the hospital (e.g., to support member's continued ability to address clinical needs)

   a. **Partnership Structure:** Please identify all organizations that are party to the proposed model, including which departments, units, or divisions within each organization will participate

   b. **Expected Impact of Proposed Model**

      i. **Estimated Impact for Members:** What impact this pilot model is expected to have on member outcomes – including clinical and housing outcomes. This should serve as the **"theory of change"** for the pilot. Please include:

         - The rationale linking the model's key design features (e.g., embedded staff, on-call availability) to anticipated member-level outcomes such as successful HSP enrollment, housing stability, or reduced ED utilization; and
         - What target populations are expected to be served using this pilot model, including whether there are any specialty populations (e.g., veterans, individuals with serious mental illness, etc.) that are anticipated to be particularly supported in receiving access to Housing Supports services
         - Any assumptions underlying this theory of change that the applicant acknowledges as uncertain, and how the pilot will help test or validate those assumptions.

      ii. **Estimated Member Volume**

         - Any assumptions underlying this theory of change that the applicant acknowledges as uncertain, and how the pilot will help test or validate those assumptions.
         - Provide an estimate of the number of Housing Supports–eligible members the proposed model is expected to serve over the two-year pilot period.
         - Applicants must show the methodology used to arrive at this estimate. A high-level calculation is acceptable (e.g., total patients seen at the pilot site = X, estimated percentage with housing-related needs = Y%, uptake rate for members successfully screened and forwarded to services = Z%; projected eligible volume = X × Y% * Z%).

3. **Implementation Plan (Maximum length - 2 Pages, non-inclusive of attachments)**

   Provide a high-level implementation plan detailing how the pilot will be operationalized. This plan should be agreed-to by all organizations that are party to the proposed model.

   Note: After RFP awards are granted, the TA provider will support pilot participants in further enumerating this implementation plan by providing a playbook to support HSP providers and hospitals in establishing effective partnerships, including developing milestones for activities completed within first week, month, etc.

   In this narrative response, at a minimum, include:

   a. **Current Progress of Partnership:** Describe the current status of the partnership between the applicants. Please include as an attachment:

      i. Any executed or draft partnership agreements (e.g., LOIs, MOAs). If no formal partnership agreements exist yet, please describe the process and expected timeline for drafting and executing such agreements, including identification of responsible parties and planned approval steps;

      ii. Evidence of joint planning efforts, if they have occurred (e.g., meetings to work together on brainstorming care model for RFP application);

      iii. Evidence of prior collaboration between partners, if applicable.

   b. **Pilot launch plan:** Describe a sequenced list of activities that need to be completed prior to pilot operationalization to ensure readiness. Activities should reflect pre-launch preparation across both partners, and include estimated timeline for completion. Activities required prior to pilot operationalization could include, but are not limited to:

      i. Shared workflow development (e.g., referral, engagement, handoffs, communication protocols);

      ii. Staffing deployment, onboarding, and required trainings; and

      iii. Technology procurement, configuration, and implementation (including any data-sharing or referral mechanisms required for operations).

   c. **Funding Request and Budget Narrative (Maximum length - 1 Page, non-inclusive of attachments):** Applicants must submit a narrative justification in this section detailing the total funding amount requested and the purpose of line items. A proposed budget in a format similar to the example provided in Appendix A must be completed in the SAGE Budget section in the application.

      i. Budgets must clearly align with the allowable cost categories described in Section 12, Eligible Activities.

      ii. Applicants requesting more than $500,000 must provide a written justification explaining why additional funding is necessary. Such requests are not guaranteed to be approved. Applicants are strongly encouraged to also submit an alternative, scaled version of their

operating model and budget that falls within the $500,000 funding cap, which may be submitted as an attachment, if applicable.

iii. **Note:** The budget submitted as part of the application process is intended to reflect the applicant's proposed operating model and anticipated use of funds. Following award, DCA and DMAHS may require revisions to the budget and budget narrative to ensure alignment with approved pilot activities, allowable expenses, partner roles and responsibilities, reporting requirements, and other programmatic or fiscal considerations. Submission of the proposed budget does not constitute approval of all proposed expenditures.

4. **Organizational Experience and Capabilities (Maximum length - 2 Pages, non-inclusive of attachments)**

   a. **Healthcare Entity**

      i. **Staff Commitment:** The healthcare entity must designate dedicated staff capacity to oversee and manage the HSP partnership throughout the pilot. This must include:

         - Identification of a named project lead responsible for operational oversight of the partnership;
         - Allocation of defined staff time (FTE commitment) to manage workflow implementation, problem-solving, coordination with the HSP provider, and participation in Technical Assistance activities. Please specify the total FTE allocation.; and
         - Clear internal escalation pathways for addressing operational or partnership challenges (e.g., a designated point of contact at appropriate hospital leadership level who is empowered to address and resolve workflow issues, staffing gaps, or partnership disputes).

      ii. **Optional:** Please describe any prior experience implementing social service interventions – including partnerships with external social service providers – and specify the relevant initiatives and outcomes

   b. **Housing Supports Program Provider**

      i. **Level of Existing Participation in the Housing Supports Program:** Provide the following information, as of the date of RFP posting:

         - Date as of which organization began delivering Housing Supports services (e.g., date of first approved authorization)
         - Total number of members served;
         - Total number of authorizations submitted;
         - Total number of claims submitted, including what number have been approved;
         - Narrative description demonstrating organizational commitment to the Housing Supports Program.

ii. **Staff Commitment:** Submit a staffing plan identifying the care managers, supervisors, and administrative staff who will participate in the pilot. Applicants must demonstrate sufficient staffing capacity to absorb increased member volume and meet engagement expectations. The plan must include:

- Identified project lead responsible for supervisory and operational oversight for participating staff;
- Designated Housing Supports care manager(s) responsible for pilot-referred members;
- Administrative or billing staff responsible for managing authorizations, claims submission, and reporting; and
- Estimated FTE allocation dedicated to pilot activities.

iii. **Optional:** Describe prior experience partnering with hospitals or healthcare systems in cross-sector initiatives similar to this pilot

XV. Application process – Threshold requirements / required attachments

Please submit all required attachments combined into a single document for upload into SAGE. Only applications that submit all the following attachments along with your application will be scored; ***applications missing any documents will be provided 5 days to upload them.***

Please include the below for all applicants (e.g., primary applicant and sub-recipient(s)), unless otherwise noted**:**

Documents with dedicated SAGE upload links (uploaded individually)

1. Articles of Incorporation
2. Job descriptions of positions created via project (if proposed project will create additional positions at/for entity) (Schedule A)
3. Verification of Current SAM Registration (showing an unexpired registration date)
    a. Subrecipient(s) must, at a minimum, have a Unique Entity ID (UEI) registered in SAM.
4. Complete all Certification Sheets:
    a. Certification Regarding Debarment and Suspension (Schedule G)
    b. Certification Regarding Lobbying (Schedule H)
    c. DCA Board Resolution (Schedule I)
5. IRS Determination Letter
6. Organizational Chart
7. Project Budget
8. Executed application cover page (primary applicant only).

Documents without dedicated SAGE upload links (combined into 2 PDF files: 1 for the HSP primary applicant and one for the subrecipient(s). Upload using the Supporting Documents 2 upload fields)

Primary Applicant (Housing Supports Provider)

1. Project Narrative
2. Letter of Intent (LOI) or other document establishing that all parties have formally agreed to work together to participate in pilot and intend to further codify responsibilities if award is granted

3. Attestation of commitment stating that all parties will participate in good faith and actively collaborate with the State-sponsored Technical Assistance provider assigned to this pilot program, including participation in required meetings, reporting, and evaluation activities
4. Submit the last 3 years of audits [to include statement cash flows [or equivalent]) and latest IRS Form 990
    a. Note: Applicant's submissions **must demonstrably show** that they have sufficient cash flows to sustain staff and effectively administer the grant. The primary applicant is solely responsible for ensuring that the sub-recipient(s) have the financial capacity and administrative infrastructure to successfully perform the activities under this grant program.
5. Materials to demonstrate eligibility outlined in Section VIII of this document:
    a. Affirmation of Housing First (Appendix C)
    b. PWLEE Inclusion and Activities (Appendix C)
    c. A Board Resolution confirming the agency board's endorsement of participation in the pilot program. The resolution must also affirm the board's approval of the agency's proposed staffing and general participation commitments to this pilot program.
    d. Documentation or written confirmation from the Executive Director (or equivalent senior leader) demonstrating organizational approval and commitment to participate in the pilot for the whole duration (1.5 years). This confirmation must indicate executive awareness of the operational, staffing, and financial commitments associated with participation.
6. Additional HSP-specific materials that demonstrate eligibility outlined in Section VIII of this document:
    a. Required program participation statistics
    b. Required organizational capacity and commitment evidence
7. Organizational By-Laws
8. Staff resumes for employees involved with the pilot

Note: For partnership models that include more than one Housing Supports Program Provider, the subrecipient Housing Supports Program Provider must also submit items 5-8, to be included with the PDF upload for subrecipient documentation.

Participating Healthcare Entity (Subrecipient)

1. Leadership Approval and Institutional Support: The proposed pilot must have documented approval and commitment from relevant executive leadership, including at minimum:
    a. Leadership of the participating clinical setting (e.g., ED, acute-care setting, street team); and
    b. Existing care coordination, social services, or member discharge leadership that is responsible for HRSN screening and referrals today.
    c. Attestation of willingness to serve in role for whole duration of this pilot (approximately 1.5 years)
    d. Applicants must demonstrate that these leaders are aware of and support the proposed model, including integration of Housing Supports Program activities into clinical workflows. Applications should identify the specific leaders who have approved the proposal and describe their role in oversight and accountability for pilot success.
2. Materials to demonstrate eligibility outlined in Section VIII of this document:
    a. NPI Confirmation Notice
    b. Demonstration of commitment to Housing First and PWLEE Inclusion principles (Appendix B)
3. Organizational By-Laws
4. Staff resumes for employees involved with the pilot

XVI. Reporting and monitoring requirements

1. Submit monthly progress reports in SAGE, summarizing implementation progress, emerging issues, technical assistance activities, and risks requiring State awareness.
2. Quarterly fiscal reporting in SAGE detailing expenditures incurred during the reporting period.
3. Participation in recurring meetings with TA provider.
4. Quarterly meetings with OHP Program Staff (via Teams)
5. Site visitation/file review by DCA OHP and / or DMAHS teams
6. Support the TA provider's mixed-methods evaluation of the pilot, including participating in evaluation-related interviews, focus groups, or structured feedback sessions as requested; collecting and sharing deidentified, member-level tracking data in alignment with the methodology established by the TA provider; and cooperating with any site visits or data requests necessary to enable the State's assessment of pilot implementation and outcomes.

a. At a minimum, grantees must maintain records sufficient to identify which NJ FamilyCare members received services through the pilot, the start and end dates of each member's engagement in pilot-related activities, and the pilot site and hospital–Housing Supports Program provider partnership through which each member was served.

b. Note: Grant recipients will be required to share de-identified member-level data with the State-selected TA provider for the purpose of pilot evaluation and assessment. The specific data elements and sharing protocols will be determined in coordination with DMAHS, DCA, and the TA provider following award. Recipients should anticipate that this will require execution of a data use agreement (DUA) or similar instrument with the TA provider prior to data transfer, and should factor the time required to negotiate and execute that agreement into their pre-launch planning. De-identified member data shared with the TA provider will be used solely for the purpose of pilot evaluation and assessment as described in this RFP and will not be used for any other purpose or shared with any additional parties without the explicit written approval of the contributing hospital or Housing Supports Program provider(s). The TA provider will be required to agree to these restrictions as a condition of the data use agreement executed prior to any data transfer.

XVII. Scoring Rubric: NJ FamilyCare Housing Supports Hospital and Housing Supports Services Integration Pilot Grant Program Evaluation Rubric

Section	Component	Component Description	Maximum Points
1. Proposed Operating Model	1a. Member Workflow and Operating Model Design	Clarity, feasibility, and specificity of the proposed member workflow from identification through transition to longitudinal HSP services	15
	1b. Partnership Structure and Delineation of Roles	Clarity of the proposed partnership structure, including identification of all participating organizations, and a delineation of roles and responsibilities across each step of the member journey described in 1a. Strength of evidence that roles are well-defined, understood, and agreed-to by both parties.	15
	1c. Theory of Change, Anticipated Member Impact, and Estimated Member Volume	Strength and credibility of the applicant's theory of change, including: the logic connecting key model design features to anticipated member-level outcomes; identification of target populations; and honest acknowledgment of key assumptions and how the pilot will test them. Also includes clarity and credibility of the estimated number of members to be served over the two-year pilot period.	20
2. Implementation Plan	2a. Current Partnership Status and Readiness	Strength of evidence that the hospital and HSP provider have an established, functional working relationship. Applications with executed or near-final partnership agreements, documented joint planning, or prior collaboration history will be scored more favorably.	10
	2b. Pre-Launch Activity Plan and Timeline	Feasibility, completeness, and realism of the pre-launch activity plan, including: sequencing of activities across both partners and estimated timelines for completion.	10
3. Budget	3a. Budget Clarity, Alignment, and Reasonableness	Clarity and specificity of the proposed budget, alignment of all line items with allowable cost categories and the proposed operating model, and reasonableness of	15

Section	Component	Component Description	Maximum Points
		the total funding request relative to the scope and scale of the pilot.	
4. Organizational Experience and Capacity	4a. Healthcare Entity — Staff Commitment and Leadership Support	Strength of evidence that the healthcare entity has secured institutional leadership support for the pilot and has designated sufficient, clearly defined staff capacity to manage the partnership.	5
	4b. HSP Provider — Existing Program Participation and Organizational Capacity	Strength of the HSP provider's demonstrated participation in and operational capacity for HSP and evidence of organizational commitment and staffing capacity to absorb volume from the pilot.	5
5. Threshold Requirements	5a. Meets All Threshold and Eligibility Requirements	Application meets all submission requirements and eligibility criteria outlined in the RFP	Pass / Fail
6. Overall Proposal Quality	6a. Clarity and Responsiveness of Proposal	Overall clarity, organization, and responsiveness of the application to the RFP instructions. Proposals that are well-organized, free of internal inconsistencies, and directly responsive to each required narrative component will score more favorably.	5
Maximum Total Score			**100**

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Appendix A: Example Budgets

Example Budget: For Clinical Partner		
Total Award: $220,000.00		
Category	***Amount ($)***	***SAGE Classification***
Technology	**$70,000**	
Software buildout for EHR to integrate HSP screening and referral workflows	$35,000	Program – Operating Cost-Equipment
Secure referral and data-sharing interface subscription and set-up fees	$12,000	Program – Operating Cost - Equipment
Virtual engagement software licenses	$8,000	Program – Operating Cost - Equipment
Data reporting and outcomes tracking software	$15,000	Program-Operating Cost-Other
Development of Business or Operational Practices	**$55,000**	
Staff time for clinical workflow redesign and implementation	$20,000	Program-Personnel-Salary/Wages
Legal and compliance fees for partnership agreement development	$20,000	Program- Purchased Services-Consultant
Staff time for data reporting and quality monitoring setup	$15,000	Program-Personnel-Salary/Wages
Workforce Development	**$75,000**	
Hospital staff training costs on HSP processes	$25,000	Program-Personnel-Training
Partial FTE salary for project manager (pilot oversight)	$50,000	Program-Personnel-Salary/Wages
Outreach, Education, and Stakeholder Convening	**$20,000**	
Printed material, signage, and collateral for internal education campaign across departments	$10,000	Program-Personnel-Training
Meeting space and materials for cross-partner coordination meetings	$10,000	Program-Operating Cost-Other
Clinical partner total:	**$220,000**	

Example Budget: For HSP Partner		
Total Award: $185,000.00		
Category	***Amount ($)***	
Technology	**$47,000**	
Case management software enhancements	$15,000	Program – Operating Cost-Equipment
EHR integration / secure communication tools	$20,000	Program – Operating Cost-Equipment
Billing and documentation system upgrades	$10,000	Program – Operating Cost-Equipment
Mobile devices (iPads) for care manager field use	$2,000	Program – Operating Cost-Equipment
Development of Business or Operational Practices	**$33,000**	
Administrative expansion (billing/compliance)	$23,000	Program-Operating Cost-Other
Partnership coordination and operational planning	$10,000	Program-Operating Cost-Other
Workforce Development	**$85,000**	
Partial Housing Care Manager Salary (time-limited)	$45,000	Program-Personnel-Salary/Wages
Administrative/billing staff expansion	$30,000	Program-Personnel-Salary/Wages
Hospital-integration onboarding and training	$10,000	Program-Personnel-Training
Outreach, Education, and Stakeholder Convening	**$20,000**	
High-touch engagement supports (medical respite, emergency shelters)	$15,000	Program-Operating Cost-Other
Community partner coordination meetings	$5,000	Program-Personnel-Training
HSP partner total:	**$185,000**	

Appendix B: Healthcare Entity Attestation of Commitment to Housing First and People with Lived Experience & Expertise (PWLEE) Principles

Healthcare Entity Name: _____

HSP Provider Partner: _____

Authorized Representative Name: _____

Title: _____

Purpose:
The Hospital and Housing Supports Services Integration Pilot is intended to strengthen coordination between healthcare entities and NJ FamilyCare Housing Supports providers to improve connections to housing-related services for eligible NJ FamilyCare members. Participating healthcare entities are not required to have formal organizational Housing First or People with Lived Experience & Expertise (PWLEE) policies or frameworks in place at the time of application. Healthcare entities are, however, required to demonstrate a commitment to supporting and incorporating these principles throughout implementation of the pilot.

Attestation of Commitment:
On behalf of **[Healthcare Entity Name]**, I attest that our organization commits to the following throughout participation in the Hospital and Housing Supports Services Integration Pilot:

1. **Alignment with Housing First and PWLEE-Informed Approaches**
   Support and operationally align with the Housing First and PWLEE-informed approaches of our HSP provider partner, including working to ensure that relevant healthcare workflows, referral processes, and staff interactions are consistent with and respectful of these principles.
2. **Training and Partnership Development**
   Participate in Housing First and PWLEE-related trainings during pilot implementation and as part of cross-system partnership development.
3. **Incorporation into Healthcare Practices**
   Make a good-faith effort to incorporate Housing First and PWLEE principles into relevant healthcare entity operations and staff practices over the course of the pilot.

Certification:
By signing below, I certify that I am authorized to make this attestation on behalf of the healthcare entity identified above and affirm the organization's commitment to the requirements described in this attestation for the duration of its participation in the Hospital and Housing Supports Services Integration Pilot.

Authorized Representative Signature: _____

Printed Name: _____

Title: _____

Date: _____

Appendix C: Housing Supports Provider Affirmation of Housing First and People with Lived Experience & Expertise (PWLEE) Inclusion

Housing Supports Provider Name: _____

Healthcare Entity Partner: _____

Authorized Representative Name: _____

Title: _____

Purpose:
Housing Supports Providers participating in the Hospital and Housing Supports Services Integration Pilot are required to demonstrate commitment to Housing First principles and the meaningful inclusion and incorporation of feedback from Persons with Lived Experience & Expertise (PWLEE).

Housing First Affirmation:
On behalf of **[Housing Supports Provider Name]**, I affirm that our organization is committed to the Housing First approach of quickly and successfully connecting individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry. Our organization affirms its commitment to the following Housing First principles:

- **Ensuring low-barrier, easily accessible assistance** to all people, including, but not limited to, people with no income or income history and people with active substance use or mental health issues;
- **Helping participants quickly identify and resolve barriers** to obtaining and maintaining housing;
- **Seeking to quickly resolve the housing crisis** without requiring other non-housing-related services;
- **Allowing participants to choose the services and housing that meet their needs**, within practical and funding limitations; and
- **Connecting participants to appropriate supports and services** available in the community that foster long-term housing stability.

PWLEE Inclusion and Incorporation of Feedback:
Our organization further affirms its alignment with, or good-faith effort toward developing alignment with, principles that promote the meaningful inclusion of PWLEE in organizational and program feedback processes.

Our organization affirms its commitment to:

- **Centering the voices of PWLEE** so their experiences, perspectives, and needs are represented in feedback processes;
- **Creating safe and supportive environments** where PWLEE feel heard and respected;
- **Using inclusive and accessible language and communication**, including plain language and accessible formats;

- **Providing meaningful and accessible opportunities for engagement**, including methods responsive to the preferences and needs of PWLEE;
- **Recognizing and addressing power imbalances** so that PWLEE perspectives and experiences are fully represented and considered; and
- Supporting the **active pursuit of inclusion, equity, diversity, and access** within organizational practices and activities.

Required Supporting Documentation:
In addition to this affirmation, the Housing Supports Provider must submit **at least one (1) supplementary material** demonstrating organizational alignment with the PWLEE principles above or, for organizations still developing alignment, evidence of a good-faith effort toward alignment.

Examples may include organizational protocols or policies; examples of PWLEE-informed program changes; documentation of PWLEE engagement or feedback activities; relevant organizational policies or training; or a detailed plan describing how the organization will develop alignment, including timelines, measurable goals, and responsible personnel.

Supporting documentation included with application:

Certification:
By signing below, I certify that I am authorized to make this affirmation on behalf of the Housing Supports Provider identified above and affirm the organization's commitment to the Housing First and PWLEE principles described above throughout its participation in the Hospital and Housing Supports Services Integration Pilot.

Authorized Representative Signature: _____

Printed Name: _____

Title: _____

Date: _____