NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES

REQUEST FOR PROPOSALS

FOR

In-Home Recovery Program - Two Sites in Union County

Available Funding of $709,905.00

There will be no Bidders Conference for this RFP

Written questions must be provided in advance by December 15, 2021 at 12:00PM at DCF.ASKRFP@dcf.nj.gov

Bids are due:

January 5, 2022

Christine Norbut Beyer, MSW

Commissioner

November 23, 2021

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Funding Agency

State of New Jersey
Department of Children and Families
50 East State Street,
Trenton, New Jersey 08625

Special Notice:

There will be no Bidders Conference for this RFP. Questions will be accepted in advance of the proposal deadline by providing them via email to DCF.ASKRFP@dcf.nj.gov until **December 5, 2021 by 12PM**. Technical inquiries about forms and other documents may be requested at any time.

Section I – General Information

A. Purpose

The New Jersey Department of Children and Family's (NJDCF) Children's System of Care (CSOC) announces the availability of funding for the purpose of providing the In-Home Recovery Program (IHRP), a family-based recovery program serving adults, families, and young children. The annualized funding available is $709,905.00.

The NJDCF is a family and child-serving agency, working to assist NJ families in becoming or remaining safe, healthy, and connected. The goals of the IHRP are to improve outcomes for parents who have a substance use disorder (SUD), referred by the NJDCF Division of Child Protection and Permanency (DCPP), and are actively parenting a child under 6 years old in Union County. This program will expand the service array for these families through the following strategies:

- funding the implementation of a specific evidence supported, trauma-informed in-home substance use disorder treatment program proposed by the applicant
- partnering with Montclair State University to support the training and reflective supervision of program staff
- partnering with Rutgers University to evaluate the implementation of the program, including post-intervention changes on parental substance use and involvement with child protective services.

NJDCF will fund one award for the implementation of two (2) sites in Union County managed by one agency. Teams in each site will serve a caseload of twelve (12) families concurrently and serve a minimum of twelve families (24 families in total) over a 12-month period, beginning on May 1, 2022, for a 12-month budget not to exceed $709,905.00.

An important objective of the IHRP is to demonstrate the effectiveness of a proposed trauma-informed in-home treatment model for families involved with DCPP who have a parent with a SUD and a child under the age of 6 years old. Outcome measures will

include parental substance use, child placement at discharge, and a family's repeat involvement with child protective services.

ELIGIBLE APPLICANTS

NJDCF intends to fund two teams that will be operationalized by the same agency but serve two different Division of Child Protection and Permanency (DCPP) local offices in Union County. Interested applicants must be New Jersey–based mental health and SUD treatment providers serving adults, families, and/or children and must have an office(s) in Union County or an adjacent county (Hudson, Essex, Morris, Somerset, or Middlesex).

Applicants must be either:

- licensed SUD treatment programs with experience providing mental health services; or
- licensed mental health agencies with experience providing SUD services, **and**
- able to meet current DCF guidance regarding in-person and telehealth services during the COVID 19 pandemic; **and**
- staff on at least one team (one parent/child clinician, one substance use clinician, and one family support specialist) are bi-lingual and able to provide bi-lingual services

Preference will be given to mental health and substance use disorder treatment providers with experience and qualifications in the following areas:

- utilizing an electronic health record
- serving families in Union County or an adjacent county (Hudson, Essex, Morris, Somerset, or Middlesex)
- working with young children utilizing an infant mental health approach
- implementing an evidence-based, trauma-informed treatment model
- working with NJDCF, including providing services to families involved with the NJDCF DCPP
- two teams able to provide bi-lingual services

B. Background

In 2017, 30.4% of NJDCF-involved children experienced a substance abuse caregiver risk factor and 13.7% had an alcohol abuse risk factor, according to the National Data Archive on Child Abuse and Neglect.[1] Ninety percent of young children (children aged 0–3) who entered care in New Jersey between 2009 and 2012 and experienced reentry within 12 months of reunification had a caregiver with a substance use issue. In addition, 50% of the DCPP's families with children aged 0–3 receiving in-home services also had a caregiver with a substance use issue.[2] In Union, CP&P Local Offices submitted 541

[1] U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2019). Child Maltreatment 2017. Available from https://www.acf.hhs.gov/cb/research-data-technology/ statistics-research/child-maltreatment.

[2] State of New Jersey Department of Children and Families, 2019.

referrals for SUD assessments to CPSAI in FY20 for which 81% were assessed and 70% of those were recommended for treatment.

Union County has long been a county of concern with regard to the opioid crisis in New Jersey and has been identified by DCPP staff as in need of more effective and readily available interventions.

The needs of parents who use substances and the potential impact on their young children are well documented.[3,4] One of the most challenging responsibilities for a Child Protective Services (CPS) social worker is weighing the developmental needs of a child against the risk associated with parental substance use in determining whether the child needs to be removed. Historically, child protection has focused primarily on the physical safety of children without taking into consideration the need to balance that with psychological safety and well-being. Children removed due to parental substance use typically remain in foster care longer and are less likely to be reunified than children removed for other reasons.[5,6] In fact, for many children, foster care placement has not resulted in positive outcomes.[7,8] Additionally, the child's placement outside of the home might have an unintended negative impact on the mother's recovery process and sense of well-being and therefore an impact on successful reunification. Some mothers may increase substance use to manage the loss experienced from removal and their sense of being judged as a less-than-competent parent. Diminished motivation to participate in treatment after a child is removed may lead to an increase in adverse life events.[9,10]

Child welfare knowledge and case practice have evolved to recognize that parent and child do not need to be separated for a parent to achieve substance use recovery and for the child to remain safe.

NJDCF intends to partner with an applicant to embark on a multipronged, two-generation, trauma-informed initiative to support parental SUD recovery, healthy attachment, family stability, and positive child development. The initiative is composed of three components:

1) Implementation and provision of the applicant's proposed program model

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[3] Seay, K.D., & Kohl, P.L., 2015. The comorbid and individual impacts of maternal depression and substance dependence on parenting and child behavior problems. *Journal of Family Violence*, *30*(7):.899–910.

[4] Whitaker, R.C., Orzol, S.M., & Kahn, R.S., 2006. Maternal mental health, substance use, and domestic violence in the year after delivery and subsequent behavior problems in children at age 3 years. *Archives of General Psychiatry*, *63*(5): 551–560.

[5] Lloyd, M.H., Akin, B.A., & Brook, J., 2017. Parental drug use and permanency for young children in foster care: A competing risks analysis of reunification, guardianship, and adoption. *Children and Youth Services Review*, *77*: 177–187.

[6] Vanderploeg, J.J., Connell, C.M., Caron, C., Saunders, L., Katz, K.H., & Kraemer Tebes, J., 2007. The impact of parental alcohol or drug removals on foster care placement experiences: A matched comparison group study. *Child Maltreatment*, *12*(2): 125–136.

[7] Villodas, M.T., Litrownik, A.J., Newton, R.R., & Davis, I.P., 2015. Long-term placement trajectories of children who were maltreated and entered the child welfare system at an early age: Consequences for physical and behavioral well-being. *Journal of Pediatric Psychology*, *41*(1): 46–54.

[8] Weiler, L.M., Garrido, E.F., & Taussig, H.N., 2016. Well-Being of Children in the Foster Care System. In M.R. Korin (Ed.), *Health Promotion for Children and Adolescents* (pp. 371–388). New York, NY: Springer.
371–388.

[9] Donohue, B., Azrin, N.H., Bradshaw, K., Van Hasselt, V.B., Cross, C.L., Urgelles, J., Romero,V., Hill, H.H., & Allen, D.N., 2014. A controlled evaluation of family behavior therapy in concurrent child neglect and drug abuse. *Journal of Consulting and Clinical Psychology*, *82*(4): 706.

[10] Nicholson, J., Finkelstein, N., Williams, V., Thom, J., Noether, C., & DeVilbiss, M., 2006. A comparison of mothers with co-occurring disorders and histories of violence living with or separated from minor children. *The Journal of Behavioral Health Services & Research*, *33*(2): 225–243.

2) Training, technical assistance, and reflective supervision funded by NJDCF and provided by Montclair State University
3) Evaluation funded by NJDCF and provided by Rutgers University

One of the program models DCF reviewed in the development of this RFP is from Connecticut. In 2006, the Connecticut State Department of Children and Families (CTDCF) recognized the need to address the dual challenges of parenting and achieving recovery if the child placement rate in Connecticut was to decrease. The CTDCF brought together faculty members from Johns Hopkins University, the University of Maryland, and the Yale Child Study Center (YCSC) to develop treatment that integrated contingency management SUD treatment with in-home, attachment-based parent-child therapy.

Johns Hopkins University's Reinforcement-Based Treatment (RBT)[11] is an evidence-based, comprehensive behavioral substance use treatment that incorporates interventions from the Community Reinforcement Plus Vouchers Approach,[12] relapse prevention,[13] and motivational interviewing.[14] The staff from Johns Hopkins University (JHU) developed RBT in 1997. The conceptual foundation of RBT is based on operant conditioning. Positive reinforcement is the most effective means of producing behavior change. The RBT approach is to replace the reinforcement of substances with healthier alternative activities that are incompatible with substance use.

RBT was originally developed as a clinic-based treatment for clients diagnosed with opioid use disorder exiting detoxification programs in Baltimore, Maryland. Two randomized controlled studies revealed that clients in RBT were more likely to be abstinent from substances, had longer treatment length of stay, and worked more days at 3, 6, and 12 months post-admission to treatment than clients in standard community-based treatment programs.[15,16] RBT has been adapted to treat pregnant substance-using women and has achieved similar treatment outcomes.[17]

The YCSC developed the Coordinated Intervention for Women and Infants (CIWI) program in 1990 with funding from the Abandoned Infants Assistance Act, administered by the Department of Health and Human Services. CIWI was an intensive, in-home, trauma-informed clinical service for women with a history of substance use who were pregnant or had an infant under the age of 12 months. The principles of attachment theory guided the clinical work. Teams focused on the caregiver's ability to provide appropriate care, nurturing, and emotional availability to the child. Parents were asked to explore how

[11] Tuten, L.M., Jones, H.E., Schaeffer, C.M., & Stitzer, M.L., 2012. *Reinforcement-based treatment for substance use disorders: A comprehensive behavioral approach*. American Psychological Association.
[12] Budney, A.J., & Higgins, S. T., 1998. *Therapy Manuals for Drug Addiction, Manual 2: A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction*. Rockville, MD: National Institute on Drug Abuse.
[13] Irvin, J.E., Bowers, C.A., Dunn, M.E., & Wang, M.C., 1999. Efficacy of relapse prevention: A meta-analytic review. *Journal of Consulting and Clinical Psychology*, *67*, 563–570.
[14] Miller, W.R., & Rollnick, S., 2002. *Motivational Interviewing: Preparing People for Change, 2nd Ed*. New York: Guilford.
[15] Gruber, K., Chutuape, M.A., & Stitzer, M.L., 2000. Reinforcement-based intensive outpatient treatment for inner city opiate abusers: A short-term evaluation. *Drug and Alcohol Dependence*, *57*(3), 211–223.
[16] Tuten, M., Defulio, A., Jones, H., & Stitzer, M., 2011. A randomized trial of reinforcement-based treatment and recovery housing. *Addiction, 107*(5), 973–982.
[17] Jones, H.E., O'Grady, K.E., & Tuten, M., 2011. Reinforcement-based treatment improves the maternal treatment and neonatal outcomes of pregnant patients enrolled in comprehensive care treatment. *The American Journal on Addictions, 20*(3), 196–204.

their own experience being parented impacted their parenting behaviors. Staff utilized an infant mental health approach to assist mothers to focus on the needs and feelings of the child in the present moment. Data from 2004 to 2006 revealed that 63% of children lived with a biological parent at the time of discharge. The CIWI program ended in 2008.

YCSC, JHU, and CTDCF integrated RBT and CIWI into a new model, Family-Based Recovery (FBR),[18] which is based on two foundational principles: attachment is critical to healthy development and substance use treatment works. The FBR model was originally implemented in 2007 by six community-based agencies. Each agency had one FBR team; each team carried a caseload of 12 families. In 2013, CTDCF expanded FBR statewide. There are currently 17 FBR teams providing this clinical in-home service. YCSC continues to provide quality assurance oversight, training, and model fidelity with FBR Services. Data provided by FBR sites and analyzed by FBR Services reveals statistically significant changes in several pre-/post-intervention assessment scores for clients in the areas of depression, parenting stress, and parental bonding. Toxicology results show a steady increase in negative screens after the first 15 weeks in FBR, suggesting a primary goal of the project is being met. In Fiscal Year 2017–2018, 84% of children lived with a biological parent at discharge. FBR is currently undergoing a randomized control trial with funding from a social impact bond project in collaboration with Social Finance, LLC, CTDCF, and the University of Connecticut.

Awardees of this RFP will provide a model to support the In-Home Recovery Program (IHRP). While NJDCF has reviewed the model outlined above, other models may be proposed that have an evidence-based structure. Two teams will be expected to perform the set of services outlined below. NJDCF will consider applicants who successfully articulate the guidance provided in Section E: Activities.

C. Target Population

The target population for the IHRP is DCPP involved parent(s) who have a SUD and child under 6 years old. Only one child per family will be enrolled in the program. DCPP will provide referrals of the target population to the provider agency. The parent(s) might have other children, but the youngest child under 6 years of age will be the target of treatment. Service level approximates ASAM 2.1. The IHRP is considered an alternative to an intensive outpatient program (IOP) or a mother-child residential treatment program. Inter-partner violence and homelessness are not exclusionary criteria.

<u>Inclusion Criteria</u>

a. Parent
    i. The parent is a mother and/or father assessed by the Child Protection Substance Abuse Initiative (CPSAI) with a SUD diagnosis.
    ii. The parent's CPSAI assessment result indicates that he/she may be served in an IOP level of care or higher, per ASAM criteria for Level 2.1 outpatient services.

[18] Hanson, K.E., Saul, D.H., Vanderploeg, J.J., Painter, M., & Adnopoz, J., 2015. Family-based recovery: An innovative in-home substance abuse treatment model for families with young children. *Child Welfare*, *94*(4), 161–183.

iii. The parent is not involved in another treatment program (such as counseling and behavioral therapies for SUD treatment or Family Preservation) or is willing to discharge from the program to participate with the IHRP. Parents whose recovery is supported by medication, prescribed by a qualified health care professional, are expected to commence or continue to receive these services.
iv. The parent is willing and able to engage in the treatment.
v. The parent is in a caregiving role to the child at least 50% of the time.

b. Child
   i. The child is under six years old.
   ii. The child resides in the parent's home, or if the child is placed outside the home, there is a plan for reunification within 30-45 days or less from the time of referral.

Exclusion Criteria

a. A parent whose psychiatric symptoms require immediate attention and stabilization prior to IHRP treatment.
b. A parent who requires medical withdrawal management in a residential or acute care setting.
c. A parent who is participating in a duplicate service and whose enrollment in IHRP would be overwhelming.

Compliance with the Americans with Disabilities Act (ADA)

Under the terms of this award, the grantee shall follow all applicable federal and State laws prohibiting discrimination, including all provisions of the Americans with Disabilities Act (ADA). For the purposes of this award, the grantee shall undertake and execute any and all duties and obligations under the ADA, including any reasonable accommodation that would be required by the Department of Children and Families under Title II of the ADA. The grantee shall be solely responsible for any and all reasonable accommodations that arise under Title II of the ADA. Any individual receiving and/or accessing services under this award that would be covered under Title II of the ADA shall have all rights available to appeal the grantee's denial or limitation of the reasonable accommodation request. The Department shall ensure that any reasonable accommodation that would have been provided by the Department under Title II of the ADA is provided by the grantee. Any failure to provide an accommodation under Title II of the ADA by the grantee may result in the award being terminated and the total amount of the award, including funds already spent and/or encumbered, returned to the Department. Provider must also comply with the Americans with Disabilities Act (ADA) and the NJ Law Against Discrimination with respect to its consultants, part-time workers, and employees as defined below, including but not limited to:

- N.J.S.A. 10:5-1 to -42 NJLAD
- N.J.S.A. 13-13-2.1 et seq. Regulations Pertaining to Discrimination on the Basis of Disability, Employment

- 28 CFR 35.104. Non-Discrimination on the Basis of Disability in State and Local Government Services
- 42 U.S.C. Section 12101. Equal Opportunity for Individuals with Disabilities

D. Resources

Required Staff Duties/Responsibilities

NOTE: At least one team (one parent/child clinician, one substance use clinician, and one family support specialist) must be bilingual and able to provide bilingual services. Preference will be given to applicants that demonstrate bilingual capacity on both teams.

The IHRP requires the following staff for model implementation for ***each*** team (note that the agency will have ***two*** teams):

- One half-time licensed master's level clinical supervisor
- Two full-time licensed master's level clinicians for whom SUD disorder treatment is within their scope of practice (licensed clinical social worker [LCSW], licensed professional counselor [LPC], licensed psychologist, licensed marriage and family therapist [LMFT], licensed clinical alcohol and drug counselor [LCADC]
- One full-time bachelor's level family support specialist, and
- One part-time (.1FTE) psychiatrist or advanced practice registered nurse (APRN) for the parent(s)

The IHRP clinical supervisor (.5 FTE) will be a licensed clinician (e.g., a master's or doctoral level behavioral health professional) with at least five years' experience providing clinical and/or substance use services to children and families. Prior supervisory experience is required. This individual will be responsible for the following activities:

- Oversee the IHRP and its staff
- Provide weekly reflective supervision to the team
- Ensure treatment follows the FBR model and tools and measures are complete and timely
- Develop a strong collaborative relationship with the NJDCF DCPP local office's IHRP liaison
- Review all referrals to determine eligibility
- Attend DCPP reviews to guide team around discussion topics
- Submit monthly reports on clients' progress toward treatment goals to DCPP staff
- Oversee data collection and provide data to the IHRP evaluator
- Provide direct clinical care at the weekly parent-child outpatient therapy group and in the home when needed due to clinical acuity or staff absence
- Attend required trainings
- Participate in technical assistance meetings and calls

The two clinicians will be master's level behavioral health professionals for whom SUD treatment is within their scope of practice. Clinicians may include licensed clinical social workers, licensed professional counselors, licensed psychologists, licensed marriage and family therapists, or licensed clinical alcohol and drug counselors who are qualified to practice independently in New Jersey. Each clinician will be cross-trained and will act as the parent-child clinician for six clients and the individual/substance use clinician for six clients. The two (2) clinician roles are as follows:

<u>Parent-Child</u>

- Deliver treatment to facilitate positive parent-child interactions and optimal child development
- Promote reflective capacity utilizing an infant mental health approach
- Conduct developmental screenings
- Address safe sleep and other safety issues
- Focus on the client's relationship with the child and the systems that interact with the child
- Conduct toxicology screens using oral or other methods that do not require urine sample collection
- Breathalyzers will be used at each visit for parents who have a diagnosis of an alcohol use disorder. IHRP staff will randomly (at least twice a month) conduct breathalyzer tests on all other parents.
- Co-facilitate weekly parent-child therapy group
- Attend required trainings
- Submit all required data to supervisor and evaluator
- Participate in technical assistance (TA) meetings and calls

<u>Individual/Substance Use</u>

- Deliver treatment that targets parental recovery and psychological well-being
- Conduct toxicology screens using oral or other methods that do not require urine sample collection
- Breathalyzers will be used at each visit for parents who have a diagnosis of an alcohol use disorder. IHRP staff will randomly (at least twice a month) conduct breathalyzer tests on all other parents.
- Utilize FBR tools to inform and guide treatment
- Use FBR-specific abstinence-related tracking tools, such as graphing
- Provide individual psychotherapy to address comorbid mental health issues
- Co-construct treatment goals related to recovery, education, employment, healthy relationships, family communication, and/or legal issues
- Refer client to medication-assisted treatment (MAT) as appropriate
- Collaborate with other systems to coordinate care to support the client and child, including with the MAT provider as needed
- Co-facilitate weekly parent-child therapy group
- Attend required trainings
- Submit all required data to supervisor and evaluator

- Participate in technical assistance meetings and calls

The IHRP family support specialist (FSS) will be a bachelor's level paraprofessional with experience or training in human services. The FSS will work with all 12 clients on one team. The FSS will fulfill the following responsibilities:

- Support the clinical work by facilitating/co-facilitating home visits
- Conduct toxicology screens using oral or other methods that do not require urine sample collection
- Breathalyzers will be used at each visit for parents who have a diagnosis of an alcohol use disorder. IHRP staff will randomly (at least twice a month) conduct breathalyzer tests on all other parents.
- Utilize abstinence-related tracking tools to graph recovery-related activities
- Assist clients with identifying and accessing basic needs and utilize online databases as needed
- Assist clients in school and job preparation
- Attend required trainings
- Submit all required data to the supervisor and evaluator
- Maintain contact with the client's MAT provider, as appropriate
- Assist clients in applying for NJ FamilyCare, as needed
- Connect clients to a medical home
- Refer children to Early Intervention Services, as needed
- Participate in technical assistance meetings and calls

The part-time (.1 FTE) psychiatrist or APRN will provide consultation to the team on cases. A practitioner with a DATA 2000 waiver is preferred. The participating provider may be reimbursed for obtaining a DATA 2000 waiver. The psychiatrist or APRN will fulfill the following responsibilities:

- Conduct clinical psychiatric evaluations for the parents(s)
- Provide pharmacotherapy, including MAT, as needed to clients

Staff Training and Reflective Supervision

NJDCF will contract with Montclair State University (MSU) to provide staff training, technical assistance, and reflective supervision. Awardees are required to collaborate with MSU within 30 days of contract award and develop a concrete plan and timeline for staff training and reflective supervision as outlined below.

Introductory Training

MSU will provide an introductory training on the provision of in-home substance use treatment and Child-Parent Psychotherapy for the In-Home Recovery Program (IHRP)

staff and Union County Department of Children and Families. The training, which will take place over a 2-day period via zoom, will introduce the basic constructs and techniques which inform the treatment program. Modules will address the theoretical framework, guiding programmatic principles, substance use treatment interventions and the provision of Child-Parent Psychotherapy.

Clinical Practice Seminar in Infant and Early Childhood Mental Health (IECMH) – 100 hours (2 hours/week/group for 12 months)

The Clinical Practice in IECHM provides a necessary foundation for work with infants, young children and their families. Attendees receive the equivalent of 60 hours of training competencies towards the NJ-AIMH IMH Endorsement (www.nj-aimh.org/endorsement), including the areas of prenatal, infancy and early childhood development, the development of emotional and relational health, the power of relationships and interpersonal neurobiology, family and community systems, the influence of culture and context, assessment, intervention, and consultation strategies, evidence-informed clinical techniques, DC: 0-5 diagnostic system, Brazelton Touchpoints Approach, etc. Attendees also receive 40 hours of Reflective Supervision/Consultation by an Infant Mental Health Clinical Mentor (IMHM-C).

Two certified consultants (1-parent/child, 1 substance use) will provide weekly clinical consultation with IHRP teams. Total weekly phone time is 2.5 hours.

- The site supervisor will have one 30-minute call per week.
- Both team(s), including the supervisor, will participate in a 2-hour virtual training/reflection supervision meeting each week.
- Both consultants will review in advance of the call clinical treatment notes, and model-specific tools and measures that have been administered.
- Consultants will be prepared to facilitate, and lead model-related discussions based on materials received.

Consultants will be available by email for questions that need to be addressed sooner than the consultation call.

Training in Child-Parent Psychotherapy – 45 hours

Child-Parent Psychotherapy (https://childparentpsychotherapy.com/providers/training) is an evidence-based model of psychotherapy endorsed by the National Child Traumatic Stress Network that is meant to support families with children under the age of 6 who have experienced or witnessed a traumatic event. Training takes place over 18- months and is distributed over three sessions that are separated by time, with the expectation that clinicians are working with cases during the time of training. The first learning session takes place over 18 hours. The second learning session is 12 hours, and the third learning session is a final 15 hours.

Reflective Consultation in CPP practice – 36 hours concurrent with Professional Formation Communities in IECMH Clinical Practice (every other week 1-hr call)

Child-Parent Psychotherapy also necessitates the experience of reflective consultation about the clinicians' CPP practice. This takes place through two one-hour meetings per week for the duration of the CPP training. At least 70% of the calls will need to be attended in order to complete the training.
Additional required training will include:

- The awardee is responsible for participating in the Nurtured Heart Approach (NHA) trainings and its implementation. NHA training is offered through CSOC Training and Technical Assistance: https://www.nj.gov/dcf/providers/csc/training/
- Identifying and reporting child abuse and neglect (Any incident that includes an allegation of child abuse and/or neglect must be immediately reported to the Division of Child Protection and Permanency (DCPP) at 1-877-NJ ABUSE in compliance with N.J.S.A. 9:6-8.10)
- HIPAA: The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-191, and regulations promulgated by the United States Department of Health and Human Services, 45 CFR Parts 160 and 164) was enacted to establish national standards for privacy and security in the handling of health-related information.
- 42 CFR Part 2 Confidentiality of SUD Patient Records training

E. Activities

Referrals

Eligible parents will be identified and screened by DCPP according to the criteria outlined in **Section C. Target Population.** Prior to implementation of the IHRP, DCPP and the contractor will collaborate to develop a process and plan for managing referrals.

- The applicant will not maintain a waiting list. The applicant will accept all referrals up to the number of families that can be assigned.
- Each of the two teams is required to treat a minimum of 12 parents during the IHRP.
- Each team must successfully enroll 75% of all referred parents. "Enrolled" is defined as completion of an intake session and three subsequent home visits.
- Teams must complete the three phases of the IHRP, as described below, for at least 40% of enrolled participants. "Completion" is defined as the parent receiving a minimum of four months of IHRP treatment, being in good standing with the

DCPP, having 12 consecutive negative toxicology screens, having custody of the child, and completing one other co-constructed treatment goal.

Intake Session

The intake session is scheduled by the IHRP team. The IHRP team and DCPP caseworker attend the intake session at the parent's home to review with the parent the reason for referral, targeted substance(s), safety agreements, and the treatment model. The parent may elect to consent for treatment, ask for a period of time of no more than 24 to 48 hours to consider treatment options, or decline IHRP treatment.

If the parent elects to enroll in the IHRP during the intake session, the parent will sign a consent form for treatment, complete a toxicology screen with an IHRP staff person, sign a release of information to the DCPP, and complete intake forms. Parents enrolled in Medically Assisted Treatment (MAT) at another agency will also sign consent for disclosure to/from the IHRP and the MAT provider. If a parent asks for a period of time to consider enrolling in the IHRP, the DCPP caseworker will communicate with the client within the agreed-upon time frame and inform the IHRP staff. If the parent agrees to participate, the protocol outlined above for the intake session will be followed.

Team responsibilities include the following:

- Offer treatment sessions minimally from 8:00 a.m. to 7:00 p.m., Monday through Friday
- Ensure flexibility in scheduling sessions before 8:00 a.m. and after 7:00 p.m. to best meet the needs of the clients served
- Provide services 52 weeks per year
- Provide 24/7 phone coverage for crisis intervention
- Provide treatment to each client for six to nine months depending on time of enrollment

The Three Phases of the IHRP

1. Assessment Phase

The IHRP team will meet with the parent three times a week. The team will conduct a comprehensive evaluation of each parent and child participating in the IHRP, which will result in the formulation of a DSM-5 diagnosis for the parent and an individualized treatment plan. The evaluation will provide a clinical integration of the parent's medical, psychosocial, substance use, legal, educational, and treatment histories, as well as an assessment of the child's development and parent-child interaction and attachment style. The evaluation should be comprehensive enough to address the needs of the child and parent within the context of the family and social community. The team will complete Family Based Recovery measures and tools.

Recovery planning will be a critical part of the IHRP team's work with parents and the DCPP. IHRP staff and the parents will develop a plan to be implemented at times when parents are experiencing strong cravings and are at high risk of relapse and/or are in crisis and need to ensure safety for themselves and their child(ren). The IHRP team will work with the parent to identify an alternative caregiver for the child if the parent chooses to use substances. The team will discuss with the parent how to manage a relapse if it should occur. The plan will be shared with the DCPP.

2. Treatment Phase

The team conducts three home visits a week for at least the first six months of treatment. After six months of treatment, the parent may be stepped down to two visits a week. Treatment consists of five components:

Parent-Child Component

The IHRP will not utilize a parenting curriculum. The IHRP team will use naturally occurring parent-child interactions as opportunities for reflection and support. The purpose of each parent-child session is to observe the back and forth of communication between parent and child, how the parent interprets the child's cues, and how the parent and child deal with ruptures and misunderstandings. The parent-child clinician will conduct a session with the parent and child once a week in the home or in the community (e.g., pediatrician visit, library). The child might have siblings residing in the home. The IHRP recognizes that all children might need assessment, possible interventions, and advocacy with systems, and this is the domain of the parent-child clinician. The parent-child clinician will facilitate assessments and referrals to all children in the home as needed but will not be expected to provide treatment to all children in the household. The parent-child work will focus on the following:

- understanding of child development
- child and household safety
- child health/well-childcare
- understanding of and response to child cues and needs
- positive parent-child interactions for secure attachment
- consistency in household routines and arrangements for childcare

Substance Use Component

The substance use clinician will provide individual, trauma-informed psychotherapy in addition to substance use treatment for the parent. The IHRP will use tools and principles from Reinforcement-Based Treatment. Treatment goals are designed to replace the function (or purpose) of

substance use for the individual. Experiencing the tangible benefits parents receive from being substance free—first and foremost, being able to parent their child—provides powerful motivation and focus to recovery. The substance use clinician will utilize a variety of tools to inform and guide the clinical work. These include the following:

- Brief Substance Use Assessment (BSUA)

This tool will be used by the clinician to assess how long a parent has used each substance and how much the parent has spent on substances in an average day. This tool provides valuable information for contracts and treatment goals. Every 90 days, the clinician and parent will complete a BSUA Follow-Up Tool.

- The Functional Assessment (FA)

The FA will provide the clinician with critical information regarding the "function(s)" that substance use serves in the parent's life. It examines how substance use fits into the parent's daily routine; what people, places, events, and feelings are associated with use; and which substances are commonly paired together. By completing the FA, the clinician will obtain information that will guide the clinical work (contracts, treatment plan, psychiatric evaluation, and management).

- Graphs

Family Based Recovery graphs are a cognitive-behavioral tool that keeps abstinence and abstinence-related goals tangible and salient to the parent.

- Contracts

Contracts are written agreements between the IHRP team, and the parent designed to improve the likelihood that he/she will engage in a particular behavior.

<u>Psychiatric Evaluation and Pharmacotherapy</u>

The psychiatrist/APRN will be available to conduct a psychiatric evaluation on all parents. The psychiatrist/APRN will provide pharmacotherapy and medication-assisted treatment (MAT) as needed. The psychiatrist/APRN will refer parents to an affiliated MAT provider as appropriate.

<u>Basic Needs Assessment and Support</u>

Many IHRP parents need assistance with obtaining basic needs for themselves and their family. The IHRP recognizes that parents need to have many of their basic needs met in order to maintain recovery and parent their children in a competent manner. The team is expected to offer assistance with referrals, as needed, in the following areas: housing, health care, education, employment, utility bills, social services, energy assistance

programs, Early Intervention Services, and child-care. Staff will assist parents with obtaining important documents (Social Security cards, birth certificates, driver's licenses, and Green Cards) as needed. The IHRP team will transport parents to offices and appointments, when appropriate.

Numerous parents are involved with the legal system due to criminal charges, housing matters, child support, domestic violence, and probation. The IHRP will offer support to parents in the legal system.

3. Transition Planning

The parent can be stepped down to Phase III, which consists of one home visit a week, four to six weeks prior to discharge. The length of service in this phase will be based on the clinical needs of the parent and child. Discharge planning should be a collaborative endeavor between the parent, the IHRP, and the DCPP caseworker. Prior to discharge, the recovery plan will be reviewed with the parent and updated as needed. A parent will be considered as successfully graduating from the IHRP if at the time of discharge the child lives with the parent, the parent has 12 consecutive negative toxicology screens, and the parent has achieved one other co-constructed goal.

Key Model Components

Substance Testing

Toxicology testing is for clinical purposes only. All IHRP staff are required to conduct toxicology screens with clients. Parents will be asked to submit a sample for screening at every encounter. IHRP staff will observe the toxicology screen when the staff member is the same gender as the parent. The IHRP will utilize a combination of CLIA-waived rapid tests and chain-of-custody procedures for testing within a licensed clinical laboratory to screen for a minimum of 12 substances. Further processes for toxicology testing for the DCPP will be determined in consultation with the Local Offices. Breathalyzers will be used at each visit for parents who have a diagnosis of an alcohol use disorder. IHRP staff will randomly (at least twice a month) conduct breathalyzer tests on all other parents.

Vouchers

Contingency management therapy provides positive reinforcement for evidence of behavioral change. The IHRP provides a $10 gift card/voucher for each negative toxicology screen during the first phase of treatment. Vouchers are one incentive for recovery and are seen as a means to jump-start recovery and engagement at the beginning of treatment. Parents earn up to $700 in vouchers for negative toxicology screens. The provider must have gift cards available to dispense at all times. It is expected that other non-monetary reinforcements for recovery, such as improved health and family relationships, will be in place consistently by the time the client has received this amount. The parent will earn a $20 gift card for completion of all discharge measures.

Parent-Child Therapy Group

The Parent-Child Therapy Group is a weekly, two-hour group that provides the parent another form of positive reinforcement for recovery. Parents must have a negative toxicology screen on the day of group in order to attend. While the group is not mandatory, all parents will be asked to sample the parent-child therapy group at least once. Parents will be encouraged to bring their child to group. All IHRP staff members will attend the group. In addition to clinical group time, the parent-child therapy group will consist of parents, children, and staff sharing a meal together. Initially, while a core group is building, staff may need to provide a more structured format, using ice breakers, recovery-related games, or art therapy as tools to initiate topics for discussion. Whatever the topic or activity, a goal of the parent-child therapy group is for the conversation to ultimately link to issues of parenting and/or recovery. Depending on the age of the children and the activity and/or topic, children may remain with parents during the therapy portion of the group. At other times, it will be more appropriate for the children to move into another room under the supervision of a staff member.

Collaboration with NJDCF

The Department is a family and child serving agency, working to assist NJ families in being or becoming safe, healthy, and connected. Parents referred to IHRP by DCPP are at risk for child maltreatment due to parental substance use. To ensure that children are safe and have minimal exposure to risk, the IHRP teams are expected to operationalize strengths-based principles and collaborate with DCPP to ensure engagement of families, ongoing safety and risk assessment, and solution-based case planning. When requested, the IHRP teams will make joint home visits with DCPP and participate in Family Team Meetings.

The IHRP team and DCPP local and area office staff will work in close collaboration from the time of referral until the parent is discharged from the IHRP. The IHRP team will frequently communicate with the assigned DCPP caseworker via phone and/or encrypted email (to ensure confidentiality) about the parent's progress and/or any concerns about the parent's functioning. The IHRP team will be required to notify the DCPP caseworker when a parent relapses and collaborate with the DCPP to ensure the child's or children's safety. The DCPP caseworker will likewise keep the IHRP team informed of any significant changes in the parent's case status.

The IHRP team, DCPP staff, and parent will meet monthly to review progress toward goal achievement. The IHRP team will attend, when asked, any case planning meetings scheduled during the case episode, as well as child and family team meetings requested by the parent. In addition, the IHRP team, DCPP caseworker, supervisor, and DCPP/IHRP liaison will meet monthly in the DCPP local office to review case progress.

DCPP case closure for parents engaged in the IHRP shall be determined according to the DCPP Case Closure in Cases with SUD Issues Policy, available at website below.

https://www.nj.gov/dcf/policy_manuals/CPP-III-C-8-300_issuance.shtm

Collaboration with Medication-Assisted Treatment Providers

IHRP clinicians and/or FSS will also collaborate with the parent's MAT provider, if applicable, and participate in case conferences telephonically or in person at least once a month.

Outreach

Since the IHRP is a home-based treatment, many of the barriers to accessing treatment are removed for IHRP parents. However, parents can avoid treatment by rescheduling frequently or not being home during scheduled home visits. Thus, the IHRP team will make multiple attempts to engage parents in treatment as outlined by the model. Staff may reach out via letter or phone call and attend scheduled sessions with the DCPP caseworker.

Measures

IHRP clinicians utilize standardized measures to inform and guide treatment and identify and track symptoms over the course of the intervention. Measures are divided into three domains: parent, child, and parent-child relationship. Areas of focus in the three domains are as follows:

- parent: depression, anxiety, post-traumatic stress, and childhood trauma history
- child: development, resilience, behaviors, and trauma exposure
- parent-child relationship: parenting stress, parental reflective capacity, attachment styles, and parenting attitudes

Tools

A three-generation **genogram** provides a structure for obtaining family history and a preliminary understanding of the fit between the parent and the parent's family system. The genogram will be co-constructed by the parent-child clinician and the parent in the early stages of treatment and encourages a parent to think about the early influences of family and environment in terms of caregivers, stability, important relationships, mental and physical health, and substance use.

F. Outcomes

Quality Assurance and Performance Improvement (QA/PI) Activities

Program Evaluation

The Program also includes a separate evaluation component. If the evaluation demonstrates evidence of clinical effectiveness and positive child welfare outcomes,

including decreased costs for foster care, a case could be made to the State of New Jersey for more widespread support of an in-home treatment model that addresses parental substance use and the parent-child dyadic relationship. Requirements for IHRP teams for the program evaluation are detailed below.

Provide Data for the Project Evaluations

More detailed information about data requirements for the separately funded evaluation will be shared with teams during the training and technical assistance sessions. Measures are used to inform and guide the clinical work in addition to providing valuable data for program evaluation. Measures are divided into three domains: parent, child, and parent-child relationship. Areas of focus in the three domains are as follows:

- parent: depression, anxiety, post-traumatic stress, and childhood trauma history
- child: development, resilience, behaviors, and trauma exposure
- parent-child relationship: parenting stress, parental reflective capacity, attachment styles, and parenting attitudes.

G. Additional Requirements

Organization/Agency Website

Publicly outlining the specific challenges exhibited by some of the families served by an agency may lead to confusion and misinformation. Without the appropriate context, the general public may wrongly assume that all families served are dealing with those challenges. The grantee must ensure that the content of their organization's website protects the confidentiality of, and avoids misinformation about, the families served. The website should also provide visitors with a mechanism for contacting upper administrative staff quickly and seamlessly.

Software and Data

All applicants are advised that any software purchased in connection with the proposed project must receive prior approval by the New Jersey Office of Information Technology.

Applicants are also advised that any data collected or maintained through the implementation of the proposed program shall remain the property of DCF.

Organ and Tissue Donation

As defined in section 2 of P.L. 2012, c. 4 (N.J.S.A.52:32-33), contractors are encouraged to notify their employees, through information and materials or through an organ and tissue awareness program, of organ donation options. The information provided to employees shall be prepared in collaboration with the organ procurement organizations designated pursuant to 42 U.S.C. §1320b-8.

Duties and Obligations

The program shall be operational and serving families on May 1, 2022.

H. Funding Information

For the purpose of this initiative, the Department will make available one award for a total annualized ceiling not to not to exceed $709,905.00 as funding is available.

Continuation funding is contingent upon the availability of funds in future fiscal years.

Matching funds are not required.

Funds awarded under this program may not be used to supplant or duplicate existing funding.

Any expenses incurred prior to the effective date of the contract will not be reimbursed by the Department of Children and Families.

Additional start-up funds are not available, so any proposed one-time expenses must be funded with **anticipated** contract accruals. Applicants must provide a justification and detailed summary of anticipated start-up costs, and the source of anticipated contract accruals, in order to begin program operations.

Universities are reminded that this is a competitive process and that no annual increases will be considered as part of this contract with regard to salaries, fringe, or other benefits for future negotiations or contracts, unless approved by the State legislature for all contracting entities.

I. Applicant Eligibility Requirements

1. Applicants must be for-profit or non-profit corporations and/ or Universities that are duly registered to conduct business within the State of New Jersey.
2. Applicants must be New Jersey–based mental health and SUD treatment providers serving adults, families, and/or children and must have an office(s) in Union County or an adjacent county (Hudson, Essex, Morris, Somerset, or

Middlesex). Applicants must be able to meet current DCF guidance regarding in-person and telehealth services. Applicants must be in good standing with all State and Federal agencies with which they have an existing grant or contractual relationship.

3. If Applicant is under a corrective action plan with DCF (inclusive of its Divisions and Offices) or any other New Jersey State agency or authority, the Applicant may not submit a proposal for this RFP if written notice of such limitation has been provided by the Agency or authority. Responses shall not be reviewed and considered by DCF until all deficiencies listed in the corrective action plan have been eliminated and progress maintained to the satisfaction of DCF for the period of time as required by the written notice.
4. Applicants shall not be suspended, terminated or barred for deficiencies in performance of any award, and if applicable, all past issues must be resolved as demonstrated by written documentation.
5. Applicants that are presently under contract with DCF must be in compliance with the terms and conditions of their contract.
6. Where required, all applicants must hold current State licenses.
7. Applicants that are not governmental entities must have a governing body that provides oversight as is legally required.
8. Applicants must have the capability to uphold all administrative and operating standards as outlined in this document.
9. All applicants must have a Data Universal Numbering System (DUNS) number. To acquire a DUNS number, contact the dedicated toll-free DUNS number request line at 1-866-705-5711 or inquire on-line at: https://www.dnb.com
10. Any fiscally viable entity that meets the eligibility requirements, terms and conditions of the RFP, and the contracting rules and regulations set forth in the DCF Contract Policy and Information Manual (N.J.A.C. 10:3) may submit an application.

J. RFP Schedule:

December 15, 2021 at 12:00PM	**Deadline for Email Questions sent to** DCF.ASKRFP@dcf.nj.gov
January 5, 2022 by 12:00PM	**Deadline for Receipt of Proposals**

Proposals received after 12:00 PM on **January 5, 2022** will **not** be considered.

All proposals must be delivered ONLINE:

To submit online, applicant must submit an AOR form. The AOR form must be completed and sent to DCF.ASKRFP@dcf.nj.gov

- Registration for the Authorized Organization Representative (AOR) Form

Once the AOR is submitted and the applicant is granted permission to proceed, instructions will be provided for submission of the proposal.

Only a registered Authorized Organization Representative (AOR) or the designated alternate is eligible to send in a submission by submitting an AOR form.

We recommend not waiting until the due date to submit your proposal in case there are technical difficulties during your submission. Registered AOR forms may be received 5 business days prior to the date the bid is due.

Submission Requirement:

It is required that you submit your proposal as one PDF document. If the Appendices file is too large, it can be separated into more pdf parts, such as Part 3, Part 4, etc...
Please do not upload separate documents.

K. Administration:

1. Screening for Eligibility, Conformity and Completeness

DCF will screen proposals for eligibility and conformity with the specifications set forth in this RFP. A preliminary review will be conducted to determine whether the application is eligible for evaluation or immediate rejection.

The following criteria will be considered, where applicable, as part of the preliminary screening process:

a) The application was received prior to the stated deadline.
b) The application is signed and authorized by the applicant's Chief Executive Officer or equivalent.
c) The applicant attended the Bidders Conference (if required).
d) The application is completed in its entirety, including all required attachments and appendices.
e) The application conforms to the specifications set forth in the RFP.

Upon completion of the initial screening, proposals meeting the requirements of the RFP will be distributed to the Proposal Evaluation Committee for its review and recommendations. Failure to meet the criteria outlined above, or the submission of incomplete or non-responsive applications constitutes grounds for immediate rejection of the proposal if such absence affects the ability of the committee to fairly judge the application.

2. Proposal Review Process

DCF will convene a Proposal Evaluation Committee in accordance with existing regulation and policy. The Committee will review each application in accordance with the established criteria outlined in Section II of this document. All reviewers, voting and advisory, will complete a conflict of interest form. Those individuals with conflicts or the appearance of a conflict will be disqualified from participation in the review process. The voting members of the Proposal Evaluation Committee will review proposals, deliberate as a group, and then independently score applications to determine the final funding decisions.

The Department reserves the right to request that applicants present their proposal in person for final scoring. In the event of a tie in the scoring by the Committee, the applicants that are the subject of the tie will provide a presentation of their proposal to the evaluation committee. The evaluation committee will request specific information and/or specific questions to be answered during a brief time-constrained presentation by the applicant. The presentation will be scored out of 50 possible points, based on the following criteria and the highest scoring applicant will be recommended for approval.

Requested information was covered-	10 Points
Approach to the contract and program design was thoroughly and clearly explained and was consistent with the RFP requirements-	20 Points
Background of organization and staffing explained-	10 Points
Speakers were knowledgeable about topic-	5 Points
Speakers effectively answered questions-	5 Points

The Department also reserves the right to reject any and all proposals when circumstances indicate that it is in its best interest to do so. The Department's best interests in this context include, but are not limited to: State loss of funding for the contract; the inability of the applicant to provide adequate services; the applicant's lack of good standing with the Department; and any indication, including solely an allegation, of misrepresentation of information and/or non-compliance with any State of New Jersey contracts, policies and procedures, or State and/or Federal laws and regulations.

All applicants will be notified in writing of the Department's intent to award a contract.

3. Special Requirements

The successful applicant shall maintain all documentation related to proof of services, products, transactions, and payments under this contract for a period of five years from the date of final payment. Such records shall be made available to the New Jersey Office of the State Comptroller upon request.

Applicants must comply with the requirements of N.J.S.A. 10:5-31 et seq. and N.J.A.C. 17:27, the State Affirmative Action policy. A copy is attached as **Exhibit A.**

Applicants must comply with laws relating to Anti-Discrimination. A copy of these laws is attached as **Exhibit B.**

Applicants must comply with confidentiality rules and regulations related to the individuals served in this program including, but not limited to:

1. 42 CFR Part 2 Confidentiality of SUD Patient Records.
2. Keeping client specific and patient Personal Health Information ("PHI") and other sensitive and confidential information confidential in accordance with all applicable New Jersey and federal laws and regulations including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").
3. Recognizing and understanding that case information is mandated by N.J.S.A. 9:6-8.10a to be kept confidential and the release of any such information may be in violation of state law and may result in the conviction of individuals for a disorderly person's level offense as well as possibly other disciplinary, civil or criminal actions pursuant to N.J.S.A. 9:6-8.10b.

Applicants must submit ***DCF Pre-Award Documents*** as **Exhibit C** with their response to this RFP.

Applicants who receive an award letter after submitting a response to this RFP **thereafter** must submit as a condition of receiving a contract, all of the documents listed in ***DCF Post-Award Documents*** as **Exhibit D**.

Applicants who receive an award letter must comply with the **Notice of Standard Contract Requirements, Processes, and Policies as Attachment 1**

Applicants must sign, date and submit the Public Law P.L. 2021, c.1 **Attestation Form for Providers with DCF Contracts, as Attachment 2**

L. Appeals:

An appeal of the selection process will be heard only if it is alleged that the Department has violated a statutory or regulatory provision in awarding the grant. An appeal will not be heard based upon a challenge to the evaluation of a proposal. Applicants may appeal by submitting a written request to:

Office of Legal Affairs
Contract Appeals
50 East State Street 4th Floor
Trenton NJ 08625

Appeals must be submitted no later than ten (10) business days following receipt of the notification or by the deadline posted in this announcement.

M. Post Award Review:

As a courtesy, DCF may offer unsuccessful applicants an opportunity to review the Evaluation Committee's rating of their individual proposals. All Post Award Reviews will be conducted by appointment.

Applicants may request a Post Award Review by contacting: DCF.ASKRFP@dcf.nj.gov.

Post Award Reviews will not be conducted after six months from the date of issuance of this RFP.

N. Post Award Requirements:

Selected applicants will be required to comply with the terms and conditions of the Department of Children and Families' contracting rules and regulations as set forth in the Standard Language Document, the Contract Reimbursement Manual and the Contract Policy and Information Manual. Applicants may review these items via the Internet at www.nj.gov/dcf/providers/contracting/manuals

Selected applicants will also be required to comply with all applicable State and Federal laws and statutes, assurances, certifications and regulations regarding funding.

Upon receipt of the award announcement, and where appropriate**,** selected applicants will be minimally required to submit one (1) copy of the following documents:

1. A copy of the Acknowledgement of Receipt of the NJ State Policy and Procedures returned to the DCF Office of the EEO/AA

2. Proof of Insurance naming DCF as additionally insured from agencies
3. Bonding Certificate
4. Notification of Licensed Public Accountant (NLPA) with a copy of Accountant's Certification
5. ACH-Credit Authorization for automatic deposit (for new agencies only)

The actual award of funds is contingent upon a successful contract negotiation. If, during the negotiation, it is found that the selected applicant is incapable of providing the services or has misrepresented any material fact or its ability to manage the program, the notice of intent to award may be rescinded.

Section II – Application Instructions

A. Proposal Requirements and Review Criteria:

All applications will be evaluated and scored in accordance with the following criteria:

The narrative portion of the proposal should be double-spaced with margins of 1 inch on the top and bottom and 1 inch on the left and right. The font shall be no smaller than 12 points in Arial or Times New Roman. There is a 25-page limitation for the narrative portion of the grant application. A one (1) point reduction per page will be administered to proposals exceeding the page limit requirements. Five (5) points will be deducted for each missing document. If the deductions total 20 points or more, the proposal shall be rejected as non-responsive. The narrative must be organized appropriately and address the key concepts outlined in the RFP.

Proposals may be fastened by a heavy-duty binder clip. Do not submit proposals in loose-leaf binders, plastic sleeves or folders. Proposals may not be stapled.

Each proposal narrative must contain the following items organized by heading in the same order as presented below:

I. Community and Organizational Fit (10 Points)

Community and Organizational fit refer to respondent's alignment with the specified community and state priorities, family and community values, culture and history, and other interventions and initiatives.

1) Provide a concise summary of the In-Home Recovery Program your organization proposes to implement. It should include its overall goals and objectives, the population(s) it will serve, and collaborating agencies.

2) Describe how this initiative is consistent with your organization's mission and priorities.

3) Describe how this initiative fits with existing initiatives/programming in your organization.

4) Explain how using the proposed evidence-informed model will meet the needs of your target population and achieve the intended outcomes.

5) Describe how the requirements of this initiative will be met through your policies implementing trauma informed practices.

- **Include written policies implementing trauma informed practices.**

6) Describe existing clinical resources that will be made available to the In-Home Recovery Program.

II. Organizational Capacity (20 Points)

Organizational Capacity refers to the Respondent's ability to financially and structurally meet and sustain the specified minimum requirements.

1) Describe how the organization's leadership is knowledgeable about, and in support of, this initiative. Include how the requirements of this initiative will be met through your governance and management structure, including the roles of senior executives and governing body (Board of Directors, Managing Partners, Board of Freeholders). Do leaders have the diverse skills and perspectives representative of the community being served?

- **Include a Governing Body List. (A "governing body" is any of the following: Board or Directors -or- Managing Partners, if LLC/Partnership, -or- Chosen Freeholders of Responsible Governing Body. List must be dated and include the following: names, titles, emails, phone numbers, addresses, and terms for all members of Governing Body.) as part of the appendix.**

- **Include a current Agency-Wide Organizational Chart as part of the appendix.**

2) Describe past or present experience in serving families involved with the DCPP, including how collaboration and communication are accomplished.

3) As part of the proposed treatment model, the clinical team will provide information and assist clients to access available community resources to address basic needs, health care, family social opportunities, and medication-assisted treatment. Each grantee will be required to develop a Resource List that can be used by the clinical team when needs are identified, and linkages are required.

The Resource List may include, but does not have to be limited to, the following:

a. housing organizations
b. shelters (family and domestic violence)
c. pediatricians
d. MAT providers
e. parenting supports (e.g., Mommy and Me groups)
f. childcare organizations (e.g., Head Start and Early Head Start)
g. child development/health organizations (e.g., Birth to Three, Visiting Nurse Association)
h. food assistance (e.g., Supplemental Nutrition Assistance Program, Women, Infants and Children [WIC], food banks)
i. rental assistance programs
j. utility assistance
k. furniture assistance
l. clothing assistance
m. infant and child furniture/supplies assistance
n. code enforcement assistance
o. legal services
p. law and public safety
q. libraries

Describe any existing partnerships or new collaborations that you plan to develop to help address families' access to basic needs and community resources.

- **As part of the appendix, include 3 written professional letters of support from community-based organizations on behalf of the applying individual/agency specific to the provisions of services under this RFP**. (That is, for example, not letters from families or individuals who previously received services from your program. Additionally, letters from any New Jersey State employees are prohibited). Template/duplicate letters of support are not acceptable. Please include telephone numbers and e-mail for all references so they may be contacted directly.

4) Briefly describe the ways in which your agency's operations (policies and/or practices) mirror the Prevent Child Abuse New Jersey's Safe-Child standards.

- **Include a brief (no more than 2 pages double spaced) Safe-Child Standards Description demonstrating ways in which your agency's operations mirror the Standards as part of the appendix.**

The Standards are available at: https://nj.gov/dcf/providers/notices/nonprofit/

5) Describe how the requirements of this initiative will be met through your commitment to cultural competency and diversity and plans to ensure needs of various and diverse cultures within the target community will be met in a manner consistent with the Law Against Discrimination (N.J.S.A. 10:51 et seq.).

6) Describe how this initiative will be supported by your willingness to engage in participatory, collaborative evaluation planning with DCF and Rutgers University to improve and finalize outcome indicators.

   - Are there designated staff with capacity to collect and use data to inform ongoing monitoring and improvement of the program or practice? If so, describe.

7) Describe how you will use information, data, and feedback during program implementation to identify and address known, or anticipated, obstacles and barriers to meeting your objectives and to ensure quality improvements are made and addressed on an ongoing basis.

8) Provide a feasible timeline for implementing the proposed services. Provide a detailed week-by-week description of your action steps in preparing to provide this service and to become fully operational within the time specified. Three months after notification of the grant award, program teams will have accomplished the following:
   - hire and/or reassign staff
   - identify and implement trainings as appropriate
   - establish and adopt policies and protocols for the program in partnership with NJDCF and proposed TA provider
   - develop strong working relationships with the DCPP local and area offices and CPSAI
   - establish a management team structure and regular meeting schedules with NJDCF staff and the TA provider
   - purchase materials
   - work with Montclair State University to develop a plan for staff training and reflective supervision within 30 days of contract award
   - planning for the data collection process and protection of data with Rutgers University
   - The program will enroll the first clients May 1, 2022

   A Program Implementation Schedule has been included in Exhibit F. Review the schedule and submit a similar table with specific target dates for completion of all objectives, as part of the Appendix.

9) Describe any fees for services, sliding fee schedules, and waivers.

10) What administrative practices must be developed and/or refined to support the initiative/program/practice? What administrative policies and procedures must be adjusted to support the work of the staff and others to implement the program or practice?

11) Describe how the organization will meet current DCF guidance regarding in-person and telehealth services during COVID 19 pandemic.

III. Program Approach/ Treatment Proposal (40 Points)

Service Description

Demonstrate the capacity to meet minimum requirements:

1) Describe the treatment model you wish to pursue and how you will maintain fidelity to the proposed in-home treatment model described in **Section E. Activities** of the RFP.

2) Describe how you will partner with DCPP to help identify eligible clients.

3) Describe how the requirements of this initiative will be met through your strategies for engaging families and for maintaining their participation in services in accordance with need.

    - If applicable, refer to your experiences from other treatment models or programs where you have worked and provided clinical care to parents and/or children aged 0-6 who are involved with DCPP.

    - Provide retention rates (if available) from prior initiatives.

    - Describe challenges you experienced in those programs and how you addressed them. Provide examples of successes with other programs to engage and retain other target populations in home-based services. Note your track record with retention and attrition.

4) Describe how you will ensure that patients who are clinically indicated for MAT will receive this service. Describe how you will partner with the prescriber to ensure continuity of care.

5) Describe how you will serve clients who do not speak English or who are bilingual and ensure that teams are able to provide bilingual services.

6) Describe how you will manage client transportation.

7) Describe your plans (location, staffing) for the parent-child therapy group.

8) Describe how you will provide referrals to other levels of SUD care if needed.

9) Demonstrate experience with, understanding of, and integration of issues of trauma in adults and how it will be integrated into the treatment plan. Articulate how both explicit and implicit trauma will be addressed within the context of staff support and assessment/treatment.

IV. Organizational Supports (15 Points)

Organizational Supports refers to the respondent's access to Expert Assistance, Staffing, Training, Coaching & Supervision.

1) Does the staff have a cultural and language match with the population they serve, as well as relationships in the community? If so, describe.

2) Describe the staff who will implement this Project and indicate whether each staff member will be hired or reassigned.
   - Job title (e.g., clinical supervisor, clinician)
   - Role(s) and responsibilities
   - Credentials, skills, and training required
     - If you already have staff who will be reassigned to the Project, indicate whether they have received training in substance use, mental health, infant mental health, motivational interviewing, and reflective supervision, and if so, describe the training previously received and if it has led to certification and/or licensure. As described in the RFP, the TA provider will provide an initial three-day training to all staff.

Following the descriptions of each staff member, explain any internal organizational processes that will need to be implemented to complete the hiring or reassignment process and your anticipated time frame for completing these tasks.

- **Include a summary (no more than one page) which describes proposed and current strategies to enhance staff retention as part of the appendix.**
- **Include an organizational chart for the proposed program operation as part of the appendix.**
- **Include job descriptions that describe all educational and experiential requirements as part of the appendix.**
- **Include professional licenses related to job responsibilities as part of the appendix, if applicable.**
- **Include resumes of any existing staff who will perform the proposed services as part of the appendix.**
- **Include a brief narrative on staffing patterns as part of the appendix.**

3) Describe how your organization will collaborate with Montclair State University to support this initiative with required/necessary training and reflective supervision.

Awardees are required to collaborate with Montclair State University (MSU) within 30 days of contract award and develop a concrete plan and timeline for staff training and reflective supervision as outlined below.

Introductory Training

MSU will provide an introductory training on the provision of in-home substance use treatment and Child-Parent Psychotherapy for the In-Home Recovery Program (IHRP) staff and Union County Department of Children and Families. The training, which will take place over a 2-day period via zoom, will introduce the basic constructs and techniques which inform the treatment program. Modules will address the theoretical framework, guiding programmatic principles, substance use treatment interventions and the provision of Child-Parent Psychotherapy.

Clinical Practice Seminar in Infant and Early Childhood Mental Health (IECMH) – 100 hours (2 hours/week/group for 12 months)

The Clinical Practice in IECHM provides a necessary foundation for work with infants, young children and their families. Attendees receive the equivalent of 60 hours of training competencies towards the NJ-AIMH IMH Endorsement (www.nj-aimh.org/endorsement), including the areas of prenatal, infancy and early childhood development, the development of emotional and relational health, the power of relationships and interpersonal neurobiology, family and community systems, the influence of culture and context, assessment, intervention, and consultation strategies, evidence-informed clinical techniques, DC: 0-5 diagnostic system, Brazelton Touchpoints Approach, etc. Attendees also receive 40 hours of Reflective Supervision/Consultation by an Infant Mental Health Clinical Mentor (IMHM-C).

Two certified consultants (1-parent/child, 1 substance use) will provide weekly clinical consultation with IHRP teams. Total weekly phone time is 2.5 hours.

- The site supervisor will have one 30-minute call per week.
- Both team(s), including the supervisor, will participate in a 2-hour virtual training/reflection supervision meeting each week.
- Both consultants will review in advance of the call clinical treatment notes, and model-specific tools and measures that have been administered.
- Consultants will be prepared to facilitate, and lead model-related discussions based on materials received.

Consultants will be available by email for questions that need to be addressed sooner than the consultation call.

Training in Child-Parent Psychotherapy – 45 hours

Child-Parent Psychotherapy (https://childparentpsychotherapy.com/providers/training) is an evidence-based model of psychotherapy endorsed by the National Child Traumatic Stress Network that is meant to support families with children under the age of 6 who have experienced or witnessed a traumatic event. Training takes place over 18- months and is distributed over three sessions that are separated by time, with the expectation that clinicians are working with cases during the time of training. The first learning session

takes place over 18 hours. The second learning session is 12 hours, and the third learning session is a final 15 hours.

Reflective Consultation in CPP practice – 36 hours concurrent with Professional Formation Communities in IECMH Clinical Practice (every other week 1-hr call)

Child-Parent Psychotherapy also necessitates the experience of reflective consultation about the clinicians' CPP practice. This takes place through two one-hour meetings per week for the duration of the CPP training. At least 70% of the calls will need to be attended in order to complete the training.

4) Describe your plan to accomplish the following:
    - ensure the staff participate in the required training when scheduled
    - ensure that staff have dedicated time to participate in the required additional training and support activities
    - address cultural competence and language barriers to treatment
    - recruit, hire, and train new staff in the event of staff turnover

5) Describe your organization's process to evaluate staff performance.

V. Responses to Case Vignettes (5 Points)

Vignette Responses: The applicant shall read the vignettes and questions included as Exhibit E and develop a maximum one-page response to the questions for each of two (2) vignettes.

The applicant's 1-page responses shall be submitted with their proposal as Exhibit E, as part of the Appendix. The vignette responses do not count toward the narrative page limitation.

VI. Budget (10 Points)

Include a budget narrative that describes the following estimated expenses:

- Staff and fringe (see required staff in **Section D.** Hire or Reassign Required Staff). For each staff person:
    - Name (if person is known)
    - Job title
    - Percentage of staff person's time that is assigned to the Project and salary
    - If you plan to hire part-time clinicians and/or FSS staff, please explain how you plan to ensure model fidelity, communication, and collaboration.

- Operating expenses
  - Reimbursement for cell phone expenses for clinical staff, if appropriate
  - Supplies
  - 12-panel CLIA-waived toxicology screens (3 screens per week per client, approximately 24 clients per week, over 12 months)
    - Breathalyzers with mouthpieces (3 breathalyzers a week for clients diagnosed with alcohol use disorder and at least twice a month for all other clients)
    - GenoPro for each clinician (GenoPro 2018, 4-user license @ $149.00) https://www.genopro.com/buy/
  - Assessments
    - Childhood Trauma Questionnaire (25 Ready Score Answer Documents @ $76.50) https://www.pearsonassessments.com/store/usassessments/en/Store/Professional-Assessments/Personality-%26-Biopsychosocial/Childhood-Trauma-Questionnaire%3A-A-Retrospective-Self-Report/p/100000446.html
    - Parenting Stress Index, Fourth Edition Short Form (PSI-4 SP @ $716 and response sheets @ $114) https://www.parinc.com/Products/Pkey/335
    - Electronic Devereux Early Childhood Assessment (eDECA) (Annual License Fee @ $299.95 and $1.00 assessment) https://www.kaplanco.com/store/trans/productDetailForm.asp?CatID=17%7CEA1000%7C0&PID=16701
    - Ages & Stages Questionnaires, Third Edition (ASQ-3) (Starter Kit @ $295) https://agesandstages.com/products-pricing/asq3/
    - Child Behavior Checklist for Ages 1.5–5: (Preschool Computer-Scoring Starter Kit @ $430, Score Sheets @ $35) https://store.aseba.org/Child-Behavior-Checklist-I-5/products/22/
  - Transportation
    - Mileage, insurance, car seats, and other transportation cost
  - Meeting expenses
    - Food for parent-child group therapy
    - Client reinforcement (gift cards)
    - Up to $700 for each client for reinforcement of negative toxicology screens and $20 for completion of discharge measures
- In-kind funding
  - Describe the services, space, or materials that are being contributed, who is providing the support, and the dollar value of the support.

Applicants must clearly indicate how this funding will be used to meet the project goals and/or requirements. Provide a line item budget and narrative for the proposed

project/program. **Include the Budget Narrative as part of Appendices**. This will not be included as part of the 25-page narrative limitation.

The budget shall be reasonable and reflect the scope of responsibilities required to accomplish the goals of this project, as per the DCF Budget form. The budget shall also reflect a 12-month operating schedule and must include, in separate columns, total funds needed for each line item, the funds requested in this grant, and funds secured from other sources.

All costs associated with the operationalizing of the program must be clearly delineated and the budget narrative must clearly articulate budget items, including a description of miscellaneous expenses or "other" items.

- **The Budget form are to be attached as an appendix.**

The grantee is expected to adhere to all applicable State cost principles.

Standard DCF Annex B (budget) forms are available at:
https://www.state.nj.us/dcf/providers/contracting/forms/ and a description of General and Administrative Costs are available at :
https://www.nj.gov/dcf/providers/notices/requests/
See *Standard Documents for RFPs* for forms.

B. Supporting Documents:

Applicants must submit a complete proposal signed and dated by the Chief Executive Officer or equivalent and should submit a CD ROM containing Word or PDF versions of all required documents. There is a 25-page limitation for the narrative portion of the grant application. A one (1) point reduction per page will be administered to proposals exceeding the page limit requirements. Failure to submit any of the required documents requested in this RFP will result in a loss of five (5) points per item from the total points awarded for the proposal.

All supporting documents submitted in response to this RFP must be organized in the following manner:

		Part I: Proposal
1	☐	**Proposal Cover Sheet** – (signed and dated) Website: https://www.nj.gov/dcf/providers/notices/requests/#2 Form: https://www.nj.gov/dcf/providers/notices/Proposal.Cover.Sheet.doc
2	☐	**Table of Contents** – Please number and label with page numbers if possible in the order as stated in Part I & Part II Appendices
3	☐	**Proposal Narrative** in following order **25 Page Limitation** I. Organizational Fit II. Organizational Capacity

		III. Program Approach IV. Organizational Support V. Case Vignettes (2) **not part of the 25-page narrative limitation** VI. Budget Narrative-**not part of the 25-page narrative limitation**
		Part II: Appendices
4	☐	**A summary (no more than one page) which describes proposed and current strategies to enhance staff retention**
5	☐	**DCF Narrative** (See Budget Section) **(10 Points)**
6	☐	**DCF Budget form**
7	☐	**Written policies implementing trauma informed practices.**
8	☐	**Current Agency-Wide Organization Chart**
9	☐	**Three (3) written professional letters of support** on behalf of the applying individual/agency specific to the provisions of services under this RFP. (That is, for example, not letters from families or individuals who previously received services from your program. Additionally, letters from any New Jersey state employees are prohibited.) A professional letter of support from the CMO(s) of the county(ies) you are serving is encouraged. Template/duplicate letters of support are not acceptable. Please include telephone numbers and e-mail for all references so they may be contacted directly.
10	☐	**Safe-Child Standards Description** of your agency's implementation of the standards (no more than 2 pages)
11	☐	**Job Descriptions that include all educational and experiential requirements**
12	☐	**Resumes of any existing staff who will perform the proposed services** (please do not provide home addresses or personal phone numbers)
13	☐	**Brief narrative on Staffing Patterns**
14	☐	**2 Response to Case Vignettes** (Max 1 page each) **(10 points) Exhibit E**
15	☐	Agency's **Conflict of Interest policy**
16	☐	**Copies of any audits (not financial audit) or reviews** (including corrective action plans) completed or in process by DCF (inclusive of DCF Licensing, Divisions and Offices) or other State entities within the last 2 years. If available, a corrective action plan should be provided and any other pertinent information that will explain or clarify the applicant's position. If not applicable, include a written statement. Applicants are on notice that DCF may consider all materials in our records concerning audits, reviews or corrective active plans as part of the review process.
17	☐	**Statement of Assurances – (Signed and dated)** Website: https://www.nj.gov/dcf/providers/notices/requests/#2Form: https://www.nj.gov/dcf/providers/notices/Statement.of.Assurance.doc
18	☐	**Program Implementation Schedule-Exhibit F**

* Standard forms for RFP's are available at:
https://www.nj.gov/dcf/providers/notices/requests/
See *Standard Documents for RFPs* for forms.

Standard DCF Annex B (budget) forms are available at:
https://www.state.nj.us/dcf/providers/contracting/forms/

** Treasury required forms are available on the Department of the Treasury website at: https://www.state.nj.us/treasury/purchase/forms.shtml
Click on Vendor Information and then on Forms.
Standard Language Document, the Contract Reimbursement Manual and the Contract Policy and Information Manual may be reviewed via the Internet at:
https://www.nj.gov/dcf/providers/contracting/manuals

C. Requests for Information and Clarification:

Written questions for technical assistance may be provided in advance by at 12:00 pm and will be answered and be posted. Technical inquiries about forms and other documents may be submitted to DCF.ASKRFP@dcf.nj.gov at any time.

Question and Answer:

DCF will provide eligible applicants additional and/or clarifying information about this initiative and application procedures through a time-limited electronic Question and Answer Period. Inquiries will not be accepted after the closing date of the Question and Answer Period. Questions must be submitted in writing via email to: DCF.ASKRFP@dcf.nj.gov.

Written questions must be directly tied to the RFP. Questions should be asked in consecutive order, from beginning to end, following the organization of the RFP. All inquiries submitted to DCF.ASKRFP@dcf.nj.gov must identify, in the Subject heading, the specific RFP for which the question/clarification is being sought. Each question should begin by referencing the RFP page number and section number to which it relates.

Written inquiries will be answered and posted on the DCF website as a written addendum to the RFP at: https://www.nj.gov/dcf/providers/notices/requests/

Technical inquiries about forms and other documents may be requested anytime through DCF.ASKRFP@dcf.nj.gov.

All other types of inquiries will not be accepted. **Applicants may not contact the Department directly, in person, or by telephone, concerning this RFP**.

EXHIBIT A
MANDATORY EQUAL EMPLOYMENT OPPORTUNITY LANGUAGE
N.J.S.A. 10:5-31 et seq. (P.L. 1975, C. 127)
N.J.A.C. 17:27
GOODS, PROFESSIONAL SERVICE AND GENERAL SERVICE CONTRACTS

During the performance of this contract, the contractor agrees as follows:

The contractor or subcontractor, where applicable, will not discriminate against any employee or applicant for employment because of age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex. Except with respect to affectional or sexual orientation and gender identity or expression, the contractor will ensure that equal employment opportunity is afforded to such applicants in recruitment and employment, and that employees are treated during employment, without regard to their age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex. Such equal employment opportunity shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. The contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Public Agency Compliance Officer setting forth provisions of this nondiscrimination clause.

The contractor or subcontractor, where applicable will, in all solicitations or advertisements for employees placed by or on behalf of the contractor, state that all qualified applicants will receive consideration for employment without regard to age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex.

The contractor or subcontractor will send to each labor union, with which it has a collective bargaining agreement, a notice, to be provided by the agency contracting officer, advising the labor union of the contractor's commitments under this chapter and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

The contractor or subcontractor, where applicable, agrees to comply with any regulations promulgated by the Treasurer pursuant to N.J.S.A. 10:5-31 et seq., as amended and supplemented from time to time and the Americans with Disabilities Act.

The contractor or subcontractor agrees to make good faith efforts to meet targeted county employment goals established in accordance with N.J.A.C. l7:27-5.2.

The contractor or subcontractor agrees to inform in writing its appropriate recruitment agencies including, but not limited to, employment agencies, placement bureaus, colleges, universities, and labor unions, that it does not discriminate on the basis of age,

race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex, and that it will discontinue the use of any recruitment agency which engages in direct or indirect discriminatory practices.

The contractor or subcontractor agrees to revise any of its testing procedures, if necessary, to assure that all personnel testing conforms with the principles of job-related testing, as established by the statutes and court decisions of the State of New Jersey and as established by applicable Federal law and applicable Federal court decisions.

In conforming with the targeted employment goals, the contractor or subcontractor agrees to review all procedures relating to transfer, upgrading, downgrading and layoff to ensure that all such actions are taken without regard to age, race, creed, color, national origin, ancestry, marital status, affectional or sexual orientation, gender identity or expression, disability, nationality or sex, consistent with the statutes and court decisions of the State of New Jersey, and applicable Federal law and applicable Federal court decisions.

The contractor shall submit to the public agency, after notification of award but prior to execution of a goods and services contract, one of the following three documents:

Letter of Federal Affirmative Action Plan Approval
Certificate of Employee Information Report
Employee Information Report Form AA302 (electronically available at www.state.nj.us/treasury/contract_compliance).

The contractor and its subcontractors shall furnish such reports or other documents to the Department of Children and Families, the Division of Purchase & Property, CCAU, EEO Monitoring Program as may be requested by the office from time to time in order to carry out the purposes of these regulations, and public agencies shall furnish such information as may be requested by the Department of Children and Families, the Division of Purchase & Property, CCAU, EEO Monitoring Program for conducting a compliance investigation pursuant to **Subchapter 10 of the Administrative Code at N.J.A.C. 17:27**.

EXHIBIT B
TITLE 10. CIVIL RIGHTS
CHAPTER 2. DISCRIMINATION IN EMPLOYMENT ON PUBLIC WORKS
***N.J. Stat. § 10:2-1* (2012)**

§ 10:2-1. Antidiscrimination provisions

Antidiscrimination provisions. Every contract for or on behalf of the State or any county or municipality or other political subdivision of the State, or any agency of or authority created by any of the foregoing, for the construction, alteration or repair of any public building or public work or for the acquisition of materials, equipment, supplies or services shall contain provisions by which the contractor agrees that:

a. In the hiring of persons for the performance of work under this contract or any subcontract hereunder, or for the procurement, manufacture, assembling or furnishing of any such materials, equipment, supplies or services to be acquired under this contract, no contractor, nor any person acting on behalf of such contractor or subcontractor, shall, by reason of race, creed, color, national origin, ancestry, marital status, gender identity or expression, affectional or sexual orientation or sex, discriminate against any person who is qualified and available to perform the work to which the employment relates;

b. No contractor, subcontractor, nor any person on his behalf shall, in any manner, discriminate against or intimidate any employee engaged in the performance of work under this contract or any subcontract hereunder, or engaged in the procurement, manufacture, assembling or furnishing of any such materials, equipment, supplies or services to be acquired under such contract, on account of race, creed, color, national origin, ancestry, marital status, gender identity or expression, affectional or sexual orientation or sex;

c. There may be deducted from the amount payable to the contractor by the contracting public agency, under this contract, a penalty of $ 50.00 for each person for each calendar day during which such person is discriminated against or intimidated in violation of the provisions of the contract; and

d. This contract may be canceled or terminated by the contracting public agency, and all money due or to become due hereunder may be forfeited, for any violation of this section of the contract occurring after notice to the contractor from the contracting public agency of any prior violation of this section of the contract.

No provision in this section shall be construed to prevent a board of education from designating that a contract, subcontract or other means of procurement of goods, services, equipment or construction shall be awarded to a small business enterprise, minority business enterprise or a women's business enterprise pursuant to P.L.1985, c.490 (*C.18A:18A-51* et seq.).

EXHIBIT C Rev. 4-1-2021

DCF Pre Award Documents
Required to Be Submitted with a Response to an OOH RFP

	▶	CONTRACT DOCUMENTS TO BE SUBMITTED ONCE WITH THE RESPONSE:
1	☐	**Standard Language Document** (SLD) (signed/dated) [Rev. 7-2-19] Form: https://www.nj.gov/dcf/documents/contract/forms/StandardLanguage.doc
2	☐	**Business Associate Agreement/HIPAA** (signed/dated under Business Associate) [Rev. 8-2019] Form: https://www.nj.gov/dcf/providers/contracting/forms/HIPAA.docx
3	☐	Proposed **Annex B Budget Form** documenting anticipated budget (include signed cover sheet) Annex B: https://www.nj.gov/dcf/documents/contract/forms/AnnexB.xls Note: Expense Summary Form is auto populated. Begin data input on Personnel Detail Tab.
4	☐	Dated List of Names, Titles, Emails, Phone Numbers, Addresses & Terms of **Board of Directors** -or- **Managing Partners**, if a LLC/Partnership -or- **Chosen Freeholders** of Responsible Governing Body
5	☐	**Disclosure of Investigations and Other Actions Involving Bidder** (signed/dated) [Rev. 3-15-19] Website: https://www.nj.gov/treasury/purchase/forms.shtml Form: https://www.nj.gov/treasury/purchase/forms/DisclosureofInvestigations.pdf
6	☐	**Disclosure of Investment Activities in Iran** (signed/dated) [Rev. 2-1-21] Website: https://www.nj.gov/treasury/purchase/forms.shtml Form: https://www.nj.gov/treasury/purchase/forms/DisclosureofInvestmentActivitiesinIran.pdf
7	☐	**Ownership Disclosure** (signed/dated) [Rev. 2-22-21] Website: https://www.nj.gov/treasury/purchase/forms.shtml Form: https://www.nj.gov/treasury/purchase/forms/OwnershipDisclosure.pdf
8	☐	**Subcontract/Consultant Agreements** related to this response If not applicable, include a signed/dated note, on agency letterhead, stating your agency will not have any subcontract/consultant agreements and the requirement does not apply.
9	☐	For Profit: **Chapter 51/Executive Order 117** Vendor Certification and Disclosure of Political Contributions [Rev 4/1/19] See instructions for applicability to your organization. If not applicable, include a signed/dated note, on agency letterhead, stating a Chapter 51 form is not required and include a brief explanation as to why. Website: https://www.nj.gov/treasury/purchase/forms.shtml Form: https://www.nj.gov/treasury/purchase/forms/eo134/Chapter51.pdf
10	☐	**Agency By Laws** -or- **Management Operating Agreement** if a LLC
11	☐	**Certificate of Incorporation** Website: https://www.nj.gov/treasury/revenue/
12	☐	Document showing **Data Universal Numbering System** (**DUNS**) Number [2006 Federal Accountability and Transparency Act (FFATA)] Website: https://fedgov.dnb.com/webform Helpline: 1-866-705-5711

13	☐	For Profit: **NJ Business Registration** Certificate with the Division of Revenue See instructions for applicability to your organization. If not applicable, include a signed/dated note, on agency letterhead, stating a NJ Business Registration is not required and include a brief explanation as to why. Website: https://www.nj.gov/njbusiness/registration/
14	☐	**Tax Exempt Organization Certificate (ST-5)** -or- **IRS Determination Letter 501(c)(3)** If not applicable, include a signed/dated note, on agency letterhead, stating the tax exempt requirement does not apply and include a brief explanation as to why. Website: https://www.nj.gov/treasury/taxation/exemptintro.shtml
15	☐	Proposed **Program Implementation Status Update Form** documenting anticipated implementation schedule --or-- some other detailed weekly description of your action steps in preparing to provide the services of the RFP to become fully operational within the time specified. Website for OOH Form: https://nj.gov/dcf/providers/contracting/forms/csoc.html
	▶	**CONTRACT DOCUMENTS TO BE SUBMITTED WITH THE RESPONSE & ANNUALLY UPDATED THEREAFTER:**
16	☐	**Affirmative Action Certificate** --or-- **Renewal Application** [AA302] sent to Treasury with payment. Note: The AA302 is only applicable to new startup agencies and may only be submitted during Year 1. Agencies previously contracted through DCF are required to submit an Affirmative Action Certificate. Website: https://www.nj.gov/treasury/purchase/forms.shtml Form: https://www.nj.gov/treasury/purchase/forms/AA_%20Supplement.pdf
17	☐	Certification Regarding **Debarment** (signed/dated) Website: https://www.nj.gov/dcf/providers/notices/requests/#2 Form: https://www.nj.gov/dcf/documents/contract/forms/Cert.Debarment.pdf
18	☐	**Tax Forms – Full Return Required** Non Profit **Form 990** Return of Organization Exempt From Income Tax -or- For Profit **Form 1120** US Corporation Income Tax Return -or- LLC **Applicable Tax Form** and may delete or redact any SSN or personal information
19	☐	Proposed **Organizational Chart** for services required by this response – Ensure chart includes the agency name and current date
20	☐	Current **Professional Licenses and/or Certificates** related to job responsibilities for this response If not applicable, include a signed/dated note, on agency letterhead, stating your programs do not require staff to be professionally licensed/certified and the requirement does not apply.
21	☐	**System for Award Management** (**SAM**) printout showing active status and expiration date Note: Should be obtained free of charge Website: Go to SAM by typing **www.sam.gov** in your Internet browser address bar Helpline: 1-866-606-8220
22	☐	Proposed **Program Staffing Summary Report (PSSR)** documenting anticipated staff levels and assignments Website for OOH Form: https://nj.gov/dcf/providers/contracting/forms/csoc.html

EXHIBIT D

Rev. 6-23-2020

DCF Post-Award Documents
Required to be Submitted for Contract Formation
if the Response to the RFP Results in an Award

	▶	CONTRACT DOCUMENTS TO BE SUBMITTED AFTER AWARD WITH THE INITIAL CONTRACT:
1	☐	**Annex A** (Include: Summary, Agency Documents 1.1, 1.2, 1.3 & Program Component Documents 2.1, 2.2, 2.3, 2.4 & 2.5) -or- other **CSOC Approved Form** (signed/dated) Annex A: https://www.nj.gov/dcf/providers/contracting/forms CSOC Form: Provided by contract administrator if applicable (e.g. OOH Annex A Attestation, PSSR, Program Summary Form, Agency Data Sheet, Program Component Form)
2	☐	**Annex A Addendum** (for each program component) - submitted online in CYBER (signed/dated)
3	☐	For Programs that Submitted a Proposed Annex B in Response to the RFP: **Updated Annex B Budget Form** (signed/dated) Annex B: https://www.nj.gov/dcf/documents/contract/forms/AnnexB.xls Note: Expense Summary Form is auto populated. Begin data input on Personnel Detail Tab.
4	☐	For Fee for Service Contracts [other than those formed by an RFQ] **Annex B-2** (DCF.CRM 5.2 and 5.3) CSOC Form: Provided by contract administrator if applicable
5	☐	For Cost Reimbursement Contract Components Including Startup: **Schedule of Estimated Claims** (SEC) (signed/dated) CSOC Form: Provided by contract administrator, if applicable
6	☐	**Acknowledgement of Receipt** of NJ State Policy & Procedures returned to the DCF Office of EEO/AA (signed/dated) Form: https://www.nj.gov/dcf/documents/contract/forms/DiscriminationAcknowReceipt.pdf Policy: https://www.nj.gov/dcf/documents/contract/forms/AntiDiscriminationPolicy.pdf
7	☐	**Chapter 271/Vendor Certification and Political Contribution Disclosure Form** (signed/dated) [Rev 7/10/17] Website: https://www.nj.gov/treasury/purchase/forms.shtml Form: https://www.nj.gov/treasury/purchase/forms/CertandDisc2706.pdf
10	☐	Document showing **NJSTART** Vendor ID Number (NJ's eProcurement system) Website: https://www.njstart.gov/ Help Desk: Call 609-341-3500 -or- Email njstart@treas.nj.gov
11	☐	For Programs that Submitted a Proposed Program Staffing Summary Report (PSSR) in Response to the RFP: **Updated PSSR Form** Form: ProgramStaffingSummaryReport.xlsm Website: https://nj.gov/dcf/providers/contracting/forms/csoc.html

	▶	CONTRACT DOCUMENTS TO BE SUBMITTED AFTER AWARD & ANNUALLY UPDATED THEREAFTER:
12	☐	**Annual Report to Secretary of State** Website: https://www.njportal.com/dor/annualreports
13	☐	**Employee Fidelity Bond** Certificate (commercial blanket bond for crime/theft/dishonest acts) Refer to policy for Minimum Standards for Insurance: https://www.nj.gov/dcf/documents/contract/manuals/CPIM_p8_insurance.pdf Bond must be at least 15% of the full dollar amount of all State of NJ contracts for the current year when the combined dollar amount exceeds $50,000. If not applicable, include a signed/dated note, on agency letterhead, stating the bond certificate is not required as your agency will not exceed $50,000 in combined State of NJ contracts for the current year. Note: The $50,000 threshold includes fee-for-service reimbursements made via Medicaid.
14	☐	**Equipment Inventory** for items purchased with DCF Funds If not applicable, include a signed/dated note, on agency letterhead, stating you will not purchase any equipment with DCF funds and the requirement is not applicable. Policy: https://www.nj.gov/dcf/documents/contract/manuals/CPIM_p4_equipment.pdf
15	☐	**Liability Insurance** (Declaration Page/Malpractice Insurance) Note: Policy must show two items… 1. List DCF as the certificate holder - NJDCF, 50 East State St, Floor 3, POB 717, Trenton, NJ 08625 2. Contain language stating DCF is an additional insured Refer to policy for Minimum Standards for Insurance: https://www.nj.gov/dcf/documents/contract/manuals/CPIM_p8_insurance.pdf
16	☐	**DCF Notification of Licensed Public Accountant Form** (NLPA) [Rev. 7-15-19] -**and**- copy of **Non-Expired Accountant's Certification** [Ensure DCF form is used and 2 signatures are provided] Form: https://www.nj.gov/dcf/providers/contracting/forms/NLPA.docx Not required for agencies expending under $100,000 in combined federal/state awards or contracts. If not applicable, submit a signed/dated note, on agency letterhead, stating the NLPA form and accountant's certificate are not required as you will not exceed $100,000 in combined federal/state awards or contracts. Note: The $100,000 threshold includes fee-for-service reimbursements made via Medicaid. Also, the NLPA is a State of NJ form and need only list federal/state funds received via contracts with the State of NJ.
17	☐	Most recent **Audit -or- Financial Statement** (certified by accountant or accounting firm) Audit: For agencies expending over $100,000 in combined federal/state awards/contracts -or- Financial Statement: For agencies expending under $100,000 Policy: https://www.state.nj.us/dcf/policy_manuals/CON-I-A-7-7.06.2007_issuance.shtml [Policy Rev.3-2-2020]
18	☐	For Cost Reimbursement Contract Components Including Startup: **Report of Expenditures** (ROE) Annex B Interim (15 days of end of 6th month) -and- Final (9 months after end of fiscal year) Form: https://nj.gov/dcf/providers/contracting/forms/ Submit To: ChildrensSystemofCare.BusinessOffice@dcf.state.nj.us

	▶	CONTRACT DOCUMENTS TO BE MAINTAINED ONSITE BY PROVIDER:
19	☐	**Agency Organizational Chart**
20	☐	Copy of Most Recently Approved **Board Minutes**
21	☐	**Personnel Manual** and **Employee Handbook** (include staff job descriptions)
22	☐	**Affirmative Action Policy/Plan**
23	☐	**Conflict of Interest Policy** and **Attestation** https://www.nj.gov/dcf/documents/contract/manuals/CPIM_p8_conflict.pdf
24	☐	**Procurement Policy** https://www.nj.gov/dcf/documents/contract/manuals/CRM2.pdf

Exhibit E: Case Vignettes

1) Pauline is a 29-year old mother. She has given birth to three children. She had her first child when she was 16 and placed the child up for adoption. She had her second child at age 22 and transferred guardianship to her mother soon after birth. Pauline visits her every weekend. Pauline relapsed on heroin and cocaine several times during her third pregnancy. The hospital referred her to the Department of Child Protection and Permanency (DCP&P) after her daughter Hope was born. DCP&P referred Pauline and Hope to your program. Pauline appears very excited to have another chance to be a mother. She has expressed feeling anxious, saying she is not sure what to do with an infant as she has never taken care of one by herself. She is very worried DCP&P will take Hope away from her. Pauline has been meeting with your program regularly. In the sixth week of treatment, Pauline's urine toxicology screen is positive for heroin. Pauline becomes animated and tearful, saying, "Your test is wrong! I have not used anything!" Pauline says she is tired of people coming into her house all of the time and asks you to leave.

   What is your formulation of Pauline's behavior?
   How do you respond to her during this session?
   How would you define successful discharge for this family?

2) Carmen is a 35-year-old mother. Carmen lives with her husband, Steven. He works a full-time construction job and is very supportive of Carmen. She just gave birth to their first child, Alex. He was born eight weeks premature and had some minor respiratory issues at the delivery. At the time of birth, Carmen and Alex were positive for THC. They have been referred by DCP&P to your treatment program. During sessions, Carmen talks about Alex being her "miracle baby" as she did not think she could have children. She holds Alex during each session, looks at him often, and talks to him quietly when he is awake. She appears very attuned to his cues and is timely in responding. When Steven or other family members ask to hold the baby, she declines, saying, "He likes being with his mother." Her family laughs and talks about how Carmen is always holding Alex even at night when she could be sleeping.

   How do you understand Carmen's wanting to hold her child?
   How might you learn more about this?
   How would you define successful discharge for this family?

3) Melany is a 22-year-old mother. She has two daughters: Lisa, age 2, and Margo, age 4. Melany and her children reside with her mother, who works two jobs and is not home much. Melany tested positive for oxycodone and cocaine throughout her pregnancy with Lisa. She began using with her boyfriend, Lisa's father, at the age of 19. She tested positive throughout her pregnancy and was referred to CP&P after Lisa's birth. After DCP&P

became involved, Melany began medication-assisted treatment and is now in your program to focus on cocaine use. During home visits, Melany sits on the couch watching her children play around the room. There are toys available to her children, though many are not appropriate for their age or developmental phase. While her children play, Melany talks about her tumultuous relationship with Lisa's father. When the children move toward Melany, she quickly points out a toy for them to play with and continues talking. At one point, Lisa knocks over Melany's drink while trying to get up on the couch next her mother. Melany quickly jumps up, grabs Lisa, and places her on the stairs, saying "How many times have I told you to watch what you're doing? Now sit here." Lisa sits quietly on the stairs for the rest of the session.

What is Melany's understanding of physical and emotional development?
How do you understand Lisa's behavior?
How might you respond to this situation?
How would you define successful discharge for this family?

4) Angel is a 25-year old mother. She has a 3-year old son named Adam. She is in your treatment program for marijuana use. Angel started smoking marijuana when she was 13 years old and never thought she would be able to stop. Most of her family members and friends smoke marijuana. She was beyond excited when she had her first negative toxicology screen after three months in your program. Angel expresses ambivalence about her abstinence; she is very proud of herself for meeting her goal of abstinence, yet she has complained of increased irritability and difficulty sleeping, symptoms she feels are due to not smoking marijuana. During a session with Angel, you are sitting outside with her and Adam, talking on their front porch. Adam is riding a scooter that is intended for an older child, and he falls and scrapes his knee. He sits on the sidewalk in front of the house and is crying, rubbing his knee. Adam looks at you and Angel on the porch and reaches his hands out. Angel remains seated on the porch and says, "He'll be fine. He needs to learn to be tough in this world," and she continues talking to you.

What is your hypothesis about Angel's response to her child?
What is your intervention?
How would you define successful discharge for this family?

5) Chris is a 20-year old father. He lives with his partner, Cherie, and their child, Neveah, who is 8 months old. Neveah is their first child. Both Chris and Cherie use marijuana and cocaine. Chris, Cherie, and Neveah are living in Cherie's mother's apartment until they can save money for their own. Both Chris and Cherie have been referred for treatment, but Cherie declined, saying she would rather go to a different program. Chris agreed to start treatment in your in-home program. During the first three weeks of

treatment, Chris canceled 4 out of 12 of his sessions. When asked about the canceled sessions, he stated that he had forgotten he had to work and could not meet. One time when you met with Chris in the home, Cherie was in the other room talking on the phone, and you overhear her say, “Chris’s stupid program is here.” The next time you went to see Chris, Neveah’s grandmother answered the door and informed you that he “just left.” No one answers the door when you attempt your second scheduled session that week. You have called Chris twice since then, and he has not returned your call.

What is your formulation of Chris’s behavior?
What are your next steps with Chris?
How would you define successful discharge for this family?

Exhibit F

Program Implementation Schedule

List All Objectives Chronologically (Quantify # and %)	Documentation to Verify Achievement of Each Process Objective	Completion Quarter/Date for Objective
Hire and/or reassign required staff: • 4 full-time master's level clinicians for whom SUD treatment is within their scope of practice (LCSW, LPC, licensed psychologist, LMFT, LCADC); one parent/child clinician and one substance use clinician must be bi-lingual • 2 full-time bachelor's level family support specialists; 1 family support specialist must be bi-lingual • 1 full-time licensed master's level clinical supervisor • 1 part-time (.2) psychiatrist or APRN	Copy of the official letter hiring or reassigning staff	Q1
Develop policies and procedures for the Project internally and in collaboration with the DCPP	Written policies and procedures document (including protocols for referrals, enrollment, MAT when clinically indicated, discharge, communication, supervision)	Q1
Ensure staff, including supervisors, complete required training	Record of attendance of staff in all required trainings and	Q1

	certificate received for staff	
Establish data collection systems for the in-home treatment model	Evidence that a data capture system has been established (e.g., screenshot of data system)	Q1
Enroll a minimum of 6 clients per team for a total of 12 (completion of the intake session with the DCPP caseworker plus 3 home visits)	De-identified service level reports	Q2
Conduct basic needs assessment for all clients in the treatment phase	De-identified summary of clients' needs	Q2
Ensure the IHRP team, DCPP staff, and each client meet monthly to review progress toward goal achievement	Meeting dates and attendance lists (de-identified for clients)	Q2
Ensure the IHRP team and DCPP staff meet monthly to discuss cases	Meeting dates and attendance lists	Q2
Ensure the team seeks and accepts TA from the TA provider	Meeting dates and summary	Q2
Submit complete and accurate data to program evaluator at the determined due date	Confirmation of completed data submission	Q2
Maintain an active caseload of 12 clients per team for a total of 24 clients (assessment and treatment phases)	De-identified service level reports	Q3

Complete the basic needs assessment for all clients in the treatment phase	De-identified summary of clients' needs	Q3
Ensure the IHRP team, DCPP staff, and each client meet monthly to review progress toward goal achievement	Meeting dates and attendance lists (de-identified for clients)	Q3
Ensure the IHRP team and DCPP staff meet monthly without the client to discuss cases	Meeting dates and attendance lists	Q3
Ensure the team seeks and accepts TA from the TA provider	Meeting dates and summary and email confirming the Project team clinicians' submission of a video recording of a parent-child session	Q3
Submit complete and accurate data to program evaluator at the determined due date	Confirmation of completed data submission	Q3
Maintain an active caseload of 12 clients per team for a total of 24 clients (assessment and treatment phases)	De-identified service level reports	Q4
Conduct the parent-child therapy group with an average of 30% of eligible clients per team in attendance	De-identified service level reports	Q4
Complete the basic needs assessment for all clients in the treatment phase	De-identified summary of clients' needs	Q4
Ensure the IHRP team, DCPP staff, and each client meet monthly to review progress toward goal achievement	Meeting dates and attendance lists (de-identified for clients)	Q4

Ensure the IHRP team and DCPP staff meet monthly without the client to discuss cases	Meeting dates and attendance lists	Q4
Ensure the team seeks and accepts TA from the TA provider	Meeting dates and summary and email confirming the Project team clinicians' submission of a video recording of a parent-child session	Q4
Submit complete and accurate data to program evaluator at the determined due date	Confirmation of completed data submission	Q4
Successfully discharge 40% of all clients enrolled between Q2 and Q6 Successful discharge: • The client received a minimum of four months of treatment. • The client is in good standing with the DCPP. • The client has 12 consecutive negative toxicology screens. • The client has custody of the child. • The client has successfully completed one other treatment goal co-constructed with an IHRP team member.	De-identified service-level reports	Q4

Attachment 1

Notice of Standard Contract Requirements, Processes, and Policies

I. Instructions:

Please carefully read all the information on these page(s) and then sign, scan, and email this executed document to: OfficeOf.ContractAdministration@DCF.NJ.Gov

II. Organizations awarded contracts are required to comply with:

A. the terms and conditions of the Department of Children and Families' (DCF) contracting rules and regulations as set forth in the Standard Language Document (SLD), or the Individual Provider Agreement (IPA), or Department Agreement with a State Entity. Contractors may view these items on the internet at: https://www.nj.gov/dcf/documents/contract/forms/StandardLanguage.doc;

B. the terms and conditions of the policies of the Contract Reimbursement Manual and the Contract Policy and Information Manual. Contractors may review these items on the internet at: https://www.nj.gov/dcf/providers/contracting/manuals;

C. all applicable State and Federal laws and statues, assurances, certifications, and regulations;

D. the requirements of the State Affirmative Action Policy, N.J.S.A. 10:5-31 et seq. and N.J.A.C. 17:27;

E. the laws relating to Anti-Discrimination, including N.J.S.A 10:2-1, Discrimination in Employment on Public Works; and

F. the confidentiality rules and regulations related to the recipients of contracted services including, but not limited to:

1. Compliance with 42 CFR Part 2 Confidentiality of Substance Use Disorder Patient Records.

2. Maintenance of client specific and patient personal health information (PHI) and other sensitive and confidential information in accordance with all applicable New Jersey and Federal laws and regulations including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
3. Safeguarding of the confidentiality of case information as mandated by N.J.S.A 9:68.10a with the understanding that the release of any information may be in violation of State law and may result in the conviction of individuals for a disorderly person's level offense as well as possibly other disciplinary, civil or criminal actions pursuant to N.J.S.A. 9:6-8.10b.
4. Ensuring the content of every contractor's web site protects the confidentiality of, and avoids misinformation about the youth served and provides visitors with a mechanism for contacting upper administrative staff quickly and seamlessly.

III. Organizations awarded contracts are advised:

A. As noted in Section 5.12 of the SLD, or in Section 5.03 of the IPA, the initial provision of funding and the continuation of such funding under this contract is expressly dependent upon the availability to DCF of funds appropriated by the State Legislature and the availability of resources. Funds awarded under this contract program may not be used to supplant or duplicate existing funding. If any scheduled payments are authorized under this contract, they will be subject to revision based on any audit or audits required by Section 3.13 Audit of the Standard Language Document (SLD) and the contract close-out described in: Contract Closeout - CON-I-A-7-7.01.2007 (nj.gov)

B. All documentation related to products, transactions, proof of services and payments under this contract must be maintained for a period of five years from the date of final payment and shall be made available to the New Jersey Office of the State Comptroller upon request.

C. Any software purchased in connection with the proposed project must receive prior approval from the New Jersey Office of Information Technology, and any data collected or maintained through the implementation of the proposed program shall remain the property of DCF.

D. Any data collected or maintained through the implementation of the proposed program shall remain the property of DCF.

E. Contractors shall maintain a financial management system consistent with all of the requirements of Section 3.12 of the SLD of the IPA.

F. As defined in N.J.S.A. 52:32-33, contractors are encouraged to notify their employees, through information and materials or through an organ and tissue awareness program, of organ donation options. The information provided to employees shall be prepared in collaboration with the organ procurement organizations designated pursuant to 42 U.S.C. §1320 b-8 to serve in this State.

G. DCF endorsed the Prevent Child Abuse of New Jersey's (PCANJ) Sexual Abuse Safe-Child Standards (Standards) as a preventative tool for contractors working with youth and children to reference when implementing policies and procedures to minimize the risks of the occurrence of child sexual abuse. The Standards are available on the internet at: https://www.nj.gov/dcf/SafeChildStandards.pdf

H. NJ Rev Stat § 9.6-8.10f (2017) requires the Department of Children and Families (DCF)to conduct a check of its child abuse registry for each person who is seeking employment in any facility or program that is licensed, contracted, regulated, or funded by DCF to determine if the person is included on the child abuse registry as a substantiated perpetrator of child abuse or neglect. Contractors are to utilize the Child Abuse Record Information (CARI) Online Application to set-up a facility account by visiting: https://www.njportal.com/dcf/cari

I. DCF staff may conduct site visits to monitor the progress and problems of its contractors in conforming to all contract requirements and in accomplishing its responsibilities. The contracto*r* may receive a written report of the site visit findings and may be expected to submit a plan of correction, if necessary, for overcoming any problems found. Corrective Action Plan (CAP) requirements, timeframes and consequences are explained on the internet at: https://www.nj.gov/dcf/policy_manuals/CON-I-A-8-8.03_issuance.shtml

J. Contractors must have the ability to maintain the full operations census specified in the contract, and to submit timely service reports for

Contracted Level of Service (CLOS) utilization in the format and at the time DCF requests.

K. Contractors awarded contracts must have the ability to achieve full operational census within the time DCF specifies. Extensions may be available by way of a written request to the Contract Administrator, copied to the DCF Director managing the contracted services.

L. As noted in Section 4.01 of the SLD or the IPA, DCF or the contractor may terminate this contract upon 60 days written advance notice to the other party for any reason whatsoever.

M. DCF will advise contractors of the documents and reports in support of this contract that they must either timely submit or retain on-site as readily available upon request. The contractor also shall submit all required programmatic and financial reports in the format and within the timeframes that DCF specifies as required by Section 3.02 of the SLD or IPA. Changes to the information in these documents and reports must be reported to DCF. Contractors are under a continuing obligation, through the completion of any contract with the State of NJ, to renew expired forms filed the NJ Department of Treasury and to notify Treasury in writing of any changes to the information initially entered on these forms. Failure to timely submit updated documentation and required reports may result in the suspension of payments and other remedies including termination.

IV. Organizations awarded contracts for the provision of certain types of services additionally shall be aware of the following:

A. If services are provided at licensed sites, contractors must meet all NJ Department of Children and Families and other applicable Federal Licensure Standards.

B. If services are paid with Medicaid funds, contractors must have the demonstrated ability, experience, and commitment to enroll in NJ Medicaid, and subsequently submit claims for reimbursement through NJ Medicaid and its established fiscal agent, within prescribed times.

C. If services are paid with federal funds (including Medicaid funds), contractors must adhere to the provisions set forth in the Rider for Purchases funded in whole or in part, by federal funds.

https://www.nj.gov/dcf/providers/contracting/forms/RIDER-For-Purchases-Funded-by-Federal-Funds-7.31.2020.pdf

D. If services are provided by programs licensed, contracted or regulated by DCF and provide services to individuals with developmental disabilities, contractors must comply with:

    1. the Central Registry of Offenders against individuals with Developmental Disabilities law, N.K.S.A 30:6D-73 et seq (Individuals on the Central Registry are barred from working in DCF-funded programs for persons with developmental disabilities. If you are not registered to access the Central Registry, DCF will facilitate the qualified applicant's registration into this system); and

    2. Danielle's Law: (https://www.state.nj.us/humanservices/dds/documents/fireprocurement/ddd/Danielle%27s%20Law.pdf)

E. If services are to be administered by the Contracted System Administrator (CSA), contractors must conform with, and provide services under, protocols that include required documentation and timeframes established by DCF and managed by the CSA. The CSA is the single point of entry for these services and facilitates service access, linkages, referral coordination, and monitoring of CSOC services across all child-serving systems. Contractors of these services will be required to utilize "Youth Link", the CSOC web-based out-of-home referral/bed tracking system process to manage admissions and discharge after being provided training.

F. If services are to be provided to youth and families who have an open child welfare case due to allegations of abuse and neglect, then contractors shall deliver these services in a manner consistent with the DCF Case Practice Management Plan (CPM) and the requirements for Solution Based Casework (SBC), an evidence-based, family centered practice model that seeks to help the family team organize, prioritize, and document the steps they will take to enhance safety, improve well-being, and achieve permanency for their children. SBC provides a common conceptual map for child welfare case workers, supervisors, leadership, and treatment providers to focus their efforts on clear and agreed upon outcomes. DCF may require contractors to participate in DCF sponsored

SBC training, and to be involved in developing plans with the consensus of other participants, incorporating the elements of the plans into their treatment, participating in Family Team Meetings, and documenting progress and outcomes by race, age, identified gender, and other criteria DCF deems relevant and appropriate.

G. If services provided under a DCF contract are for mental health, behavioral health, or addictions services by a contractor with at least 10 regular full-time or regular part-time employees who principally work for the contractor to provide those services, then P.L. 2021,c.1 (C30:1-1.2b) requires the contractor to:

    1. submit no later than 90 days after the effective date of the contract an attestation: (a) signed by a labor organization, stating that it has entered into a labor harmony agreement with such labor organization; or (b) stating that its employees are not currently represented by a labor organization and that no labor organization has sought to represent its employees during the 90-day period following the initiation or renewal of the contract; or (c) signed by a labor organization, stating that it has entered into an agreement or binding obligation to be maintained through the term of the contract that provides a commitment comparable to a labor harmony agreement, as defined in section 4 of P.L.2021, c.1 (C30:1-1.2c). The required attestation is submitted to ensure the uninterrupted delivery of services caused by labor-management disputes and is a condition of maintaining a DCF contract. The failure to submit it shall result in DCF's issuance of a financial recovery and a Corrective Action Plan (CAP). Should the contractor not adhere to the terms of the CAP, DCF shall cancel or not renew the contract upon obtaining a replacement contractor to assume the contract or otherwise provide the services. An extension of the 90-day deadline shall be warranted if a labor organization seeks to represent a contractor's employees after the contract is renewed or entered into, but within the 90-day period following the effective date of the contract. The Commissioner of DCF may review any interested person's report of a failure by the contractor to adhere to these requirements and upon finding that a covered contractor failed to adhere to the requirements shall take corrective action which may include a CAP, financial recovery and cost recoupment, and cancelling or declining to renew the contract. Should the covered

contractor fail to engage in or complete corrective action, the Commissioner of DCF shall cancel or decline to renew the contract; and

2. make good faith efforts to comply with COVID-19 minimum health and safety protocols issued by DCF to adequately ensure the safety of the contractors, employees, and service recipients as per Section 4 of P.L., c.1 (c.30:1-1.2b) until the 366th day following the end of the public health emergency and state of emergency declared by the Governor in Executive Order No. 103 of 2020. The Commissioner of DCF shall take into account, prior to awarding or renewing any contract, any prior failures reported by any interested party to demonstrate a good faith effort to contain, limit, or mitigate the spread of COVID-19 among the covered contractor's employees or service recipients and require at a minimum the submission of a CAP to contain, limit, or mitigate the spread of COVID-19 cases. Should the contractor fail to implement a plan or repeatedly fail to demonstrate good faith efforts to contain, limit, or mitigate the spread of COVID-19, the Commissioner shall take action, including financial penalties or cancellation or non-renewal of the contract.

H. If the employees of a contractor or its subcontractor enter, work at, or provide services in any state agency location, then they are covered by with Executive Order No. 271 (EO 271), which was signed and went into effect on October 20, 2021. A covered contractor must have a policy in place: (1) that requires all covered workers to provide adequate proof, in accordance with EO 271, to the covered contractor that the covered worker has been fully vaccinated; or (2) that requires that unvaccinated covered workers submit to COVID-19 screening testing at minimum one to two times weekly until such time as the covered worker is fully vaccinated; and (3) that the covered contractor has a policy for tracking COVID-19 screening test results as required by EO 271 and must report the results to local public health departments. The requirements of EO 271 apply to all covered contractors and subcontractors, at any tier, providing services, construction, demolition, remediation, removal of hazardous substances, alteration, custom fabrication, repair work, or maintenance work, or a leasehold interest in real property through which covered workers have access to State property. EO 271 excludes financial assistance; contracts or sub-contracts whose value is less than the State bid Advertising threshold under N.J.S.A. 52:34-7; employees

who perform work outside of the State of New Jersey; or contracts solely for the provision of goods

By my signature below, I hereby confirm I am authorized to sign this document on behalf of my organization. I have read, understand, and have the authority to ensure my organization will comply with the terms and conditions of providing services under my contracts with DCF as described in the text and referenced documents above. The terms set forth in this document govern all executed contracts with DCF and contracts to be entered into with DCF in the future.

Signature _____ **Date:** _____

Printed Name: _____ **Title:** _____

Attachment 2

Public Law P.L. 2021, c.1 Attestation Form for Providers with DCF Contracts

ALL DCF Providers must sign, scan, and email this executed document to: OfficeOf.ContractAdministration@Dcf.nj.us

By my signature below, I hereby confirm I am authorized to review and sign this document on behalf of my organization. I additionally confirm:

_____(1) my organization **is not** an entity entering into or renewing a contract or contracts with the Department of Children and Families to provide mental health, behavioral health, or addiction services that employs more than 10 regular full-time or regular part-time employees who principally work for the organization to provide the contracted services as defined in Public Law P.L. 2021, c.1 [if you select this response, please return the signed form as noted above].; OR

_____(2) my organization **is** such an entity and in compliance with Public Law P.L. 2021, c.1., I therefore must submit within the 90-day period following the initiation or renewal of our DCF contract(s) either:

A. An attestation:

_____signed by a labor organization confirming entry into a labor harmony agreement with such labor organization; **or**

_____stating that our employees are not currently represented by a labor organization and that no labor organization has sought to represent our employees during the 90-day period following the initiation or renewal of our DCF contract(s) after the effective date of this act and up to the time of submission; **or**

_____signed by a labor organization, confirming entry into an agreement or binding obligation to be maintained through the term of the DCF contract that provides a commitment comparable to a labor harmony agreement, as defined in section 4 of P.L.2021, c.1 (C.30:1-1.2c); **or**

B. A notice:

_____from a labor organization confirming it seeks to represent our employees after the expiration of the 90-day period following the effective date of our DCF contract, to be followed no later than 90 days after the date of notice stating that we have entered into:

(1) a labor harmony agreement with the labor organization; or

(2) an agreement or binding obligation to be maintained through the term of the contract that provides a commitment comparable to a labor harmony agreement, as defined in section 4 of P.L.2021, c.1 (C.30:1-1.2c); **and**

C. A COVID-19 health and safety commitment:

I ensure the organization will continue to make a good faith effort to comply with minimum health and safety protocols issued by DCF to adequately ensure the safety of the covered providers' employees, and service recipients at least through the 366th day following the end of the public health emergency and state of emergency declared by the Governor in Executive Order No. 103 of 2020. These efforts include our adherence to the measures service providers may take to prevent and mitigate exposure to, and spread of, the COVID-19 virus while delivering services, as explained by the DCF Commissioner's issuance of Guidance's published on the DCF website at: https://www.nj.gov/dcf/coronavirus_contractedproviders.html These Guidance's have amended and supplemented, and may continue to amend and supplement, our contract requirements. I additionally represent I am not aware of any prior failures to demonstrate a good faith effort to contain, limit, or mitigate the spread of COVID-19 among the covered provider's employees or service recipients.

Signature: _____ Date: _____

Printed Name: _____ Title: _____

Organization Name: _____

DCF Budget Form (12-month operational budget)

BUDGET CATEGORIES 12-Month Budget	**TOTAL COSTS**	**DCF Funding request**	**Cash or In-Kind Funds** note sources below*
A. Personnel - Salary (hours/week)			
Fringe (% rate)			
B. Consultants & Professional Fees			
C. Materials & Supplies			
D. Facility Costs			
E. Specific Assistance to Clients			
F. Other			
G. Gen. & Adm. (G&A) Costs			
H. Total Operating Costs			
I. Equipment			
J. Total Cost			
K. Revenue (deduct)*	( )	n/a	n/a
L. Funding Request		n/a	n/a

The budget request shall indicate the Agency's total proposed budget for delivery of the service(s) reduced by the other sources of funding (Line K). If applicable, indicate the sources of leveraged funding and the dollar amounts for each below:

Other Sources of Funding for this Program: (Specify These)			
Other Funding Amounts:	0	0	0