Governor
Mikie Sherrill

Commissioner
Jacquelyn Suárez

OFFICE OF HOMELESSNESS PREVENTION:

NJ FamilyCare Hospital and Housing Supports Services Integration Technical Assistance Grant Program

REQUEST FOR PROPOSALS - SFY26

RFP Due Completed in DCA SAGE: No later than 11:59pm on 09/25/2026

Table of Contents

I. Name of the grant program

NJ FamilyCare Hospital and Housing Supports Services Integration Technical Assistance Grant Program

II. DCA contact information

Tina McGill, Director, OHP, Tina.McGill@dca.nj.gov

Rita Mirabelli, OHP Project Director, Rita.Mirabelli@dca.nj.gov

Christie Zelek, OHP Program Administrator, Christie.Zelek@dca.nj.gov

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. The Housing Supports benefit is designed to assist eligible NJ FamilyCare members who have both a clinical risk factor (e.g., 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.

Overview of Housing Supports program

Goals	• Help **find & maintain housing** for housing insecure members to **improve health outcomes** • Drive greater connection of the housing and health care ecosystems
Authority	• 1115 demonstration approved by CMS through June 2028
Geography	• Statewide
Services	• **Pre-tenancy services**: case management supports to help member find housing • **Tenancy sustaining services**: case management supports to help members maintain housing • **Residential modification and remediation**: modifications or repairs to home to ensure health & safety • **Move-in supports**: payment to support the setup of new housing or a move • Does not include payment for rent or housing production
Eligibility	• MCO enrolled • At least 1 clinical risk factor (e.g., chronic health condition, mental health condition) • At least 1 social risk factor (e.g., homeless, at risk of homelessness)
Provider qualifications	• Pre-tenancy and tenancy sustaining services: organizations with experience serving housing insecure populations; can demonstrate experience via participation in other comparable government programs • Modification and remediation services: licensed home contractors will deliver • Move-in supports: housing supports providers or MCOs can pay directly and be reimbursed for these costs
Admin model	• MCOs responsible for building network, paying claims, authorizing services, and MCO care management • Housing supports providers responsible for delivering services

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.

These 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.

IV.1. Hospital and Housing Supports Services Integration Pilot

(Issued under a separate RFP – NOT this solicitation)

Through a separate 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.

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

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

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

This 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:

1. **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; and
2. **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 selection of the technical assistance provider and does not fund direct service delivery or pilot participation by hospitals or Housing Supports Program providers.

V. Detailed description of responsibilities of TA provider

The primary responsibility of the TA provider is to ensure the effective operation of the Hospital and Housing Supports Services Integration Pilot and to capture key learnings in a final report.

While DCA OHP will be the official administrator of the grant program, including fund disbursement and required reporting, the TA provider is principally responsible for supporting pilot participants and enabling day-to-day operational success of the pilot.

DCA expects the TA provider to approach this role as an adaptive implementation partner. The TA provider should be prepared to adjust strategies, activities, and supports over time in response to pilot conditions, partner needs, and emerging challenges in order to achieve the definition of success outlined below.

To support applicant understanding of this role and to inform proposal development, this section describes:

1. The State's definition of success for the Hospital and Housing Supports Services Integration Pilot; and
2. Illustrative requirements and activities the TA provider is expected to undertake to support achievement of that success.

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**.

V.1. **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:

1. **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.
2. **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.
3. **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. The goal is to build sustainable referral and coordination pathways that will last beyond the pilot period.

V.2. **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:

1. **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.
2. **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.
3. **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.
4. **Informing future policy and scale decisions:** The pilot generates clear, well-documented, outcome-oriented insights—grounded in qualitative evidence—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.

The TA provider is expected to orient its work toward achieving these outcomes and to adapt its approach as necessary to support pilot success across sites.

Detailed requirements:

1. **Pilot Implementation Support:** The TA provider will serve as the primary implementation partner supporting participating hospitals and Housing Supports Program providers throughout the launch and operation of the pilot. The TA provider is expected to play an active, hands-on role in facilitating collaboration, supporting operational readiness, and ensuring consistent and effective pilot execution across sites. Key responsibilities include, but are not limited to:

   a. **Pilot Launch**

      i. Support the launch of the Hospital and Housing Supports Services Integration Pilot, including early-stage coordination with pilot participants (e.g., convening initial kickoff meetings with participating hospitals and Housing Supports Program providers to review pilot goals, roles, and expectations, and, where applicable, grant administration responsibilities between the primary grantee and subrecipient, including financial management, reporting, and documentation requirements).

      ii. Conduct a structured partnership readiness assessment, as appropriate, to help ensure that selected hospital–Housing Supports Program provider partnerships have the foundational capacity, roles, and workflows in place to participate successfully in the pilot.

   b. **Hospital–Provider Partnership Formation and Workflow Development**

      iii. Support participating hospitals and Housing Supports Program providers in establishing clear, well-defined partnership agreements (e.g., MOAs or similar instruments) that articulate the partnership model, roles and responsibilities, governance structures, communication protocols, and expectations for collaboration.

      iv. Develop playbook to support Housing Supports Program providers and hospitals in establishing effective partnerships, including developing milestones for activities completed within first week, month, etc. Example activities include defining legal structure and identifying and scheduling meeting cadences.

      v. Work collaboratively with pilot participants to co-design and refine hospital–housing workflows that are 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.

      vi. Assist partners in translating partnership agreements and workflow designs into operational practices that can be consistently implemented, monitored, and adapted over the course of the pilot.

   c. **Training and Capacity Building**

      i. Design and host targeted trainings for participating hospitals and Housing Supports Program providers focused on effective execution of the pilot model.

         - Topics may be general best practices: operating within hospital environments,

managing cross-organizational communication, navigating hospital policies and norms,

- Topics may also be reactive to ongoing pilot challenges: adapting established workflows to real-world conditions encountered during pilot operations, managing referral volume, coordinating across clinical and non-clinical teams, supporting frontline staff working across settings, and maintaining fidelity to program expectations while operating in fast-paced hospital contexts

ii. Provide training in formats accessible to pilot participants, which may include virtual sessions, in-person workshops, or recorded materials.

d. **Conduct 1:1 pilot participant Technical Assistance**

i. Provide individualized, one-on-one technical assistance to participating hospitals and HSP providers to support effective collaboration and pilot implementation. The expectation is for some engagement to be in-person, as is effective for both parties.

ii. Offer targeted guidance to HSP providers operating within hospital environments, including support related to hospital workflows, care coordination expectations, and cross-organizational communication.

iii. Develop and disseminate practical tools, templates, guidance documents, and implementation resources to support consistent and effective pilot execution across sites. These tools are all expected to be shared fully with pilot participants throughout the pilot, and also transmitted to DCA and DMAHS.

iv. Provide ongoing implementation support to participating hospitals and HSP providers throughout the pilot period.

e. **Convening and Shared Learning**

i. Convene participating hospitals and Housing Supports Program (HSP) providers on a regular basis to facilitate peer learning, shared problem-solving, and exchange of implementation experiences across pilot sites.

ii. Design convenings to focus on cross-site themes, such as common operational challenges, adaptations to workflows or partnership models, and emerging effective practices. If possible, the expectation is for some engagement to be in-person, as is effective for all parties.

iii. Synthesize insights from convenings and shared learning activities to identify recurring patterns, lessons learned, and areas of divergence across pilot sites.

f. **Ongoing Coordination with the State**

i. Serve as a liaison between pilot participants and DMAHS and DCA, ensuring timely, consistent communication and alignment throughout the pilot period.

ii. Provide **monthly status updates** through a written report and live meetings to DMAHS and DCA summarizing pilot implementation progress, emerging operational issues, technical assistance activities provided, and risks requiring State awareness or action.

iii. Submit **quarterly pilot progress and fiscal reports** to DMAHS and DCA via SAGE that synthesize implementation developments across sites, highlight key challenges and adaptations, document early learnings, and identify opportunities for improvement or future scale, as well as report expenditures incurred during the reporting period.
   - Note: The lead applicant of the Hospital-Provider partnership will also submit quarterly progress and fiscal reports on behalf of the partnership, separate of the TA progress and fiscal reports.

iv. Participate in additional check-in meetings with DMAHS and DCA, as scheduled by the State, to review progress, discuss findings, and align on next steps.

2. **Pilot Assessment and Impact Evaluation:** In addition to providing implementation support, the technical assistance provider will be responsible for designing and conducting a structured assessment of the Hospital and Housing Supports Services Integration Pilot, using mixed methods. The purpose of this evaluation is to generate actionable learning about how hospital–housing integration models function in practice, what implementation approaches appear most effective, and what challenges arise during implementation. This will directly inform future collaborations and scaling of partnerships between health systems and housing supports providers.

   Recognizing that pilot sites may adopt different operating models and that evaluation needs may evolve over time, the State intends for the TA provider to play a leading role in proposing and refining the evaluation approach. The TA provider should therefore approach the evaluation as a collaborative design process with DMAHS and DCA.

   a. **Evaluation Design and Iterative Development:** Following selection, the TA provider will develop a proposed evaluation framework as part of the required pre-Launch Implementation and Evaluation Plan.

      i. This framework should describe the TA provider's recommended approach to assessing pilot implementation and learning across sites. The framework should reflect the provider's professional judgement regarding effective cross-site synthesis and evaluation.

      ii. The proposed framework will be reviewed with DMAHS and DCA and may be refined through an iterative process prior to finalization. This process is intended to ensure alignment between the State and the TA provider regarding:
         - Key learning objectives for the pilot
         - Appropriate qualitative methods, limited quantitative analysis, where feasible, and data collection strategies, including procedures for protecting participant privacy, confidentiality, and data security
         - The cadence of evaluation activities across the pilot period
         - Stakeholder engagement strategies
         - Expected outputs and reporting products

      iii. The final evaluation design should balance rigor with feasibility and should be structured to support both real-time learning implementation and summative

insights at the conclusion of the pilot.

iv. The TA provider shall submit the final evaluation framework to DMAHS and DCA for review and approval and shall not begin evaluation activities until approval has been received.

b. **Qualitative Assessment (Core Expectations) -** While the TA provider will have flexibility to design the evaluation approach, the state expects that a comprehensive qualitative assessment will include engagement with key stakeholder groups involved in the pilot and will generate systematic insight into implementation experiences across sites. **At a minimum, the evaluation should incorporate perspectives from**:

i. **Hospital staff:** Perspectives should include both frontline staff (e.g., clinicians, care managers, social workers) and administrative or leadership personnel (e.g., population health staff, program managers, or hospital leadership)

ii. **Housing Supports Program provider staff** participating in the pilot**:** Perspectives should include a mix of leadership, supervisory, and frontline housing case management staff involved in pilot implementation.

iii. **Participating NJ FamilyCare members:** Perspectives received through interviews or structured feedback sessions with NJ FamilyCare members who received Housing Supports services through the pilot. Member engagement must be voluntary and conducted using trauma-informed and culturally responsive approaches. The TA provider is responsible for ensuring that appropriate participant consent processes are in place prior to conducting any interviews or structured feedback sessions with members, and must comply with all applicable confidentiality, privacy, and data-use requirements governing the collection and handling of member-level information.

iv. **Oversight staff:** Incorporate perspectives of DMAHS and/or DCA staff involved in pilot oversight across the life of the pilot.

v. **Other relevant stakeholders:** Include perspectives of other stakeholders (e.g., Managed Care Organizations, community partners) where relevant to pilot operations.

vi. **Methodology:** Applicants may propose a range of qualitative methods to capture these perspectives. Methods may include, but are not limited to, interviews, structured feedback sessions, focus groups, site visits, learning convenings, or written reflections. Applicants are encouraged to propose the combination of methods they believe will most effectively capture implementation experiences and generate actionable lessons for the state.

vii. **Focus of Evaluation Activities:** Evaluation activities conducted as part of the qualitative assessment should be designed to generate insights related to the State's definition of pilot success. At a minimum, evaluation activities should explore:

- Elements of the pilot that worked well, including operational approaches perceived as most effective;
- Impact of care model on member outcomes, including health outcomes and housing-focused outcomes

- Key challenges encountered during implementation, including operational, partnership, or system-level barriers, and strategies used to address or mitigate those challenges;
- Reflections on whether and how the pilot model should be continued, refined, or scaled, including what participants would do differently if implementing the model again; and
- Perspectives on alternative operating models or approaches that participants would have considered testing, had conditions or constraints allowed.

c. **Member Tracking and Quantitative Analysis:**

i. While the technical assistance provider is not responsible for conducting comprehensive claims-level or advanced quantitative outcomes analyses, limited descriptive, quantitative analysis related to pilot implementation and outcomes is welcomed and encouraged where feasible. Examples of appropriate quantitative indicators may include, but are not limited to:

- The number of NJ FamilyCare members identified and referred to Housing Supports services through each pilot site
- The percentage of participating members who were successfully connected or transitioned into stable housing
- Differences in service engagement or housing outcomes across pilot sites
- Estimates of spend and service utilization at hospital prior to pilot engagement (e.g., due to repeat ED visits) and after participation in HSP
- Other implementation-related metrics that help illustrate pilot reach, engagement, or service delivery metrics.
- Note: The Housing Supports Providers & Hospital grantees will be responsible for collection of the underlying data. The TA provider will be responsible for synthesizing and analyzing de-identified data. The TA provider should work collaboratively with the Housing Supports Providers and Hospital grantees to ensure required data for evaluation is collected.

ii. Additionally, the TA provider must work collaboratively with the Housing Supports Providers and Hospitals to establish and maintain a clear, consistent methodology to track all NJ FamilyCare members who participate in these pilots to enable retrospective claims-based analysis by the State or its partners. **At a minimum, this methodology must support the ability to identify:**

- Which NJ FamilyCare members received services through the pilot;
- The specific pilot site and hospital–Housing Supports Program provider partnership through which each member was served; and
- The start and end dates of each member's engagement in pilot-related activities.
- Where possible, these identifiers should be structured to align with claims or

encounter data systems to support future analysis of service utilization and outcomes (e.g., Medicaid ID)

iii. The TA provider may propose additional analyses, reporting products, or dissemination materials beyond these minimum requirements where necessary to fully assess pilot impact and support State decision-making.

3. **Reporting and Synthesis -** The TA provider must produce written deliverables that synthesize implementation and evaluation findings and support State learning and decision-making. At a minimum, this includes:
   a. **One pre-launch implementation and evaluation plan**, submitted to DCA for review and approval prior to the operationalization of the Hospital and Housing Supports Services Integration Pilots. This plan must:
      i. Describe the TA provider's proposed approach to supporting pilot launch and ongoing implementation across all participating sites;
      ii. Outline planned implementation support activities, including trainings, the cadence of shared learning convenings, and one-on-one technical assistance with each pilot participant;
      iii. Describe the proposed approach to pilot evaluation, including methods and learning objectives; and
      iv. Establish shared expectations for coordination with participating hospitals, Housing Supports Program providers, DMAHS, and DCA at pilot outset.
   b. **One interim learning and implementation report**, submitted to DCA by no later than **12 months from the start of the grant term**, intended to highlight early implementation insights and emerging lessons from pilot sites. This interim report should:
      i. Highlight early and emerging pilot learnings relevant to hospital–housing integration, including challenges and barriers experienced;
      ii. Document promising practices, implementation successes, and illustrative case examples or success stories from pilot sites, with a focus on member on outcomes;
      iii. Describe how the pilot is advancing Housing Supports Program goals and strengthening coordination between healthcare and housing systems; and
      iv. Surface preliminary insights – including quantitative analyses – that may inform future program continuation, refinement, or inclusion in NJ FamilyCare 1115 Waiver Demonstration renewal discussions.
         - At the discretion of DMAHS, in partnership with DCA OHP, the due date for the interim report may be adjusted to better align with pilot implementation progress and the NJ FamilyCare Waiver Demonstration renewal timeline. At least two months notice will be given to TA provider, if due date is being adjusted.
   c. **One comprehensive final report**, submitted to DCA for review and upon conclusion of the grant term, unless another date is agreed upon, that includes:

i. A description of pilot design and implementation across sites;
ii. Mixed-method analysis results, including perspectives from hospital staff, HSP provider staff, participating members, and quantitative analysis;
iii. Identification of key implementation successes and challenges;
iv. Lessons learned related to hospital–housing integration; and
v. Actionable recommendations to inform future program design, sustainability, or potential scale.
vi. Note: Conclusion of the pilot is defined as the end of the grant term

VI. Ownership and Dissemination of Evaluation Materials

All reports, deliverables, evaluation findings, analyses, data summaries, and related materials developed by the TA provider under this contract, including interim and final evaluation reports, shall be the property of DMAHS and DCA. The TA provider shall not publish, post, distribute, present, reproduce, or otherwise disseminate any evaluation reports, findings, data, analyses, or other materials developed under this contract without the prior express written approval of DMAHS and DCA.

VII. RFP Due Date:

***RFP Due Completed in SAGE*:** No later than 11:59pm on 09/25/2026

***Award Notification Date*:** On or about 10/23/2026

VIII. Award Amount

Bidders are encouraged to submit competitive proposals. The award amount will be determined based on the competitiveness of the proposal submitted, including the applicant's proposed budget, scope of work, and overall approach.

Applicants must submit a proposed budget for the use of grant funds as part of their application. The proposed budget should reflect the applicant's best estimate of costs necessary to carry out the full scope of responsibilities described in this RFP, including both pilot implementation support and qualitative assessment activities. Proposed budgets must be itemized by cost category and must include sufficient narrative to demonstrate that proposed expenditures are reasonable, necessary, and directly tied to the activities described in the application. Budgets should outline estimated annual hours required for each project element, along with the type and level of staff assigned to those components and their corresponding hourly rates. An example budget template is provided in Appendix A.

DCA will award a grant to the applicant whose proposal is determined to be most advantageous to the State, with cost and other factors considered in accordance with the scoring rubric set forth in this RFP. DCA reserves the right to negotiate budget revisions with the selected applicant prior to contract execution, or to reject any or all proposals if it is determined to be in the best interest of the State. This RFP does not commit DCA to award a grant to any applicant, nor to reimburse

any costs incurred in the preparation or submission of a proposal.

The State reserves the right to award an engagement based on the initial pricing submitted without requesting a Best and Final Offer (BAFO). BAFOs will be conducted only in those circumstances where it is deemed by DCA to be in the State's best interests and to maximize the State's ability to get the best value.

DCA may invite one Bidder or multiple Bidders to submit a BAFO. DCA may conduct more than one round of BAFO in order to attain the best value for the State. Any BAFO that does not result in more advantageous pricing to the State will not be considered, and the State will evaluate the Bidder's most advantageous previously submitted pricing.

IX. Eligible entities

Eligible applicants must meet **all** of the following requirements at the time of application:

1. Demonstrate a minimum of three (3) years of experience providing technical assistance, implementation support, or systems-level capacity-building to healthcare providers, social service providers, housing or homelessness service systems, or cross-sector partnerships.
2. Demonstrate existing or prior working relationships with New Jersey healthcare providers and Housing Supports Program providers, or comparable healthcare and housing service organizations operating within New Jersey. Ideally, existing relationships are both at the systems and member or service level.
3. Commit to serving in the technical assistance role for base a period of approximately one year and 7 months (1.5 years) following the official launch of the Hospital and Housing Supports Services Integration Pilot, with possibility for extension.

X. Ineligible entities

1. Entities listed on the DCA list of High-Risk grantees and, as applicable, the current audit submission is not overdue.
2. Entities listed on the State Debarment list, located at www.state.nj.us/cgi-bin/treas/revenue/debarsearch.pl
3. Entities who do not agree to enroll in DCA SAGE and complete necessary reporting through this system.

XI. Eligible Activities

All grant-funded activities and expenditures under this program must directly support the goals and objectives of the Hospital and Housing Supports Services Integration Pilot, as described in this RFP. Applicants must use the budget template provided in Appendix A to develop their proposed budget, organized by the following cost categories. All proposed expenditures must be reasonable, necessary, and clearly tied to the scope of work outlined in this RFP. If applicants have specific questions about eligible activities, they should reach out to DCA for more

information.

Any budgeted expenditure with a per-unit cost exceeding $5,000, excluding Salary & Wages and Fringe Benefits, requires submission of a High-Cost Purchase Approval Form to DCA prior to obligating or expending grant funds, in accordance with DCA Procurement Guidelines. All expenditures charged to this grant must comply with applicable federal and state laws, regulations, and cost principles, and any additional requirements established by DCA.

1. **Salary & Wages:** Personnel costs for staff employed by the applicant and directly allocated to carrying out the responsibilities described in this RFP. Costs must be tied to specific activities within the scope of work and documented by position title, hourly rate, hours per week, and FTE allocation using the Salary & Wages Breakdown tab in Appendix A.
2. **Fringe Benefits:** Fringe benefit costs for personnel employed by the applicant charged to this grant, including FICA, health insurance, retirement contributions, and workers' compensation. The applicable fringe rate should be explained in the budget narrative.
3. **Consultants / Subcontractors:** Costs for individuals or firms not employed by the applicant who are engaged to provide professional services in support of pilot implementation or evaluation, such as subject matter experts, facilitators, or evaluators. Each consultant's role and rate must be identified in the budget narrative.
4. **Equipment:** Costs for tangible, non-expendable property with a useful life of more than one year and a per-unit acquisition cost of $5,000 or more.
5. **Supplies:** Costs for consumable materials directly supporting grant activities, across the following subcategories:
    a. *Educational:* Printed training materials, workbooks, and participant resource packets used to support pilot training, onboarding, or capacity-building activities.
    b. *Marketing / Communications:* Outreach materials, branded collateral, or materials used to disseminate pilot findings to external audiences.
    c. *Convening:* Printed agendas, name tags, flipcharts, and other event materials associated with hosting convenings, shared learning sessions, or stakeholder meetings. Note: venue rental and facilitation support should be captured under Other.
    d. *Office:* General office supplies necessary to administer the grant, such as paper, printing, postage, and binders.
    e. *Other:* Any supply costs not captured in the subcategories above, described and justified in the budget narrative.
6. **Technology & Software:** Costs for software licenses, platforms, and technology tools directly used to support pilot implementation and evaluation activities, including project management software, qualitative analysis tools (e.g., transcription or coding software), virtual meeting platforms, secure data storage and file-sharing systems, and reporting tools.

7. **Other:** Costs not captured in the categories above, across the following subcategories:
    a. *Education & Training:* Staff professional development, training programs, or capacity-building activities, such as conference registrations, training fees, or certification costs for TA staff, that directly support the TA provider's ability to perform the responsibilities described in this RFP and provide effective implementation support and technical assistance to participating hospitals and Housing Supports Program providers.
    b. *Reporting & Dissemination:* Costs associated with producing and disseminating required deliverables, including final report design, layout, printing, and, as applicable, distribution of pilot findings in accordance with DMAHS and DCA approvals.
    c. *Other – Specify:* Any remaining costs not fitting the categories above, described and justified in the budget narrative.

Activities or expenditures that do not clearly align with the purpose of this grant program or the scope of work described in this RFP will not be considered allowable. DCA reserves the right to request revisions to a proposed budget prior to contract execution if proposed costs are inconsistent with these guidelines.

XII. Ineligible activities

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

The TA provider is prohibited from charging pilot participants for any services, training, or materials provided in their capacity as TA provider. Any training or capacity-building activities funded through this grant may not be sold to non-grantee organizations or agencies at a cost to them.

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.

XIII. Funding Distribution

Payments under this grant program will be made through a combination of an initial advance and subsequent milestone-based disbursements:

1. Fifty percent (50%) of the total award will be issued as a cash advance upon grant selection, prior to the completion of any milestones, to support start-up and early implementation activities.

2. The next forty percent (40%) of the total award amount shall be disbursed upon the submission and acceptance by DCA and DMAHS of the interim learning and implementation report described in Section V.3.b of this RFP, which is due no later than 12 months from the start of the grant term. This disbursement is contingent upon the technical assistance provider's demonstrated fulfillment of the roles and responsibilities outlined in this RFP, as determined by DCA and DMAHS. In the event that DCA and DMAHS exercise their discretion to adjust the due date of the interim report, the timing of this milestone payment shall be adjusted accordingly.
3. The remaining ten percent (10%) of the total award will be disbursed upon submission and acceptance by DCA and DMAHS of a final report documenting pilot implementation activities and assessing the impact of the pilot programs.

DCA and DMAHS will review the technical assistance provider's progress during each milestone period independently. Incomplete submission or partial completion of required activities, deliverables, or reporting obligations may result in only a proportional portion of funds being awarded. DCA and DMAHS may also request documentation or additional supporting materials to verify progress towards milestone requirements prior to payment authorization.

To be eligible for a cash advance, grantees must be current on all required FSR and IPR submissions. Late, missing, or substantially incomplete reports may delay advance payments.

1. In addition to milestone deliverables, grantees will be required to submit quarterly fiscal reports documenting expenditures incurred during each reporting period. DCA will require supporting documentation demonstrating both the cost incurred and proof of payment. Failure to submit required fiscal reports or supporting documentation may delay future grant payments.
2. Grantee will have approximately **1.5 years** from the official launch of all pilots sites under the Hospital and Housing Supports Services Integration Pilot as defined above to **complete activities** and earn funding (unless extension given).

XIV. Grant term

November 1, 2026- June 30, 2028

XV. Application process - Narrative

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

1. **Organizational Experience and Capacity to Serve as Program Implementation Support *(Maximum length - 4 pages, non-inclusive of attachments)***

   Applicants must describe their organizational experience and capacity to serve as a neutral, intermediary technical assistance provider supporting the implementation of the Hospital and Housing Supports Services Integration Pilot. As part of the narrative, applicants must attest to meeting the experience required to successfully fulfil the objectives of this grant, as well as attest to their willingness to serve as the TA provider

throughout the entire duration of this program. Responses should address, at a minimum, the following:

a. **Experience providing technical assistance and implementation support:** Describe the applicant's experience delivering technical assistance, capacity-building, or implementation support to healthcare providers, homelessness service providers, social service providers, or cross-sector partnerships. Applicants should describe how their prior work equips them to support program launch, operational readiness, troubleshooting implementation challenges, and supporting continuous improvement over the course of a multi-site initiative involving hospital partners and community-based service providers. Applicants should focus on concrete examples from prior projects that demonstrate their ability to support efforts similar in scope to the Hospital and Housing Supports Services Integration Pilot. Responses should address the following areas of experience:

   i. **Experience providing technical assistance, implementation support, and relevant expertise for health system-community integration initiatives:** Describe the applicant's experience delivering day to day, hands-on technical assistance or implementation support to housing-focused service providers and hospitals, healthcare systems, or cross-sector partnerships operating in healthcare environments. This expertise may be demonstrated through prior program implementation work, research, publications, or other professional contributions. Relevant experience may include:

   - Supporting the launch and operationalization of new programs within hospital or healthcare delivery settings;
   - Supporting implementation within complex hospital environments such as emergency departments, care management teams, or multi-site healthcare initiatives; and
   - Demonstrating substantive expertise in clinical operations and/or social services, including understanding healthcare delivery environments, care management workflows, and social service interventions.

   ii. Working with housing-focused community-based providers and demonstrating familiarity with the broader housing and homelessness services ecosystem, including Continuums of Care (CoCs), coordinated entry systems, shelter and outreach providers, and other housing resources.

   - Designing or refining workflows that connect hospitals with community-based service providers, including housing or social service organizations. Applicants should highlight experience facilitating shared initiatives, defining roles and responsibilities of each party, developing shared workflows or referral pathways, and supporting sustained collaboration among participating entities.;
   - Supporting integration of social service interventions within hospital care management or discharge planning processes. This may include experience embedding social service functions into clinical workflows, supporting

multidisciplinary care teams, or integrating social needs interventions into healthcare operations without reliance on formal partnerships with external social service agencies;

- Convening stakeholders across healthcare and community sectors to support coordination, problem-solving, and shared learning;

b. Describe **relevant experience managing multi-site initiatives**, providing ongoing technical assistance to multiple partners simultaneously, facilitating cross-sector coordination, and maintaining consistent engagement with public-sector partners.

2. **Organizational Experience and Capacity to Serve as Pilot Evaluator** (***Maximum length – 3 pages, non-inclusive of attachments)***

   Applicants should describe their experience supporting assessment and evaluation activities related to the pilot. Responses should address, at a minimum, the following:

   a. **Experience Conducting Mixed-Method Assessments** (***Recommended length - 2 page, non-inclusive of attachments)*****:** Describe the applicant's experience conducting mixed-method assessments of healthcare, housing, or social services initiatives. This should include prior experience designing and implementing mixed-method evaluation activities—such as interviews, focus groups, listening sessions, or structured feedback sessions—with program participants, service providers, healthcare partners, members or clients served, and government or state agency stakeholders. This should also highlight the ability to conduct meaningful quantitative analyses to assess efficacy of pilot programs.

   b. **Experience Synthesizing Assessments into a Report** (***Recommended length - 1 page, non-inclusive of attachments)*****:** Applicants must also describe their experience synthesizing qualitative findings into written products that document program implementation, lessons learned, and practical insights. Examples may include interim briefs, memos, or final reports prepared for policymakers, program administrators, or other public-sector audiences. Applicants should submit relevant examples of similar qualitative reports or learning products produced in the past.

3. **Experience based on Past Partners** ***(Maximum length - 1 page, non-inclusive of attachments)*****:** Provide vignettes or examples from prior partners or clients for whom the applicant has served in a similar technical assistance role, including serving as an intermediary and/or conducting mixed-method assessment, evaluation, or learning activities. This information should demonstrate the applicant's effectiveness, collaborative approach, and impact in prior engagements, and ability to produce actionable findings through qualitative insights to inform program improvement or decision-making. Please include contact information for these partners or clients.

4. **Staff Capabilities and Dedicated Capacity** ***(Maximum length - 2 pages, non-inclusive of attachments):*** Describe the staff who will be assigned to this project, including their roles, relevant experience, qualifications, and level of effort. Applicants should explain how staff expertise aligns with the responsibilities of this RFP, including implementation support, partnership facilitation, workflow development, technical

assistance, and mixed-methods evaluations. Resumes for key staff should be included as attachments.

5. **Proposed approach *(Maximum length - 9 pages, non-inclusive of attachments)***

   Applicants must describe their proposed approach to carrying out the responsibilities of this RFP. Responses should be clear, feasible, and aligned with the goals of the Hospital and Housing Supports Services Integration Pilot. Given that pilot sites may implement different operating models for hospital–Housing Supports Program integration, applicants should demonstrate an ability to add value across varying implementation contexts. At a minimum, applicants must address the following:

   a. **First Principles for Providing Technical Assistance to a Hospital–Housing Integration Pilot *(Recommended length - 7 pages)***

      Applicants must describe their high-level framework for serving as a technical assistance provider for a hospital–housing integration pilot. This section is intended to assess the applicant's underlying approach, judgment, and value-add as a TA provider, independent of any specific operating model. Applicants must address both operational implementation support principles and qualitative evaluation and learning principles, as outlined below.

      i. **First Principles for Operational Implementation Support *(Recommended length - 5 pages)*:**

         - The key areas where the applicant believes a technical assistance provider can add the most value in supporting hospital–Housing Supports Program integration, based on the applicant's experience and professional judgment, including which responsibilities outlined in this RFP are most critical to enabling successful pilots;
         - The primary operational risks or failure points the applicant anticipates in a hospital–housing integration pilot (e.g., unclear roles, workflow breakdowns, staffing constraints, hospital culture barriers, referral volume mismatch);
         - The strategies the applicant would use to mitigate those risks and support successful pilot implementation across diverse sites; and
         - How the applicant balances standardization and flexibility when supporting pilot sites with different structures, capacities, and operating environments.
         - An actionable implementation plan for delivering technical assistance under this RFP. This section should list a concrete plan of execution and should focus on what the applicant would do, when, and in what sequence. Responses should emphasize specific activities, timing, and coordination. The implementation plan should describe:
            - How the applicant would sequence and carry out technical assistance activities prior to pilot launch to support readiness, alignment, and timely implementation, independent of the final operating models selected by pilot participants;

- How the applicant would deploy and adapt technical assistance activities during pilot implementation to support operational execution of hospital–housing integration models, recognizing that operating models may vary across sites; and
- How evaluation and learning activities would be integrated into technical assistance delivery during and following pilot implementation, including how insights would support real-time learning, continuous improvement, and required interim and final reporting.

ii. **First Principles for Mixed-Method Evaluation *(Recommended length - 2 pages):***

- The applicant's high-level approach to qualitative study design, including the types of qualitative methods they typically employ (e.g., interviews, site visits, structured feedback sessions) and how those methods support learning during implementation;
- How the applicant approaches engagement with key stakeholder groups—including hospitals, Housing Supports Program providers, frontline staff, and participating members—and how member engagement is conducted in a trauma-informed and culturally responsive manner;
- How the applicant will conduct a harmonized multi-site evaluation across different partnership/operating models; and
- How the applicant structures qualitative activities to surface meaningful, actionable insights related to implementation experiences, operational challenges, partnership dynamics, and promising practices, and how those insights are used to inform continuous improvement and State-level learning
- How the applicant approaches quantitative analysis and will use quantitative data as available to support and strengthen qualitative analyses and improve the fidelity of insights produced in pilot analysis

b. **Assessment of the Hospital–Housing Operating Models, and Associated Strengths and Limitations *(Recommended length - 1 page)*:** Based on the applicant's experience and perspective, applicants must identify potential hospital–housing operating models to advance the core goals of the Hospital and Housing Supports Services Integration Pilot. As described above, DCA and DMAHS are allowing pilot participants to propose creative approaches to partnership and implementation in pursuit of the pilot's goals, without the State prescribing a specific operating model. Accordingly, to understand the technical assistance provider's perspective on pilot design, applicants should list operating models they can identify from the literature and their experience in the space.

In doing so, applicants should provide a detailed narrative describing the key features of the operating model, including description of roles and responsibilities for hospital and HSP providers involved. Responses should include an assessment of the model's strengths and limitations, including related to the model's operational feasibility, implications for hospital workflows, Housing Supports Program provider

capacity, and partnership coordination. Applicants should also explain strengths of these models in terms of how these models could improve access to Housing Supports Program services for eligible members, strengthen coordination across the healthcare and housing ecosystem, and reduce avoidable acute care utilization.

Pilot participants are not required to operationalize the specific model described by the technical assistance provider in this application. Rather, applicants should demonstrate thoughtful, experience-informed judgment about which strengths and limitations of potential pilot operating models.

c. **Plan for Use of Grant Funds *(Recommended length - 1 page + Appendix A showing line-item projected budget spend):*** Describe how grant funds will be used to support the proposed activities, including alignment with allowable cost categories and the goals of this RFP. Applicants should demonstrate that proposed expenditures are reasonable, necessary, and appropriate to support both implementation support and evaluation functions. Applicants must submit a proposed budget for the use of funds, using the template provided in Appendix A.

   Applicants should note that proposed budgets are expected to reflect the applicant's best estimate based on information available at the time of application. Final budgets may be subject to refinement or revision, with DCA and DMAHS approval, as pilot design details are finalized and implementation requirements become clearer. Applicants should also indicate in their response if they have flexibility in the deployment of their resources within the projected budget. Given that the pilot operating models will be finalized after this grant is awarded, potential for flexibility in an applicant's ability to deploy resources may be scored favorably. Submission of a proposed budget does not constitute approval of all proposed expenditures.

XVI. Application process – Threshold requirements / required attachments

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.***

Documents with dedicated SAGE 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)
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)
d. IRS Determination Letter
e. Organization Chart
f. Executed Application Cover Page

5. Project Budget (Appendix A)

Documents without dedicated SAGE upload links (combined into one or two PDF files and uploaded using the Supporting Documents upload field):

1. Narrative materials outlined in Section XV of this document, including:
   a. Attestation of meeting the minimum experience requirement
   b. Attestation of willingness to serve in the Technical Assistance role for the duration of the grant
2. Organizational By-Laws
3. The last 3 years of audits (to include statement cash flows [or equivalent]) and latest IRS Form 990.
   a. If organization does not have audit materials to share, please submit last 3 years of federal tax returns and internal financials.
   b. Applicant's submissions **must demonstrably show** that they have sufficient cash flows to sustain staff and effectively administer the grant.

Note: any required documents without a dedicated upload location in SAGE should be combined into one or two PDF files and uploaded using the Supporting Documents upload field.

XVII. Reporting and monitoring requirements

1. Submit monthly operational and fiscal reports in SAGE, including a summary of pilot implementation progress, emerging issues, technical assistance activities provided, risks requiring State awareness, and expenditures incurred during the reporting period.
2. Participate in quarterly meetings with OHP and DMAHS Program Staff, accompanied by a written quarterly summary submitted in advance of each meeting that synthesizes implementation developments across pilot sites, key challenges and adaptations, early learnings, and opportunities for improvement or future scale.

XVIII. Scoring Rubric: NJ FamilyCare Housing Supports Hospital and Housing Integration Technical Assistance Grant Program Evaluation Rubric

Section	Component	Component Description	Maximum Points
1. Organizational Experience & Capacity – Implementation Support	1a. Experience providing TA and implementation support to health system-community integration initiatives	Demonstrated experience delivering hands-on technical assistance or implementation support to healthcare providers, community-based organizations, homelessness service programs, or cross-sector partnerships operating in healthcare environments. This includes experience supporting program launch and operational readiness, designing or refining workflows connecting hospitals with community-based providers, supporting integration of social services into clinical workflows, and working with housing-focused community-based providers.	20
	1b. Experience supporting multi-site initiatives and cross-sector coordination	Demonstrated experience managing multi-site initiatives, providing concurrent technical assistance to multiple partners, and maintaining consistent engagement with public-sector partners.	10
2. Organizational Experience & Capacity – Pilot Evaluation	2a. Experience Conducting Mixed-Methods Assessments	Demonstrated experience designing and conducting mixed-methods assessments of healthcare, housing, or social services initiatives, including qualitative methods (e.g., interviews, focus groups, listening sessions) and meaningful quantitative analyses to assess program efficacy.	15
	2b. Experience Synthesizing Findings into Written Products	Demonstrated experience synthesizing mixed-methods findings into clear, actionable written products (e.g., briefs, memos, final reports) for policymakers or public-sector audiences. Applicants must submit relevant examples of prior reports or learning products, if requested.	10
3. Experience based on Past Partners	3a. Experience Based on Past Partners	Strength and relevance of vignettes or examples from prior partners or clients for whom the applicant has served in a similar technical assistance, intermediary, or mixed-methods evaluation capacity. Responses should demonstrate effectiveness, collaborative approach, and impact in prior engagements.	10

Section	Component	Component Description	Maximum Points
4. Staff Capabilities	4a. Staff Capabilities and Dedicated Capacity	Qualifications, experience, and dedicated level of effort of staff proposed for project, including alignment between staff expertise and the day-to-day, hands-on nature of responsibilities outlined in the RFP.	10
5. Proposed Approach	5a.i. First Principles for Operational Implementation Support	Clarity and strength of the applicant's framework for providing TA to a hospital–housing integration pilot, including identification of highest-value areas of TA support, anticipated operational risks or failure points, mitigation strategies, and approach to balancing standardization with flexibility across diverse sites. Includes proposed sequencing of activities, how the applicant would adapt across varying operational models, and how evaluation activities are integrated into TA delivery for real-time learning and required reporting	20
	5a.ii. First Principles for Mixed-Methods Evaluation	Clarity and strength of the applicant's approach to mixed-methods evaluation design, including qualitative methods, member engagement approach (trauma-informed and culturally responsive), multi-site harmonization, and use of available quantitative data to strengthen qualitative analysis.	15
	5b. Assessment of Hospital–Housing Operating Models	Thoughtfulness and experience-informed judgment in identifying a range of potential hospital–housing operating models from the literature and practice, including description of key features, roles and responsibilities, and honest assessment of each model's strengths and limitations in terms of operational feasibility, partner capacity, and potential to improve member access to Housing Supports services.	10
	5c. Plan for use of grant funds	Clarity and organization of the applicant's proposed plan for using grant funds, including how proposed activities and expenditures align with the scope of work described in this RFP. Evaluators will assess whether the budget narrative clearly explains the purpose of proposed expenditures and demonstrates a coherent, well-structured approach to resourcing the work.	5

Section	Component	Component Description	Maximum Points
6. Threshold Requirements	4a. Meets All Threshold Requirements	Application meets all submission and eligibility requirements outlined in the RFP.	Pass / Fail
7. Overall Proposal Quality	5a. Quality and Clarity of Proposal	Overall clarity, organization, and responsiveness of the proposal to the RFP instructions.	5
Minimum Technical Score Threshold		Applicants must achieve a minimum technical score of 91 points out of 130 (70%) to have their cost proposal evaluated. Applications that do not meet this threshold will not advance to cost scoring and will not be considered for award.	
Maximum Technical Score			130
8. Applicant Cost	8a. Applicant proposed cost	A competitive budget is one that represents strong value to the State relative to other compliant proposals received. A cost score be applied only to proposals that have met the minimum technical score threshold and have not been disqualified.	20 *See cost scoring below*
Maximum Total Score			**150**

8a. Applicant proposed cost: The proposed cost will be evaluated holistically by the evaluation committee and scored on a 0–20 point scale. Evaluators will assess the proposed budget based on two considerations:

Reasonableness: Whether the proposed budget reflects a realistic, efficient, and well-justified estimate of the costs necessary to carry out the full scope of responsibilities described in this RFP. Evaluators will consider whether proposed expenditures are clearly tied to the scope of work, adequately explained in the budget narrative, appropriate in scale relative to the activities proposed, and reflect an efficient use of grant funds — avoiding unnecessary costs that are not clearly warranted by the scope of work.

Competitiveness: Whether the proposed budget represents strong value to the State relative to other compliant proposals received. Evaluators will consider the overall cost of the proposal in the context of the level of effort, staffing, and activities proposed.

This evaluation will be conducted only for proposals that have met the minimum technical score threshold and have not been disqualified.

THIS PAGE INTENTIONALLY LEFT BLANK.

Appendix A: Budget Template

Please fill out Appendix A via Excel attachment.