NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES

REQUEST FOR PROPOSALS

FOR

INTENSIVE MOBILE TREATMENT SERVICES FOR YOUTH AND YOUNG ADULTS WITH INTELLECTUAL / DEVELOPMENTAL DISABILITIES

Publication Date: September 20, 2022

Response Deadline: October 26, 2022, by 12:00 P.M.

Funding of $4,700,000 Available

ARP Funding-CFDA #93.778

There will be a virtual Mandatory Respondent's Conference on October 6, 2022 at 12:00PM-2:00PM

The link to the Respondent's Conference is:
https://www.zoomgov.com/j/1614263845

Christine Norbut Beyer, MSW
Commissioner

The Department of Children and Families (DCF) is the agency dedicated to ensuring all New Jersey residents are safe, healthy, and connected. To that end, DCF announces to potential Respondents its intention to award a new contract.

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Section I - General Information

A. Pre-Response Submission Information:

There will be a virtual Mandatory Conference for all Respondents held on October 6, 2022, at 12:00PM-2:00PM.

Join ZoomGov Meeting
https://www.zoomgov.com/j/1614263845

Meeting ID: 161 426 3845
One tap mobile
+16692545252,,1614263845# US (San Jose)
+16468287666,,1614263845# US (New York)

Dial by your location
+1 669 254 5252 US (San Jose)
+1 646 828 7666 US (New York)
+1 669 216 1590 US (San Jose)
+1 551 285 1373 US
Meeting ID: 161 426 3845
Find your local number: https://www.zoomgov.com/u/ad0m9qE0pw

Join by SIP
1614263845@sip.zoomgov.com

Join by H.323
161.199.138.10 (US West)
161.199.136.10 (US East)
Meeting ID: 161 426 3845

Respondents may not contact the Department directly, in person, or by telephone, concerning this RFP. Questions may be sent in advance of the Respondent's Conference until October 3, 2022, at 12:00 PM by email to: DCF.ASKRFP@dcf.nj.gov

Questions should be asked in consecutive order, from beginning to end, following the organization of the RFP and reference the page number and section number to which it relates. All inquiries submitted should reference the above Program Name in the subject heading. Written inquiries will be answered and posted on the DCF website as a written addendum to this Response at: https://nj.gov/dcf/providers/notices/requests/

Technical inquiries about forms, documents, and format may be requested at any time prior to the Response deadline.

B. Summary Program Description:

The New Jersey Department of Children and Families' (DCF) Children's System of Care (CSOC) announces the availability of funding for the purpose of providing **Intensive Mobile Treatment Services for Youth and Young Adults with Intellectual / Developmental Disabilities (IMTS-IDD)** that have been determined eligible for Children's System of Care (CSOC) functional services pursuant to N.J.A.C. 3A:40-2.1 – 3A:40-2.3, and are ages five (5) through twenty (20) years old with intellectual/developmental disabilities (I/DD) and who present with complex, challenging behavior and/or co-occurring mental health conditions.

The IMTS-IDD services aim to deliver a safe, stable, and therapeutically supported intensive treatment program with a comprehensive array of services delivered in the youth's and family's home and community.

Through an individualized approach, based on an assessment of the youth and family system, services will be tailored to each youth and their family. A multi-disciplinary team will be comprised of behavioral, psychiatric, and medical experts, supported by a team of direct support from other specialists. Through a family-centered approach, the IMTS-IDD team will assist the youth with acquiring, retaining, improving, and generalizing the behavioral, self-help, socialization, relational and communication skills needed to enhance relationships, increase independence and functioning (e.g., improve self-care, negotiation and conflict resolution skills, develop effective coping skills, healthy limit-setting, and social skills, manage stress and symptom/medication, and pursue self-fulfillment, education and potential employability). Services will be accessible 24/7 and consist of daily check points among the treatment team and with the family to assess the effectiveness of treatment interventions and supports and adjust these as needed to improve outcomes. Targeted approaches will assist youth in regulating emotional and behavioral responses, developing meaningful relationships, and effectively understanding and expressing their needs to the best of their ability, which will aid in the successful transition to less intensive community services.

DCF anticipates making one (1) award to fund one (1) agency with the ability to provide holistic care through two (2) treatment teams each serving nine (9) (18 total) male and female children, youth, and young adults concurrently. The anticipated duration of engagement for those served by this program is six (6) to twenty-four (24) months with an average of twelve (12) months.

The successful Respondent will propose to establish a total of two (2) teams, with one (1) team for two (2) of the following counties: Bergen, Gloucester, or Middlesex. The designated county service areas may be adjusted by CSOC as needed to ensure full utilization of program resources. The annualized funding available is up to $4,700,000.00. All

funding shall be subject to the appropriation of sufficient funds and the availability of sufficient resources.

An awardee must have the program fully operational within sixty (60) days of award.

A successful Respondent shall demonstrate their ability to provide a comprehensive in-home program with a full range of services beyond traditional functional-based interventions and crisis response. Using evidence-based and promising practices, the model shall include 24/7/365 crisis response; comprehensive, coordinated continuum of supports; intensive transition planning; collaboration with key system partners; equitable access for all families; a culturally and linguistically competent team; an appropriate framework for monitoring and quality assurance; and the development of a robust individual youth and program outcomes tracking system.

C. Funding Information:

For the purpose of this initiative, the Department will make available one (1) award totaling an annualized amount not to exceed $4,700,000 per year for up to two (2) years, or $9,400,000 in total. Funds must be expended by December 31, 2025.

All funding is subject to appropriation. The continuation of funding is contingent upon the availability of funds and resources in future fiscal years. DCF reserves the right to award all or a portion of the requested amount.

Any expenses incurred prior to the effective date of the contract will not be reimbursed by DCF. Funds awarded under this program may not be used to supplant or duplicate existing funding.

Additional funds are not available. Any proposed one-time expenses must be funded with anticipated contract accruals. This is a competitive process and Respondents are on notice that no annual increases will be considered as part of this contract to salaries, fringe, or benefits in future negotiations or contracts, unless approved by the State legislature for all contracting entities.

Operational start-up costs are not permitted to be reimbursed under this contract. Matching funds are not required.

This awarded contract will involve the allocation and expenditure of COVID-19 Recovery Funds and is covered by Executive Order No. 166 (EO166), which was signed by Governor Murphy on July 17, 2020. The Office of the State Comptroller (“OSC”) is required to make all such contracts available to the public by posting them on the New Jersey transparency website developed by

the Governor's Disaster Recovery Office (GDRO Transparency Website), and by subjecting them to possible review by an Integrity Monitor.

D. Respondent Eligibility Requirements:

Respondents must be business entities and/or Universities that are duly registered to conduct business within the State of New Jersey, including for profit or non-profit corporations, partnerships, and limited liability companies.

Respondents must be in good standing with all State and Federal agencies with which they have an existing grant or contractual relationship and in compliance with all terms and conditions of those grants and contracts.

Respondents must 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.

DCF will not accept, receive, or consider a Response from those under a corrective action plan with DCF, or any other New Jersey State agency or authority.

Respondents must be fiscally viable and be able to comply with the contracting rules and regulations set forth in the DCF Contract Policy and Information Manual and N.J.A.C. 10:3.

Respondents must execute sub-contracts, after the review and approval of DCF, within forty-five (45) days of contract execution.

Where required, all Respondents must hold current State licenses.

Respondents that are not governmental entities must have a governing body that provides oversight as is legally required in accordance with how the entity was formed such as a board of trustees, non-profit, for profit, LLC.

Respondents must have the capability to uphold all administrative and operating standards as outlined in this document.

Respondents must have the program operational within sixty (**60) days of award**. Extensions may be available by way of written request to the CSOC Assistant Commissioner. **Award is subject to be rescinded if not operationalized within sixty (60) days of RFP award.**

Medicaid Enrollment

The awardee will enter into a cost-reimbursement contract for up to two (2) years, contingent on available funding. Although not required for payment under the cost-reimbursement contract, Respondents must have the demonstrated ability, experience, and commitment to enroll as a NJ Medicaid

provider and subsequently to submit claims for reimbursement through NJ Medicaid and its established fiscal agent, Gainwell Technologies, within prescribed timelines.

E. Response Submission Instructions:

All responses must be delivered ONLINE on the due date by 12:00 PM. Responses received after 12:00 PM on October 26, 2022, will not be considered.

To submit online, Respondent must complete an Authorized Organization Representative (AOR) form. The completed AOR form must be signed and dated by the Chief Executive Officer or designated alternate and sent to DCF.ASKRFP@dcf.nj.gov

Authorized Organization Representative (AOR)
Form: https://www.nj.gov/dcf/providers/notices/AOR.doc

Registered AOR forms may be received five (5) business days prior to the date the response is due. Upon receipt of the completed AOR, DCF will grant the Respondent permission to proceed and provide instructions for the submission of the Response. DCF recommends not waiting until the due date to submit your Response in case there are technical difficulties during your submission.

F. Required PDF Content of the Response:

Submit as your Response in response to this RFP separate PDF documents labeled as follows:

PDF 1 – *Section II: Required Performance and Staffing Deliverables* ending with a Signed Attestation of Acceptance

PDF 2 - *Section III: Documents Required to be Submitted with This Response, subsection A. Documents to be Submitted in Support of This Response*

PDF 3 - *Section III: Documents Required to Submitted with This Response, subsection B. Organizational Documents Prerequisite to a Contract Award to be Submitted with the Response*

PDF 4 – *Section IV: Respondent's Narrative Responses, subsections A. Community and Organizational Fit; B. Organizational Capacity; and C. Organizational Supports;* D. *Population of Focus and Statement of Need; E. Proposed Program Model and Implementation Approach; E. Staff Recruitment & Retention; G. Proposed Budget; H. Reduction of Seclusion and Restraint Use and I. Response to IMTS-IDD RFP Vignette*

Section II - Required Performance and Staffing Deliverables

NOTE: AFTER REVIEWING THE REQUIRED DELIVERABLES LISTED BELOW, RESPONDENTS MUST SIGN THE SIGNATURE ATTESTATION AT THE BOTTOM OF THIS SECTION TO SIGNIFY ACCEPTANCE OF ALL OF THEM.

(SUBMIT A COMPLETE COPY OF THE CONTENT OF SECTION II, ENDING WITH YOUR SIGNED ATTESTATION, AS A SINGLE PDF DOCUMENT. THIS WILL BE THE FIRST PDF SUBMISSION IN YOUR RESPONSE PACKET AND IS TO BE LABELED AS: PDF 1: SECTION II - REQUIRED PERFORMANCE AND STAFFING DELIVERABLES)

A. Subject Matter - The below describes the needs Respondents must address in this program, the goals they must meet, and the vulnerabilities they will target for prevention.

The Respondent shall describe a wide array of developmentally appropriate interventions for youth ages five (5) through twenty (20).

CSOC serves children, youth, and young adults with emotional and behavioral health challenges, intellectual/developmental disabilities, substance use challenges, and their families. CSOC is committed to providing these services with an approach that is strength-based, family-focused, culturally competent, healing centered and delivered within community-based environments based on the youth and family's needs, elements reflective of the System of Care approach, Wraparound values and principles, and the Six Core Strategies.

CSOC contracted programs utilize a clinical treatment approach that supports the utilization of evidence-based practices and an approach to service delivery that promotes flexible, individualized treatment, and effective utilization of program resources. CSOC continues to develop appropriate resources and services to support individuals with the most significant behavioral challenges. Since 2013, new residential programming has included Intensive Services for Youth with Intellectual Disabilities (I-IDD), Residential Treatment Centers for Youth with Intellectual Disabilities (RTC-IDD), Group Level One for IDD (GH1-IDD), and Group Level Two for IDD (GH2-IDD), as well as a new model of care through ten five-bed Crisis Stabilization and Assessment Services (CSAP-IDD) programs. CSOC's goal is to continue to develop a system of services to support individuals in the least restrictive environment and concurrently ensure appropriate treatment and targeted planning to transition individuals out of more intensive and restrictive settings or maintain them in the least restrictive setting.

CSOC commits to serving youth within their home and community whenever possible. Youth with intellectual or developmental disabilities who experience more complex and co-occurring disorders are often unable to remain at home and connected with their families while also receiving the interventions and supervision necessary to ensure their safety and wellbeing. Currently, the most

intensive supports available to this subgroup of youth and their families are located within a residential setting. However, removing youth from their home can disrupt healthy family dynamics and supportive relationships, which are vital in any youth's healing and development when facing challenges. Ultimately this can complicate the treatment process and lead to extended lengths of stay and a delayed discharge and transition to home. Longer lengths of stay can lead to feelings of hopelessness, disengagement from natural supports in their community, as well as limit access to residential services for other youth needing residential care, resulting in youth further decompensating and presenting in emergency rooms, psychiatric screening centers, and psychiatric inpatient units.

DCF reviewed numerous models in the development of this RFP. While none of the identified models alone address all elements needed to implement this IMTS-IDD pilot program successfully, several contain best practices and approaches for working with youth with serious challenges related to IDD, effective approaches to the delivery of services in the community that are traditionally rendered in residential settings, and essential elements for ensuring 24/7 availability and crisis management. The below represent the models approved for use in this program:

- Residential Enhancement Service, Planning Opportunities for New Directions (RESPOND): RESPOND provides intensive and innovative assessment, treatment, and support to youth, including those with a dual diagnosis of a serious emotional disturbance and intellectual disability. The program is a collaboration between Western Psychiatric Institute & Clinic of UPMC (WPIC), FamilyLinks, Fayette Resources and the Allegheny County Department of Human Services. While this program is designed to be an enhancement to residential services and the residential provider agency hires direct care professionals, each residence is also supported by a Mobile Treatment Team (MTT). The MTT includes a child clinical psychologist with a specialization in applied behavior analysis, a child and adolescent psychiatrist, a psychiatric nurse, a behavior analyst, a social worker, and a community-based clinician who have a range of clinical expertise in providing services and supports for youth with intellectual disabilities and child psychopathology. A Mobile Treatment Team develops highly individualized behavioral treatment plans (MTT). The treatment plan is fluid, with frequent, ongoing changes made as a refined understanding of the child develops. The plan includes strategies to address mental health, physical health (nutrition, dental, etc.), educational and vocational needs, and daily living skills. The MTT travels from residence to residence on scheduled visits and in response to urgent needs. Their combined expertise integrates behavioral health supports with physical health

supports to improve outcomes.

MTT outcome data revealed that psychiatric hospitalizations and the use of restraints were all positively affected by program engagement. Youth also made moderate progress on indicators in functional and mental health domains. Individuals' progress in these areas varied, with some youth experiencing little to no change and others demonstrating a substantial improvement. No indicator or measure showed a post-enrollment decline in RESPOND youths' performance or progress.

Families repeatedly identified the following items as strengths of the program: the coordination of services; communication with the RESPOND team; the expertise and impact of the MTT; their child's development and maintenance of coping skills; and the overall impact the program had on their quality of life.[1]

- Assertive Community Treatment (ACT) is an evidenced-based, comprehensive community-based model for delivering treatment, support, and rehabilitation services to individuals with severe mental illness endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA). ACT has been seen as appropriate for adults who experience the most intractable symptoms of severe mental illness and the most significant level of functional impairment. Programs that adhere most closely to the ACT model are more likely to get the best outcomes.

  Traditional ACT is characterized by:
  - A team approach where practitioners with various professional training and general life skills work closely together to blend their knowledge and skills.
  - In vivo services are delivered in the places and contexts where they are needed.
  - Small staff-to-consumer ratio.
  - Services are provided as long as needed.
  - Shared caseload where the team as a whole is responsible for ensuring that individuals receive the services they need to live in the community and reach their personal goals.
  - Flexible service delivery where the team meets daily to discuss the individual's progress and quickly adjust services to respond to the individual's changing needs.
  - Fixed point of responsibility where the team provided most of the needed services instead of sending individuals to

[1] Good, M., Odah, C., Bell, B., and Dalton, E., 2011. *Residential Enhancement Service Planning Opportunities for New Directions Program RESPOND): A Program Evaluation*. Allegheny County Department of Human Services.

various providers; however, the team ensures the individual receives the needed services.

- Services are available 24 hours a day, seven days a week. However, team members often find that they can anticipate and avoid crises. [2]
- Research demonstrates that the ACT model effectively reduces hospitalization, is no more expensive than traditional care, and is more satisfactory to consumers and their families than standard care.[3]

Youth-ACT has been implemented in several states. While ACT for adults has been extensively investigated and shown to be effective, and the literature on youth-ACT is limited, some research has shown there are indications that Youth-ACT is effective in "reducing severity of psychiatric symptoms, improving general functioning, and reducing duration and frequency of psychiatric hospital admissions." [4]

In July 2021, New York State's Office of Mental Health published the "Youth Assertive Community Treatment (ACT) Program Guidance Document," which describes Youth-ACT as a program to meet the significant needs of youth who are at risk of entering or are returning home from inpatient or residential settings. The following guiding principles are described as necessary to ensure services are person-centered and meet the needs of the youth.

- *Accessible and Available:* Services are flexible and mobile and adapt to the specific and changing needs of each child/family; utilize the home/community for service delivery, along with therapeutic, rehabilitative, and supportive approaches that best fit the needs of each child and family
- *Family-Driven*, Y*outh Guided:* Services recognize that youth have the right to be empowered, educated, and given a decision-making role in the care of their own lives, including guiding the treatment, rehabilitative and supportive service delivery process.
- *Developmentally Appropriate:* Services and interventions are provided in a manner appropriate for a youth's age and anchored to their developmental, social, and emotional stage and attuned to the relationship between the

[2] Substance Abuse and Mental Health Services Administration. *Assertive Community Treatment: The Evidence.* DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2008.

[3] Phillips SD, Burns BJ, Edgar ER, Mueser KT, Linkins KW, Rosenheck RA, Drake RE, McDonel Herr EC. *Moving assertive community treatment into standard practice.* Psychiatr Serv. 2001 Jun;52(6):771-9. doi: 10.1176/appi.ps.52.6.771. PMID: 11376224.

[4] Vijverberg R, Ferdinand R, Beekman A, van Meijel B. *The effect of youth assertive community treatment: a systematic PRISMA review*. BMC Psychiatry. 2017 Aug 2;17(1):284. doi: 10.1186/s12888-017-1446-4. PMID: 28768492; PMCID: PMC5541424.

child/youth and family/caregiver. As the child/youth's needs indicate, the scope of service and interventions enable the family/caregiver's active involvement and are reflected in the treatment plan.

- *Culturally and Linguistically Competent*: Services are respectful of and responsive to the values and needs of the family and contain a range of expertise in treating and assisting families in a manner responsive to cultural and linguistic diversity. Services are delivered in a manner that recognizes and respects the culture and practices of the child/youth and family, including the awareness and understanding of different cultural groups' experiences.
- *Strength-based:* Services rely upon a collaborative process between the team members, youth, and family, enabling them to work together to determine a treatment plan that draws on their strengths and assets. This process includes identifying family members and significant others who support and have a meaningful role in the child/youth's ongoing care or development. This may also include interventions and activities which build upon the youth's or family's competencies, interests, beliefs, values, and practices that serve as a source of support or growth.
- *Recovery-Oriented*: Services incorporate a process of change through which the child/youth and family improves their health and wellness, live a self-directed life, and strive to reach their full potential.
- *Trauma-Responsive and Trauma-Specific* Services that are based on understanding the vulnerabilities or triggers experienced by children who have experienced or witnessed trauma that may be exacerbated through traditional service delivery approaches. These services and programs can be more supportive and avoid re-traumatization.
- *Evidence-Based/Promising Practices*: Services utilize or apply core components of evidence-based and promising practices, supported by continuing education activities for staff to promote learning and implementation.[5]

- <u>Systematic, Therapeutic, Assessment, Resources and Treatment (START):</u> START is an evidence-informed crisis prevention and intervention services model. It has been operated by the Center for START Services at the Institute on Disability at the University of New

[5] https://omh.ny.gov/omhweb/guidance/youth-act-program-guidance.pdf?msclkid=54632333c32211ec8cfe095ee9ab7d2e

Hampshire since 2009 and has been implemented in numerous states. The START program addresses the need for community-based crisis prevention and intervention services for individuals with intellectual/developmental disabilities (I/DD) and co-occurring behavioral/mental health needs. START was cited as a model program in the 2002 U.S. Surgeon General's Report on mental health disparities for persons with intellectual/ developmental disabilities.[6]

The START crisis intervention model guiding principles are evidence-based/best practices; positive psychology and strengths-based; cultural and linguistic competence; trauma-informed; bio-psycho-social assessment; and treatment and coaching. START elements include cross-systems crisis prevention and response; comprehensive multimodal assessments; outreach; coaching; education; training and collective learning; systems linkage; well-trained workforce; and research and evaluation.

A primary goal of all START programs is to promote effective supports and services for persons with I/DD and behavioral health needs. Service elements aim to accomplish goals to improve:

- *Access to Care and Supports:* Care must be inclusive, timely, and community based.
- *Appropriateness of Care* is reflected in the ability of service providers to meet the specific needs of an individual, which requires linkages to several services and service providers, as individual service needs range and change over time. It also requires expertise to serve the population.
- *Accountability:* There must be specified outcome measures to care. Outcome measures must be clearly defined, and data review must be frequent and ongoing. Service systems must be accountable to everyone involved in the provision of care. The service delivery system must be accountable to the persons receiving care. Therefore, outcome measures need to account for whether an individual's service/treatment plan is effective over time. Service recipient satisfaction with services is an important outcome measure as well. Accountability measures should also pay attention to cost.

The three goals only conflict with each other when attention to the appropriateness of care and the need for access is lacking.[7]

[6] https://centerforstartservices.org/
[7] Program Overview - The NADD. http://thenadd.org/wp-content/uploads/2017/10/START-Overview_2017.pdf

Positive outcomes of the START model include reduced use of emergency services and hospital stays, cost-effective service delivery, high rates of satisfaction by families and care recipients, increased professional linkages between multiple disciplines, and improved expertise across systems of care and services designed to fill service gaps. [8]

- Mindfulness Based Positive Behavioral Supports: Parents of children with autism report high levels of stress as compared to parents of neurotypical children or even those with chronic illnesses or other developmental disabilities. The stress associated with caring for individuals with IDD, especially when they engage in aggressive behavior, often compromises the medical and psychological well-being of caregivers. Mindfulness-Based Positive Behavior Support (MBPBS) has been shown to enable parents and other caregivers to reduce their psychological stress and to support children with ASD or ID to self-manage their challenging behaviors through positive behavior support (PBS).[9] In one study, both parents and their children were maintained for three years post-intervention. After time and training type were controlled for, meditation time was a significant predictor in reducing aggressive and disruptive behaviors, and in enhancing compliance of the children with mothers' requests.[10] Results in some studies suggest that MBPBS is equally beneficial for mothers of adolescents with ASD or ID[11] and demonstrated statistically significant improvement on outcome measures following treatment.[12]

  MBPBS has been shown to be effective in reducing stress and professional caregivers of children and adolescents with ID and ASD who are often the demands of the job, including the nature and severity of challenging behaviors of the clients, work conditions, degree of management support for the staff, and the demands of implementing some interventions under adverse conditions.[13] When

[8] istart_brochure2_final.pdf (centerforstartservices.org)
[9] Singh NN, Lancioni GE, Medvedev ON, Myers RE, Chan J, McPherson CL, Jackman MM, Kim E. *Comparative Effectiveness of Caregiver Training in Mindfulness-Based Positive Behavior Support (MBPBS) and Positive Behavior Support (PBS) in a Randomized Controlled Trial. Mindfulness* (N Y). 2020;11(1):99-111. doi: 10.1007/s12671-018-0895-2. Epub 2018 Jan 30. PMID: 32435317; PMCID: PMC7223775.
[10] Singh NN, Lancioni GE, Medvedev ON, Hwang YS, Myers RE. *A Component Analysis of the Mindfulness-Based Positive Behavior Support (MBPBS) Program for Mindful Parenting by Mothers of Children with Autism Spectrum Disorder. Mindfulness* (N Y). 2020 May 11:1-13. doi: 10.1007/s12671-020-01376-9. Epub ahead of print. PMID: 32421103; PMCID: PMC7223597.
[11] Singh NN, Lancioni GE, Karazsia BT, Myers RE, Hwang YS, Anālayo B. *Effects of Mindfulness-Based Positive Behavior Support (MBPBS) Training Are Equally Beneficial for Mothers and Their Children With Autism Spectrum Disorder or With Intellectual Disabilities*. Front Psychol. 2019 Mar 6; 10:385. doi: 10.3389/fpsyg.2019.00385. PMID: 30894823; PMCID: PMC6414461.
[12] Ferraioli, S. J., & Harris, S. L. (2013). *Comparative effects of mindfulness and skills-based parent training programs for parents of children with autism: Feasibility and preliminary outcome data*. Mindfulness, 4(2), 89–101. doi:10.1007/s12671-012-0099-0
[13] Singh NN, Lancioni GE, Medvedev ON, Myers RE, Chan J, McPherson CL, Jackman MM, Kim E. *Comparative Effectiveness of Caregiver Training in Mindfulness-Based Positive Behavior Support (MBPBS) and Positive Behavior*

compared to pre-MBPBS training, the MBPBS training resulted in reduced staff stress and staff turnover[14] significant reductions in aggressive events by the individuals and need for 1:1 staffing of the individuals in their care.[15]

- DIR (Developmental, Individual differences, Relationship-based): The DIR® Model is a model of human development and comprehensive framework for assessment and intervention developed by Drs. Stanley Greenspan and Serena Wieder. This framework enables parents and professionals to develop an individualized program tailored to the child's unique differences, strengths, and challenges. The goal is to help your child build healthy foundations for social, emotional, and development. It is often described as a paradigm or lens through which one sees and interprets the world, relationships, and development. It is delivered by a DIR/Floortime certified professional. As a comprehensive framework, DIR/Floortime model is an intervention that is used to promote an individual's development through a respectful, playful, joyful, and engaging process. It uses the power of relationships and human connections to promote engagement, communication, positive behaviors and thinking. It is based on the developmental theory that all children need to reach certain milestones so they can keep developing emotionally and intellectually, and that children with autism and other disabilities have difficulty reaching these milestones; therefore, need intense, individualized support. Overall, it helps clinicians, parents, and educators conduct a comprehensive assessment and develop an intervention program tailored to the unique challenges and strengths of children with Autism Spectrum Disorder (ASD) and other developmental challenges. The objectives of this model are to build healthy foundations for functional emotional development capacities (FEDCS). FEDCS are six basic developmental capacities (also known as stages, milestones, or levels) which lay a foundation for all our learning and development. Children without special needs often master these skills relatively easily. Children with challenges often don't, not necessarily because they can't, but because their biological challenges make the mastery more difficult. By understanding these skills and the factors that influence them, and by working directly on them, caregivers, educators, and therapists often can help even those

*Support (PBS) in a Randomized Controlled Trial. Mindfulnes*s (N Y). 2020;11(1):99-111. doi: 10.1007/s12671-018-0895-2. Epub 2018 Jan 30. PMID: 32435317; PMCID: PMC7223775.

[14] Singh NN, Lancioni GE, Karazsia BT, Myers RE. *Caregiver Training in Mindfulness-Based Positive Behavior Supports (MBPBS): Effects on Caregivers and Adults with Intellectual and Developmental Disabilities*. Front Psychol. 2016 Feb 9; 7:98. doi: 10.3389/fpsyg.2016.00098. PMID: 26903906; PMCID: PMC4746712.

[15] Singh NN, Lancioni GE, Karazsia BT, Chan J, Winton AS. *Effectiveness of Caregiver Training in Mindfulness-Based Positive Behavior Support (MBPBS) vs. Training-as-Usual (TAU): A Randomized Controlled Trial*. Front Psychol. 2016 Oct 6; 7:1549. doi: 10.3389/fpsyg.2016.01549. PMID: 27766088; PMCID: PMC5053082.

children with what are thought to be chronic disorders master many of them. Appropriate emotional experiences during each of the six developmental capacities help develop critical cognitive, social, emotional, language, and motor skills, as well as a sense of self.

There is a body of research that supports the efficacy of the DIR approach in addressing needs in areas such as communication, navigating relationships, and decreasing caregiver stress. The International Council on Development and Learning (ICDL) has compiled the DIR® and DIRFloortime® Evidence-Base Quick Facts which provides a summary of research supporting the efficacy of the approaches. The ICDL summary includes reference to multiple sources of reference in support of the research base of DIR some of which are referenced below:

Multiple randomized-controlled studies have been published since 2011 identifying statistically significant improvements for children with autism who used Floortime versus traditional behavioral approaches (Solomon, et. al., 2014; Casenheiser, Shanker & Steiben, 2011; Lal and Chhabria, 2013; Pajareya and Kopmaneejumruslers, 2011, Pajareya et. al., 2019).

Solomon, Necheles, Ferch, and Bruckman (2007) conducted a pre-post survey of the Play and Language for Autistic Youngsters (PLAY) Project Home Consultation program. This program is a Floortime program. Results indicated statistically significant improvement in the children's Functional Developmental Capacities and 100% of the parents reported satisfaction in participating. Floortime and related DIR-based approaches are listed in evidence-based treatment reviews.

For example, the Journal of Clinical Child and Adolescent Psychology published an article entitled, "Evidence Base Update for Autism Spectrum Disorder" where they categorized Floortime as a "Developmental Social Pragmatic (DSP) Parent Training" and listed focused DSP Parent Training in their second level evidence base category indicating it as "Probably Efficacious." (Smith & Ladarola, 2015)

In addition, a systematic review of developmental social pragmatic approaches including DIR/Floortime was published in January, 2019 that supported the efficacy of developmental social pragmatic approaches for children with autism (Binns and Cardy, 2019).[16]

Intensive Mobile Treatment Services for Youth and Young Adults with Intellectual / Developmental Disabilities (IMTS-IDD) is a hybrid program model intended to meet the unique needs of youth with significant IDD challenges and complex co-occurring disorder/s and their families by

[16] ICDL. (n.d.). DIR® and DIRFloortime® Evidence-Base Quick Facts. Retrieved June 16, 2022, from https://drive.google.com/file/d/1_W4XNxuUe4QMqlaUJLuLn-nED-pvWX40/view

bringing intensive specialized services and supports into a youth's home in the context of their caregiving system and natural supports. These youth would otherwise be eligible for and require residential treatment. In this DCF pilot program, the IMTS-IDD strengthens the youth's natural support system, relationships, and skills through a highly individualized, comprehensive set of services and supports customized to the youth and family's needs. The Respondent awarded a contract will implement a model for this Intensive IMTS-IDD pilot. While DCF referenced several models outlined above, none of these models, alone or combined, fully address the scope of services, and intended target population for this program. DCF encourages the examination of other models that have an evidence-based structure.

B. Target Population/Admission Criteria - The below describes the characteristics and demographics of those the Respondents must serve for this program.

IMTS-IDD services are designed to provide flexible and responsive, community-based, in-home treatment. They are limited to youth ages five through twenty who are eligible to receive developmental disability services through CSOC pursuant to NJAC 3A:40. Youth considered for this program shall present with the most complex challenging behavior(s) of such intensity, frequency, and duration that they prevent personal development and inclusion in family life and community, threaten their ability to remain in home, and may jeopardize the health or life safety of themselves or others. Challenging behaviors include, but are not limited to, not being able to follow verbal directives; boundary issues including fixation on body parts, sexual reactivity, and socially/environmentally problematic behaviors due to sexual discovery; fecal smearing; self-injurious behaviors; destructive, aggressive and assaultive behaviors that require medical attention (e.g., hitting/scratching/biting oneself or others, head butting/choking/kicking others); elopement; pica; and property destruction.

In addition to Autism Spectrum Disorder (ASD), youth may have a variety of underlying conditions, including but not limited to intellectual disabilities, cerebral palsy, and epilepsy; genetic syndromes associated with autism, including, but not limited to Fragile X, Rhett, Prader-Willi, Williams Syndrome; and co-occurring mental health diagnoses including but not limited to attention, conduct, and disruptive behavior disorders; mood disorders; anxiety disorders and adjustment disorders. In addition, youth may present with various cognitive abilities and medical and physical needs (e.g., toileting, eating, hygiene and dressing, and other activities of daily living).

The average duration of services is anticipated to be 12 months. However, dependent upon the unique situation of each youth, the length of stay may be longer or shorter and may range from 6-24 months. The CMO care manager and CSOC's CSA will monitor the length of stay via the Joint Care Review (JCR) process adapted to this unique program.

Programs are required to provide services to non-verbal, limited English or non-English speaking individuals. The Respondent should clearly specify within this Response the type of services and staff supports that will be provided to meet this requirement.

All program staff must hold professional and experiential competencies in the field of intellectual/developmental disabilities, especially autism spectrum disorder, as well as mental health and clearly display the knowledge and skills, in particular, therapeutic use of self, necessary to provide appropriate supervision, and targeted clinical, behavioral, and self-care interventions via a variety of service delivery models that promote persistence and creativity of program staff, in contexts relevant and meaningful to the youth and their families.

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 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 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.A.C. 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

C. Resources - The below describes the resources required of Respondents

to ensure the service delivery area, management, and assessment of this program.

Required Staff Duties/Responsibilities

All staff positions below are full-time except for the Medical Director, which is a .5 FTE position.

Required staff include:

Psychiatrist / Medical Director (one .5 FTE dedicated to the program) who is a New Jersey Board Certified or Board Eligible Child / Adolescent Psychiatrist with extensive experience treating individuals with Intellectual and Developmental Disabilities (IDD). The responsibilities shall include, but need not be limited to, the following:

- A minimum of 3 clinical hours per month per youth
- Complete, along with the RN, Assessment to identify evident medical conditions that may be contributing to target behaviors in the home and community
- Coordinate medical care with the youth's primary and specialty care providers
- Collaborate with primary treating physicians of youth enrolled in the program
- Consultation with psychiatric hospitals regarding the treatment of individuals with IDD and mental or behavioral health needs
- Participate in recurring team meetings, as needed
- Complete a Psychiatric Intake Assessment and report (within the first week)
- Participate in the development of the initial treatment and safety and soothing plan (within the first 24 hours)
- Participate in medication management meetings (monthly)
- Complete clinical visits with youth as needed
- Provide training and consultation to staff, families, and providers, including ongoing organization and conducting of treatment team meetings
- Participate in on-site meetings with youth and families, as needed
- Attend treatment team meetings (monthly)
- 24/7 availability by contract
- All the above must be provided in accordance with the DCF Psychotropic Medication Policy available at https://www.nj.gov/dcf/policy_manuals/CPP-V-A-1-1500_issuance.shtml
- At least 75% of each clinical hours must be dedicated to face-to-face interaction with youth and/or families, and the time remaining may be dedicated to all ancillary tasks such as documentation in the youth's record of services provided,

meetings, consultation, telephone calls, relevant research, and supervisory responsibilities.

Program Director (full-time dedicated 100% exclusively to this program) with a Master's Degree in Social Work, Psychology, or other human service field with at least five (5) years' experience working with people who have IDD and mental health and/or challenging behavioral needs (at least two years shall be in a supervisory capacity). The responsibilities shall include, but need not be limited to, the following:

- Provide support and oversight for the program and each team
- Review youth referrals and coordinate admissions
- Oversee all Quality Assurance/Program Improvement activities with a focus on attaining benchmark activities for all team members
- Establish community linkages and serve as liaison to community partners
- Based on the feedback of Clinical Teams, identify the training/support needs of the community
- Coordinate training utilizing the expertise of psychologists and psychiatrists, Team Leaders, and specialists within the community
- Identify and coordinate necessary training for team members
- Ensure the collection of required data and documentation on consumer access and utilization of services
- Provide support as needed to the clinical team 24/7/365
- Manage program evaluation activities including, but not limited to, gathering, reviewing, and utilizing youth and family feedback for continuous quality improvement

Clinical Director may be either a) Doctoral-level (one full-time dedicated 100% exclusively to this program); BCBA preferred OR Ph.D. in Psychology and licensed in the State of New Jersey; OR b) Master's degree in Mental Health, Psychology or Social Work and independently clinically licensed in the State of NJ with a minimum of 10 years clinical experience working with the IDD/BH population AND Extensive experience in Intellectual and Developmental Disabilities (IDD), specifically with people with IDD and mental health and/or challenging behavioral needs. The responsibilities shall include, but need not be limited to, the following:

- Provide oversight and consultation on behavioral supports and other clinical activities
- Provide training and consultation to staff, families, and providers, including ongoing organization and conducting of treatment team

meetings
- Participate in on-site meetings with youth and families, as needed
- Oversee development of behavior/support/safety plans, as needed, for youth with more intensive needs
- Participate in discussion regarding referrals and provide in-home consultation, as needed, to teams
- Supervise/oversee clinical teams
- If the Clinical Director is a master's level clinician, there MUST be a Ph.D. clinical psychologist available for consultation and support to assist with evaluations, interpreting psychological testing and case consultation. Supervise on-call coverage to ensure a timely telephonic response to crises within one hour of the call and face-to-face within 24 hours of the call

Registered Nurse (RN) (two full-time dedicated 100% exclusively to this program) with a current New Jersey registered nursing license and one-year direct care nursing experience with youth; experience with youth with IDD challenges and/or mental health needs preferred. The responsibilities shall include, but need not be limited to, the following:

- Provide consultation as needed
- Assess the physical condition of the youth in the program under the direction of the medical director or psychiatrist/APN and integrate findings into the child's treatment plan
- Complete, along with a psychiatrist, assessment to identify evident medical conditions that may be contributing to target behaviors
- Monitoring adherence to medication regimen and consultation with the Medical Director as clinically indicated
- Provide education and support to staff around medical / health issues, including possible medication side effects, under the direction of the psychiatrist
- Provide education and support to youth and families
- Attend treatment team meetings
- Share on-call responsibilities to ensure a timely telephonic response to crises within one hour of the call and face-to-face within 24 hours of the call

Mobile Team Coordinator (<u>two</u> full-time dedicated 100% exclusively to this program) may be either a) a bachelor's level practitioner(s) with 3+ years of supervisory experience and relevant experience with youth with I/DD challenges; OR b) an unlicensed master's level practitioner with 1-year relevant experience with youth with I/DD challenges. The responsibilities shall include, but need not be limited to, the following:

- Supervise team and schedules
- Oversee daily operational aspects of the program
- Arrange and participate in family orientation (within the first 24 hours)
- Assess case management needs of youth and family and provide case management as appropriate (not within the scope of the care management organization)
- Coordinate with the care management organization and CFT as needed
- Provide on-site family psycho-educational activities consistent with the comprehensive treatment and discharge plan
- Share on-call responsibilities to ensure a timely telephonic response to crises within one hour of the call and face-to-face within 24 hours of the call

New Jersey Licensed Clinician (<u>two</u> full-time dedicated 100% exclusively to this program) with a master's or doctoral degree in counseling, social work, psychology, or a related field and a license to practice independently in NJ, including LCSW, LMFT, LPC, PsyD, Ph.D. with a minimum of one-year experience working with youth and family systems and 1 year experience working with people who have IDD and mental health and/or challenging behavioral needs. The responsibilities shall include, but need not be limited to, the following:

- Serves as a liaison between the program and the family
- Provide family therapy with the family of origin or natural supports with regularity so that the family is aware of their child's ongoing treatment and challenges. They will also interact with the family and the CFT during the referral and admission process
- Complete a Biopsychosocial (BPS) assessment and other assessments as needed and report within the first week of admission
- Complete IMDS SNA updates within the first 24 hours and as needed in conjunction/coordination with CFT
- Develop a comprehensive individualized treatment and transition plan (within the first week, and update as required)
- Provide individual therapy as indicated in the youth's treatment plan
- Attend and facilitate treatment team meetings
- Share on-call responsibilities to ensure a timely telephonic response to crises within one hour of the call and face-to-face within 24 hours of the call

*75% of each clinical hour must be dedicated to face-to-face interaction with

youth in individual, group and family therapy, and the time remaining may be dedicated to all ancillary tasks such as documentation in the youth's record of services provided, meetings, consultations, telephone calls, relevant research, and supervisory responsibilities. A clinician's time on case management must be in addition to these clinical services. Clinical services delivered must be grounded in evidence-based practice.

Master's Level Board Certified Behavioral Analyst (BCBA) (four full-time dedicated 100% exclusively to this program). The responsibilities shall include, but need not be limited to, the following:

- Implement behavioral support interventions and activities based on individual needs and ongoing assessment; frequency and duration may decrease over time or vary throughout the length of stay
- Provide Applied Behavioral Analysis (ABA) – Functional Behavioral Assessment and development of a Behavioral Support Plan
- Complete the initial safety and soothing plan development, documentation, and consultation (within the first 48 hours of admission)
- Complete the initial safety and soothing plan debriefing with family and youth (within the first 48 hours of admission)
- Implement the individualized Behavior Support Plan
- Provide Positive Behavioral Supports
- Provide training and supervision to support staff providing ABA services
- Provide direct supervision of the behavior technicians as required by Board Certification standards.
- Modify the Behavioral Support Plan based on frequent, systematic evaluation of direct observational data
- Provide coordinated support with program staff and participate as part of the clinical team
- Share on-call responsibilities to ensure a timely telephonic response to crises within one hour of the call and face-to-face within 24 hours of the call

Registered Behavior Technicians (RBT) (sixteen full-time dedicated 100% exclusively to this program) with a bachelor's degree in psychology, special education, guidance and counseling, social work or a related field; At least one year of supervised experience in implementing behavior support plans for youth who have intellectual/developmental disabilities; OR High school diploma, or GED; and at least three years of supervised experience in implementing behavior support plans for youth who have intellectual/developmental

disabilities. The responsibilities shall include, but need not be limited to, the following:

- Provide instructions in activities of daily living based on individual needs and ongoing assessment; frequency and duration may decrease over time or vary throughout the length of stay
- Implement all activities included in the youth's individualized behavioral support plan
- Provide individual support, such as positive behavioral supports
- Provide training/coaching for youth/parents
- Provide training/coaching for the youth to meet the individual's behavioral needs
- Provide modeling for families, as needed
- Support community integration via focused recreational activities
- Attend treatment team meetings
- Available to work on a rotating coverage schedule, including weekends

Resource/ Respite Coordinator (one full-time dedicated 100% exclusively to this program) with a Bachelor's degree in social work, counseling, psychology, or human service field with a minimum of 2 years of experience providing services to people with IDD and mental health and/or challenging behavior needs. The responsibilities shall include, but need not be limited to, the following:

- Maintain linkages and relationships with community partners
- Ensure the coordination of support meetings and safety, soothing and self-care plans for individuals in collaboration with the CMO
- Ensure coordination of in-school services and supports to ensure continuity and consistency of services and avoid duplication of efforts in collaboration with the CMO
- Share on-call responsibilities to ensure a timely telephonic response to crises within one hour of the call and face-to-face within 24 hours of the call
- Participate in recurring meetings with leadership, and mobile team
- Development of cross-systems crisis plans, intake/assessments, intervention and outcomes, and any other applicable documentation of services provided
-

Peer Support Partner Specialists (two full-time dedicated 100% exclusively to this program) with required experience as caregiver or primary support person of youth with IDD and/or dual diagnosis. Preferred bachelor's degree in human service or related field with two

(2) years of experience providing support to youth caregivers who have I/DD and/or I/DD and mental health needs. Hold NJ Peer Support Partner certification or has ability to obtain.

- Responsible for family support, education, and advocacy, coordinating resources, connecting families within the community, and participating in building support teams as well as ensuring family and youth voice is incorporated in all program operations

Administrative Assistant (one full-time dedicated 100% exclusively to this program) with two years of experience as an administrative assistant and basic knowledge of Microsoft Office suite.

- Maintaining all records in accordance with the state regulations/requirements
- Maintain a record of mobile team meetings and daily triage calls
- Contact youth/families for reminders of scheduled home visits.

Consultant Descriptions

Contractor's consultants shall be available to provide consultation to the program team as needed and work with youth and families to support individual care planning and implementation. In addition to the required consultants below, Respondents may propose to engage other clinical or behavioral professionals to be available to ensure comprehensive, individualized care.

Occupational Therapist (OT) Master's Degree in Occupational Therapy, appropriate NJ license and three (3) years of experience working with children, shall be responsible for the following:

- Promoting skill development and independence in activities of daily living (ADL) as needed per assessment and in coordination with the youth's IEP
- Providing treatment for sensory processing difficulties
- Identifying and eliminating environmental barriers to participation and daily activities
- Attending treatment team meetings
- Providing other services as identified in the treatment plan
- Partnering with existing school providers to ensure continuity of care
- Working in conjunction with the OT in an educational setting to augment services both in the house and with the family

Speech Therapist (ST) with a master's or doctoral degree in speech-language pathology OR a person certified as a speech-language specialist certified by the NJ state department of education. Service in addition to the ST in school will:

- Provide individualized techniques that assist with developing communication skills as needed per assessment and in coordination with the youth's IEP
- Train milieu staff and family members to implement communication techniques
- Provide other services as identified in the treatment plan
- Attend treatment team meetings
- Partner with existing school providers to ensure continuity of care

It is the responsibility of the Respondent awarded a contract to provide services in accordance with the New Jersey State Board of Social Work, State Board of Psychological Examiners, State Board of Medical Examiners, State Board of Nursing, State Boards of Marriage and Family Therapy Examiners, Professional Counselors Examiners Committee, Occupational Therapy Advisory Council, Audiology and Speech-Language Pathology Advisory Committee for licensure regulations. These guidelines are not to be interpreted as comprehensive of each staff member's total responsibilities. Respondents agree that by accepting this RFP and applying for this funding, they shall meet or exceed the following requirements during the term of the contract meet or exceed the following requirements. Respondents must demonstrate, through narrative, Annex B, and with necessary letters of affiliation, that the guidelines below are achievable.

Respondents must ensure that all employees of the agency who provide direct service will have State and Federal background checks with fingerprinting completed and pass now and every two (2) years thereafter. The cost of the fingerprinting and criminal history background check to become a qualified provider will be paid for by DCF. Instructions on the fingerprinting process and background checks will be provided to each qualified Respondent.

Respondents must ensure that all staff complete a TB Skin Test. Staff rendering in-home services are required to pass a TB Skin Test. Do not send protected health information; Respondents shall record and maintain records of staff on file in the Respondent office available for review and audit upon reasonable notice.

In addition, provider agencies must comply with N.J.S.A. 30:6D-73 et seq.

Central Registry of Offenders Against Individuals with Developmental Disabilities. Agencies must ensure that the names of all agency employees, volunteers, consultants, and IIH Clinical services providers that provide services to youth with I/DD will be checked against those names in the central registry. Additional information can be found at: http://www.state.nj.us/humanservices/staff/opia/central_registry.html

NOTE: If you are not registered to access the Central Registry, DCF will facilitate the qualified Respondent's registration into this system.

Providers must ensure behavioral support services are provided consistent with NJ Rev Stat § 45:8B-98 (2020), which sets forth the licensure required to practice applied behavior analysis.

Staff Retention

The development of meaningful relationships between youth and staff can improve outcomes for youth. Therefore, a high staff retention rate shall be maintained. Competitive compensation for employees is more likely to attract seasoned Respondents and maintain a consistent, highly qualified, and experienced team. Providers of in-home treatment services must implement a business model that minimizes staff turnover for direct care/milieu staff. This shall include adequate support, supervision, training, and other staff retention incentives, as well as a program to support workforce wellness.

Staff Training

All staff must participate in training in the following areas prior to program implementation:

- Orientation on program approach: Population served, program model, staffing, deliverables, expected outcomes
- Crisis management including de-escalation techniques and safety planning
- Navigating boundaries of home-based interventions
- Identifying and reporting child abuse and neglect (Any incident that includes an allegation of child/abuse and neglect must be immediately reported to the Division of Child Protection and Permanency (DCP&P) at 1-800-NJ ABUSE in compliance with NJSA 9:6-8.10)
- Reporting and management of unusual incidents per AO 2:05 (2004) and the Addendum (2005) available promulgated by the NJ Department of Human Services
- 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 C.F.R. (Parts 160 and 164) was

enacted to establish national standards for privacy and security in handling health-related information.

All staff must participate in training in the following areas within three months of onboarding:

- CSOC core approaches
- Intercultural effectiveness
- Motivational interviewing
- Orientation to family systems approach
- Infusing trauma informed care
- Basic First Aid and CPR

Professional staff must participate in training in the following areas within three months of onboarding within their discipline*:

- Evidence-based approaches and promising practices for youth with IDD challenges and their families focused on:
  - Emotional and behavior regulation
  - Optimizing activities of daily living
  - Connection and engagement in the community
  - Caregiver support and services
  - Leveraging natural supports to optimize treatment

* Documentation of training can be used in lieu of additional training

Note: A significant number of required trainings are offered by the DCF contracted training and technical assistance provider. Providers may access the DCF CSOC training site and staff may attend offered training(s) which are funded by the DCF and are at no cost to the providers. Staff may receive training in the required topics from any other appropriate source. Many agencies have their own curriculums and train staff in-house.

Organization/Agency Website

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

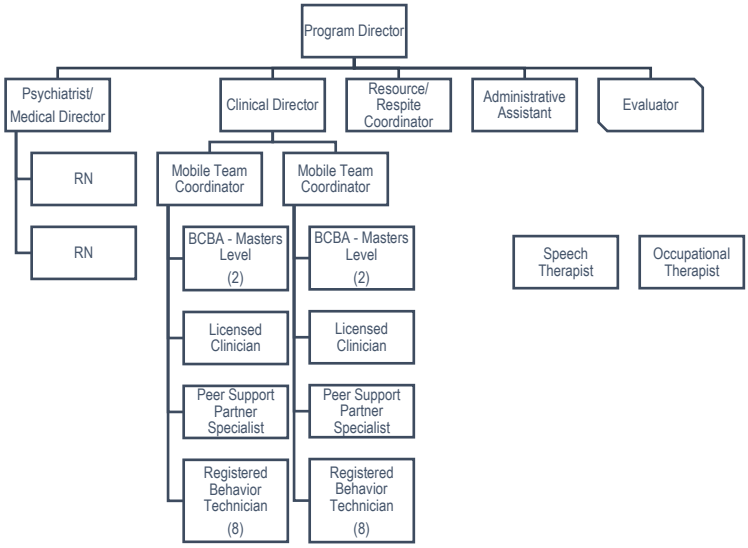
D. Activities - The below describes the activities this program initiative requires of Respondents, inclusive of how the target population will be identified and served, the direct services and service modalities that will be provided to the target population, and the professional development

and training that will be required of, and provided to, the staff delivering those services.

Treatment Process and Structure of Each Team

IMTS-IDD treatment services shall be uniquely tailored to the needs of youth in a manner that extends beyond the usual expectations of individualized care. The IMTS-IDD program must conceptualize the etiology and the "driving dynamics" of youth's needs. Respondents must demonstrate their understanding of the target population by describing the source, nature, intensity, frequency, and duration of the challenges and needs that youth present. Moreover, services and delivery models should reflect a direct correlation to etiology. Successful Responses will articulate that etiology and include a detailed discussion of the links between the intervention model, strategies, and techniques.

This program consists of two multi-disciplinary direct service teams, one in each of two counties, overseen by supervising and support staff, to support up to 18 youth and families within their communities. The model staffing structure includes supports to address integrated health components of care necessary for the identified population, such as medical, psychiatric, behavioral, communication, social and emotional, family dynamics, and respite.



Services shall include, but are not limited to:

- Comprehensive safety and soothing plan, including but not limited to prevention, de-escalation, intervention, and debriefing;

- Implementation of behavior intervention strategies and behavior plans;

- Modeling of interventions with family;
- Assistance with identifying necessary environmental adaptations;
- Accompanying youth and family to necessary appointments until an effective behavior plan is in place;
- 24/7/365 crisis response;
    - Psychiatric treatment services, including routine and emergency psychiatric evaluations, medication evaluations, monitoring and prescription adjustments;
    - Psychiatric consultation (including input into the clinical component of an individualized treatment plan developed by the multi-disciplinary treatment team)
    - Collaboration and coordination with CMO and child family team as required without duplication of services;
    - Individual and family therapy;
    - Trauma-informed counseling;
    - Relationship and Skill-building;
    - Linking and ensuring access to other necessary services, such as psychological testing, vocational counseling, and medical services;
    - Transition planning for youth 16 years old and older;
    - Building system level connections with partners and providers

The objectives of this program are to:

- Assess immediate needs
- Engage family to ensure active participation;
- Provide comprehensive assessments that result in an Individualized Service Plan (ISP) which is strength-based, youth-centered, family-focused, and goal-oriented. Other assessment tools as indicated; clinicians must be familiar with the array of considerations that would indicate preferred assessment methods over others;
- Outline short-term stabilization goals while pursuing plans for long-term stabilization at home;
- Complete the ISP within 30 days of admission and a skill-building routine and relationship building strategies in preparation for their transition to lesser intensive community services;

- Identify and develop family and youth strengths-based strategies within the ISP and foster interests for growth opportunities;
- Coordinate educational needs with school districts as needed.
- Engage youth and their families in a strength-based and compassionate manner sensitive to cultural and linguistic differences to facilitate feelings of safety and comfort, identify and address behavioral health challenges and stabilize symptoms through evidence-based practices;
- Provide comprehensive and collaborative treatment plans that focus on transition planning in collaboration with the Care Management Organization (CMO) through Child Family Team (CFT) meetings that include all team members;
- Empower youth and their families to actively participate in the care planning process through responsiveness to youth and family voice;
    - Engage and support youth's siblings in participating in the care planning process and treatment;
    - Outline short-term treatment goals while actively pursuing plans for long-term stabilization at home;
    - Provide a consistent and predictable in-home environment with intensive support and supervision in which there is a demonstrative understanding of the explicit and implicit trauma the youth may have experienced;
    - Provide interventions that reflect CSOC's commitment to Wraparound, the Nurtured Heart Approach and Six Core Strategies to Reduce Seclusion and Restraint;
    - Provide consistent and robust collaboration with CSOC, CMO, and the Division of Child Protection and Permanency (DCPP) when involved; and
    - Evaluate youth, and their family's progress in meeting treatment goals.

IMTS-IDD programs are expected to operationalize the principles of individualized, needs-driven, and family-focused care, identify strengths-based strategies, and display sustainable progress throughout the course of treatment. CSOC values an approach to service delivery that promotes the commitment and creativity of professional staff. IMTS-IDD programs must ensure youth have a stable, predictable, familiar, consistent, and nurturing treatment experience. Successful IMTS-IDD programs can recruit and retain

staff, maintain consistent and appropriate staffing patterns, utilize program design to support program goals, and ensure full inclusion of family members in the youth's service plan, including the type, scope, and frequency of family involvement in the youth's treatment.

CSOC believes that the family or caregiver plays a central role in the health and well-being of children, youth, and young adults. CSOC values and promotes the advice and recommendations of families and involves families/caregivers/guardians throughout the treatment planning and delivery process. CSOC provides families with the tools and support needed to meet the treatment goals of the youth and create life experiences for the youth that set the youth on a path to success and sustain positive treatment outcomes. All services offered within the New Jersey Children's System of Care are expected to function within the Wraparound Model and the values and principles of the System of Care approach.

Many individuals exhibit symptoms of Post-Traumatic Stress Disorder (PTSD), which is thought to be significantly under diagnosed in individuals with intellectual/developmental disabilities. While some individuals may exhibit overt symptoms of trauma, others may exhibit implicit trauma. Implicit trauma indicators are reflective of situations and experiences that may not result in an explicit memory of a specific traumatic event and/or manifest reactive behaviors. Such indicators may include, but are not limited to, in utero/infant trauma, adoption, caregiver terminal illness, caregiver separation/grief/loss, cultural trauma, multiple placements, and multiple system involvement. However, these experiences are prone to cause reaction by the individual at some point and thus should be considered during the assessment and treatment planning process.

Key Model Components

The successful Respondent will be required to include the following essential elements in their model of care:

- **Engagement of caregivers -** early in the referral process to meet caregivers where they are and incorporate increased family therapy, coaching, and peer support as a critical component of service planning and delivery. Increased intensity of services when services begin, ensuring that planned respite is scheduled, and other wraparound services are utilized to ensure the caregivers have adequate breaks and supports needed.

- **24/7 Crisis Response –** Develop a crisis response system that is available 24 hours a day, seven days a week, to provide in-community, face to face crisis services and treatment with a particular focus family defined crisis and on cross-systems crisis prevention and intervention planning to help maintain an individual in their existing residence.

Establish relationships with local hospital emergency rooms and Designated Psychiatric Emergency Screening Service (PESS.) Centers, Police and Other First Responders. Focus is not only when youth and family enter a crisis but the point before, they enter a crisis. Priority must be placed on youth safely remaining in their home.

- **Comprehensive Assessment and Treatment Planning –** This process forms the basis for interventions to help youth and their families work towards their vision and achieve sustainable progress. Comprehensive Assessment is a process of engaging with youth and families around gathering clinical and other relevant information to gain an understanding of the needs of a youth and family across life domains and within applicable contexts. Components important to inform the assessment include presenting needs and related history (onset, duration, course, severity), emotional and behavioral needs, current functioning (across domains for example, education/employment, family, social) youth and family culture, risk and protective (strengths) factors, previous assessments, interventions and diagnosis, youth and family history of behavioral health needs, current medications, medical and developmental history, legal history, exposure to trauma, relationship and attachment needs, goals and needs across domains of social determinants of health. Comprehensive assessment begins with engagement and requires a multidisciplinary and team approach and yields a clinical conceptualization and integrative summary using a biopsychosocial that will inform prioritizing needs and treatment recommendations. Assessment should provide clear context and synthesis of the youth and family's strengths, needs and presentation and should strengthen the engagement of the youth and their family in their story telling process, offering them the opportunity to gain education, perspective, and insight to their unique circumstances and move forward with clear steps designed to help them identify strategies that will ultimately help them feel better.

  Treatment planning is the process by which families, providers and teams develop family vision, targeted goals and desired outcomes driven by identified needs as well as the strategies, activities, supports and services necessary to promote progress towards meeting needs, improving relationships, and functioning and maintaining youth at home and connected to school and community. Treatment planning includes safety and self-care planning as well as transition planning from the beginning of a family's involvement with caret. Treatment planning is part of the care planning process grounded in wrap around that includes both informal and formal strategies and supports and

cultivates a team approach to care that promotes family capacity to facilitate their own individual team to support them after formal treatment and care management systems have transitioned. Assessment and treatment planning are ongoing throughout care to inform additional areas of need that may arise, progress made, identify what is helpful and inform when additional strategies, services, supports, or team members are necessary.

- **Intensive Transition Planning** – Ensure youth referred to the IMTS-IDD program from highly restrictive settings, such as inpatient treatment and higher intensity settings, including but not limited to Crisis Stabilization and Assessment Programs (CSAP-IDD), Intensive Residential Services for Intellectual and Developmental Disabilities I-IDD, receive a coordinated and comprehensive step-down plan focused on preventing readmission into a highly restrictive setting.

- **Comprehensive, coordinated continuation of supports** between multi-disciplinary services, which ensure a therapeutic environment in the home with an intensity of services, should decrease throughout the intervention as progress towards addressing needs is made.

- **Highly individualized services** offering a combination of face-to-face, virtual, and technology integrated services. Youth and caregivers participate in daily mood check-ins with the ability to contact the IMTS team 24/7 for support.

- **Environmental modification** assessment and consultation of home and vehicles for safety, monitoring and accommodations.

- **Behavioral support and treatment including Applied Behavioral Analysis (ABA),** Functional Behavioral Assessment and development of a Behavioral Support Plan, Positive Behavioral Supports, and developmental, individual differences and relational approaches.

- **Individual and family therapy** by staff trained in evidence-based practices, including Cognitive Behavioral Therapy, Motivational Interviewing, and Trauma-Informed Care, multiple times a week in person and virtually, depending on the family's needs and preferences.

- **Collaboration with key system partners**, including CMO, FSO and DCPP, when appropriate to identify transition and treatment gaps (continuation of care) to ensure services and supports are

appropriately in place before transition. Consistent participation in Child Family Team is required.

- **Coordination of services** to ensure linkages and relationships with community partners for ensure coordination of ongoing care, planned respite, Family Support Services and development of cross-systems crisis planning.

- **Speech and occupational therapy** to include a sensory integration lens that complements but does not supplant, educational services.

- **Equitable access for all families** requires a targeted and sensitive approach to support families who may not have an enhanced natural support system to ensure successful engagement in this high-intensity service.

- **Culturally and linguistically competent team** that is responsive to youth and their families.

- **Holistic, integrated care,** including psychiatric assessment, medication management, nursing evaluations, health and wellness education, nutritional planning, **exercise** coaching, and health and wellness treatment.

- **Robust assessment and care coordination based on identified Social Determinants of Health needs. IMTS Team** coordinates with families, the CMO, and local helping organizations to assist with housing, food, education, utility, medical, and vocational needs.

- **Workforce Wellness plan** designed to promote staff health and well-being, including availability of supports and resources to support job satisfaction and work-life balance

- **Commitment** to participating in program evaluation with DCF's selected program evaluator

Program referrals & authorization for services

IMTS-IDD referrals will come exclusively through the CSOC Office of the Clinical Director and will be strictly managed on a no eject/no reject basis. CSOC's CSA will monitor lengths of stay via the adapted Joint Care Review (JCR) process.

Each youth receiving IMTS-IDD shall have an approved, documented

service plan developed by the team of credentialed staff individually crafted to address identified needs that impact on the youth's ability to function at home, school or in the community. The service plan shall identify the services to be delivered. Services shall be subject to prior authorization by the CSA. Respondents will be required to demonstrate the ability to conform with and provide services under all protocols, including documentation and timeframes, established by CSOC, and managed by the Contracted System Administrator.

Requests for authorization for service utilization and continuing care shall include justification of the need for the level of service intervention; the frequency of the intervention, and the period of time the intervention is needed. Such justification shall be provided for the initial request, as well as for each request for continued services beyond the initial authorization. All IMTS-IDD services and interventions must be directly related to the goals and objectives established in each youth's Individual Service Plan (ISP)/treatment plan.

Within the first 48 hours of IMTS-IDD Services, the treatment team will complete the following:

- Develop an initial safety and self-care plan for each youth. The safety and self-care plan will identify triggers and provide specific interventions for staff, and be updated on a regular basis;
- Ensure the youth and family members are oriented to the service via at least one face to face visit;
- Complete IMDS: Review and update Strengths and Needs Assessment;
- Complete other assessment tools as indicated; clinicians must be familiar with the array of considerations that would indicate preferred assessment methods over others;
- Complete a nursing assessment and incorporate it into the initial treatment and safety and soothing plan;
- Provide the youth and family with copies of the initial safety and self-care plan; and
- Complete and file all necessary consents and releases.

Within thirty (30) days of admission, the treatment team will complete the following:

- Comprehensive safety and self-care plan that details triggers and specific interventions for staff. This safety and self-care plan shall be reviewed with the family and youth and updated on a regular basis;
- A psychiatric assessment, report and recommendations will be completed

- A psychosocial evaluation and accompanying recommendations will be completed;
- Complete other assessment tools as indicated; clinicians must be familiar with the array of considerations that would indicate preferred assessment methods over others;
- A psychological evaluation, if indicated, will be completed;
- Conduct a treatment team meeting if indicated, resulting in a comprehensive treatment, safety and self-care and discharge plan (Individualized Service Plan, ISP) that integrates all the treatment team's input, assessments, and recommendations; (The treatment plan shall contain clearly delineated goals and objectives with specified timelines and benchmarks for success, including a detailed description of the treatment goals that must be attained in order for the youth to be considered discharge ready);
- Participate in a Child and Family Team (CFT) meeting with the youth's Care Management Organization and all CFT members;
- Complete a Functional Behavioral Assessment if appropriate and a Behavior Support Plan; and
- Complete and submit an adapted Joint Care Review to the CSA and obtain CSA approval.

Each month, the treatment team will complete the following:

- Conduct comprehensive treatment and discharge plan meetings that include all members of the multi-disciplinary treatment team will be convened to review, discuss, and modify the treatment plan as needed.

60 days before discharge, the treatment team will complete the following:

- The treatment team will work with the CFT to begin planning for transition immediately upon the youth's admission to IMTS, as reflected in the initial and subsequent ISPs;
- The treatment team will provide a "step down" action plan detailing week-to-week activities supporting a smooth and well-planned transition from treatment. At a minimum, the action plan must include:
    - At least three (3) meetings of the treatment team to discuss youth and family strengths, continuing goals, successful strategies, and potential pitfalls;
    - Revised plan for times during the discharge phase when youth and family encounter difficulties that make discharge appear less likely. This plan will delineate critical staff

necessary to re-focus, rally, and support youth and family through the completion of the treatment episode; and

- Action steps youth and family might take to capitalize on successes include formal feedback (in addition to satisfaction surveys) to service staff and any multi-media activity documenting youth and family achievement.

At the time of transition, where a need is demonstrated, Intensive In-Home Habilitative Supports (IIH) or Intensive In-Community/ Behavior Assistance (IIC-BA) will be built into the community plan. The IIH or IIC-BA provider will gather information through observation and interaction with the youth, family and team members and review the youth's clinical records. The IIH or IIC-BA provider's familiarity with the family will provide a sense of security and increased confidence for the family. This will enable the IIH or IIC-BA provider to train the parents/caregiver on the treatment and/or behavior support plan and modify it where needed more quickly.

Unusual Incident Reporting & Management

All required documentation and activities will be provided in accordance with applicable licensing regulations and Administrative Order 2:05 and related Addendum, which address the reporting of Unusual Incidents.
https://www.nj.gov/humanservices/staff/opia/cimu/

Reducing the Use of Seclusion and Restraint

DCF/CSOC is committed to reducing and ultimately eliminating seclusion and restraints (S/R) in treatment settings, as seclusion and restraints are considered a treatment failure rather than a treatment intervention. It is associated with high rates of youth and staff injuries and is a coercive and potentially traumatizing and retraumatizing intervention with no established therapeutic value.

Additional information on *The Six Core Strategies for Reducing Seclusion and Restraint Use* can be located at:
https://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strateg ies%20Document.pdf

The awardee is responsible for participating in trainings and for the implementation of Six Core Strategies to Reduce Seclusion and Restraint, offered through available CSOC training at:
https://www.nj.gov/dcf/providers/csc/training/

Nurtured Heart Approach

The awardee is responsible for participating in the trainings and for the implementation of the Nurtured Heart Approach offered through CSOC Training: https://www.nj.gov/dcf/providers/csc/training/

Implementation of Healing Centered Care

CSOC is concerned with managing, treating, and preventing trauma that affects many youth. Trauma may affect youth in a multitude of ways, such as disruption in emotional responses, behavior, cognition, physical health, self-concept, and future orientation. There is a higher prevalence of trauma within the population of people with intellectual and developmental challenges than in the general population. Increased isolation, differing abilities, and fewer social opportunities can contribute to low self-esteem/less opportunity to learn about abuse prevention. Respondents must be cognizant of this fact and describe how they plan to assure safety, predictability, and comfort for this vulnerable population. Youth who present with challenges requiring services should also be understood in terms of their experiences of trauma and consequent difficulties in forming and maintaining healthy attachments.

Student Educational Program Operations Requirements

Assessment of school performance is an essential component of treatment planning, as is involvement with school personnel to monitor the ongoing impact of treatment and facilitate constructive ways of working with the youth. Accordingly, genuine and proactive coordination and collaboration between the grantee and educational providers is expected. To that end, Respondents shall ensure:

- Strategies to be employed to coordinate clinical treatment with educational planning and service delivery
- Daily before and after school communication strategies with school staff, as needed
- Support of student homework, special projects, and study time
- Specific strategies, including responsible staff and timelines, for including families-of-origin and natural supports available to the youth in an educational update, progress, and planning
- Mechanisms to stay abreast of the educational progress of each student
- Problem resolution strategies

All Respondents must also ensure:

- Immediate and therapeutic responses to problems that arise during the school day
- Coordination of programming or services for students who do not have a summer school curriculum or who have graduated high school, as well as for breaks/vacations
- Planned collaboration with all school personnel ensuring youth remain in school as appropriate

No Eject/No Reject Policy

The awardee must comply with DCF No Eject/No Reject policies governing this service.

Rejection:

If the clinical supervisor or program supervisor/director wishes to challenge the appropriateness of any referral (which is made in strict adherence to the notes the provider has made in their Provider Information Form), they may do so by sending an email request to the CSOC IMTS-IDD Liaison. This email request must be received within three (3) business days of the initial referral. CSOC will review these challenges and make the final decision with the program within two business days of receipt. Admission will be put on hold until a decision is made only if the email is received within the defined time frame. The provider must accept the final decision of CSOC.

Ejection:

Under no circumstances may a provider terminate a youth enrolled from its service without first contacting and receiving written approval from CSOC. The provider must submit this request in writing with supporting documentation. CSOC will make the final determination about the disposition of the youth.

Eject/Reject Follow-up:

Careful controls and monitoring regarding the number and type of disputes will be maintained by CSOC and may result in regulatory action within the contract year. Additionally, any eject/reject activities will be addressed throughout the contract term.

Contract System Administrator (CSA).

DCF contracts with the CSA to serve as DCF's single point of entry for the Children's System of Care (CSOC). The CSA facilitates service access, linkages, referral coordination, and monitoring of CSOC services across all child-serving systems. The Respondent awarded a contract must demonstrate the ability to conform with and provide services under protocols, including documentation and timeframes, established by CSOC and managed by the CSA.

E. Outcomes: Program Evaluation & Continuous Quality Improvement

Respondents must dedicate resources to participate in the program evaluation. This will include meetings with CSOC and designated evaluator, gathering and reporting on data and partnering in performance improvement initiatives.

F. Signature Statement of Acceptance:

By my signature below, I hereby certify that:

I have read, understand, accept, and will comply with all the terms and conditions of providing services described above as *Required Performance and Staffing Deliverables* and any referenced documents. I understand that the failure to abide by the terms of this statement is a basis for DCF's termination of my contract to provide these services. I have the necessary authority to execute this agreement between my organization and DCF.

Name:

Signature:

Title:

Date:

Organization:

Federal ID No.:

Charitable Registration No.:

Unique Entity ID #:

Contact Person:

Phone:

Email:

Section III - Documents Required to be Submitted with This Response

In conjunction with DCF's review of the narrative responses below in Section IV, DCF will assess the following documents that must be submitted with each Response. Respondents must organize the documents submitted in the same order as presented below under one of the two corresponding title headings: A. Documents *to be Submitted in Support of This Response*; and B. *Organizational Documents to be Submitted with This Response*. **Each of these two sections must be submitted as a separate PDF, which would be the third and fourth PDF submission in your Response packet.**

A. Documents to be Submitted in Support of This Response

(THIS WILL BE THE SECOND PDF SUBMISSION IN YOUR RESPONSE PACKET AND IS TO BE LABELED AS: *PDF 2: SECTION III - REQUIRED DOCUMENTS, SUBSECTION A. DOCUMENTS TO BE SUBMITTED IN SUPPORT OF THIS RESPONSE*.)

1) **List any programs** awarded to your agency within the last 18 months through an RFP process with DCF that are not yet implemented, if applicable.

2) Provide details around any **licensure violations** in the past 12 months.

3) **Respondents that were awarded other programs** through a previous RFP within the last eighteen (18) months shall submit the status of implementation, if applicable. (no more than 5 pages).

4) Copy of the letter from the **accrediting body** regarding the agency's accreditation status. If not applicable, include a written statement.

5) Policy regarding engaging and sustaining the involvement of family and/or **natural supports.**

6) Policy or Procedures regarding **community-based activities.**

7) A description of how your **accounting** system has the capability to record financial transactions by funding source, to produce funding source documentation and authorization to support all expenditures, and timesheets which detail by funding source how the employee spent their time, invoices, etc.

8) A **Statement of Assurances** signed and dated.
Website: https://www.nj.gov/dcf/providers/notices/requests/#2
Form:
https://www.nj.gov/dcf/providers/notices/Statement.of.Assurance.doc

9) All **Corrective action plans or reviews** completed or in process by DCF (inclusive of DCF Licensing, Divisions and Offices) or other State entities within the last 2 years. If applicable, a copy of the corrective action plan should be provided and any other pertinent information that will explain or clarify the Respondent's position. If not applicable, include a written statement. Respondents 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.

10) **Policy or procedures regarding timelines;** program operations; and staff responsible for admission, orientation, assessment, engagement, treatment planning, and transition planning.

11) A summary of **Evaluation** tools that will be used to determine the effectiveness of the program services (no more than 5 pages).

12) An **Implementation Plan** for the program that includes a detailed timeline for implementing the proposed services, or some other detailed weekly description of your action steps in preparing to provide the services and to become fully operational within the time specified.

13) **Job Descriptions** that include all educational and experiential requirements.

14) **Three (3) Letters of Commitment** specific to a service or MOU to demonstrate commitment to the program.

15) **One (1) Letter of Support** from community organizations with which you already partner. Letters from any New Jersey State employees are prohibited.

16) **Consultant agreements**, letters of affiliation and proposed Student-School Service Provider contracts if graduate students will be involved in the provision of care.

17) Proposed **Program Organizational Chart** for the program services required by this response that includes the agency name and the date created.

18) **Resumes** of any existing staff who will perform the proposed services (Do not provide home addresses or personal phone numbers).

19) A brief narrative on the **Staffing Patterns** you anticipate will satisfy the staffing requirements as described and attested to in the Resources/Staff Requirements (Section II. C.) of the Required Performance and Staffing Deliverables of this RFP. Indicate the number, qualifications and skills of all staff, consultants, sub-grantees and/or volunteers who will perform the proposed service activities and describe the management and supervision methods that will be utilized.

20) A **Training Curricula Table of Contents** for the current and proposed staff consistent with the Staff Training requirements described and attested to in the Resources Requirements (Section II. C.)

21) A **Curricula Table of Contents** for age, gender, and developmentally appropriate psycho-educational groups **including those focused on wellness and recovery.**

B. Organizational Documents Prerequisite to a Contract Award to be Submitted with the Response:

(THIS WILL BE THE THIRD PDF SUBMISSION IN YOUR RESPONSE PACKET AND IS TO BE LABELED AS: *PDF 3: SECTION III - REQUIRED DOCUMENTS, SUBSECTION B. ORGANIZATIONAL DOCUMENTS PREREQUISITE TO A CONTRACT AWARD TO BE SUBMITTED WITH THE RESPONSE.)*

Pre-Award Documents Prerequisite to All Contracts

1) **Affirmative Action Certificate:** Issued after the renewal form [AA302] is 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.state.nj.us/treasury/contract_compliance/

2) **Agency By-Laws -**or- Management **Operating Agreement** if a LLC

3) **Attestation Form for Public Law P.L. 2021, c.1** - Complete, sign and date as the provider. Form:
Attestation.Form.To.Be.Completed.by.Providers.Covered.by.Public.Law.2021c.1.-6.7.21.pdf (nj.gov)

4) Dated List of Names, Titles, Emails, Phone Numbers, Addresses & Terms of either the **Board of Directors** of a corporation, or the **Managing Partner**s of a LLC/Partnership, or the **members** of the responsible governing body of a county or municipality.

5) For Profit: **NJ Business Registration Certificate** with the Division of Revenue (see instructions for applicability to your organization.)
Website: https://www.nj.gov/njbusiness/registration/

6) **Business Associate Agreement/HIPAA -** Sign and date as the Business Associate
Form: https://www.nj.gov/dcf/providers/contracting/forms/HIPAA.docx

7) For Profit: **Chapter 51/Executive Order 117** Vendor Certification and Disclosure of Political Contributions (See instructions for applicability to your organization.)
Website: https://www.nj.gov/treasury/purchase/forms.shtml

8) **Conflict of Interest Policy and Attestation Form**
Form:
https://www.nj.gov/dcf/documents/contract/manuals/CPIM_p8_conflict.pdf

9) Certification Regarding **Debarment:**
Form:
https://www.nj.gov/dcf/documents/contract/forms/Cert.Debarment.pdf

10) **Disclosure of Investigations & Other Actions Involving Bidder**
Form:
https://www.nj.gov/treasury/purchase/forms/DisclosureofInvestigations.pdf

11) **Disclosure of Investment Activities in Iran**
Form:https://www.nj.gov/treasury/purchase/forms/DisclosureofInvestmentActivitiesinIran.pdf

12) **Disclosure of Ownership**
Form:
https://www.nj.gov/treasury/purchase/forms/OwnershipDisclosure.pdf

13) **Disclosure of Prohibited Activities in Russia and Belarus**
Form:
Certification.on.Non-Involvement.Prohibited.Activites.in.Russia.or.Belarus.pdf (nj.gov)

14) **Source Disclosure Form (Disclosure of Source Location of Services Performed Outside the United States)**
Form:http://www.state.nj.us/treasury/purchase/forms/SourceDisclosureCertification.pdf

15) Document showing **Unique Entity ID (SAM)** Number
Website: https://sam.gov/content/duns-uei

16) **Certificate of Incorporation**
Website: https://www.nj.gov/treasury/revenue

17) **Notice of Standard Contract Requirements, Processes, and Policies**
Sign and date as the provider
Form: Notice.of.Standard.Contract.Requirements.pdf (nj.gov)

18) **Organizational Chart for Agency-** Ensure chart includes the agency name, current date, and the allocation of personnel among each of the agency's DCF programs with their position titles and names.

19) **Standard Language Document (SLD) (or Individual Provider Agreement or Department Agreement with another State Entity)**
Sign and date as the provider

Form:
https://www.nj.gov/dcf/documents/contract/forms/StandardLanguage.doc

20) **System for Award Management** (**SAM)** Submit a printout showing active status and the expiration date. Available free of charge.
Website: https://sam.gov/content/home
Helpline:1-866-606-8220

21) **Tax Exempt Organization Certificate** (ST-5) -or- **IRS Determination Letter** 501(c)(3)
Website: https://www.nj.gov/treasury/taxation/exemptintro.shtml

22) **Tax Forms: Submit a copy of the most recent full tax return** Non-Profit: Form 990 Return of Organization Exempt from Income Tax or- For Profit: Form 1120 US Corporation Income Tax Return -or- LLCs: Applicable Tax Form and may delete/redact any SSN or personal information
Note: Store subsequent tax returns on site for submission to DCF upon request.

Pre-Award Documents Prerequisite to This Specific Contract

23) **Proposed Annex B Budget Form (Cost Proposal Form) -** Include Signed Cover Sheet
Form: https://www.nj.gov/dcf/documents/contract/forms/AnnexB.xls
Note: The Annex B Expense Summary Form is auto populated. Begin data input on Personnel Detail Tab.

24) **Professional Licenses and/or Certificates** (If related to job responsibilities) Submit currently effective documents.

25) **Subcontract/Consultant Agreements** (If related to this contract)

26) **Proposed Program Staffing Summary Report (PSSR)**
A full updated report must be submitted with this proposal and then **annually** by the 10th day of the month following each contract year.
Form:
https://www.nj.gov/dcf/providers/contracting/forms/ProgramStaffingSummaryReport.xlsm

Section IV - Respondent's Narrative Responses

Respondents who complete the above attestation to provide services in accordance with the *Required Performance and Staffing Deliverables* additionally must submit a narrative response to every question below. An Response will be evaluated and scored as indicated on each of the following Narrative Sections: A. Community and Organizational Fit; B. Organizational Capacity; and C. Organizational Supports; D.

Population of Focus and Statement of Need; E. Proposed Program Model and Implementation Approach; E. Staff Recruitment & Retention; G. Proposed Budget; H. Reduction of Seclusion and Restraint Use and I. Response to IMTS-IDD RFP Vignette.

Respondents must organize the Narrative Response sections submitted in the same order as presented below and under one of the three corresponding title headings. **All questions and answers for these sections should be submitted as a single PDF document, which would be the fourth PDF submission in your Response packet.**

There is a 35-page limitation for the narrative sections of the Response.

The narrative should be double-spaced with margins of 1 inch on the top and bottom and 1 inch on the left and right. Narrative Sections of the Responses 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.

The narrative must be organized appropriately and address the key concepts outlined in the RFP.

(ALL NARRATIVE RESPONSES MUST BE SUBMITTED AS A SINGLE PDF DOCUMENT, WHICH WOULD BE THE FOURTH PDF SUBMISSION IN YOUR RESPONSE PACKET AND IS TO BE LABELED AS: *PDF 4 – SECTION IV: RESPONDENT'S NARRATIVE RESPONSES, SUBSECTIONS A. THROUGH I*.)

A. Community and Organizational Fit (10 Points)

Community and Organizational fit refers 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 IMTS-IDD program your organization proposes to implement.

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) Describe how the requirements of this initiative will be met through your policies implementing Trauma Informed practices.

5) Describe your ability to provide bilingual services to meet the needs of youth and families in the counties they propose to serve. Programs that can provide services to limited-English speaking and non-English speaking individuals are required.

B. Organizational Capacity (10 Points)

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

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?

2) Describe past or present experience in serving individuals with IDD and their families including how collaboration and communication are accomplished.

3) DCF endorsed the Prevent Child Abuse New Jersey's (PCA-NJ) Safe-Child Standards in August 2013. These standards are used as a tool for implementing policies and procedures and ensure a baseline of quality services. 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.

   The PCA-NJ Safe-Child Standards are available at:
   https://nj.gov/dcf/providers/notices/nonprofit/ and
   https://www.nj.gov/dcf/SafeChildStandards.pdf

4) 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.).

5) Describe your willingness and capacity to engage in participatory, collaborative evaluation planning with DCF to assess program outcomes, including but not limited to, gathering and monitoring data and implemented performance improvement.

6) List any programs closed in the last eighteen (18) months and include documentation for the reasons the contracts were ended, if applicable**.**
   - Party that initiated closure (DCF or agency) and include detailed description of reason(s)
   - Program intensity of service

- Date of closure
- Time from notification to youth, families, and staff to safe transfer/discharge of all youth served in the program (the “transition period”)
- Challenges encountered during the transition period (staff coverage, disruption in programming)

If the Respondent has not had any closures and these questions do not apply, it will not impact the score, however, Respondents that have had a closure may have up to 10 points deducted from their total score depending upon the responses to this section.

C. Organizational Supports (10 Points)

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

1) 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 for each staff member. If you already have staff who will be reassigned to the Project, indicate whether they have received training in treating youth with intellectual and development disabilities and cooccurring behavioral challenges, motivational interviewing, and reflective supervision, and if so, describe the training previously received and if it has led to certification and/or licensure.

2) 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.

3) Provide supplemental explanation of the Respondent’s ability to manage
this project described in this RFP and the other ongoing
programs.

4) Describe how your organization will support this initiative with required/necessary training, coaching, supervision. Describe your organization’s process to evaluate staff performance.

5) Describe how your organization will support this initiative by leveraging the resources of providers; communities; and other stake holders.

D. Population of Focus and Statement of Need (10 Points)

Population of focus and statement of need refers to the agency's understanding of the specific needs of the youth and families being targeted by this grant in the target area.

1) Describe the population of focus and the geographic catchment area where services will be delivered that align with the intended population of this program. Provide a demographic profile of the population of focus in the catchment area in terms of race, ethnicity, language, sex, gender identity, sexual orientation, age, and socioeconomic status.

2) Describe the extent of the problem in the catchment area, including service gaps, and document the extent of the need (i.e., current prevalence rates or incidence data) for the population of focus. Identify the source of the data.

E. Proposed Program Model and Implementation Approach (25 points)

Proposed Program Model and Implementation Approach refers to the agency's strategies for deploying the program services and staff in a manner consistent with Evidence Based Practices and the needs of those to be served.

1) Describe the goals and measurable objectives of the proposed project and align them with the needs of the target population.

2) Identify the Evidence-Based Practice(s) (EBPs), evidence-informed, and/or culturally promising practices that will be used. Explain how using the proposed evidence-informed model will meet the needs of your target population and achieve the intended outcomes. Describe any modifications that will be made to the EBP(s) and the reason the modifications are necessary. If you are not proposing any modifications, indicate so in your response.

3) Describe the teaming structure and process you will utilize to ensure an integrated approach to care to ensure continuity of care including the inclusion of family and/or natural supports.

4) Describe how services will be delivered within the community while ensuring equitable access, safety, healthy boundaries, and therapeutic integrity.

5) Describe how staff scheduling will be managed to ensure on call coverage in accordance with program expectations.

6) Provide a Proposed Program Implementation Plan, including a detailed timeline for implementing the proposed services with actionable steps in preparing to provide the services of the RFP and to become fully operational within the time specified.

F. Staff Recruitment & Retention (10 Points)

Provide a summary (no more than one page) that describes a structural business framework in which recruitment is maximized and turnover is minimized. This includes adequate support and supervision, training, incentives, and competitive salary offerings and means for ensuring work life balance.

G. Proposed Budget Narrative (15 points)

Include a budget narrative that describes the following estimated expenses:

- Staff and fringe (see required staff in **Section D.** 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
- In-kind funding

Respondents must clearly indicate in the Budget Narrative how funding will be used to meet the project goals, responsibilities, and requirements. It must clearly explain budget line items, including miscellaneous expenses or "other" items, associated with the completion of the project. Describe any services, space, or materials that are being contributed, by whom, and the dollar value of the support. This Budget Narrative references the line items you enter in the Proposed Annex B Budget Form requested above as Pre-Award Document #23 to be included in **PDF 3: SECTION III - *REQUIRED DOCUMENTS, SUBSECTION B. ORGANIZATIONAL DOCUMENTS PREREQUISITE TO A CONTRACT AWARD TO BE SUBMITTED WITH THE RESPONSE.***

The Respondent awarded a contract is expected to adhere to all applicable State cost principles.

A description of General and Administrative Costs are available at: https://www.nj.gov/dcf/providers/notices/request/

H. Reduction of Seclusion & Restraint Use (5 points)

All staff providing in-home service must have documented training in an accredited or nationally recognized crisis de-escalation program (i.e., Handle with Care, Crisis Prevention Institute, Professional Crisis Management, Elwyn). The use of seclusion is prohibited. Please describe your policies and protocols on the use of personal restraints and seclusion.

I. IMTS-IDD RFPRESPONSE Vignette *(*5 Points)

Vignette Response: The Respondent shall read the following vignette and respond to each of the questions below.

Intensive Mobile Treatment Services for IDD Vignette:

Jack is a 16-year-old Hispanic male diagnosed with Autistic Spectrum Disorder. He lives with his mother and her boyfriend Paul, along with his 12-year-old sister Cay. His mother is currently 6 months pregnant. Historically Paul has been the disciplinarian, but the family does not understand much about Jack's condition which includes aggression towards others. Jack attends a district school and is in a self-contained classroom with a 1:1 aide.

A year ago, Jack, had broken his mother's wrist during an incident where Jack was attempting to hit Cay and his mother attempted to stop him. During the incident Paul grabbed Jack by the arm leaving a bruise. Jack's school contacted DCPP when they observed the bruising on Jacks arm and the family was opened for an investigation. At this time the family was referred to CMO.

Jack is non-verbal and engages often in significant self-injurious behaviors by banging his head and biting his hands which at times needs medical attention. In the last 2 years he has become increasingly aggressive towards family members and sometimes his aid at school. The school has been unable to manage Jack's behavior and is looking to refer him to a specialized school. The CMO has advocated with the school, added IIH clinical/therapeutic services and agency hired respite in place as well as engaged the Medicaid MCO for ABA. They have assisted the family with the completion of the CSOC DD functional eligibility Response.

After a period of 6 months Jack's behaviors continued to worsen, the respite agency could not staff anyone willing to work with Jack and his mother and sister were afraid for their safety. The CMO then made an OOH referral and Jack received an IOS of IPCH IDD. The family has been waiting for a period of 3 months for an OOH admission and the family's condition continues to worsen.

1) Please describe your approach to assessing the youth and family system including the process and areas of focus.
2) Please describe your approach to treatment planning that represents an integrated approach to care.
3) Please describe your approach to safety assessment and planning.
4) Please describe how you will engage in a cultural and ethical approach to providing home based services in the context of assessment, treatment planning and the implementation of interventions.

Section V - Response Screening and Review Process

A. Screening for Eligibility, Conformity and Completeness:

DCF will conduct a preliminary review of each Response to determine whether it is eligible for evaluation or immediate rejection in accordance with the following criteria:

1) The Response was received prior to the stated deadline.
2) The Response is signed by an authorized Chief Executive Officer or designated alternate.
3) The Response is complete in its entirety, including all documents required to be submitted in support of the Response listed in Section III. A. and the organizational documents prerequisite to a contract award listed in Section III. B. If documents are missing from the application, DCF may provide an email notice to the applicant after the application is submitted. Applicants will have up to five (5) business days after notice from DCF to provide any potentially missing documentation, except those documents required by the RFP and/or applicable law to be submitted with the proposal. If the documents are not then timely submitted in response to that notice, the application may be rejected as non-responsive.
4) The Response conforms to the specifications set forth in the RFP.
5) At least one representative of the Respondent must have been present at the mandatory Respondent's Conference.

Responses meeting the initial screening requirements of the RFP will be distributed to the Evaluation Committee for its review and recommendations.

Failure to meet the criteria outlined above, constitutes grounds for rejection of the Response.

B. Response Review Process

The Department convenes an Evaluation Committee in accordance with existing regulation and policy to review all responses. All voting and advisory reviewers complete a conflict-of-interest form. Those individuals with conflicts or with the appearance of a conflict are disqualified from participation in the review process. The voting members of the Evaluation Committee will review Responses, deliberate as a group, and recommend final funding decisions.

The Department also reserves the right to reject Responses when there is a loss of State or Federal funding for the RFP, or an indication or allegation of misrepresentation of information or non-compliance with any State of New Jersey contracts, policies and procedures, or State or Federal laws and regulations.

An Response in response to an RFP will be evaluated and scored by the Evaluation Committee based on quality, completeness, and accuracy on the Narrative Sections: A. Community and Organizational Fit; B. Organizational Capacity; and C. Organizational Supports; D. Population of Focus and Statement of Need; E. Proposed Program Model and Implementation Approach; E. Staff Recruitment & Retention; G. Proposed Budget; H. Reduction of Seclusion and Restraint Use and I. Response to IMTS-IDD RFP Vignette.

The proposal earning the highest score may result in a contract award. The narrative must be organized appropriately and address the key concepts outlined in the RFP. The quality and completeness of the required documents may impact the score of the Narrative Sections to which they relate.

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

C. 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 contract. Respondents may file a written appeal no later than ten (10) business days following receipt of the date on the Notice of Regret letter by emailing it to DCF.AHUAppeals@dcf.nj.gov. and mailing it to:

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

D. Post Award Review

As a courtesy, DCF may offer unsuccessful Respondents an opportunity to review the Evaluation Committee's rating of their individual Response. Respondents may request a Post Award Review by contacting: DCF.ASKRFP@dcf.nj.gov. Post Award Reviews will not be conducted after six (6) months from the date of issuance of this RFP.

Section VI - Post Award Requirements

A. General Conditions of Contract Execution:

The Respondent who receives notice of DCF's intent to award them a contract will be referred to the DCF Office of Contract Administration (OCA). As a condition of executing a contract, awardees must resolve with OCA any issues raised in the award letter or otherwise found to be need of clarification. If DCF finds after sending a notice of intent to award that the awardee is incapable of providing the services or has misrepresented any material fact or its ability to manage the program, the award may not proceed to contract execution. DCF determines the effective date of any contract, which is the date compensable services may begin.

Awardees will be required to comply with the terms and conditions of the Department of Children and Families' contracting rules, regulations, and policies as set forth in the Standard Language Document, the Notice of Standard DCF Contract Requirements, the Contract Reimbursement Manual, and the Contract Policy and Information Manual. Awardees may review these items via the Internet at www.nj.gov/dcf/providers/contracting/manuals and https://www.state.nj.us/dcf/providers/contracting/forms/. Awardees also will be required to comply with all applicable State and Federal laws and statutes, assurances, certifications, and regulations regarding funding.

B. Organizational Documents Prerequisite to Contract Execution to be Submitted After Notice of Award:

The OCA contract administrator assigned to initiate and administer an awardee's contract will require the awardee to submit the following documents prior to finalizing the contract for funding:

Post-Award Documents Prerequisite to the Execution of All Contracts

1) **Acknowledgement of Receipt** of NJ State Policy and Procedures:
   Return the receipt to DCF Office of EEO/AA.
   Form:https://www.nj.gov/dcf/documents/contract/forms/DiscriminationAcknowReceipt.pdf
   Policy:https://www.nj.gov/dcf/documents/contract/forms/AntiDiscriminationPolicy.pdf

2) **Annual Report to Secretary of State** proof of filing.
Website: https://www.njportal.com/dor/annualreports

3) **Employee Fidelity Bond Certificate (**commercial blanket bond - crime/theft/dishonest acts)

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. The $50,000 threshold includes fee-for-service reimbursements made via Medicaid. Not Applicable Note: Should state your agency will not exceed $50,000 in combined State of NJ contracts for the current year.

Email To: OfficeOfContractAdministration@dcf.nj.gov and copy your contract administrator
Policy:https://www.nj.gov/dcf/documents/contract/manuals/CPIM_p8_insurance.pdf

4) **Liability Insurance** (Declaration Page/Malpractice Insurance/Automobile Liability Insurance)
Important: Policy must show:
1. DCF as the certificate holder – NJDCF 50 E State Street, Floor 3, P.O. Box 717, Trenton, NJ 08625
2. Language Stating DCF is “an additional insured”
3. Commercial Liability Minimum Limits of $1,000,000 an occurrence, $3,000,000 aggregate
4. Commercial Automobile Liability Insurance written to cover cars, vans or trucks, limits of liability for bodily injury and property damage should not be less than $2,000,000/occurrence.

Email To: OfficeOfContractAdministration@dcf.nj.gov and copy your contract administrator

Policy:https://www.nj.gov/dcf/documents/contract/manuals/CPIM_p8_insurance.pdf

5) Document showing **NJSTART** Vendor ID Number (NJ's eProcurement System)
Website: https://www.njstart.gov/
Helpline: 609-341-3500 -or- njstart@treas.nj.gov

6) **Standardized Board Resolution Form**
Form:https://www.nj.gov/dcf/documents/contract/manuals/CPIM_p1_board.pdf

7) **Chapter 271/Vendor Certification and Political Contribution Disclosure Form**

[2006 Federal Accountability & Transparency Act (FFATA)]
Form:https://www.nj.gov/treasury/purchase/forms/CertandDisc2706.pdf

8) Program **Organizational Chart**
Form should include agency name & current date

Post-Award Documents Prerequisite to the Execution of This Specific Contract:

9) **Annex A -** Summary & Sections 1.1, 1.2, 1.3
Note: Contract Administrators will provide any Annex A forms customized for programs when they are not available on the DCF public website. Website: https://www.nj.gov/dcf/providers/contracting/forms

10) **Updated Final Annex B Budget Form -** Include Signed Cover Sheet
Form: https://www.nj.gov/dcf/documents/contract/forms/AnnexB.xls

Note: The Annex B Expense Summary Form is auto populated. Begin data input on Personnel Detail Tab.

11) **Schedule of Estimated Claims** (SEC) signed
Form:
Provided by contract administrator when applicable.

12) **Equipment Inventory** (if items purchased with DCF funds)
Policy:https://www.nj.gov/dcf/documents/contract/manuals/CPIM_p4_equipment.pdf

13) For Programs Hosting Youth, Adults, and Families or relying on Rent, Interest, or Depreciation in their Annex B Budget
Form: **Lease, Mortgage** or **Deed-** submit copies of executed documents.

14) For Programs Hosting Youth, Adults, and Families or relying on Rent, Interest, or Depreciation in their Annex B Budget
Form: **Current/Continued Certificate of Occupancy**

15) For Programs Hosting Youth, Adults, and Families or relying on Rent, Interest, or Depreciation in their Annex B Budget
Form: **Current Health/Fire Certificates**

16) **Updated Program Staffing Summary Report (PSSR)**
A full updated report must be submitted **annually** by the 10th day of the month following each contract year.

Form:https://www.nj.gov/dcf/providers/contracting/forms/ProgramStaffingSummaryReport.xlsm

17) **Program Activity Schedule**
Schedule should detail the structure/activities of the entire day of each week including evening shifts, 24/7.

18) **Agency Data Sheet**
Ensure all fields are completed with accurate info. Sheets with incomplete/inaccurate info will be returned. This includes all agency identifying numbers i.e., FEIN, UEI and NJSTART as well as staff contact info.
Note: For multi-year contracts, the contract number will remain the same each year. Form: Provided by contract administrator, if applicable.

C. Contractor Requirements for Reporting

In addition to the reporting requirements specified in this RFP relative to the delivery and success of the program services, Contractors are obligated to produce the following general reports as a contracting requirement.

1) **Audit** or **Financial Statement** (Certified by accountant or accounting firm.)
A copy of the Audit must be submitted to DCF by all agencies expending over $100,000 in combined federal/state awards/contracts if cognizant with any department of the State of NJ. As noted in Audit Policy 7.06, Section 3.13 of the Standard Language Document, DCF also may request at any time in its sole discretion an audit/financial statement from agencies expending under $100,000 that are not cognizant with any department of the State of NJ. Note: Document should include copies of worksheets used to reconcile the department's Report of Expenditures (ROE) to the audited financial statements. (DCF.P7.06-2007)

Contractors are to submit the most recent audit or financial statement with the initial contract and then each subsequent one within 9 months of the end of each fiscal year.
Policy:
https://www.nj.gov/dcf/documents/contract/manuals/CPIM_p7_audit.pdf

2) **DCF Notification of Licensed Public Accountant Form** (NLPA)**-and-** copy of **Non-Expired Accountant's Certification**
Contractor must ensure DCF form is used, and 2 signatures are provided. Not required for agencies expending under $100,000 in combined federal/state awards or contracts. 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.

Contractors are to submit this form with each Audit, providing info related to the year subsequent to the audit.

Not Applicable Note: Must state your agency will not exceed $100,000 in combined Federal/State awards or contracts.
Form: https://www.nj.gov/dcf/providers/contracting/forms/NLPA.docx

3) **Reports of Expenditures (ROE)**:
Quarterly ROEs must be submitted for contracted program budgets funded with federal grants such as this one and the final ROE is due 60 days after the close of the contract. The format for the ROE must match that of the Annex B budget form. **Note:** Must be prepared in accordance with the governing cost principles set forth in the DCF Contract Reimbursement Manual (CRM Section 6).

4) **Level of Service (LOS) Reports**
Enter the cited DCF Standard Template Form for each month the number of youth, adults, and families served and ages of those receiving services, and the hours/days, county locations, etc. of those services, or record this data into another form, survey, or database that DCF agrees can serve to track LOS for the contracted program.
Website: https://www.nj.gov/dcf/providers/contracting/forms/

5) **Significant Events Reporting:**
Timely reports as events occur to include, but not be limited to, changes to: (1) Organizational Structure or Name [DCF.P1.09-2007]; (2) Executive and/or Program Leadership; (3) Names, titles, terms and addresses, of the Board of Directors; (4) Clinical Staff; (5) Subcontract/consultant agreements and the development or execution of new ones; (6) a FEIN; (7) Corporate Address; (8) Program Closures; (9) Program Site locations; Site Accreditations (TJC,COA,CARF); the contents of the submitted Standard Board Resolution Form, and Debarment and SAM status.

Note: Agencies are under a continuing obligation, through the completion of any contract with the State of NJ, to renew expired forms filed with the NJ Department of Treasury and to notify Treasury in writing of any changes to the information initially entered on these forms regarding: Investment Activities in Iran as per P.L. 2012, C.25; Investment Activities in Russia or Belarus as per P.L. P.L.2022, c.3; Disclosures of Investigations of the Vendor; Ownership Disclosure if for profit; Service Location Source Disclosure as per P. L. 2005, C.92; Political Contribution Disclosure as per P.L. 2005, C.271; Report of Charitable Organizations, and the Two-Year Chapter 51 Vendor Certification and Disclosure.
Policy:
https://nj.gov/dcf/documents/contract/manuals/CPIM_p1_events.pdf
Website: https://www.state.nj.us/treasury/purchase/forms.shtml

D. Contractor Requirements to Store Organizational Documents on Site

1) Affirmative Action Policy/Plan

2) Copy of Most Recently Approved Board Minutes

3) Books, documents, papers, and records which are directly pertinent to this contract for the purposes of making audits, examinations, excerpts, and transcriptions, and to be produced for DCF upon request.

4) Personnel Manual & Employee Handbook (include staff job descriptions)

5) Procurement Policy