**Families First Prevention Services RFP Questions**

1. Are the prevention clearinghouse ratings available yet?
2. Yes, at <https://preventionservices.abtsites.com/program>  or <https://preventionservices.abtsites.com/>
3. Do the mental health therapists have to be certified in the evidence-based programs or just have the training?
	1. Yes, certified in the evidence-based program they are providing.
4. According to the California-Evidence Based Clearinghouse for Child Welfare, our selected model is not yet able to be rated, but it is characterized as a #3 (showing promising research evidence) - is this the same as emerging (and therefore would be a qualifying program)?
5. Yes.
6. Waiver process for State Request for Waiver of Evaluation Requirement for a Well-Supported Practice in accordance with the Prevention Services Clearinghouse: The way the guidelines read, the State must submit the waiver. Is the state willing to submit a waiver to HHS? Have you established a process for this waiver submission? If so, what is it?
7. Recommendations for waiver services will be submitted through the State’s prevention plan.
8. County referral flexibility:  If we submit for certain counties, will we be only considered for those? Is there flexibility in county assignments? Will we be given an opportunity to expand or decline the counties we will accept referrals from in the event that the State desires/needs a geographic modification to our proposal?
9. Initial considerations are for the counties applied for. However, there is flexibility depending on applications received and the State is willing to negotiate geographic needs.
10. Assessment Tool: How will this program be audited? What Audit Tool will be used? Will it be considered encounter data for CSFR Review?
11. Evaluations will be done by an outside grantee. There will also be reviews performed through the children and family service reviews.
12. Which is the correct email address for communications re: this RFP? The packet includes two: dcf.grants@ks.gov and dcfgrants@dcf.ks.gov.
13. dcf.grants@ks.gov
14. Page 7, Service Population and Referral:
15. How will DCF determine if a family is appropriate for a Family Prevention or Family Preservation referral? What is the referral criteria for each?
16. Can referrals come from other agencies for this service (ie. schools?)
	1. Based on the needs of the family and the evidence-based and/or well supported services provided by the grantee.
	2. No.
17. Page 7, Service Population and Referral: “Prevention Services in this scope are allowable for up to 12 months with no limit how many times a child or family can receive prevention and treatment services across different program or from the same program or service if the child continues to be at risk of entry into foster care out of home placement.”
18. Can a family receive both Family Preservation and Prevention services at the same time?
19. Can a family receive two different Prevention services at the same time?
	1. Yes.
	2. Yes.
20. Page 7, Services to be Provided: If therapeutic services are warranted, more often than Medicaid requirements allow for reimbursement, can prevention funds be used to help supplement services?
21. Yes.
22. Page 7, Services to be Provided: Can case management along with a well-supported, supportive, or promising practice be included in the model?
23. DCF welcomes proposals that might include case management. DCF will also see the family monthly.
24. Page 7, Services to be Provided: Can a portion of the prevention funds be used as flex funds to assist families with concrete services?
25. No.
26. General: Can a Prevention grant be awarded to the same entity who has a case management grant?
27. Yes.
28. Will referrals begin on 10/1/19 or will time be allowed to hire, train and implement staff for the EBP model proposed?  In addition, office space may need to be obtained.
29. Yes, referrals could be made on 10/1/19 if the Grantee is ready to accept them.
30. Can applications be post-marked no later than 2pm on 7/15/19 or must they be in DCF hands by that time (which means if being mailed they must get done sooner)?
31. They must be in DCF hands no later than 2 pm on 7/15/19.
32. On Page 8 of the RFP it states accept all referrals; does this mean if the program is full- based on caseload standards of the EBP model that the agency must still accept the referral from DCF?
33. Accept all referrals if and when the program has openings.
34. Will families be able to be referred to family preservation at the same time as the EBP funded under Families First?
35. Yes.
36. How will DCF determine if a child is at risk for out of home placement for an additional 12 months of service?
37. Based on the needs of the family as determined by the DCF Case Manager.
38. For the letter declaring an agency’s intent on applying-is that one letter per agency or per program?
39. One letter per agency.
40. Can applicants submit one proposal for the same geographic location and multiple EBPs if costs are identified clearly by the proposed EBPs?
41. No.
42. What is the plan for coordination of referrals for these new services with existing services (Family Preservation, etc.)?
43. Based on the needs of the family and the evidence-based and/or well supported services provided by the grantee.
44. What is the plan for coordination of training and technical assistance for providers of these new services?
45. Training needs will be addressed with each awarded grantee based on their proposal and coordinated as needed.
46. Can an applicant submit a proposal under this RFP for statewide training and technical assistance to support selected service providers? And if yes, can an applicant be awarded a T/TA proposal and a direct service grant?
47. No. This RFP is for Evidence-Based Practice Prevention Services.
48. What was the result of the RFI for the evaluator of Families First Prevention services?
49. The RFI resulted in sufficient information for DCF to write an effective RFP.
50. Has an external evaluator been selected? Who is the external evaluator (Number 11, page 8)?
51. An evaluator has not yet been selected as the RFP has not yet been posted to the public.
52. Do proposals need to include an evaluation component? What components are handled by the external evaluator and what components should be included in the proposal?
53. Your proposal should include the evaluation components as established in your evidence-based practice model.
54. Can applicants propose a promising or evidence-based practice from recognized clearinghouses such as the California Evidence-Based Clearinghouse for Child Welfare?
55. Yes.
56. What does DCF intend to do as new EBPs are added to the Prevention Clearinghouse? Will another RFP be issued? Will DCF be holding back some of the $13.9 million to fund future/new EBPs added to the Prevention clearinghouse?
57. As new EBPs are added DCF will consider amending grants currently awarded. No. No.
58. Does DCF have a plan to distribute funding base on geography, regional data about removal reasons, or other data/criteria?
59. Awards will be based on many different criteria, which may include geography, regional data, practices proposed, etc.
60. What is the difference between the family preservation target population and the target population for this RFP?
	1. What will happen if a child/family is receiving services from a Family First Prevention provider and the child/family is referred to Family Preservation services?
	2. Can a child/family receiving Family Preservation services be referred to Family First Prevention services too?
		1. FPS uses an evidence base of intensive in-home services approaches with families across a specific time period and modality. Population in this prevention grant  RFP may have their needs best met through an array of specific evidenced based mental health, substance use or parent skill building programs that may be delivered in the home, in the community or in peer settings depending on their emphasis and age of children or youth.
61. Can Family Preservation service provider refer to a Family First Prevention service provider? What happens if they are the same provider?
62. DCF will make this determination and referral.
63. What is the definition of “engaged timely” for this population (Outcome 1, pg. 9 of RFP)?
64. Final decisions regarding measures for timely engagement may depend on best practice standards for the evidence-based model.
65. What is the criteria for a retraction? And who will be implementing/initiating the retraction?
66. This is not yet established for Families First.
67. Can we address allowable use of funds in the budget/budget narrative rather than the implementation plan?
68. Please respond as requested within the RFP.
69. Can incentives be provided to families and the cost be allocated to this funding? Is contingency management allowable with IV-E funding?
70. Yes, we will consider that information as submitted in a budget relative to the evidence-based program proposed.
71. Can you provide current outcomes data for the EBPs throughout the state that are currently implemented (for example FFT and MST projects funded through KDOC)?
72. We do not have this data.
73. Please clarify if a separate RFP is required for each evidenced based program; would this require 4 separate RFP’s to bid on each category (mental health, substance use, in home parent skill, kinship navigation)
74. A separate response is required for each evidence-based program. Yes.
75. Will families potentially be referred to more than one program if multiple agencies are providing services for the various programs? If so, and a child enters OOH will this impact the outcome of all agencies providing services to the family?
76. Yes. Yes.
77. Will agencies be expected to accept referrals afterhours, weekends and holidays, thus requiring a 24/7 Admissions Department?
78. This is determined by the evidence-based practice model proposed by grantee and what the grantee is proposing to provide for services. DCF work hours are traditionally Monday to Friday daytime business hours.
79. What will PPS consider when determining whether to refer the family to Family Preservation Services or the Family Prevention Grant?
80. Based on the needs of the family and the evidence-based and/or well supported services provided by the grantee.
81. Will the Family Prevention Grant be based on head of household for case counts or number of children regardless of how many children are in one family?
82. Based on head of household.
83. The Foster Care Contractor typically provides services to the entire family regardless if all children in the home are in OOH. Will the Foster Care Contractor also provide services to a pregnant parent if they have an existing open case with the family?
84. This does not apply to this RFP.
85. If a child needs to live with a relative and the child is not in DCF Custody; who will address the legal aspect including benefits, releases, consent to provide care to the child; etc. What if the family does not agree to relative placement outside DCF Custody or what if the family initially agrees then takes their child back home during the open case?
86. These matters around safety plans and what needs to happen in the intervention with a family depend on the service intervention and interaction with safety networks alongside the family. If a service provider/ grantee has worries about a safety plan or a family does not reach agreement on that safety plan, DCF may be notified of case progress or status.
87. If a child is to live with a relative, is the provider to work with the relative caregiver and/or the birth parents as well as the children? Is it the expectation that reintegration with the birth parent or visitation, etc. is to be coordinated by the provider?
88. The service grantee works alongside birth and relative caregivers and/or  the family’s safety network according to the evidence based program to meet the family’s needs and prevent entry into foster care.
89. Will the provider be expected to develop a formal case plan and if so will their database need to be set up to enter case plans in the database and submit them to DCF electronically as the Foster Care System is set up?
90. DCF is the Case Management provider and will be completing case plans.
91. If a child/family moves outside the provider’s catchment area will the case close and DCF refer to a new provider in that service area?
92. This is determined by the grantee and the DCF Case Manager.
93. Will all cases referred to Family First Prevention be non DCF Custody cases?
94. Yes - All families referred will be children who are not removed from their home into foster care. It is possible some families might have children in DCF custody, but not removed into foster care.
95. If there is Court involvement such as informal supervision will the provider be expected to submit Court reports and attend Court or will DCF submit those reports?
96. The grantee will be required to report to DCF information for court report submittal and potentially may be required to report to court.
97. When calculating the potential number of referrals by county what percentage of Family Preservation Cases and/or OOH cases should be estimated in Family Prevention Grant referrals? Is there any other numbers that should be considered as well such as Family Services cases?
98. Referrals will be based on the needs of the family and the evidence-based and/or well supported services provided by the grantee.
99. According to the service referral population; a youth exiting foster care to adoption, permanent custodianship, guardianship or reintegration may be referred. Is the Foster Care Provider going to be providing aftercare services for 365 from date of permanency? If so are the providers to work together or will referrals only occur after the 365 days?
100. No.
101. Evidence Based Training may not be available to be completed by Oct. 1st when the grant goes into effect, will there be a grace period of sorts to allow for staff to obtain the needed training?
102. Referrals could be made on 10/1/19 if the Grantee is ready to accept them.
103. For services that have CPT codes, should they be billed to Medicaid and/or Commercial insurance and thus, not fall under the grant? Or, if they are referred under this program, are all services under this program covered by the grant and not billed to Medicaid/Commercial Insurance?
104. Yes. All services shall be billed to Medicaid and/or Commercial insurance prior to be submitted under this grant award.
105. If a client referred under this program is in need of additional services offered through a CMHC that are outside of the grant are there any stipulations or approvals needed before offering those services?
106. No.
107. If a therapist provides grant-related and non-grant related services during a given month, how are the personnel costs to be split? Does the therapist need to maintain a time record breaking out grant-related service time, grant-related administrative time, and non-grant time worked?
108. Costs will need to be tracked based on Medicaid billable and non-billable. Yes.
109. Do administrative personnel need to maintain a time record for time spent related to the grant and only bill the actual time spent to the grant each month?
110. Yes.
111. If the family refuses services/engagement following a referral being sent; does this allow for a request for retraction or will it be counted against outcomes?
112. Referrals may be retracted. However, retracted referral do not impact outcomes.
113. Throughout the proposal and in the *Substance Use* program area it appears that individual family interventions are preferred. However, we are proposing both individual as well as group-based emerging as well as evidence-based interventions. Is this acceptable?
114. We cannot advise on what to include or exclude within a proposal.
115. Often federal funds have Modified Total Direct Cost (MTDC) indirect cost rates that carve-out or exclude items such as computers, software, participant costs, etc. Is the 10% listed in the RFP for all budget lines or are there MTDC rates? If so, what are they?
116. This statement applies to all line items.
117. The first period of the potential three-year grant is not a full 12 mos. (ie., Oct. 1, 2019-June 30, 2020), so is the potential time period for the funding 3 years + 8 mos or does the 8mos at the beginning count as the first "year"?
118. The initial term is for 8 months. There will be 3 additional 12-month renewal options available after that 8 months. Those renewals will run July 1 to June 30, in line with the State Fiscal Year.
119. Since start-up costs are allowed upon award is there a start-up period allowed so that grantee staff can be put-in-place before the first referrals come from PPS? If so, when might our organization expect to receive the first referrals?
120. Start-up costs may be considered and have not yet been confirmed as allowed. If they are requested, they shall be clearly identified separate from other costs within a proposal submitted.
121. The RFP requires that complete or continual Plans for Safe Care for families with infants be provided (item 6 in Services to be Provided) consequently, is it acceptable and appropriate, to include a line item for physical health checks for infants based on Bright Futures guidelines whose families may not be privately or publicly insured?
122. We cannot advise on what to include or exclude within a proposal.
123. If an agency intends to use the same evidence-based program for two different areas (ex: one program to address mental health and the same program for parent skill building), does a separate response need to be given for each of the areas (one response for mental health and one response for parent skill building)?
124. Yes, a separate response is required for each EBP proposed.
125. Will selected proposals go through a negotiation stage with DCF to finalize and potentially modify the services to be provided and the awarded amount, or will a proposal be considered as is and be either accepted or not accepted as it is written?
126. Selected proposals may go through negotiations.
127. The grant refers to “Motivational Interviewing?”. Where do we find information that defines and discusses this?
128. https://www.cebc4cw.org/search/
129. What is meant by: “Plan of Sare Care?”
130. This can be found at [http://www.dcf.ks.gov/services/PPS/Pages/PPSpolicies.aspx](https://dcfauth.dcf.ks.gov/services/PPS/Pages/PPSpolicies.aspx) under Policy Procedure Manual, PPM #2050 Plan of Safe Care.
131. Since the RFP says that the start date of the grant is October 1, 2019, when will provider know if they are awarded grant?
132. The goal is to have fully executed awards no later than middle September.
133. To clarify: If a mental health provider wanted to implement, say, both CBT and MST, they would need to submit two complete RFPs, correct?
134. Yes.
135. If a mental health provider proposed to implement, say, MST in their designated service area, will DCF locate providers of the other three EBPs listed in the RFP for that service area or is it possible that MST be the sole EBP provided for that area?
136. There could be more than one provider in each area.
137. If a referred individual is violent, belligerent or unwilling to undergo mental health treatment, does a grantee have the right to say that the person is not appropriate for services?
138. Grantee must accept all referrals. A retraction process of a referral is to be determined.
139. Will the grant cover expenses for missed appointments, especially since this is a population of families that are difficult to engage?
140. No.
141. In the RFP, under “Cost Allocation Plan,” it reads, “The cost allocation plan must summarize how the applicant agency will allocate its costs to its various funding sources.” What various funding sources? Please explain what is intended in this sentence.
142. A better term may be “business activities.” This statement means that only costs that can be reasonably and fairly charged to a Family First grant can be charged to that grant, that for any item of cost charged there must be a relationship and benefit to the Family First grant, and that there be a reasonable and fair plan to distribute shared costs across multiple business activities. These principles apply to direct and indirect costs.
143. Please define “indirect costs." What can be included?
	1. The identification, distribution, and reporting of indirect costs will generally follow Appendix IV to 2 CFR 200 “Indirect (F&A) Costs Identification and Assignment, and Rate Determination for Nonprofit Organizations”. Providers may propose alternative methods that will be subject to review and acceptance. DCF may prescribe exceptions to Appendix IV as necessary or desirable.
	2. Indirect costs are defined in Appendix IV as ‘those that have been incurred for common or joint objectives and cannot be readily identified with a particular final cost objective (i.e., business activity)’. Please note that this means that costs are to be directed to the provider’s various business activities/functional areas as much as possible and reasonable. Appendix IV describes the types of costs generally considered as indirect, as well as the allocation bases for them.
	3. DCF is opting to rely on Appendix IV because it provides an existing, defined process for identifying and distributing indirect costs that is likely already familiar to many providers.
144. In item 10 on page nine of the RFP, it reads that a data tracking system has not yet been completed. Who – DCF or the grantee – will determine how data will be tracked?
145. DCF and the evaluation grantee.
146. The first grant year is only eight months long; however, services are authorized for 12 months. How will you handle the possibility of services extending beyond the end of the grant’s first year?
147. Services may go up to 12 months and are not required to be provided the entire 12 months. The length of service provided shall be determined by the EBP practice model proposed.
148. What level of training and experience in a given EBP is required? Is it acceptable for a provider to use key elements of an EBP in their treatment? If a few staff members are trained in the EBP and they supervise other members of the treatment team, will that suffice? Will a mental health care provider and/or program/site (as is the case with FFT) be required to be fully certified in a given EBP and meet fidelity or at least demonstrate that they have had training in that particular EBP (and how much)? Please note that for a provider to be “certified” or for a particular program to meet fidelity will take more than one year, and will limit the pool of available resources who can accept referrals for mental health services.
149. Depends on the model proposed. We can’t advise on what to propose. Service must be provided to fidelity. Yes.
150. How many applicants are anticipated to be awarded?
151. No set number.
152. What is the per applicant award ceiling?
153. There is not one.
154. What are you anticipating the average amount to be awarded per application?
155. There is not one.
156. Should LOI’s request an amount that covers the first grant period only or all four grant periods (initial award and 3 contract renewal years)?
157. Please see Section V. Application Process, Letter of Intent on page 12 of the RFP for what is to be included in the Letter of Intent.
158. How many referrals can an agency expect to receive in any given month? (We are working to identify the number of staff that need to be hired to effectively field the number of referrals).
159. There is no referral estimation. The referrals will be based on the needs of the family and the evidence-based and/or well supported services provided by the grantee.
160. What is the average number of staff a successful single community would hire?
161. This is up to the applicant.

1. I have double clicked on the attachments and they are not opening please advise.
2. The attachments are Microsoft Excel and Word as well as Adobe files. When clicking on the attachments if there is a box asking for a password just click cancel until it finally opens the document. Please also check with your organization’s IT team to see if they can assist from that side as it is difficult to make presumptions from this side as to the error. If that still does not work please email dcf.grants@ks.gov ASAP.
3. When will we be notified of approval or decline of grant application?
4. The goal is to have fully executed awards no later than middle of September.
5. Can we mail the copies of applications and flash drive as long as they arrive by the due date or do we need to hand deliver?
6. You can mail as long as they arrive by the date AND time required within the RFP. They must be to DCF Administration no later than 2:00 pm on the due date or they will not be considered.
7. How many letters of support do you need and what types of agencies or people do you need these letters to come from?
8. Three per proposal submitted.
9. FFT has been shown to be effective with treating substance use/abuse. Could we use it to bid those services?
10. We cannot advise on what to include or exclude within a proposal.
11. PMTO is rated as rated as well supported by evidence in the Calif Clearinghouse – Can we add this as a service? It’s not on their list. Is it classified as emerging? We need to find that.
12. We cannot advise on what to include or exclude within a proposal.
13. What are the criteria for referrals to FFPSA funded FFT vs. Community Services and Family Preservation
14. Based on the needs of the family and the evidence-based and/or well supported services provided by the grantee.
15. Population of Possible Referral: Can we get info on the number and age of investigations/assessments done quarterly? How many referrals should we count on?
16. This link will have this information [http://www.dcf.ks.gov/services/PPS/Pages/CPSReports.aspx](https://dcfauth.dcf.ks.gov/services/PPS/Pages/CPSReports.aspx).
17. Unknown on number of referrals.
18. How often will the list of approved practices be updated?
19. Unknown. The feds are requesting public comment annually for program inclusion.
20. How often will RFP’s released?
21. DCF is considering a mechanism to refresh this RFP if and when new Evidence based programs are approved as rated on the Prevention Clearinghouse so that bidders might have a new deadline to submit proposals on that program if they have not already.
22. How were the standards (i.e. 95%) determined on the outcomes?
23. Final decisions regarding measures may depend on best practice standards for the evidence-based model proposed.
24. If an organization is planning to submit applications for more than one program (e.g., Mental Health, Substance Abuse, In-Home Parent Skill Based, Kinship Navigation, Motivational Interviewing), will a separate LOI need to be submitted for each of these applications? Or will only one LOI be required as an umbrella for all programs for which an organization intends to apply?
25. Only one Letter of Intent per organization is necessary.
26. In working on the FFPSA grant application, I came upon an item in the Debarment Memorandum for which I have a question. The link identified in the Debarment Memorandum template in the RFP is <http://www.sam.gov/portal/public/SAM> - however this link delivers an "Error 404" message. Will you please kindly verify if the correct link is actually <https://sam.gov/SAM/pages/public/index.jsf> ?
27. Appears Sam.gov has changed their website. The correct link is <https://www.sam.gov/SAM/>.
28. Has the Event Details (ED) document for the FFPSA grant been posted or if not, when will it be available?
29. There is not an Event Details document available for this RFP as this is not being processed through Department of Administration, which is the State agency that requires that document.
30. Is a transmittal letter required as part of the submission?
31. What is required for submission of an application is identified within the RFP.
32. If a bidding agency intends to provide services in more than one DCF region, can one RFP proposal be submitted for an EBP delivered across multiple regions or is a separate proposal required for each DCF region even if it’s the same EBP being proposed across multiple regions?
33. Proposals shall be submitted per EBP and identify which areas will be covered.
34. Page limit: The checklist on page 17 of the RFP indicates that length of proposal should not exceed 25 pages and includes several items marked with an asterisk \*.  Can you clarify if attachments A, E,F,G and H (also marked with \* on the checklist) must be included as part of the 25 total page limit? If so, this will mean that the statement of the problem, project design, implementation plan, management structure and sustainability plan will be limited to 9 pages as there are 16 pages between attachments A-H).
35. Attachments are not included in the total page limit.
36. Motivational Interviewing: Since MI should be integrated with all EBPs proposed, what level of training, coaching and fidelity rating specific to the MI will be required as part of each implementation plan. For example, if the primary EBP has a robust fidelity monitoring plan, will MI also require the same level of fidelity monitoring?
37. We cannot advise on what to include or exclude within a proposal.
38. Section I, page 4. In submitting a response for the entire West Region, our program will be impacted by adding KDAD certificated Substance Use Disorder programs to cities we are not currently serving. We understand the need for these programs in the frontier and rural counties in the region. Acquiring KDAD certifications, could delay us being operational in the new locations by the October start date. Will this be a problem?
39. No.
40. Section I, page 4. We also understand the hiring and training of qualified staff for the more remote areas of the West Region will be a challenge and subsequentially could delay the start. Will this be a problem?
41. No.
42. Section II, page 6. Does a separate proposal need to be submitted for each geographical service area an agency intends to bid?
43. No.
44. Section II, page 6. Do we submit a separate budget for each region/catchment area?
45. No.
46. Section II, page 7. Service Population and Referral (in paragraph above eligible family referrals). Since each child will be determined as a candidate for care, will the service provider be responsible for completing a Case Plan either family or individual?
47. DCF is determining candidate for care and completing the case plan.
48. Section II, page 7. Service Population Section – item 3: is the fact that a child is in a placement with relative caregivers make this an “automatic referral”? Does this mean that this child is considered “at risk” by virtue of this arrangement? Does this mean any type of relative arrangement – formal or informal?
49. No. Based on the needs of the family and the evidence-based and/or well supported services provided by the grantee.
50. Section II, page 7. Service Population section – item 5- Is the “at risk” child the baby? Does that mean services are offered to the “parent” regardless of age?
51. Applicant shall propose their suggestions for service to the population.
52. Section II, page 7. Service Population and Referral: Are children who exited foster care that are at risk of entering out of home placement, eligible during aftercare? Can exit be defined?
53. Yes, as determined by DCF Case Manager. Exit as identified in this section means the child is no longer in the legal custody of the Secretary of DCF.
54. Section II, page 7. Service Population and Referral: Are the 12 months of prevention services measured through child’s years between age 0-18 or family’s time?
55. Prevention services are allowable for up to 12 months.
56. Section II, page 7. Service Population and Referral: Child or Family can receive prevention and treatment across different programs – Are children or parents receiving Tier 2 Family Preservation Case management services eligible for Evidence Based Prevention Programs funded through Family First?
57. Yes.
58. Section II, page 8. #8 Services to Be Provided. Is DCF stating there should be an open exchange of information between the Service Provider and DCF without a release of information? Would this also include medical record information such as diagnosis and therapy notes.
59. Yes.
60. Section II, page 8. #10 Services To Be Provided. Is the Provider required to assess/monitor/track “all” the children in the home?
61. Depends on the needs of the family and the evidence-based and/or well supported services provided by the grantee.
62. Section II, page 8. #11 refers to work with an external evaluator, will DCF identify this external evaluator or is DCF the external evaluator?
63. An evaluator has not yet been selected as the RFP has not yet been posted to the public.
64. Section 2, page 9. Program Outcomes section, Outcome 1 – please define “engaged” and “timely”. What happens if the family “refuses” service once contacted by the provider? Does that count against the provider’s outcomes?
65. Final decisions regarding measures for timely engagement may depend on best practice standards for the evidence-based model.
66. Section V & VIII, Page 12 & 17. For the four (4) copies, should the Attachments starting with Attachment C to the Support letters be included?
67. Yes. There should be 4 complete copies of the organization’s response to the RFP.
68. Section V, page 14. What is the minimum number of letters of support required for each organization and/or program?
69. Three per proposal submitted.
70. Section VIII, page 17. Items with an asterisk are considered part of the narrative and narrative page count. Do these items also include Attachments E, F, G, and H, since these documents have asterisks next to them as well?
71. Attachments are not included in the total page limit.
72. Section V, page 12. Does a LOI need to be submitted for each EBP proposal?
73. Only one Letter of Intent is necessary per organization.
74. Will the service provider be asked to follow the DCF Policy and Procedure Manual?
75. Yes.
76. Is a “case” defined as a family case or child’s case? If PPS identifies a specific child in a family as “at risk” but there are other children in the home, are all the children expected to participate in the service?
77. Based on head of household. Depends on the needs of the family and the evidence-based and/or well supported services provided by the grantee
78. Is the Provider required to assess/monitor/track other adults in the home? Are the other adults required to participate in the service also?
79. Based on the needs of the family and the evidence-based and/or well supported services provided by the grantee.
80. Page 4. Funding Opportunity/Program Background. What is the expected number of clients per region who require services on a monthly basis? Can the Department share a map of their expected service locations?
81. This is unknown. See page 6 of the RFP.
82. Page 5. Purpose, Goals and Objectives. Does this RFP allow for reimbursement for services that are supporting the Well-Supported treatment models, but may not fall within the purview of those models (for instance, children who may benefit from psychiatric medication management)? If not, could you describe the methods by which those services may be provided and reimbursed outside of the grant?
83. We cannot advise on what to include or exclude within a proposal
84. Page 5. Purpose, Goals and Objectives. What, if any, telemedicine services are allowed under the contracted scope of services?
85. We cannot advise on what to include or exclude within a proposal.
86. Page 6. Purpose, Goals and Objectives. Would there be an opportunity to work with youth and families outside of the jurisdiction or catchment area?
87. This is determined by the grantee and DCF Case Manager.
88. Page 7. Service Population and Referral. If a child and family is perceived to need multiple services (i.e. Mental Health services and In-Home Parenting Skills), will the 12-month timeline run concurrently at the time of the referral or can timelines be staggered based on the evaluated needs of each child and family?
89. The allowable services are limited to a 12-month period that begins on the date on which a child is identified in a prevention plan as either a “candidate for foster care” or a pregnant/parenting youth in need of services.
90. Page 7. Service Population and Referral. On page 7 of the RFP, the third paragraph describes that prevention services can be provided with no limitations. Could you please describe how the Department for Children and Families intends to provide utilization management oversight of winning bidders (i.e. the number of sessions provided per week, per month or annually)?
91. Evaluations will be done by an outside grantee. There will also be reviews performed through the children and family service reviews.
92. Page 7. Service Population and Referral. Does the Department have any intention to utilize the services proposed under this RFP as a way to “step down” youth who are already in foster care or placed in other out-of-home settings through DCF? If so, could you please provide information on the number of children who leave custody on a monthly or annual basis in each of the 4 regions?
93. Children currently in Foster Care cannot receive services through this RFP.
94. Page 7. Service Population and Referral. Does the Department have any preferences on the qualifications/credentials of the providers who will be serving under this contract (assuming that they meet the fidelity standards of the proposed Well-Support Clinical Treatment model)?
95. Must meet fidelity of evidence-based practice model.
96. Page 7. Service Population and Referral. How much time would be allotted for training for therapists once RFP has been awarded?
97. Depends on the model proposed.
98. Page 9. Program Outcomes. Does this Grant RFP include a performance-based/value-based reimbursement structure that is tied to the achievement of the identified performance measures?
99. No.
100. Page 9. Program Outcomes. Would the Department please describe any time requirements for face-to-face meetings with children and families in order to meet the requirements of Outcome 1 (Families are engaged timely in program or services)?
101. Requirements are based on meeting the fidelity of the evidence-based model proposed.