NYC Administration for Children's Services

Request for Proposals (RFP)

ACS Prevention Services

EPIN: 06819I0007

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[1]Please note that ACS reserves the right to revise the Preventive Services Quality Assurance Standards and Indicators and anticipates issuing revised standards that incorporate the Therapeutic and Treatment models in 2020. Contractors would be required to comply with current and revised Preventive Services Quality Assurance Standards and Indicators.

4. Basis for Contract Award and Procedures
    A. Proposal Evaluation
    B. Contract Award

IMPORTANT NOTE: This Request for Proposals is issued through the HHS Accelerator system to those organizations prequalified in the relevant service areas. Proposals must be submitted through the HHS Accelerator system in the manner set forth in the 'Procurements' section of the system by those same prequalified organizations. Go to www.nyc.gov/hhsaccelerator to learn more.

Basic Information

<table>
<tr><td>RFP Release Date</td><td colspan="5">06/12/2019</td></tr>
<tr><td>Proposal Due Date</td><td colspan="5">08/8/2019 at 2:00 p.m.</td></tr>
<tr><td rowspan="4">Model Educational Sessions (optional but recommended)
Model Support Organizations will present detailed information on each family support, therapeutic, and treatment model /framework at these events. These sessions will be recorded and posted online.</td><td></td><td>Models Covered:</td><td>Date:</td><td>Time:</td><td>Place:</td></tr>
<tr><td>FAMILY SUPPORT:</td><td>Mobility Mentoring, Family Connections, Solution-Based Casework</td><td>6/17/2019</td><td>3:00pm - 5:00pm</td><td>The Graduate Center - CUNY, 365 5th Ave, New York, NY 10016 RSVP (limited to two representatives per agency)</td></tr>
<tr><td rowspan="3">THERAPEUTIC & TREATMENT:</td><td>Child Parent Psychotherapy (CPP), Brief Strategic Family Therapy (BSFT)</td><td>6/24/2019</td><td>BLOCK A 9:30am-10:45am</td><td>The Children's Center, 492 1st Avenue, New York, NY 10016 RSVP (limited to two representatives per agency)</td></tr>
<tr><td>Functional Family Therapy (FFT), Trauma Systems Therapy (TST)</td><td>6/24/2019</td><td>BLOCK B 11:00am-12:40pm</td><td>The Children's Center, 492 1st Avenue, New York, NY 10016 RSVP (limited to two representatives per agency)</td></tr>
<tr><td>Multisystemic Therapy for Substance Abuse (MST-SA), Multisystemic Therapy-Prevention (MST-PREV), Multisystemic Therapy for Child Abuse and Neglect (MST-CAN), Family Treatment/ Rehabilitation (FT/R), Special Medical</td><td>6/24/2019</td><td>BLOCK C 2:00pm-4:30pm</td><td>The Children's Center, 492 1st Avenue, New York, NY 10016 RSVP (limited to two representatives per agency)</td></tr>
<tr><td colspan="3" rowspan="2">Pre-Proposal Conferences (optional but recommended)
Proposers will be able to ask questions about the RFP. Responses will be shared following the event. For more information, see Questions Regarding this RFP section below.</td><td>Date:</td><td>Time:</td><td>Place:</td></tr>
<tr><td>7/8/2019</td><td>1:00pm - 5:00pm</td><td>The Children's Center, 492 1st Avenue, New York, NY 10016 RSVP (limited to two representatives per agency)</td></tr>
</table>

	7/17/2019	9:30am - 1:30pm	The Children's Center, 492 1st Avenue, New York, NY 10016 RSVP (limited to two representatives per agency)

Anticipated Contract Term	07/01/2020 – 06/30/2023 with an option to renew for two (2) additional three (3) year terms. The parties must mutually agree to renew the contract and contractor must provide prior written notice to ACS in the event the contractor does not want to renew.
Agency Contact Person	Prevention-RFP@acs.nyc.gov
Anticipated Funding and Payment Structure	● Anticipated total maximum available funding is approximately $663 million ● Estimated number of contracts: 123 ● Payment structure: reimbursement will largely be cost-based (that is, based on contractors' spending against approved line-item budgets), with a portion of payment driven by performance using utilization, quality, and outcome metrics set by ACS. Such metrics may include staff training goals, client utilization and length of service targets, casework contacts, levels of parent engagement, post-services outcomes, increasing Advocate cases, and community outreach, among other measures. ACS reserves the right to modify the basis of reimbursement of the contract in the future.
Questions Regarding this RFP	● Questions regarding this RFP must be transmitted in writing to the Agency Contact Person at the email address listed above. ● Questions received prior to the Pre-Proposal Conferences will be answered at the conferences. ● Substantive information/responses to questions addressed at the conference and those received subsequently will be released in an addendum to the RFP to all organizations that are prequalified to propose to this RFP through the HHS Accelerator system, unless in the opinion of the Agency, the question is of proprietary nature. ● The Agency cannot guarantee a timely response to written questions regarding this RFP received less than one week prior to the proposal due date.
Subcontracting Information	Subcontracting for direct services to families is allowed subject to the following conditions: ● Services provided by the subcontractor must be integrated into the overall program design. ● Subcontracting is not allowed for case planning or supervision of direct service staff. ● All subcontractors and subcontracts are subject to ACS approval before any expenses are incurred or any payments are made to them by the prime contractor and must be reported using the City's Payee Information Portal. https://www1.nyc.gov/site/doh/business/opportunities/payee-information-portal.page **Note:** ● Subcontractors are not required to be prequalified in HHS Accelerator and are not required to be nonprofit organizations.

	• Contractors are encouraged to utilize business and individual proprietors listed on the NYC Online Directory of Certified MWBE Businesses, available at www.nyc.gov/sbs, as sources for its purchases of goods, supplies, services and equipment using funds obtained through the Agreement. Contractors are also encouraged to utilize businesses and individual proprietors owned/operated by people with disabilities as sources for its purchases of goods, supplies, services and equipment using funds obtained through the Agreement.

Proposal Submission Instructions

General Guidelines	• All Proposals must be submitted utilizing the Procurement Tab of the HHS Accelerator system at www.nyc.gov/hhsacceleratorlogin by providers with approved HHS Accelerator Applications, including Business Application and required Service Application(s) for the areas listed in the Services and Providers Tab. • Proposals received after the Proposal Due Date and Time are late and shall not be accepted, except as provided under New York City's Procurement Policy Board Rules, Section 3-16(o)(5). • Please allow sufficient time to complete and submit Proposals, which includes entering information, uploading documents and entering login credentials. The HHS Accelerator system will only allow Providers to submit Proposals prior to the Proposal Due Date and Time. • Providers are responsible for the timely electronic submission of proposals. **It is strongly recommended that Providers complete and submit their Proposals at least 24 hours in advance of the Proposal Due Date and Time.** • Resources such as user guides, videos, and training dates are listed at www.nyc.gov/hhsaccelerator. For more information about submitting a proposal through the HHS Accelerator system, please contact help@mocs.nyc.gov.
Proposal Details	
Competition Pools	Indicate which competition pool the provider is proposing for:

Program Competition	**Geographic Level of Service**	**Proposal Type**
Family Support	Catchment area (see table below)	A single, complete proposal must be submitted for each catchment area to be served.

<table>
<tr><td></td><td>
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<tr><td>Therapeutic and Treatment Programs</td><td>Borough-wide except for MST-CAN and Special Medical, which are Citywide (see table below)</td><td>A single, complete proposal is required for each Model and catchment area combination to be served.</td></tr>
</table>

Proposers wishing to apply for multiple program models (i.e., Family Support and Therapeutic and Treatment Programs) and/or more than one catchment area must submit separate and complete proposals for each one, even if the proposed programs would be co-located.

Proposers should bear in mind that they may not ultimately be awarded all program competitions they propose, so each proposed program must be able to operate on its own.</td></tr>
<tr><td>Basic Information</td><td>● Enter Proposal Title</td></tr>
<tr><td>Provider Contact</td><td>● Select a member of your organization who will be the primary contact for this RFP, enter primary contact name, primary contact title, organization name, address, phone number, and email address.</td></tr>
<tr><td>Service Type and Units:</td><td>● The number of slots listed below are the only number of slots to be awarded per program; however, ACS reserves the right to award less than the total number of slots noted below and to reallocate the number of slots among competitions prior to making awards when ACS determines such action is in the best interests of the City.
● Select the program and number of slots the proposer is applying for in this proposal. Complete and separate proposals must be submitted for each program and catchment area that a proposer is applying for.

<table>
<tr><td colspan="2"><u>Family Support Programs</u></td></tr>
<tr><td>96 Slots</td><td>Family Support - Bronx Catchment 1</td></tr>
<tr><td>96 Slots</td><td>Family Support - Bronx Catchment 2</td></tr>
<tr><td>96 Slots</td><td>Family Support - Bronx Catchment 3</td></tr>
<tr><td>96 Slots</td><td>Family Support - Bronx Catchment 4</td></tr>
<tr><td>96 Slots</td><td>Family Support - Bronx Catchment 5</td></tr>
<tr><td>96 Slots</td><td>Family Support - Brooklyn Catchment 1</td></tr>
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96 Slots	Family Support - Brooklyn Catchment 2
96 Slots	Family Support - Brooklyn Catchment 3
96 Slots	Family Support - Brooklyn Catchment 4
96 Slots	Family Support - Brooklyn Catchment 5
96 Slots	Family Support - Brooklyn Catchment 6
96 Slots	Family Support - Manhattan Catchment 1
96 Slots	Family Support - Manhattan Catchment 2
96 Slots	Family Support - Manhattan Catchment 3
96 Slots	Family Support – Queens Catchment 1
96 Slots	Family Support – Queens Catchment 2
96 Slots	Family Support – Queens Catchment 3
96 Slots	Family Support – Queens Catchment 4
96 Slots	Family Support – Staten Island Catchment 1
Boroughwide Therapeutic and Treatment Programs	
64 Slots	BSFT in Bronx
64 Slots	TST in Bronx
64 Slots	FFT in Bronx
128 Slots	CPP in Bronx
144 Slots	FFT adaptations for a child welfare population in Bronx
40 Slots	MST-PREV/MST-SA in Bronx
128 Slots	FT/R in Bronx

64 Slots	BSFT in Brooklyn
64 Slots	TST in Brooklyn
64 Slots	FFT in Brooklyn
128 Slots	CPP in Brooklyn
144 Slots	FFT adaptations for a child welfare population in Brooklyn
40 Slots	MST-PREV/MST-SA in Brooklyn
128 Slots	FT/R in Brooklyn
64 Slots	BSFT in Queens
64 Slots	TST in Queens
64 Slots	FFT in Queens
64 Slots	CPP in Queens
144 Slots	FFT adaptations for a child welfare population in Queens
40 Slots	MST-PREV/MST-SA in Queens
128 Slots	FT/R in Queens
64 Slots	BSFT in Manhattan
64 Slots	TST in Manhattan
64 Slots	FFT in Manhattan
64 Slots	CPP in Manhattan
144 Slots	FFT adaptations for a child welfare population in Manhattan
40 Slots	MST-PREV/MST-SA in Manhattan
128 Slots	FT/R in Manhattan
32 Slots	BSFT in Staten Island
32 Slots	TST in Staten Island
32 Slots	FFT in Staten Island
64 Slots	CPP in Staten Island

	128 Slots — FT/R in Staten Island 144 Slots — FFT adaptations for a child welfare population in Staten Island 40 Slots — MST-PREV/MST-SA in Staten Island Citywide Therapeutic and Treatment Programs 128 Slots — Special Medical 48 Slots — MST-CAN
Custom Question #1	• Enter the total number of proposals submitted in response to this RFP.
Custom Question #2	• If applying to Family Support, enter the proposed case practice framework. If not applying for Family Support, enter N/A.
Custom Question #3	• Is the provider willing to serve a special population outside of the proposed borough or catchment area? (yes or no)
Custom Question #4	• If YES to Q3, identify which special populations the provider is willing to serve. A list can be found in Section 4. If NO to Q3, enter N/A.
Custom Question #5	• If funds are available, would the provider accept additional slots in the proposed model or a similar model? If yes, please describe briefly.
Site Information	• Enter the site name and address. • Providers must be able to demonstrate site control (e.g., ownership or executed lease) deemed sufficient by ACS before the contract start date.

Proposal Documents

	Document Type	**Description**
Required Documents Note: A complete and separate proposal, including all required documents, must be submitted for each competition.	Proposal	Completed Structured Proposal Form, Attachment A.
	Model Proposed Letter	A signed letter from Proposer organization's Executive Director indicating the model proposed. For FFT adaptations for a child welfare population, include data on the effectiveness of the approach with the population, an overview of the adaptation, including full model requirements, and an implementation plan demonstrating how proposers will meet all staffing and training requirements in partnership with a model support organization.
	Past Performance from the last two (2) years (FY17 and FY18)	As supporting documentation for this part of a proposer's response, ACS is seeking to review evaluation and performance monitoring material. Organizations that have not had prevention services contracts with ACS in the past three years must submit copies of formal evaluation materials, performance monitoring letters, and

		reports they have received from other funders (including, if applicable, other government agencies) during the past two years (FY17 and FY18) of relevant service provision. Organizations that have had prevention services contracts with ACS are not required to submit the aforementioned documents. Instead, current ACS providers should attach a listing of all Prevention contracts with ACS. ACS will review its own files of performance ratings, monitoring letters and reports, and evaluations during the past two years of relevant service provision (FY17 and FY18).
	Organizational Chart	Completed organizational chart that includes titles of all staff involved in providing the required services.
	Community Asset Map	Completed Community Asset Map.
	Timeline for Implementation	Completed implementation timeline from contract award date (estimated December 1, 2019) through first year of implementation (estimated June 30, 2021) including: hiring, site control and construction, trainings, service start, model coaching and/or model support organization consultations, evaluation, quality improvement, and other proposed activities.
	Life of Case	Provide a business process for the life of a case from intake through closure including assessments, casework contacts, conferences, referrals, advocacy, any post-closing supports provided by proposer's agency, and other proposed activities.
	Hiring and Onboarding Timeline	Provide a hiring and onboarding timeline from the point of identifying the need to hire, to creating and posting a job description, through initial onboarding training (including trainings provided by ACS as well as required by model or framework support organization).
	Family/Client Feedback and Co-Design	Attach an example of a family-facing feedback tool the Proposer has used in the past, or a letter signed by the Executive Director or higher, stating that no feedback tool has been used in the past.
	Proposal Budget Template	Completed Proposal Budget Template Form, Attachment B.
	Doing Business Data Form	Completed Doing Business Data Form, Attachment C.
	Corrective Program Improvement Plans from the last five (5) years	Attach any improvement Plans, if any, within the last five years from ACS, a model support organization, or other funder of the Proposer's services if the Proposer was placed on any Corrective Action Status, Heightened Monitoring Status or similar status, or a letter signed by the Executive Director or higher stating that no improvement plans were issued during this period.

Additional Requirements for Uploaded Documents	● Proposal document file size may not exceed 12 MB. ● Proposal documents must be in one of the following file formats: Word (.doc, .docx), PDF (.pdf), and Excel (.xls, .xlsx). ● Only one document file may be added to each required document slot. If you need to combine documents, complete one of the following steps: ○ For Word documents: Cut and paste all contents into one Word document. ○ For PDF documents: Combine files into a single PDF. ○ For printed documents: Scan the multiple documents into a single document.

Section 1 – Program Background

A. Overview

The New York City Administration for Children's Services (ACS) protects and promotes the safety and well-being of New York City's children and families by providing child welfare, juvenile justice, and early care and education services. ACS contracts with nonprofit organizations to support and stabilize families experiencing difficulties that could lead to a child's placement in foster care, and to provide foster care services for those children not able to safely remain at home.

ACS and its partner organizations seek to support the physical, psychological, and emotional needs of children by working closely with families and their communities. As part of the collective responsibility for keeping children safe, ACS seeks to address underlying factors that may lead to child maltreatment. ACS prevention services are provided to approximately 20,000 families per year. Prevention services aim to support families in their communities, promote family stability and well-being, and reduce the need for placement in foster care. These services address ranging needs and may include case management, counseling, and clinical interventions offered primarily in the home and in a way that embraces the rich cultural diversity of NYC families.

ACS and its network of providers have achieved great success in serving some of NYC's most vulnerable and resilient families. This Request for Proposals (RFP) signals ACS's intention to build upon that success while modernizing the way we meet the changing needs of families across our city. ACS is committed to delivering child welfare services in a socially just and culturally competent manner and our experience indicates that a community-based approach to services furthers these goals. ACS leads the country in the implementation of evidence-based, evidence-informed, and promising practice prevention programs. Over the past six years, these research-based programs have demonstrated success in meeting ACS's goals of reducing the likelihood of a child entering foster care or experiencing abuse or neglect, often in a shorter timeframe than traditional case management services. Through this procurement, ACS intends to expand the use of evidence-based and evidence-informed practices citywide. To support this work, ACS seeks to invest in the expansion of practice frameworks and programmatic supports necessary to sustain high-quality implementation on a citywide scale.

This RFP is the product of extensive collaboration and research. It is informed by extensive input from more than 300 stakeholders, including families, parent councils, all levels of prevention provider staff, subject matter experts, legal advocates, and clinicians. During the past year, ACS conducted more than 50 focus groups and listening sessions, and more than 100 expert interviews in addition to literature reviews, jurisdictional scans, and comprehensive data analysis. ACS received robust feedback on the Prevention Services Concept Paper, which has been incorporated into this RFP. Additionally, the concepts below are aligned with federal and state policy as of May 2019, with the understanding that ACS is planning for compliance with the federal Family First Prevention Services Act ("FFPSA") and that funding, legislative, and regulatory requirements are subject to change.[2] ACS is committed to prevention services that are rooted in evidence and effectively meet the needs of the families we serve.

[2] 115 P.L. 123, 132 Stat. 64, 2018 Enacted H.R. 1892, 115 Enacted H.R. 1892.

ACS is seeking contractors that can successfully engage and serve children and families, with a high level of cooperation, coordination, and communication with ACS direct service staff and others across the social and clinical services systems in NYC. In many cases, children and families need support from more than one ACS or other government-funded program. All contractors should be prepared to work closely with other entities that are working concurrently with the same families. This includes, but is not limited to, the ACS Division of Child Protection, other public agencies such as the New York City Housing Authority (NYCHA), Department of Homeless Services/Department of Social Services (DHS/DSS), Human Resources Administration (HRA), Department of Education (DOE) and other educational institutions, medical providers, mental health and substance use programs, child care, and other programs or services utilized by the families we serve. It also includes other ACS-contracted programs, including foster care providers. ACS is committed to establishing a shared framework across prevention, foster care, and other services for a robust, comprehensive, and seamless system that improves child and family outcomes for safety, permanency and well-being.

B. Program Purpose and Goals

Through this RFP, ACS is seeking to contract with providers to achieve the following goals and actions:

- To address concerns that may place children at risk of harm and could potentially lead to a child's placement in foster care, ACS will make every effort to engage families in prevention services. ACS seeks to support families so that children are safe and able to thrive in stable, nurturing homes and communities;
- Families that need support to keep their children safe will receive that help in a manner consistent with their goals, values, beliefs, and culture;
- Families that engage with prevention services will have opportunities to build economic mobility, social connections, health, well-being, and educational advancement. Providers that deliver prevention services will align and incorporate families' goals and needs into their service plans and work alongside them to achieve success;
- Children and families engaged in prevention services will have access to the available resources they need to meet their concrete and emotional needs, and ultimately thrive;
- Prevention services providers will employ and supervise staff who are well-trained and prepared to abide by ACS child welfare goals and to provide services to families and children in their homes and communities, including assessing the safety of all children in the home throughout the life of a case;
- When children enter foster care, ACS and its providers seek to offer families needed services while the children are still in care, during the transition home, and after reunification, as appropriate, so that children and families receive the support they need to reunify and remain together in stable homes. Prevention and foster care services will coordinate with the goal of providing seamless services for children and families;
- When families enter Court-Ordered Supervision, ACS and its providers seek to support and stabilize families, monitor child safety and mitigate risks, and in doing so, reduce the need for court involvement;

- Prevention services providers will receive the resources they need to deliver high-quality services in a socially just manner, ensuring that services provided are of such quality that families will voluntarily seek to enroll in them regardless of involvement in the child welfare system;
- ACS will partner with and provide support to prevention services providers in the form of implementation support, training, technical assistance, quality assurance, continuous quality improvement, and customer service; and
- ACS is committed to ongoing collaboration and communication with its contractors to address emerging needs.

ACS seeks to contract with organizations, including social service and clinical providers, to deliver these critical services to families. ACS encourages a diverse array of applicants to ensure services reflect the cultures, languages, communities, and needs of families in New York City.

Contracts resulting from this RFP will focus on two categories of services:

- **Family Support (formerly referred to as "General Preventive")**
- **Therapeutic and Treatment Models**

ACS is continuing to transform its continuum of services to better meet the needs of families in New York City. Family Support programs are designed to serve families in need of case management, advocacy, and other support services. Therapeutic and Treatment models are designed for families with acute, clinical needs who would benefit from in-home therapeutic intervention.

Proposers must submit one proposal for each program model and catchment area in which they seek to operate. For Family Support, proposers must submit one proposal for each catchment area. For Therapeutic and Treatment Models, proposers must submit one proposal for each catchment area and model combination.

NOTE: For reference to state policies and regulations please visit the NYS Office of Children and Family Services website: http://www.ocfs.state.ny.us/main/ and Title 18 NYS Department of Health rules and regulations at https://www.health.ny.gov/regulations/nycrr/title_18/. For reference to ACS policies mentioned in this document please refer to ACS Preventive Services Quality Assurance Standards and Indicators (Attachment G) and the ACS policy library: https://www1.nyc.gov/site/acs/about/policy-library-search.page. For reference to the City of New York's General Provisions Governing Contracts for Consultants, Professional, Technical, Human, and Client Services (Attachment I), and visit the Doing Business with ACS page of ACS website at: www.nyc.gov/acs.

C. Services Areas

FAMILY SUPPORT

ACS anticipates that 5,568 slots of Family Support services will be funded through this RFP. These slots will be allocated to multiple programs across catchment areas based on proposals received and needs identified for each catchment area to be served. All Family Support programs will be 96 slots. Contractors must provide services to families residing in the catchment area they propose to serve. Rates per slot are standardized across all programs and catchment areas, as shown in the table below.

The following table shows the projected rates per slot and total annual funding per program within defined catchment areas.

Table 1: Family Support Services Catchment Service Areas Slots and Funding

Annual Funding per Program: $1,440,000.00

Bronx						
RFP Catchment	**CD #**	**CD Name**	**Total Slots in Catchment Area**	**Total Number of Programs in Catchment Area**	**Number of Slots in Each Program**	**Annual Funding per Slot**
BX Catchment 1	B03	Morrisania/Crotona	288	3	96	$15,000
	B06	Belmont/East Tremont				
	B10	Throgs Neck/Co-op City				
BX Catchment 2	B07	Kingsbridge Heights/Bedford PK	288	3	96	$15,000
	B12	Williamsbridge/Baychester				
BX Catchment 3	B01	Mott Haven/Melrose	288	3	96	$15,000
	B02	Hunts Point/Longwood				
	B08	Riverdale/Fieldstone				
BX Catchment 4	B09	Parkchester/Soundview	288	3	96	$15,000
	B11	Morris Park/Bronxdale				
BX Catchment 5	B04	Highbridge/Concourse	384	4	96	$15,000
	B05	Fordham/University Heights				

Brooklyn						
RFP Catchment	**CD #**	**CD Name**	**Total Slots in Catchment Area**	**Total Number of Programs in Catchment Area**	**Number of Slots in Each Program**	**Annual Funding per Slot**
BK Catchment 1	K02	Fort Greene/Brooklyn Heights	288	3	96	$15,000
	K06	Park Slope/Carroll Gardens				
	K08	Crown Heights				
	K14	Flatbush/Midwood				
BK Catchment 2	K05	East New York/Starrett City	384	4	96	$15,000
	K09	Crown Heights South/Prospect Lefferts Gardens				
BK Catchment 3	K15	Sheepshead Bay	384	4	96	$15,000
	K17	East Flatbush				
	K18	Flatlands/Canarsie				
BK Catchment 4	K01	Greenpoint/Williamsburg	288	3	96	$15,000
	K03	Bedford Stuyvesant				
BK Catchment 5	K04	Bushwick	192	2	96	$15,000
	K16	Brownsville				
BK Catchment 6	K07	Sunset Park	384	4	96	$15,000
	K10	Bay Ridge/Dyker Heights				
	K11	Bensonhurst				
	K12	Borough Park				
	K13	Coney Island				
Manhattan						
RFP Catchment	**CD #**	**CD Name**	**Total Slots in Catchment Area**	**Total Number of Programs in Catchment Area**	**Number of Slots in Each Program**	**Annual Funding per Slot**
MN Catchment 1	M09	Morningside Heights/Hamilton	192	2	96	$15,000
	M10	Central Harlem				
	M11	East Harlem	192	2	96	$15,000

MN Catchment 2	M12	Washington Heights/Inwood				
MN Catchment 3	M01	Financial District	192	2	96	$15,000
	M02	Greenwich Village/Soho				
	M03	Lower East Side/Chinatown				
	M04	Clinton/Chelsea				
	M05	Midtown				
	M06	Stuyvesant Town/Turtle Bay				
	M07	Upper West Side				
	M08	Upper East Side				
Queens						
RFP Catchment	**CD #**	**CD Name**	**Total Slots in Catchment Area**	**Total Number of Programs in Catchment Area**	**Number of Slots in Each Program**	**Annual Funding per Slot**
QN Catchment 1	Q06	Rego Park/Forest Hills	288	3	96	$15,000
	Q08	Hillcrest/Fresh Meadows				
	Q12	Jamaica/Hollis				
QN Catchment 2	Q02	Woodside/Sunnyside	384	4	96	$15,000
	Q03	Jackson Heights				
	Q04	Elmhurst/Corona				
	Q05	Ridgewood/Maspeth				
QN Catchment 3	Q09	Ozone Park/Woodhaven	288	3	96	$15,000
	Q10	South. Ozone Park/Howard Beach				
	Q14	Rockaway/Broad Channel				
QN Catchment 4	Q01	Astoria	288	3	96	$15,000
	Q07	Flushing/Whitestone				
	Q11	Bayside/Little Neck				

	Q13	Queens Village/Rosedale				
Staten Island						
RFP Catchment	**CD #**	**CD Name**	**Total Slots in Catchment Area**	**Total Number of Programs in Catchment Area**	**Number of Slots in Each Program**	**Annual Funding per Slot**
SI Catchment 1	S01	St. George/Stapleton	288	3	96	$15,000
	S02	South Beach/Willowbrook				
	S03	Tottenville/Great Kills				

THERAPEUTIC AND TREATMENT PROGRAMS

ACS anticipates that 6,056 slots of Therapeutic and Treatment services will be funded through this RFP. These slots will be allocated to multiple programs of various sizes, based on proposals received and needs identified for each catchment area. The number of slots per program listed below is the only number of slots to be awarded per program. Proposers must provide services to families living within the catchment area they propose to serve. Rates per slot vary by program size as shown in the table below.

The following table shows the projected rates per slot, program size, and total annual funding per program within defined catchment areas.

Table 2: Therapeutic and Treatment Programs Catchment Competitions and Funding

Bronx						
Program Model	**Catchment**	**Total Number of Slots in Catchment**	**Total Number of Programs in Catchment Area**	**Total Number of Slots per Program**	**Payment per Slot**	**Annual Funding per Program**
Brief Strategic Family Therapy (BSFT)	Borough	64	1	64	$ 23,643.16	$ 1,513,162.40
Child-Parent Psychotherapy (CPP)	Borough	128	1	128	$ 20,664.42	$ 2,645,046.11
Family Treatment/Rehabilitation (FT/R)	Borough	768	6	128	$ 21,467.27	$ 2,747,810.56
Functional Family Therapy (FFT)	Borough	64	1	64	$ 23,643.16	$ 1,513,162.40
Functional Family Therapy adaptations for a child welfare population	Borough	720	5	144	$ 18,320.14	$ 2,638.100.11
Multisystemic Therapy Substance Abuse / Multisystemic Therapy Prevention	Borough	80	2	40	$ 33,000.00	$ 1,320,000.00
Trauma Systems Therapy (TST)	Borough	64	1	64	$ 23,643.16	$ 1,513,162.40

Brooklyn						
Program Model	**Catchment**	**Total Number of Slots in Catchment**	**Total Number of Programs in Catchment Area**	**Total Number of Slots per Program**	**Payment per Slot**	**Annual Funding per Program**
Brief Strategic Family Therapy (BSFT)	Borough	64	1	64	$ 23,643.16	$ 1,513,162.40
Child-Parent Psychotherapy (CPP)	Borough	128	1	128	$ 20,664.42	$ 2,645,046.11
Family Treatment/Rehabilitation (FT/R)	Borough	768	6	128	$ 21,467.27	$ 2,747,810.56
Functional Family Therapy (FFT)	Borough	64	1	64	$ 23,643.16	$ 1,513,162.40
Functional Family Therapy adaptations for a child welfare population	Borough	432	3	144	$ 18,320.14	$ 2,638.100.11
Multisystemic Therapy Substance Abuse / Multisystemic Therapy Prevention	Borough	80	2	40	$ 33,000.00	$ 1,320,000.00
Trauma Systems Therapy (TST)	Borough	64	1	64	$ 23,643.16	$ 1,513,162.40

Manhattan						
Program Model	**Catchment**	**Total Number of Slots in Catchment**	**Total Number of Programs in Catchment Area**	**Total Number of Slots per Program**	**Payment per Slot**	**Annual Funding per Program**
Brief Strategic Family Therapy (BSFT)	Borough	64	1	64	$ 23,643.16	$ 1,513,162.40
Child-Parent Psychotherapy (CPP)	Borough	64	1	64	$ 23,643.16	$ 1,513,162.40
Family Treatment/Rehabilitation (FT/R)	Borough	256	2	128	$ 21,467.27	$ 2,747,810.56
Functional Family Therapy (FFT)	Borough	64	1	64	$ 23,643.16	$ 1,513,162.40
Functional Family Therapy adaptations for a child welfare population	Borough	288	2	144	$ 18,320.14	$ 2,638.100.11
Multisystemic Therapy Substance Abuse / Multisystemic Therapy Prevention	Borough	40	1	40	$ 33,000.00	$ 1,320,000.00
Trauma Systems Therapy (TST)	Borough	64	1	64	$ 23,643.16	$ 1,513,162.40

Queens						
Program Model	**Catchment**	**Total Number of Slots in Catchment**	**Total Number of Programs in Catchment Area**	**Total Number of Slots per Program**	**Payment per Slot**	**Annual Funding per Program**
Brief Strategic Family Therapy (BSFT)	Borough	64	1	64	$ 23,643.16	$ 1,513,162.40
Child-Parent Psychotherapy (CPP)	Borough	64	1	64	$ 23,643.16	$ 1,513,162.40
Family Treatment/Rehabilitation (FT/R)	Borough	384	3	128	$ 21,467.27	$ 2,747,810.56
Functional Family Therapy (FFT)	Borough	64	1	64	$ 23,643.16	$ 1,513,162.40
Functional Family Therapy adaptations for a child welfare population	Borough	144	1	144	$ 18,320.14	$ 2,638.100.11

Multisystemic Therapy Substance Abuse / Multisystemic Therapy Prevention	Borough	40	1	40	$ 33,000.00	$ 1,320,000.00
Trauma Systems Therapy (TST)	Borough	64	1	64	$ 23,643.16	$ 1,513,162.40

Staten Island

Program Model	Catchment	Total Number of Slots in Catchment	Total Number of Programs in Catchment Area	Total Number of Slots per Program	Payment per Slot	Annual Funding per Program
Brief Strategic Family Therapy (BSFT)	Borough	32	1	32	$ 21,931.70	$ 701,814.40
Child-Parent Psychotherapy (CPP)	Borough	64	1	64	$ 23,643.16	$ 1,513,162.40
Family Treatment/Rehabilitation (FT/R)	Borough	128	1	128	$ 21,467.27	$ 2,747,810.56
Functional Family Therapy (FFT)	Borough	32	1	32	$ 21,931.70	$ 701,814.40
Functional Family Therapy adaptations for a child welfare population	Borough	144	1	144	$ 18,320.14	$ 2,638.100.11
Multisystemic Therapy Substance Abuse / Multisystemic Therapy Prevention	Borough	40	1	40	$ 33,000.00	$ 1,320,000.00
Trauma Systems Therapy (TST)	Borough	32	1	32	$ 21,931.70	$ 701,814.40

Citywide Models

Program Model	Catchment	Total Number of Slots in Catchment	Total Number of Programs in Catchment Area	Total Number of Slots per Program	Payment per Slot	Annual Funding per Program
Special Medical	Citywide	384	3	128	$ 22,583.13	$ 2,890.640.11
Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	Citywide	48	1	48	$ 60,000.00	$ 2,880,000.00

Section 2 – Program Expectations and Proposal Instructions

A. Program Plan

1. **Program Approach:**
   - **a. Target Population / Catchment Area:** ACS seeks to support families so that children are safe and able to thrive in stable, nurturing homes and communities. Prevention services should be made available to families with varying needs across our continuum ranging from low to moderate or high service needs.
   - **b.** The target population for all prevention services, including Family Support and Therapeutic and Treatment programs, will include:
     - **i.** Families whose children are at imminent risk of removal and entry into foster care, including those referred by ACS's Division of Child Protection during or following an investigation, as well as families referred by ACS-contracted foster care provider agencies and ACS when children are preparing to return home or have returned home following a stay in foster care.
     - **ii.** Families referred by community partners, or who seek services of their own accord.
     - **iii.** Families that have adopted children or are serving as guardians (including kinship guardians) and would benefit from services to help stabilize and support permanency.
     - **iv.** There are additional specialized target populations for Therapeutic and Treatment models. Please see Section 2.A.1.g.
   - **c.** Contractors would accept all ACS and other city agency referrals to prevention services. The contractor would not reject eligible referrals from ACS unless the program is 100% utilized or the program has received written approval from ACS to temporarily close intake. Contractors would also actively engage families in the local community to enroll in services as voluntary walk-in cases.[3] Family Support contractors would aim to have a minimum of 20% voluntary walk-in cases enrolled at any given time. For certain Therapeutic and Treatment models, ACS reserves the right to require contractors to accept referrals only from ACS's Division of Child Protection.
   - **d.** Contractors would refer to the NYS OCFS Preventive Services Practice Guidance Manual (Attachment J) to ensure families meet candidacy criteria for prevention services.
   - **e. For Family Support Programs**: Contractors would serve families throughout their awarded catchment area with children ages 0-18, or, if exiting foster care, up to age 21. Family Support is designed to serve families with a core focus of case management, resource navigation, economic mobility, family stability, and child safety. ACS intends to ensure referrals to Family Support programs align with these criteria.
   - **f. For Therapeutic and Treatment Programs**: Contractors would serve families throughout their awarded catchment areas with children aged appropriately based on targeted age ranges for each model. Targeted age ranges and family needs vary for each model. Contractors would serve families who align with the model's criteria or as otherwise referred by ACS for services. Therapeutic and Treatment programs are designed to address issues that place children at risk of foster care placement including substance use, trauma, family violence, and other challenges

[3] Walk-in cases may also be known as "Advocate's cases." These cases have different documentation requirements. For more information see Attachment G.

as designed for each model below. ACS intends to ensure referrals to Therapeutic and Treatment programs align with these criteria.

g. Target populations for each Therapeutic and Treatment model are listed below:

Model	Target Population	Ages Served
Brief Strategic Family Therapy (BSFT)[4]	• Children and youth with serious behavior problems and/or substance use • Families with limited behavioral management capacity, parental discord, anger, blaming interactions, and other problematic relations	6 to 18 years old, or, if exiting foster care, to age 21.
Child-Parent Psychotherapy (CPP)[5]	• Children who have experienced one or more traumatic events such as: maltreatment, the sudden or traumatic death of someone close, a serious accident, sexual abuse, exposure to domestic violence, and/or neighborhood violence	Birth to 5 years old
Family Treatment/ Rehabilitation (FT/R)[6]	• Families where the primary issue is a caregiver or child's substance use or mental health challenge	Birth to 18 years old; if exiting foster care, to age 21.
Functional Family Therapy (FFT)[7]	• Youth with very serious problems, such as conduct disorder, truancy, family violence, violence outside the home, or abuse	11 to 18 years old (younger siblings included in treatment).
Adaptations of FFT for a child welfare population[8]	• Adaptations of FFT for a child welfare population that use a developmental approach, serving parents and children with behavioral challenges, mental health concerns, and/or substance use • Families where there is minimal engagement and acceptance of services	Birth to 18 years old
Multisystemic Therapy for Substance Abuse	**MST-SA** • Youth with delinquent/challenging behaviors and/or substance use problems	12 to 18 years old (MST-SA)

[4] Brief Strategic Family Therapy: http://www.cebc4cw.org/program/brief-strategic-family-therapy/.

[5] Child-Parent Psychotherapy: http://www.cebc4cw.org/program/child-parent-psychotherapy/.

[6] For more information about FT/R: https://www1.nyc.gov/assets/acs/policies/init/2016/D.pdf/.

[7] Functional Family Therapy: http://www.cebc4cw.org/program/functional-family-therapy/.

[8] Proposers wishing to propose an adaptation of FFT for a child welfare population under Therapeutic and Treatment Models should refer to proposal instructions on page 37 of the Request for Proposals.

(MST-SA) and Multisystemic Therapy for Prevention (MST-PREV)[9]	• Families with a high level of conflict **MST-PREV** • Youth at risk of abuse or neglect due to delinquent behaviors and/or other challenging behaviors • Youth with substance use problems • Families with a high level of conflict	10 to 18 years old (MST-PREV)
Trauma Systems Therapy (TST)[10]	• Youth with a history of traumatic experiences who are experiencing emotional and/or behavioral problems as a result	5-18 years old; if exiting foster care, to age 21.
Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)[11]	• Families with an indicated case of physical abuse and/or neglect within the past 180 days, and/or an open investigation will likely become an indicated case based on evidence at time of referral • A family must have a Child Safety Conference, and/or a High Priority 13 Factor Code in the most recent child protective investigation (i.e., four or more SCR reports), and/or be referred as a result of an Elevated Risk Conference	6 to 18 years old; if exiting foster care, to age 21.
Special Medical	• Families in which a parent or child has special medical needs • Child who has special medical needs and who is ready for discharge from the hospital and family needs assistance to prepare for child's return • Families in which a parent is suffering from a progressively chronic or terminal illness in need of early permanency planning for their child(ren)	Birth to 18 years old; if exiting foster care, to age 21.

h. Case Practice Framework or Program Model

i. **For Family Support Programs:** These programs would provide services tailored to the needs of families and children through case management, resource navigation, service referrals, parenting skills, and support with concrete needs, as well as regular in-home assessments of child safety and well-being. Family Support programs would have an average length of service of 6-12 months. Contractors would integrate one of the following three research-

[9]Multisystemic Therapy adaptations must include a basis in the Multisystemic Therapy model but with adaptations made to better serve a child welfare population. Any adaptation proposed must be rooted in research demonstrating positive outcomes with the target population. More information on Multisystemic Therapy can be found here: http://www.cebc4cw.org/program/multisystemic-therapy/. Additional information on adaptations of Multisystemic Therapy can be found at http://www.mstservices.com/mst-whitepapers.

[10]Trauma Systems Therapy: http://www.cebc4cw.org/program/trauma-systems-therapy-tst/.

[11]MST-CAN: http://www.cebc4cw.org/program/multisystemic-therapy-for-child-abuse-and-neglect/.

informed case practice frameworks into all Family Support programs: Family Connections,[12] Mobility Mentoring,[13] or Solution-Based Casework[14] (see Attachment K, Model Descriptions, and table below). A practice model is a conceptual map and organizational ideology of how provider staff, families, and community resources come together to plan for the safety, permanency, and well-being of families and children, and is a framework for service delivery.

Case Practice Framework Options:

Program Model	Description	Ages Served
Family Connections[15]	Family Connections is a multi-faceted community-based program that works with families in their neighborhoods to help them meet the basic needs of their children, reduce the risk of child maltreatment, and strengthen overall functioning of the family and children.	Birth to 18 years or if exiting foster care, up to age 21
Mobility Mentoring[16]	Economic Mobility Pathways (EMPath), based in the Boston area, has created and implemented a research-based framework called the Bridge to Self-Sufficiency, which guides the Mobility Mentoring practice by providing a structured approach for low-income individuals to plan, reach, and sustain economic self-sufficiency in five core areas: 1. family stability, 2. well-being, 3. education and training, 4. financial management, and 5. employment and career management. Mobility Mentoring is the coaching component of the model. It places participants with trained mentors (case planners) to support them in meeting their goals. Mentors work in close partnership with participants, creating high levels of trust along with high expectations (a "growth mindset"), to help participants succeed.	Birth to 18 years or if exiting foster care, up to age 21

[12]California Evidence-Based Clearinghouse (2018) Family Connections: http://www.cebc4cw.org/program/family-connections/.
[13]EMPath (2019): https://www.empathways.org/approach/mobility-mentoring/.
[14]California Evidence-Based Clearinghouse (2018) Solution-Based Casework: http://www.cebc4cw.org/program/solution-based-casework/.
[15]California Evidence-Based Clearinghouse (2018) Family Connections: http://www.cebc4cw.org/program/family-connections/
[16]EMPath (2019): https://www.empathways.org/approach/mobility-mentoring/.

Solution-Based Casework[17]	Solution-Based Casework (SBC) is a casework practice model for families in child welfare. The model is based on three theoretical underpinnings: solution-focused family therapy, family life cycle theory, and relapse prevention.	Birth to 18 years or if exiting foster care, up to age 21

ii. **For Therapeutic and Treatment Programs:** Proposers must submit one proposal for each catchment area and model combination that they seek to operate. These models have demonstrated evidence of efficacy with the identified target populations and in the context of New York City's child welfare system. Additional information on each of these models can be found at the links footnoted and in Attachment K, Model Descriptions. The California Evidence-Based Clearinghouse[18] provides information about research, model requirements, and target populations. Interested providers are strongly encouraged to visit this website and read the relevant research prior to applying. Contractors would be expected to deliver Therapeutic and Treatment programs with model fidelity, while also complying with ACS policies and expectations pertaining to the ongoing assessment of child safety and well-being. In some cases, contractors' programs would be expected to participate in Family Court proceedings and ACS Division of Child Protection Family Team Conferences.

Therapeutic and Treatment Program Model Options:

Program Model	Description	Average Length of Service
Brief Strategic Family Therapy (BSFT)[19]	The BSFT model is a brief family intervention for children and youth with serious behavior problems and/or drug use. The BSFT intervention works well for families with poor behavior management and problematic relationships. The intervention identifies patterns of family interaction and improves them to restore effective parental leadership and involvement with the youth. BSFT also seeks to reduce drug use and delinquency in youth. BSFT therapists meet weekly with families and work with all family members.	**4-6 months**
Child Parent Psychotherapy (CPP)[20]	CPP is an intervention model for children aged birth-5 years old who have experienced at least one traumatic event and/or are experiencing mental health, attachment, and/or	**12 months**

[17]California Evidence-Based Clearinghouse (2018) Solution-Based Casework: http://www.cebc4cw.org/program/solution-based-casework/.

[18]California Evidence-Based Clearinghouse www.cebc4cw.org.

[19]Brief Strategic Family Therapy: http://www.cebc4cw.org/program/brief-strategic-family-therapy/.

[20]Child-Parent Psychotherapy: http://www.cebc4cw.org/program/child-parent-psychotherapy/.

	behavioral problems. CPP examines how the child's and/or caregivers' trauma histories affect the parent-child relationship and the child's development. CPP supports and strengthens the caregiver-child relationship to restore the child's sense of safety and attachment and improve the child's functioning. Treatment also focuses on contextual factors that may affect the caregiver-child relationship (for example: cultural, socioeconomic, and immigration-related stressors are addressed). Treatment focuses on safety and stabilization and incorporates case management.	
Family Treatment/ Rehabilitation (FT/R)[21]	FT/R is appropriate for families where the primary issue is a caregiver or child's substance use or mental health challenge. The intervention is organized in treatment phases with the support of a Clinical Diagnostic Team.	**12 months**
Functional Family Therapy (FFT)[22]	FFT is a family therapy intervention for the treatment of violent, criminal, behavioral, school, and conduct problems with youth and their families. Both intra-familiar and extra-familial factors are addressed. An FFT belief is that the motivation of a family is also the responsibility of the therapist, not just the family. The intervention is home-based. The frequency of contacts between therapist and the family depends on the stage of treatment, with more frequent contacts in the beginning of the intervention.	**3-5 months**
Adaptations of FFT for a child welfare population[23]	Adaptations of FFT for a child welfare population target family functioning using a developmental focus. Adaptations focus on family relationships and risk factors to address mental health, substance use, and behavioral needs of parents and children. Sessions take place in the home and are designed to meet the needs of families with both concrete and relational needs.	**5-7 months**
Multisystemic Therapy for Substance Abuse (MST-SA) and Multisystemic Therapy for	**Multisystemic Therapy for Substance Abuse (MST-SA)** Multisystemic Therapy for Substance Abuse (MST-SA) is an adaptation of Multisystemic Therapy (MST) and was developed for families with teens who are engaging in substance use and/or other challenging or delinquent behaviors. MST-SA is also targeted for families with high levels of conflict. MST-SA aims to improve families' capacity to work	**3-5 months (MST-SA)** **4-8 months (MST-PREV)**

[21]For more information about FT/R: https://www1.nyc.gov/assets/acs/policies/init/2016/D.pdf/.

[22]Functional Family Therapy: http://www.cebc4cw.org/program/functional-family-therapy/.

[23]Proposers wishing to propose another adaptation of FFT for a child welfare population under Therapeutic and Treatment Models should refer to proposal instructions on page 37 of the Request for Proposals.

Prevention (MST-PREV)[24]	effectively with all systems involved with the adolescent to encourage more responsible behavior. If the caregiver's substance use is negatively affecting the ability to adequately parent the MST-SA youth, then addressing the caregiver's substance use will become a treatment goal within MST-SA. There are limited outside referrals, with the expectation that therapists will provide most/all behavioral health interventions for the family **Multisystemic Therapy for Prevention (MST-PREV)** Multisystemic Therapy for Prevention (MST-PREV) is an adaptation of Multisystemic Therapy (MST) and was developed for families in child welfare. The model has the same clinical foundations of MST and MST-SA, focusing on improving parenting and family interactions. MST-PREV includes additional clinical features, such as enhanced use of motivational interviewing and skills-building with caregivers to increase impulse control and decrease dysregulation; high sense of urgency regarding child safety through weekly and long-term goal-setting and enhanced safety assessment protocols; focus on child welfare outcomes; and supplemental training for staff.	
Trauma Systems Therapy (TST)[25]	TST is a trauma-informed clinical and organizational model designed to help agencies understand and address the needs of families with youth who have been exposed to traumatic events and are experiencing emotional and behavioral problems as a result. TST focuses on the interaction between the child's difficulties regulating his/her emotions and the deficits within the child's social environment (home, school, and neighborhood). Trauma-informed psychotherapy and casework strategies are used in TST. Families are engaged as allies in the treatment.	**7-12 months**
Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)[26]	MST-CAN is an adaptation of Multisystemic Therapy (MST) and was developed to treat families with children aged 6 to 18 that have come to the attention of ACS due to high risk and safety issues. MST-CAN is reserved only for very high-risk cases. MST-	**6-9 months**

[24]Multisystemic Therapy Prevention is an adaptation of Multisystemic Therapy designed to better serve a child welfare population. More information on Multisystemic Therapy can be found here: http://www.cebc4cw.org/program/multisystemic-therapy/. Additional information on adaptations of Multisystemic Therapy can be found at http://www.mstservices.com/mst-whitepapers.

[25]Trauma Systems Therapy: http://www.cebc4cw.org/program/trauma-systems-therapy-tst/.

[26]MST-CAN: http://www.cebc4cw.org/program/multisystemic-therapy-for-child-abuse-and-neglect/.

	CAN therapists complete a functional assessment of the family and safety plans. Therapists provide treatment in the home, including parent training; safety planning; substance use treatment; Post-Traumatic Stress Disorder (PTSD) treatment for children, youth and adults; anger management; marital therapy; and family therapy. There are limited outside referrals. Therapists have very small caseloads to allow for intensive involvement with a family.	
Special Medical	Special Medical Prevention Services are intended to serve the following populations of families whose children are at imminent risk for foster care placement: families in which a parent or child has special medical needs; and families in which a parent is suffering from a progressively chronic or terminal illness and in need of early permanency planning for their child(ren). The program provides case management, counseling, and referrals to community-based services.	**12 months**

i. Contractors would provide Family Support and/or Therapeutic and Treatment (collectively "Prevention Services") that combine case management, evidence-based and/or evidence-informed case practice, and a commitment to cultural connection.

j. Contractors would assess children's safety, promote their well-being, and address issues that led or could lead to a risk of foster care placement.

k. Contractors would provide services in accordance with all existing federal, state, and city laws, rules, and regulations, and consistent with policies, procedures, and standards promulgated by OCFS and ACS.

l. Contractors would review the ACS Preventive Services General Scope of Services, ACS Preventive Services Quality Assurance Standards and Indicators (2011) (Attachment G) and policies, NYS OCFS Preventive Services Practice Guidance Manual (2015),[27] (Attachment J), New York State Social Services Rules and Regulations, Social Services Laws (SSL), and other New York State policies and regulations to design an effective program that provides the basic elements of prevention services, including:

  i. Outreach and engagement of families in need to provide interventions as early as possible;

  ii. Identification, monitoring, and response to safety and risk concerns that emerge within the family, including ongoing communication with the ACS Division of Child Protection when cases are under investigation or open for court-ordered supervision;

  iii. Individualized assessment of families' strengths and needs, and service planning that reflects these assessments;

  iv. Strengths-based Family Team Conferencing and case planning that puts families in charge of creating their service plan while incorporating the Case Planner's assessment of the family's strengths and needs;

[27] Additional information regarding New York State regulations: http://www.ocfs.state.ny.us/main/.

v. Facilitation of access to a range of services provided both by the contractor and by community organizations as appropriate, and as necessary to address the family's service plan goals and to address any safety and risk concerns;
vi. Group and individual parent support, education, and skills training when appropriate;
vii. Provision of or referral for family counseling and other mental or behavioral health care as needed;
viii. Interventions to promote access to and consistent utilization of health care;
ix. Promotion and support of parent involvement in children's education;
x. Client advocacy to assist families to navigate governmental and private sector service systems and benefits;
xi. Discharge planning in close coordination with foster care providers and aftercare services for families whose children are leaving foster care and returning to their homes;
xii. Timely documentation of case activities in the ACS and New York State systems of record, as required by ACS standards and policy;
xiii. Support for families leaving prevention services where some level of contact is warranted or requested by the family - including ongoing support by contractor, or referrals to other organizations that can provide ongoing support;
xiv. Professional staff who are qualified and adequately trained, and who provide services that support racial equity, are culturally competent and linguistically accessible, and reflect the diversity of the communities they serve; and
xv. The collection and reporting of required data to participate in ACS's monitoring and quality assurance evaluation processes.

m. **Length of Service**
   i. **For Family Support:** Contractors would provide Family Support services to families for an expected duration averaging 6-12 months. All contracted programs will be expected to prioritize the assessment and monitoring of child safety, risk, and well-being on an ongoing basis, and develop, implement and monitor a service plan and any necessary safety plans that address and mitigate identified risk factors.
   ii. **For Therapeutic and Treatment Programs:** Therapeutic and Treatment programs will be high-intensity and lengths of service are expected to range from 4-12 months based on the model's prescribed measures to achieve intended impact. Please refer to the table above entitled "Therapeutic and Treatment Program Model Options" in this Request for Proposals.
n. **Referrals and Linkages:** Contractors would be aware of and facilitate access to the full range of services necessary to address presenting issues and promote the safety and well-being of the children and families to be served. These services include services to be provided directly by the contractor and/or those to be provided by other neighborhood providers. Contractors would utilize the fullest range of services available to ensure child safety, reduce, and remove identified risks, and strengthen the family unit.
   i. **For Family Support programs**: Contractors would make referrals to Group Attachment Based Intervention (GABI)[28] services for all families with children ages 0-3 who would

[28]Group Attachment Based Intervention (GABI) is a group therapeutic model provided through a partnership between ACS and Montefiore Medical Center for caregivers and children ages 0-3 who have experienced trauma or other challenges that make parenting difficult. GABI is an evidence-informed model that helps parents build secure attachment with their children, boosts children's social emotional and cognitive development, and helps mitigate stress and trauma caused by challenges such as domestic violence, housing instability, etc. There are GABI sites in each borough with dedicated slots to serve families

benefit from these services. Contractors would make referrals to other enhanced services as directed by ACS or where needed to ensure families have maximum support to address their needs.

ii. **For Therapeutic and Treatment models**: Contractors would facilitate referrals and linkages according to model requirements and fidelity. For children aged 0 to 3 in all models, contractor would make appropriate early intervention referrals for specialized services and/or child care. For Family Treatment Rehabilitation and Special Medical programs contractors would make referrals to Group Attachment Based Intervention (GABI)[29] services for all families with children ages 0-3 who would benefit from these services.

o. **Safety and Risk Assessment:** Contractors would conduct thorough assessments and identify and provide services that address the presenting issues that place a child at risk of foster care placement or replacement. Assessments and service plans must consider and reflect any primary and secondary diagnoses, if applicable, for children and family members and indicate arrangements for treatment of any identified conditions and health needs. For children in foster care, the contractor would work with the foster care contractor to identify those factors that are delaying successful discharge and family reunification. Comprehensive assessment of child safety and risk is a fundamental component of prevention services and must be conducted in accordance with and make full use of assessment and decision-making tools provided by New York State Office of Children and Family Services and ACS. Assessment of risk must include consideration of underlying causes and contributing factors for each identified risk to a child or children in the household, so that the safety plan and intervention is appropriately linked to the factors and concerns that led to the introduction of prevention services.

p. **Monitoring Child Safety and Mandated Reporting:** Contractors would assess the safety and well-being of all children in the home in an ongoing manner and take necessary and appropriate measures to ensure their ongoing protection and safety. This includes, but is not limited to, actions required of all New York State Mandated Reporters and collaboration with ACS staff, including cooperation with child protection teams, conference facilitators, and others, and developing, implementing, and monitoring safety/service plans that address and mitigate identified risk factors. ACS has created standards that require prevention service providers to monitor safety and risk throughout the life of a case for all children and families they serve. Contractors would conduct the following activities: information-gathering consisting of complete reviews of investigation information and consultations with child protective services staff, which would guide assessment of safety and risk and ongoing service planning for children and families; casework contacts with families--including all parents and

currently enrolled in Family Support, Family Treatment/ Rehabilitation (FT/R), and Special Medical programs. Families must remain enrolled in Family Support, FT/R, or Special Medical for the duration of GABI. These services are free to families and available for up to 12 months.

[29]Group Attachment Based Intervention (GABI) is a group therapeutic model provided through a partnership between ACS and Montefiore Medical Center for caregivers and children ages 0-3 who have experienced trauma or other challenges that make parenting difficult. GABI is an evidence-informed model that helps parents build secure attachment with their children, boosts children's social emotional and cognitive development, and helps mitigate stress and trauma caused by challenges such as domestic violence, housing instability, etc. There are GABI sites in each borough with dedicated slots to serve families currently enrolled in Family Support, Family Treatment/ Rehabilitation (FT/R), and Special Medical programs. Families must remain enrolled in Family Support, FT/R, or Special Medical for the duration of GABI. These services are free to families and available for up to 12 months.

caregivers when possible--and schools, physicians and others as required by ACS standards for both quality and frequency; and effective and timely supervision of the contractor's staff, including the monitoring of ongoing safety and risk assessments, and of timely documentation. Contractors would prioritize the safety assessment of children in each household and take all necessary and appropriate measures to ensure their safety including, but not limited to, all actions required of mandated reporters as well as notification of ACS of any elevated risk concerns that warrant an Elevated Risk Conference.

q. **Addressing Core Child Welfare Challenges and Potential Risks to Child Safety:** Contractors would have the organizational capacity, including sufficiently skilled staff, to identify and assess critical risks, and to develop and implement safety plans related to mitigating the impact of substance use, family violence, and other such risks present in the home on child development and well-being. Contractors would assist families and older youth in seeking and participating in appropriate supportive services and interventions related to these risks. Contactors would have access to ACS-contracted clinical experts in behavioral and mental health, domestic violence, substance use, and early childhood development.
r. **Casework Contacts:** Throughout a family's participation in the program, contractors would have frequent and regular casework contact, including extensive home-based casework contact, with the child(ren) and family members living in the home. Contractors would have regular contact with non-resident family members to the extent appropriate to develop and achieve the family's service plan goals. All casework must be in accordance with ACS's casework contact requirements and program model requirements. For detailed information on casework contacts, see Section D of Attachment G, ACS Preventive Services Quality Assurance Standards and Indicators. For Therapeutic and Treatment models, contractors would adhere to model-specific requirements for casework contacts, which can be found in Attachment K, Model Descriptions.
s. **Trauma-informed Care:** Contractors would utilize a trauma-informed approach to service delivery that involves all levels of the organization, including leadership, managerial, direct service and administrative staff. All staff must understand the prevalence and effects of trauma, recognize the signs and symptoms, and understand the complex and diverse paths to healing. It is critical for staff to participate in their own personal healing to ensure that they do not consciously or unconsciously pass on their own pain to program participants, and that they are able to hold space for others to heal. Towards that purpose, contractors would adopt an organizational approach to staff wellness, that could include a wellness committee, monthly staff wellness days, and/or other activities and services that support the well-being of staff who are exposed to secondary trauma.
t. **Communicating and Coordinating with Other Service Providers Involved with Families:** Contractors would develop and maintain open and frequent communication, as outlined in ACS standards, with schools, child care programs, behavioral and mental health providers, drug treatment programs, medical providers, homemakers, and others providing supportive or clinical services to families, to make certain services are available and have been obtained, to the degree possible.
u. **Building Relationships between ACS, Providers, and Parents in their Communities:** Contractors would build relationships with ACS, other service providers, and parents in their communities. Relationship building is paramount, and contractors would build community outreach that results in appropriate community walk-ins and referrals, so parents can find

support and address their needs. For some Therapeutic and Treatment models, ACS reserves the right to require contractors to accept referrals solely from ACS's Division of Child Protection.

v. **Supporting Families and Children During Court-Ordered Supervision:** Contractors would serve families who are involved in court-ordered supervision in accordance with a co-designed practice model for ACS and providers. Contractors would partner with the ACS child protection team while the family is under court-ordered supervision. Across all program models and types, contractors would participate in Initial Child Safety Conferences where decisions regarding court involvement are made, and be prepared to accept immediate referrals, including to divert families from the court process, with supportive services and to address risk and safety. Once a family is enrolled in services, contractors would continue to participate in Family Team Conferences. Contractors would maintain purposeful communication with ACS case managers, prepare court reports, appear in court, prepare court reports, and coordinate with staff from ACS's Division of Child Protection and Family Court Legal Services. Contractors would engage in additional activities as required by ACS and/or as needed by the family to ensure early engagement with prevention services, compliance with Court-Ordered Supervision, and the successful completion of goals. Contractors would make adjustments as needed within the prevention program to ensure sufficient and qualified staffing to support these activities. By collaborating with ACS in family conferences, jointly planning services, sharing updated assessments, and participating in court processes, as needed, ACS and its contractors will seek to reduce the overall need for Court-Ordered Supervision. Contractors would participate with ACS in co-design of practice models for Court-Ordered Supervision cases, which involve collaboration with ACS's Division of Child Protection.

w. **Building Protective Factors and Preventing Adverse Childhood Experiences:**[30] Contractors would assess families for safety, risk, and protective factors,[31] as well as for the presence or likelihood of adverse childhood experiences in accordance with ACS policy and guidance. Contractors would educate families about adversity, resilience, and protective factors and would work to prevent children from experiencing adverse childhood experience by building family and community strengths. Contractors would ensure staff are trained on protective factors, adverse childhood experiences and their impact on child development and well-being, mitigating the long-term impacts of early adversity, and all other core case practice skills as required by ACS. Contractors would make appropriate referrals to services that support healthy childhood development, including to early intervention, early childhood education, pre- and postnatal services, and other developmental programs as requested/as appropriate.

x. **Promoting Economic Mobility:** Most families served by ACS prevention experience the stresses of poverty, housing instability, and the impacts of systemic racism and oppression. These challenges often contribute to child welfare concerns. Contractors would be expected to assess for these underlying challenges and provide families with access to educational, employment, and career advancement opportunities that promote financial security and build economic mobility. Contractors would use research-informed practices to support economic mobility

[30]For more information on adverse childhood experiences, including research on impacts, see Centers for Disease Control and Prevention "Adverse Childhood Experiences (ACEs)" https://www.cdc.gov/violenceprevention/acestudy/index.html/.

[31]For more information on the Strengthening Families framework and protective factors, see the Center for the Study of Social Policy at https://cssp.org/our-work/project/strengthening-families/.

and/or build partnerships with organizations that offer economic mobility services. Contractors would ensure staff are aware of resources to support families living in poverty as well as the impact of poverty, toxic stress, and housing insecurity on family dynamics and child development. Contractors would guide staff to have high expectations for families and what they can achieve, ensuring that families are counseled about career ladders, educational opportunities, financial mobility, and goals for the future of their families.

y. **Promoting Family Well-Being and Success:** Contractors would assess and document families' well-being, including mental, physical, social, and emotional health, as well as family self-perception of well-being; and work with families to identify goals to improve well-being as appropriate. Contractors would engage families in co-designing service plans that enable them to identify strengths, achieve success, and celebrate that success at critical milestones. Contractors would use a trauma-informed approach to physical space, staff supervision, and all other activities to ensure the well-being of families and reduce the impact of secondary trauma on staff. In all case practice with families, the contractor's staff would be mindful of the impact of trauma on behavior and incorporate the principles of trauma-informed care, such as meeting families where they are and promoting trust and transparency.[32] Contractors would utilize ACS resources to promote safe sleep and safe medication practices.

z. **Meeting Concrete Needs:** Contractors would assess and support families to help them address their basic needs for income, food, diapers, clothing, furniture, housing, and transportation. Additionally, contractors would support families' navigation of, and access to, essential community services such as child care, health services, health insurance, housing programs such as Homebase, as well as public benefits and entitlements, including income supports, SNAP, public assistance, child support, Medicaid, and other resources available through the Department of Social Services and other government agencies.

aa. **Preventing Child Sexual Abuse and Commercial Sexual Exploitation of Children/Sex Trafficking:** Contractors would adopt protocols for universal screenings for child trafficking and/or abuse. If, after screening, further assessment is warranted, contractors would complete a full assessment and take appropriate actions to address safety and risk issues in accordance with state and federal law and ACS policies. Contractors would educate families on prevention of sexual abuse, including risk factors, warning signs, behavioral indicators, and research-informed prevention strategies. If a contractor suspects or a child discloses sexual abuse, contractors would take immediate action to protect the child from further abuse, secure appropriate treatment for the child, and make use of ACS and other community resources to ensure trauma is addressed.

bb. **Complex Needs:** Many families referred to prevention services struggle with complex and co-occurring challenges, including poverty, trauma exposure, mental health diagnoses, substance use, domestic violence, and other hardships that make parenting difficult. Recognizing the need for an interdisciplinary and cross-sector approach to addressing these complex needs, contractors would identify and expand partnerships with government agencies, community-based organizations, and other entities to ensure that families with complex needs have access to the services and supports necessary for their success. Contractors would serve as advocates

[32]Substance Abuse and Mental Health Services Administration (2014). SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach. HHS Publication No. (SMA) 14-4884. Rockville, MD: Substance Abuse and Mental Health Services Administration, https://store.samhsa.gov/system/files/sma14-4884.pdf2014.

on behalf of the children and families, with activities that include providing families with information on how to access services and requirements for maintaining benefits/services and helping families to navigate governmental and private sector entities such as managed care plans, the New York City Department of Education, the New York City Human Resources Administration, and the New York City Housing Authority. When needed, contractors would assist families in obtaining health insurance coverage and other public benefits for which they are eligible. Contractors would collaborate with the New York City Department of Homeless Services or DHS-contracted shelter staff if the family is living in shelter.

cc. **Supporting Families with Intellectual or Developmental Delays or Disabilities:** Contractors would assess all family members' developmental and intellectual functioning to determine whether parents or children may have a delay and/or a disability. When concerns arise, contractors would refer families to ACS contractors responsible for assessing families' eligibility for services through New York State Office for People with Developmental Disabilities and/or the New York City Department of Health and Mental Hygiene. If families are found eligible, contractors would coordinate with service providers to ensure families receive appropriate services. For all families, contractors would adapt their practice to enable families with limited literacy or cognitive challenges to understand and participate in services offered by the contractor regardless of whether a diagnosis of intellectual/ developmental disability has been made. When needed, contractors would advocate for the family with the New York City Department of Education to secure appropriate educational services for children who have intellectual or developmental disabilities, and with the New York City Department of Health and Mental Hygiene for the children under age three (3) requiring early intervention, and to obtain appropriate services for their siblings, when necessary.

dd. **Promoting Housing Stability**: Contractors would assess all families for current or imminent housing instability using the Homebase assessment tool.[33] Where housing instability is present, contractors would explore all available housing options--including eviction prevention strategies and support from the New York City Human Resources Administration Homebase program--with families who have active child welfare cases including child protection, prevention, or foster care services (ACS-involved families) before referring such families to the New York City Department of Homeless Services' (DHS) Prevention Assistance and Temporary Housing (PATH) family intake center for shelter placement. Contractors would also follow up and maintain contact with shelter staff and families throughout their stay in shelter. During an ACS-involved family's stay in DHS shelter, contractors and DHS and shelter staff would continue to coordinate and share information so that the family's day-to-day needs are being met, any outstanding issues are addressed, and the family's service needs are identified for the purposes of efficient and non-duplicative service planning. Contractors would take all appropriate actions as needed to support a family experiencing housing instability as directed by ACS. If requested, for families experiencing domestic violence, contractors would support survivors in obtaining safe housing and follow all applicable ACS policies in protocols in maintaining confidentiality and safety for residents of domestic violence shelters.

ee. **Supporting Reunification and Stability of Families with Children in Foster Care and/or Juvenile Justice:** Contractors would engage in cross-systems collaboration and support for foster care and juvenile justice-involved families, to help access the services they need to

[33]See Attachment O for the Homebase Screening Tool for Prevention programs.

succeed, especially during times of transition. Contractors would work closely with foster care programs when children in prevention programs enter foster care and before, during, and after the time when children are transitioning home from foster care. Contractors would ensure staff are trained in the Crossover Youth Practice Model (CYPM)[34] and complete all required reports and contacts following the arrest of any child receiving prevention services. Contractors would work to ensure staff are trained on risk factors for foster care and criminal/juvenile justice involvement and guide staff in supporting families in a manner that reduces risk of such involvement occurring for families engaged in prevention services.

ff. Promoting Positive Relationships and Social Connections: Contractors would engage families in conversation about their supportive relationships and social connections and support families in building social capital. Contractors would build associations with stakeholders, organizations, and institutions in their communities that enable families to access resource networks and promote formation of supportive relationships to improve family well-being and success.

gg. Supporting Reproductive Health and Safe Sex: Contractors would provide counseling on reproductive health and safe sex practices. Contractors would provide access to short- and long-acting reversible contraception including condoms, intrauterine contraception, and implant contraception. Contractors would educate teens on safe sex practices and offer referrals for sexually transmitted infection and pregnancy testing. Contractors would develop protocols to assist pregnant youth or adults to obtain comprehensive high-quality, accessible prenatal and postnatal counseling and health services, including referring eligible pregnant women to primary prevention home visiting programs, such as Nurse-Family Partnership or Healthy Families New York. Contractors would support families regardless of their decision to carry a pregnancy to term or terminate the pregnancy by offering nonjudgmental support. Where requested, contractors would make referrals for reproductive health and abortion services. Contractors would follow all applicable state and federal laws regarding access to health care. Please see Attachment N, Reproductive and Sexual Health Resources.

2. Implementation Plan:

a. Contractors would develop an implementation plan to ensure that all staff use the selected framework or model with proficiency, as well as a method for ongoing monitoring of fidelity to the model. Fidelity is defined as degree to which an intervention is implemented as intended.[35] In addition, the implementation plan would include different phases of implementation and define activities and goals for each phase.

b. Collaboration and Interdisciplinary Practice: Contractors would work collaboratively with stakeholders in the communities and systems that impact family stability and well-being. Contractors would engage and develop partnerships with courts, schools, medical and mental health services, social services, and other institutions and experts as needed to support families across NYC. Contractor staff would appear in Family Court at the request of ACS when ACS determines that the court appearance is necessary based upon the particular case

[34]California Evidence-Based Clearinghouse (2018) *The Crossover Youth Practice Model* https://www.cebc4cw.org/program/crossover-youth-practice-model-cypm/.

[35]Schoenwald, Sonja K. (2011). It's a Bird, It's a Plane, It's - Fidelity Measurement in the Real World. *Clinical Psychology: Science and Practice,* 18(2), p. 142-147.

circumstances when the court proceeding involves a family who is receiving or has received services from the contractor. Contractors must also cooperate with ACS Family Court Legal Services attorneys representing ACS in case preparation, including by submitting pertinent service plan and service progress information in a timely manner preceding scheduled Family Court hearings.

3. **Operations and Technology:**
   a. **Site Control:** Contractors would be able to demonstrate they will have site control (e.g., ownership or executed lease) before the contract start date. Contractors would operate a site in the catchment area proposed. Given that most services will be based in clients' homes, ACS understands that in some cases contractors' office may be outside the catchment area. If so, the site must be easily accessible to families living in the proposed catchment area through public transportation. All sites are subject to the approval of ACS and must comply with ACS policies.
   b. **Trauma-informed Sites**: Contractors would fulfill all health, safety, accessibility, aesthetically pleasing, and culturally relevant site requirements as stated in the ACS Preventive Services Quality Assurance Standards and Indicators (Attachment G). Additionally, contractors would use a trauma-informed approach to physical space for sites they maintain. A trauma-informed space uses design to integrate the core principles of trauma-informed care to promote the physical, mental, and social health for people who have experienced trauma. Trauma-informed design recognizes that the physical environment has an impact on attitude, mood, and behavior, and attempts to create a sense of safety and comfort in the way spaces are made and used. Spaces must have natural light, calming/neutral paint colors, be well-lit and clean, and otherwise comply with ACS policies.
   c. **Technology and Case Records:** Contractors would maintain case and program data in the New York State Office of Children and Family Services system of record for all child welfare cases, CONNECTIONS (CNNX), and in ACS's system for tracking provision of preventive services, Preventive Organization Management Information System (PROMIS), and any successor systems of record. Contractors would use the Safe Measures dashboard website provided by ACS to monitor staff activities and program performance. Contractors would provide their staff with access to the technology necessary to effectively serve families and also to support staff safety. Contractors would provide families with access to technology where necessary to support achievement of goals, including computer access to prepare for employment. ACS and providers will work collaboratively to keep pace with new technological innovations and continuously seek to utilize technology to improve service delivery and access. Contractors would maintain adequate case files, fiscal and personnel records, and would ensure that staff follow appropriate, confidential record-keeping practices and procedures in a manner which adheres to all existing federal, state and city laws, rules and regulations, and is consistent with policies, procedures and standards promulgated by ACS.
   d. **Subcontracting:** If the contractor does not have the expertise or capacity to directly provide all services necessary to assist and support clients, the contractor may subcontract with other service providers or develop linkages through memorandums of understanding or other linkage letters with other service providers to meet the full range of client needs. Subcontractors and subcontracts must be approved by ACS before the subcontract is executed and all subcontractors must enroll in the City's Payee Information Portal (https://www1.nyc.gov/site/doh/business/opportunities/payee-information-portal.page).

Subcontracting is not allowed for case planning or supervision of direct service staff and services provided by the subcontractor must be integrated into overall program design. Contractors would be responsible for the work of the subcontractor and would establish a mechanism to monitor the subcontractors and interventions with their clients. Contractors would demonstrate organizational capacity to implement the programming detailed in the scope above.

4. **Child Welfare Practices and Program Operations:** ACS expects and requires contractors to conform to the following guidance regarding child welfare practice and program operations. Contractors will adhere to all New York State laws and regulations regarding child welfare and all OCFS and ACS policies.
   - **a.** Contractors will adhere to the full Scope of Services described.
   - **b.** Contractors will adhere to the attached ACS Preventive Services Quality Assurance Standards and Indicators (Attachment G) and any amended or successor Standards and Indicators. Compliance with all standards and requirements is mandatory for all contractors.
     Pursuant to state and federal laws and regulations, services will be provided to all children of New York City, regardless of race, color, age, national origin, sex, handicap, ethnicity, religion, disability, and sexual orientation.

5. **Proposal Instructions:**
   - **a.** Proposers should complete the required Program Plan section of Attachment A - Structured Proposal Form.
   - **b.** Proposers should attach a signed letter from the Proposer organization's Executive Director indicating the model proposed. If a proposer wishes to propose an adaptation of Functional Family Therapy for a child welfare population, the proposer should include data on the effectiveness of the approach with the population, an overview of the adaptation, including full model requirements, and an implementation plan demonstrating how proposers will meet all staffing and training requirements in partnership with a model support organization. Adaptations of Functional Family Therapy for a child welfare population must be rooted in Functional Family Therapy, serve children and youth ages 0-18, include case management and clinical interventions, and be appropriate for families with a range of needs.
   - **c.** Proposers should complete and attach a Community Asset Map. Community Asset Maps identify resources within a geographic area. The process of creating this Map of support systems inherently leads to the discovery and assemblage of links between different community associations and organizations. The knowledge of these linkages can then be used to revitalize relationships and mutual support; rebuild communities and neighborhoods; rediscover collective power and purpose; and highlight the intersections of community assets with community hopes and dreams. The process of creating a Community Asset Map is as follows:
     - **i.** Find a detailed and accurate area map of the community. Look for one that provides as many details as possible, including parks, street names, waterways, and other landmarks.
     - **ii.** Compile a list of various resources and their locations. This includes community-based organizations, civic organizations, local businesses, foundations, houses of worship, medical facilities, ACS-contracted community partners, and other community assets.
     - **iii.** Categorize resources into color coded categories.

iv. Use color-coded symbols to mark the location of identified resources to create a visual representation of community resources.
v. Use the map to identify gaps in services and opportunities for improvement. Summarize key points. Questions to consider include: What are underutilized assets? Where are the most obvious gaps? How can those gaps be filled?

d. Proposers should attach a Timeline for Implementation, from contract award date (estimated December 1, 2019) through the end of the first year of implementation (estimated June 30, 2021) including: hiring, site control and construction, trainings, service start, model coaching and/or model support organization consultations, evaluation, quality improvement, and other proposed activities.

e. Proposers should attach a Life of a Case map, which is a business process for the life of a case from intake through closure including assessments, casework contacts, conferences, referrals, advocacy, any post-closing supports provided by proposer's agency, and other proposed activities.

6. **Evaluation:**
   a. The Program Plan section will be evaluated based on the quality of the program plan for providing Family Support or Therapeutic and Treatment Services based on the criteria in this section. It is worth a maximum of 20 points in the Proposal Evaluation.

B. Experience and Results

1. **Past Program Experience:** Contractors would have relevant experience delivering human or social services to families experiencing poverty, mental health challenges, housing instability, domestic violence, substance use issues, family conflict and/or other challenges that make parenting difficult. Contractors would have experience in program design and development, including developing logic models, planning for implementation, engaging in basic program data monitoring, and participating in quality improvement activities.

2. **Program Planning and Measurement:** Contractors would develop a program logic model[36] to inform implementation, ongoing program management, continuous quality improvement, and quality assurance activities.

3. **Evidence-Based and Evidence-Informed Models:** Contractors with experience implementing and sustaining evidence-based and evidence-informed models and/or case practice frameworks would be prepared to apply lessons learned in the areas of staff recruitment and training, staff retention, use of technology, alignment with government policies and standards, and fidelity to adopted models.

4. **Partnership and Mutual Accountability:** ACS may collect and monitor data at both the case and program level as part of a full evaluation and accountability process and to monitor program performance indicators as appropriate and needed. Contractors would encourage genuine

[36] See the W.K. Kellogg Foundation Logic Model Development Guide https://www.wkkf.org/resource-directory/resource/2006/02/wk-kellogg-foundation-logic-model-development-guide.

commitment by staff at all levels to programmatic goals, build team-driven accountability for achieving these goals, and forge effective relationships with valuable external child welfare stakeholders in service of supporting families in achieving their goals.

5. **Contract Management:** Contractors would be accountable for reporting on programmatic outcomes, maintaining fidelity to program models, maintaining all financial records and complying with all ACS policies and standards. The ACS contract manager in the Division of Prevention Services will serve as the primary point of contact for support, reviewing all budgets and budget modifications, analyzing invoices, conducting site visits, monitoring model fidelity, and tracking contract compliance in real time. Contractors would be required to participate in all of these activities in collaboration with the contract manager. Both parties will endeavor to identify monitoring activities and feedback loops to understand provider progress and compliance with and build on what works and share best practices. Contractors would allow ACS to make regular announced and unannounced site visits to assess contract compliance. Contractors would engage in weekly communication with an ACS contract manager to discuss progress, identify challenges, and develop program improvements. Contractors would use the ACS contract manager as the primary point of contact at ACS. Contractors would submit regular reports as required and requested by ACS using information systems prescribed by ACS. Contractors would also be required to participate in all quality assurance activities, including collaborative quality improvement, learning collaboratives and others as required by ACS.

6. **Performance-Based Contracting:** ACS will hold Contractors accountable for program performance, which will be assessed through annual metrics. In year one of the contracts awarded from this RFP, ACS intends to closely monitor start-up activities including client services, but during this time, funding provided to contractors would be exempt from performance-based metrics. Beginning in year two, contractors would be accountable for achieving targets as defined by ACS which may include: frequency of casework contacts, maintaining optimum utilization, complying with length of service requirements, quality of safety outcomes following services, and/or the number of new families served. At the end of year two, if contractors have not achieved agreed upon targets, ACS may reduce and redistribute program slots. Contractors that achieve their targets in an area of need may receive additional slots. This process will occur on an annual basis thereafter.

7. **Aligning Slot Capacity to Meet Families' Needs Across the City:** At the time of contract renewal (prior to the end of the three-year contract end date), ACS intends to conduct a cumulative review of contractor performance that includes annual output metrics as well as outcomes and family feedback. ACS will make a determination based on these factors and up-to-date community need regarding the number of slots the contractor would receive in the renewal period. This process will enable ACS to keep pace with family needs across the city and also reward contractors that achieve positive outcomes for children and families.

8. **Metrics and Evaluation for Proposed Program:**
   - **a.** Contractors would develop internal oversight and accountability metrics to ensure program success as well as achieve measurable results along the following dimensions required by ACS:
     - **i.** Effective family engagement, including respectful engagement of families who are reluctant to accept child welfare services.

ii. Reduced incidence of maltreatment while receiving, or subsequent to receiving, prevention services.
iii. Focused, efficient, and effective practice that results in timely achievement of families' goals and timely completion of preventive services and a reduced likelihood of foster care placement.
iv. A high level of productivity, as evidenced by the program's utilization rate and volume of new referrals accepted in each quarter.
v. Improved physical, developmental, cognitive (including educational), emotional, psychological, health, and/or social well-being.
vi. Timely and substantive participation in ACS family conferences and, when appropriate, Family Court hearings.

9. **Using Data and Evidence for Quality Assurance and Quality Improvement:** Contractors would use research and quantitative and qualitative data, both self-generated (including family and community feedback) and provided by ACS, to drive quality assurance and continuous improvement in programmatic and practice decision-making. Quality Assurance "uses standards that define acceptable or unacceptable levels of performance. A retrospective process, it assesses practice that has already occurred."[37] Continuous quality improvement (CQI) is the process of identifying, describing, and analyzing key data indicators and challenges; identifying and carrying out potential solutions; monitoring their effectiveness; and revising solutions based on results. Effective CQI requires an organizational culture and system that fosters continuous learning and improvement and is routinized in an agency's mission, vision, and organizational practices.[38] Continuous quality improvement differs from quality assurance in that quality assurance is focused on meeting specific compliance standards.[39] Contractors' quality assurance staff would play a significant role in building capacity to use data and dashboards to guide planning and case practice within agencies, as well as participate in the Quality Assurance/Quality Improvement (QA/QI) learning collaborative. Contractors would participate in the ACS-facilitated continuous quality improvement program, which includes development and implementation of annual improvement plans rooted in qualitative data, including the findings of ACS's semi-annual qualitative reviews of case practice, and quantitative outcomes data also provided by ACS. Contractors would engage in model-specific learning collaboratives and quality improvement activities and submit reports on fidelity and other program-specific data to ACS on a regular basis.

10. **Celebrating Success and Rewarding Innovation**: Contractors would develop a culture of service delivery that celebrates the success of the children and families at all levels of progress. Additionally, contractors would reward innovation and celebrate the success of staff—at all levels, but especially front-line staff—in supporting families to achieve their goals by implementing recognition programs and defining career ladders that offer promotional opportunities to staff who excel.

[37]Child and Family Services Review. (2019) Quality Assurance and CQI Activities. https://training.cfsrportal.acf.hhs.gov/section-3-continuous-quality-improvement-cqi-child-welfare/2513
[38]Lee SJ, Bright CL, Berlin LJ. Organizational influences on data use among child welfare workers. *Child Welfare.* 2012;92(3):97–118.
[39]Child and Family Services Review. (2019) Quality Assurance and CQI Activities. https://training.cfsrportal.acf.hhs.gov/section-3-continuous-quality-improvement-cqi-child-welfare/2513

11. **Monitoring, Evaluation, and Quality Improvement:** Contractors would participate in all ACS required monitoring, evaluation, and quality improvement activities. Contractors would also build internal performance monitoring, evaluation and continuous quality improvement capacity. Contractors would regularly participate in ACS collaborative quality improvement, learning collaboratives, contract management activities, and all other required processes to ensure high-quality performance, desired outcomes, and continuous program improvement. Contractors would participate in ACS program assessment, evaluation, and monitoring systems and provide all information necessary to allow ACS to conduct these reviews. This includes working with the ACS Office of Agency Program Assistance, the ACS Provider Accountability and Measurement System (PAMS), the ACS Office of Research and Analysis, ACS Office of Preventive Technical Assistance, ACS Community Based Strategies, ACS Office of Program Management and Sustainability, the ACS Workforce institute, and consultants and research partners as identified and approved by ACS.

12. **Proposal Instructions:**
    a. Proposers should complete the required Experience and Results section of Attachment A - Structured Proposal Form, which includes a Program Logic Model[40] table. Proposers should complete the table using following definitions:[41]
        - Resources: Sometimes described as inputs, resources include the "human, financial, organizational, and community resources a program has available to direct toward doing the work. Examples include staff and technology."
        - Activities: "what the program does with the resources. Activities are the processes, tools, events, technology, and actions that are an intentional part of the program implementation. These interventions are used to bring about the intended program changes or results." Examples include home visits, counseling sessions, Family Team Conferences.
        - Outputs: "direct products of program activities and may include types, levels, and targets of services to be delivered by the program." Examples include number of contacts, number of sessions, number of conferences.
        - Outcomes: "the specific changes in program participants' behavior, knowledge, skills, status and level of functioning." Examples include reduced incidents of repeat maltreatment and foster care placement.
        - Impact: "the fundamental intended or unintended change occurring in organizations, communities, or systems over time as a result of program activities." Examples include improved family functioning or indicators of well-being.
        - Quality Assurance: "uses standards that define acceptable or unacceptable levels of performance. A retrospective process, it assesses practice that has already occurred."
        - Quality Improvement: Continuous quality improvement is the process of identifying, describing, and analyzing key data indicators and challenges; identifying and carrying out potential solutions; monitoring their effectiveness; and revising solutions based on results. Effective CQI requires an organizational culture and system that foster continuous learning

[40]For guidance on creating a program logic model, see Kellogg Logic Model Guide: https://www.wkkf.org/resource-directory/resource/2006/02/wk-kellogg-foundation-logic-model-development-guide.
[41] All definitions come from the W.K. Kellogg Foundation Logic Model Development Guide https://www.wkkf.org/resource-directory/resource/2006/02/wk-kellogg-foundation-logic-model-development-guide.

and improvement and is routinized in an agency's mission, vision, and organizational practices.[42]

b. Proposers should attach an Improvement Plan, Corrective Action Plan, documentation of any other disciplinary status, or a letter stating that no contract has been under such monitoring in the past five years.

c. Proposers should attach any relevant examples of reports, evaluations, summary data, or other existing documents that demonstrate the contractor's past performance in the last two years (FY17 and FY18). Examples include, but are not limited to, outcome reports, external program evaluation reports. If a current ACS prevention services provider, please include a listing of all current prevention contracts.

13. Evaluation:

a. The Experience and Results section will be evaluated based on the quality of the Proposer's experience and results for providing Family Support or Therapeutic and Treatment Services based on the criteria in this section. It is worth a maximum of 20 points in the Proposal Evaluation.

C. Readiness

Readiness is defined as the developmental point at which a person, organization, or system has the capacity and willingness to engage in a particular activity; and provider agency members at every level of the organization are psychologically and behaviorally prepared to implement the new innovation or evidence-based practice. Contextual fit is the "match between the strategies, procedures, or elements of an intervention and the values, needs, skills, and resources available in a setting."[43] Further, research shows that "implementation of an innovation will be successful to the degree that the innovation matches the mission, values, and service provider tasks and duties of the organization."[44] Organizations considering specific models should assess models for fit and feasibility within the context they will be implemented. Fit and feasibility assessment should include the collection and analysis of data from multiple sources, including administrative data, interviews, focus groups with key stakeholders, and program observations.[45]

1. **Pre-Implementation Research:** Contractors would conduct a comprehensive assessment prior to launching a Family Support casework practice or Therapeutic and Treatment model. In this assessment, the contractor would identify key implementation science drivers to ensure quality implementation of the case practice framework or program model. During pre-implementation, contractors would assess the need for, and the fit and feasibility of, the casework practice or Therapeutic and Treatment model; and identify the necessary supports to ensure effective implementation.

[42]Child and family Services Review. (2019) Quality Assurance and CQI Activities. https://training.cfsrportal.acf.hhs.gov/section-3-continuous-quality-improvement-cqi-child-welfare/2513

[43]Horner R., Blitz, C., & Ross, S. (2014). The importance of contextual fit when implementing evidence-based interventions, ASPE Research Brief, U.S. Department of Health and Human Services, September 2014, p3.

[44]Aarons, G., Hurlburt, A., & Horwitz, M. (2011). Advancing a Conceptual Model of Evidence-Based Practice Implementation in Public Service Sectors. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(1), pp4-23, p14.

[45]See the National Implementation Research Network Implementation Guide and additional tools and resources. https://implementation.fpg.unc.edu/resources/implementation-action-guide-1-assessing-fit-and-feasibility

2. **Staff Engagement and Buy-in:** Contractors would ensure buy-in for the case practice framework or Therapeutic and Treatment model at all levels of staff and ensure ongoing training, coaching, and supports are in place to drive successful implementation. Contractors would work closely with ACS and ACS-contracted partners to prepare for implementation, assess programs, make program improvements, and evaluate the success of the program.

3. **De-Implementation:** De-Implementation is defined as stopping or abandoning practices that have not proved to be effective and are possibly harmful, and dismantling the infrastructure developed to support those practices.[46] Best practice in implementation science dictates that systems must get rid of old standards when implementing new practices to avoid overloading staff and imposing competing priorities. Contractors would conduct a full assessment of internal practices and processes that must end or change for the casework practice model or Therapeutic and Treatment model to be implemented effectively. As part of the implementation plan, the contractor would work in collaboration with staff to remove or streamline workload elements before adding requirements. The contractor would approach de-implementation as a core part of planning for a new casework practice or therapeutic and treatment model.

4. **Implementation Team:** An implementation team is a group of stakeholders that oversees, attends to, and is accountable for, performing key functions in the selection, implementation, and continuous improvement of an intervention. As the formal implementation structure, teams systematically move an intervention through stages of implementation by ensuring families and community members are engaged, the practice is well-defined and a good fit with the context and setting, implementation supports are in place, fidelity is measured and improved, and outcomes are achieved and sustained. Contractors would create an implementation team to ensure the successful installation, monitoring, and ongoing integration of the case practice framework into the Family Support approach, or the Therapeutic and Treatment program. This implementation team typically includes representation from staff at many levels, including but not limited to: case planners, supervisors, directors, quality assurance staff, and senior leadership. This implementation team would begin planning at the time the contract begins and remain active throughout the life of the contract. Contractors would participate in ACS program assessment, evaluation, and monitoring systems and provide all information necessary to allow ACS to conduct these reviews.

5. **Communication and Feedback Loops:** Policy-Practice Feedback Loops are formal structures and processes that facilitate two-way communication to provide organizational leaders and policymakers with information about implementation barriers and successes so that a more aligned system can be developed. Contractors would engage in regular communication with all levels of staff and establish feedback loops to support continuous quality improvement activities and ensure quality service delivery. Contractors would use internal and/or ACS data, fidelity tools, clinical assessments, feedback from families, and other relevant measures to inform practice.

[46]Rabin, B.A and Brownson, R.C. (2018) Terminology for dissemination and implementation research R.C. Brownson, G.A. Colditz, E.K. Proctor (Eds.), Dissemination and implementation research in health (Second edition), Oxford Press, New York (2018), pp. 19-46.

6. **Areas of Growth and Need for Support:** Contractors would have experience with implementation of casework practice or Therapeutic and Treatment models; or would commit to work closely with ACS, model support organizations, and other external partners to ensure effective implementation.

7. **Proposal Instructions:**
   a. Proposers should complete the required Readiness section of Attachment A - Structured Proposal Form.

8. **Evaluation:**
   a. The Readiness section will be evaluated based on the quality of the Proposer's readiness for providing Family Support or Therapeutic and Treatment Services based on the criteria in this section. It is worth a maximum of 20 points in the Proposal Evaluation.

D. Resources and Capacity

1. **Staffing:**
   a. The contractor's staff would be skilled at engagement of children and families and have a thorough understanding of child and adolescent development. Contractors would make all efforts to employ social work staff experienced with the practice and concept of family treatment, including working with domestic violence, mental health, and substance use issues. Contractors would seek to have staff that are knowledgeable about trauma, child development, social services, and the specific needs of the families they intend to serve.
   b. Contractors would have staff that are trained to work with a range of families, children, and youth, representing a variety of service needs, including staff with sensitivity and expertise in working with families in which parents or children identify as lesbian, gay, bisexual, transgender, or questioning (LGBTQ). Contractors would have the capability to do family counseling and/or mediation with parents who do not accept their children's sexual orientation or gender identity. For additional details see Sections B-D of Attachment G, ACS Preventive Services Quality Assurance Standards and Indicators.
   c. **Training:** Contractors would participate in the ACS-mandated onboarding core training and would also fulfill the annual training requirements outlined in ACS policies, standards, and guidance, including required trainings in the assessment of safety and risk, family engagement, building coaching competencies of supervisors, and understanding and undoing implicit bias. Contractors would participate in the ACS Workforce Institute course registration, enrollment tracking, and course approval system. Contractors would ensure that all staff receive training (and, when applicable, certification) in the appropriate casework practice model or Therapeutic and Treatment model and participate in refresher and recertification training as dictated by the model and ACS policies, standards and guidance. Contractors would ensure relevant staff also participate in trainings offered by other city agencies, including those about Medicaid and other benefits access and enrollment, financial empowerment, and others as appropriate based on the needs of the target population and as required by ACS. Contractors would have a strong commitment to ongoing learning and would seek out opportunities to elevate the skills of their staff to better serve children and families.
   d. **Staff Recruitment and Hiring:** Contractors would have the organizational and management capacity to recruit and hire qualified staff in a timely fashion to maintain required caseloads, case contacts and supervisory oversight in compliance with program standards. Contractors

would align their staff selection practices and criteria with the skill sets, capacities, qualifications, and experience required by the selected model or framework. Contractors would work with model support organizations to prepare model-aligned job descriptions and recruitment materials. Contractors would ensure all staff must have appropriate background checks and clearances pursuant to ACS and OCFS policy. During the hiring process, contractors would make diligent efforts to check references, assess the appropriateness of the candidate's fit, and utilize best practices to ensure staff are able to safely work with children and families.

e. **Staff Well-Being:** Contractors would promote staff well-being and retention by providing high-quality, individualized supervision and peer group support, well-being programming, and professional development opportunities, including those available from the ACS Workforce Institute. Contractors would have a staff well-being committee consisting of staff from all levels of the agency that would be tasked with assessing staff well-being, developing improvement strategies, implementing solutions, and assessing improvement on an ongoing basis. Contractors would track staff retention, promotions, resignations, and conduct exit interviews and make this information available to ACS upon request.

f. **For Family Support Programs**: Contractors would operate the program with the required staffing structure of core staff outlined below. For each program, only whole numbers of staff are allowed for the core staff positions outlined below. Sharing of direct staff (including directors, case planners, and supervisors) across different programs or contracts is prohibited, except in the case of the QA/QI Specialist funded for each prevention agency (rather than for each prevention program).

Program	Program Size	Staffing Structure	Supervisor to Case Planner/Therapist Ratio	Case Planner/Therapist Caseloads
Family Support	96 slot programs	1 director 2 supervisors 8 case planners 2 case aides/parent advocates 1 QA/QI Specialist (1 per provider organization) 2 conference facilitators	1:4	1:12

g. **For Therapeutic and Treatment programs**: Contractors would adhere to all ACS and model-specific staffing requirements, including required positions, training, and supervision, to ensure the models are delivered with fidelity. Please see Attachment K, Model Descriptions. Contractors would operate the program with the required core staff outlined below. Only whole numbers of staff are allowed for these core staff positions. Sharing of direct staff (including directors, case planners, and supervisors) across different programs or contracts is prohibited, except in the case of the QA/QI Specialist funded for each prevention agency (rather than each prevention program). Models may require additional clinical staff to ensure model fidelity. Please see Attachment K, Model Descriptions.

Program	Program Size	Staffing Structure	Supervisor to Case Planner/Therapist Ratio	Case Planner/Therapist Caseloads
Child-Parent Psychotherapy (CPP) in the Bronx and Brooklyn	128 slot programs	1 director 4 supervisors 16 case planner/therapists 4 case aides/parent advocates 1 QA/QI Specialist (1 per provider organization) 2 conference facilitators	1:4	1:8
Child-Parent Psychotherapy (CPP) in Staten Island, Queens, and Manhattan	64 slot programs	1 director 2 supervisors 8 case planners/therapists 2 case aides/parent advocates 1 QA/QI Specialist (1 per provider organization) 1 conference facilitator	1:4	1:8
Family Treatment/Rehabilitation (FT/R) in all boroughs	128 slot programs	1 director 4 supervisors 16 case planners/therapists 1 Licensed Mental Health Clinician 1 Credentialed Alcohol and Substance Use Counselor 4 case aides/parent advocates 1 QA/QI Specialist (1 per provider organization) 2 conference facilitators	1:4	1:8
Functional Family Therapy adaptations for a child welfare population, in all boroughs	144 slot programs	1 director 4 supervisors 16 clinicians/therapists/interventionists addressing low and/or high risk 4 case aides/parent advocates 1 QA/QI Specialist (1 per provider organization) 2 conference facilitators	1:4	High Risk: 1:8 Low Risk: 1:10
Brief Strategic Family Therapy (BSFT), Functional Family Therapy (FFT), and Trauma Systems Therapy (TST) in the Bronx, Brooklyn, Queens, and Manhattan	64 slot programs	1 director 2 supervisors 8 case planners/therapists 2 case aides/parent advocates 1 QA/QI Specialist (1 per provider organization) 1 conference facilitator	1:4	1:8

Brief Strategic Family Therapy (BSFT), Functional Family Therapy (FFT), and Trauma Systems Therapy (TST) in Staten Island	32 slot programs	1 supervisor 4 case planners/therapists 1 case aide 1 QA/QI Specialist (1 per provider organization)	1:4	1:8
Multisystemic Therapy Substance Abuse / Multisystemic Therapy Prevention	40 slot programs	1 director 2 supervisors 8 case planners/therapists 2 case aides/parent advocates 1 QA/QI Specialist (1 per provider organization) 1 conference facilitator	1:4	1:5
Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)	48 slots (citywide)	1 director 4 supervisors 12 therapists 4 case aides/parent advocates/parent advocates 1 QA/QI Specialist (1 per provider organization) 1 conference facilitator	1:3	1:4
Special Medical	128 (citywide)	1 director 4 supervisors 16 case planners/therapists 4 case aides/parent advocates 1 QA/QI Specialist (1 per provider organization) 2 Registered Nurses 2 conference facilitators	1:4	1:8

2. **Budget:**
   - **a.** The proposed budget represents the annual costs to provide services for the proposed program.
   - **b.** Contractors would operate the program with a budget based on the anticipated available funding stated in the "Basic Information" chart.
   - **c.** The contractor's cost items would enable the effective delivery of services described in this RFP.

3. **Proposal Instructions:**
   - **a.** Proposers should complete the required Resources and Capacity section of Attachment A - Structured Proposal Form.
   - **b.** Proposers should attach a Hiring and Onboarding Timeline.
   - **c.** Proposers should complete Attachment B - Proposal Budget Template and adhere to all ACS Fiscal policies.

d. Proposers should attach an Organizational Chart that includes titles of all staff involved in providing the required services.

4. **Evaluation:**
   a. The Resources and Capacity section will be evaluated based on the quality of the Proposer's resources and capacity for providing Family Support or Therapeutic and Treatment Services based on the criteria in this section. It is worth a maximum of 20 points in the Proposal Evaluation.

E. Family Voice, Inclusivity, and Social Justice

1. **Languages Offered:** Contractors would provide culturally and linguistically competent services through staff that is representative of the community served. Contractors would be knowledgeable about the cultural affiliations of the communities they serve and the values and practices they hold; and proficient in the languages spoken by participating children and family members. Contractors would have the capacity to assess the needs of the local community, develop meaningful linkages to local community resources, and demonstrate that program leadership and operations recognize and respect community needs and cultures. Contractors would make diligent efforts to recruit and hire qualified staff that reflects the race/ethnicity and languages spoken by families in the community served. Based on the American Community Survey NYC Language Data (Attachment L), at a minimum, contractors would hire a bilingual staff person for every 5,000 or 10% of people who speak a language other than English in the community districts served by the contractor. Contractors would satisfy this requirement by using the lesser of the 5,000 or 10% benchmark provided.

2. **Addressing Racial Equity:** Contractors would recognize and work to redress the historical legacy of current racial inequities that results in differences in application of practices, policies, and experiences of prevention families. Contractors would examine factors that drive these differences among children and families in prevention and deploy strategies to correct them. Contractors would establish a racial equity committee within their organization which includes staff at all levels who will be responsible for assessing and improving racial equity across the organization. Such improvements would include, but would not be limited to, baseline and ongoing assessments of equity, improvement plans and actions to address equity in hiring practices, representation and inclusivity, opportunities for advancement, and in other relevant domains as needed and/or required by ACS.

3. **Providing Services in Families' Homes and Communities:** Contractors will meet with families and teens as frequently as required by each specific program model, primarily in their homes and communities where they reside. Contractors would be responsible for supporting staff in planning and coordination to ensure home visits are being made, and that transportation is not unduly burdensome for families or for staff.

4. **Family-Team Conferencing:** Contractors would partner with ACS in the Family Team Conference model. ACS's Family Team Conference model is designed to engage families, their self-identified support system, and community members in critical child welfare decisions related to safety, risk, well-being, and service planning, including reassessments of parent or caregiver's protective

capacity. Decisions are made jointly, and service plans are developed by the family, social supports, community supports, and service providers. The Family Team Conferences must be used to promote practice that reflects ACS's core principles and outcomes, thus enhancing children's safety and well-being. For detailed information regarding the Family Team Conference model and its use in prevention services programs, refer to Section D of Attachment G - ACS Preventive Services Quality Assurance Standards and Indicators, Attachment H - Child Welfare Programs' Integrated Family Team Conference Policy, and ACS policy.[47]

5. **Promoting Family Voice and Choice:** Contractors would ensure families are treated with respect and dignity and that families have a voice and choice in every aspect of their service experience, including their service plan. Contractors would use best practices in engaging parents, not only in individualized casework, but also on an agency level. The latter may include: having parents serve on hiring committees, convening a parent advisory board, holding family focus groups, and having regular conversations with families throughout and beyond their engagement in services, and/or ensuring they are active participants in the referral and decision-making processes surrounding their engagement with services. Feedback from families may also be used by ACS in contractor oversight.

6. **Addressing Inclusivity and Social Justice:** Contractors would provide a high quality of service and care that is inclusive of, but not limited to, the history, traditions, values, family systems, race and ethnicity, immigration and refugee status, religion and spirituality, sexual orientation, gender identity or expression, social class and mental or physical abilities of client populations. Contractors would be aware of the impact of social systems, policies, practices, and programs on multicultural client populations, advocating for and with multicultural clients. Contractors would develop strategies to address the tension in child welfare between the need to monitor child safety and risk and the desire to build relationships with families and strengthen well-being through community support. Further, contractors would be committed to a mission of creating a socially just social service system - ensuring that services provided are of such quality that a family would voluntarily seek to enroll in them regardless of system involvement.

7. **Listening and Customer Service:** Contractors would provide a high level of customer care and satisfaction to the children and families they serve. Organizations will be expected to have or develop formal feedback loops that capture the experiences of the families they serve and demonstrate how this feedback continuously informs programmatic and operational improvement plans. Contractors would conduct or make reasonable efforts to conduct exit interviews with parents or caregivers and each child over the age of 10 upon termination of services to assess client satisfaction, and the degree to which the family's needs were met by the program. When appropriate, exit interviews should also be conducted with other members of the child's household. Contractors would develop their own interview instruments. Utilization of at least one additional method for soliciting input on an ongoing basis is also required and may include consumer satisfaction surveys, family interviews, human-centered design activities, focus groups, or other activities as appropriate and approved by ACS.

[47]Information on ACS policies can be found at https://www1.nyc.gov/site/acs/about/policy-library-search.page

8. **Proposal Instructions:**
   a. Proposers should complete the required Family Voice, Inclusivity, and Social Justice section of Attachment A - Structured Proposal Form.
   b. Proposers should attach an example of a family-facing feedback tool the Proposer has used in the past or a letter signed by the Proposer organization's Executive Director or higher, stating that no feedback tool has been used in the past.

9. **Evaluation:**
   a. The Family Voice, Inclusivity, and Social Justice section will be evaluated based on the quality of the Proposer's approach to Family Voice, Inclusivity, and Social Justice in providing Family Support or Therapeutic and Treatment Services based on the criteria in this section. It is worth a maximum of 20 points in the Proposal Evaluation.

Section 3 – List of Attachments

**All attachments for this RFP can be found in the RFP Documents tab in the HHS Accelerator system.*

List of Attachments

A. Attachment A - Structured Proposal Form
B. Attachment B - Proposal Budget Template
C. Attachment C - Doing Business Data Form
D. Attachment D - Map of Geographic Competition Areas
E. Attachment E - Proposal Budget Instructions
F. Attachment F - Questions and Answers About the Doing Business Data Form
G. Attachment G[48] - ACS Preventive Services Quality Assurance Standards and Indicators (2011)
H. Attachment H - Child Welfare Programs' Integrated Family Team Conference Policy
I. Attachment I - General Provisions Governing Contracts for Consultants, Professional, Technical, Human, and Client Services
J. Attachment J - NYS OCFS Preventive Services Practice Guidance Manual (2015)
K. Attachment K - Model Descriptions
L. Attachment L - American Community Survey NYC Language Data
M. Attachment M - City of New York Health and Human Services Cost Policies and Procedures Manual
N. Attachment N - Reproductive and Sexual Health Resources
O. Attachment O - Homebase Screener Tool
P. Attachment P - General Requirements for Health & Human Services Contractors
Q. Attachment Q - ACS Fiscal Manual - Addendum Guide to Prevention Service Programs

[48]Please note that ACS reserves the right to revise the Preventive Services Quality Assurance Standards and Indicators and anticipates issuing revised standards that incorporate the Therapeutic and Treatment models in 2020. Contractors would be required to comply with current and revised Preventive Services Quality Assurance Standards and Indicators.

Section 4 – Basis for Contract Award and Procedures

A. Proposal Evaluation

All proposals accepted by ACS will be reviewed to determine whether they are responsive or nonresponsive to the requirements of this RFP. Proposals which ACS determines to be nonresponsive will be rejected. ACS Evaluation Committees will evaluate and rate all remaining proposals based on the Evaluation Criteria outlined in this RFP. ACS reserves the right to conduct site visits, to conduct interviews, or to request that proposers make presentations, as deemed applicable and appropriate. Although ACS may conduct discussions with proposers submitting acceptable proposals, ACS reserves the right to award contracts on the basis of initial proposals received, without discussion; therefore, the proposer's initial proposal should contain its best programmatic and price terms.

B. Contract Award

Contracts will be awarded to the responsible proposers whose proposals are determined to be the most advantageous to the City, taking into consideration the criteria and factors set forth in this RFP. Proposals will be ranked in descending order of their overall average technical scores within each competition and ACS will establish a shortlist through a natural break in scores for technically viable proposals.

For Family Support Services, awards will be made to the highest-rated providers in each competition pool whose proposals are technically viable, consistent with ACS's need for programmatic and geographic distribution and whose prices do not exceed the conditions set forth in the RFP. Providers will be limited to one 96-slot program award per competition. In the event that there are insufficient technically-viable proposals to meet the need in a competition, with the one-program limitation, ACS reserves the right to consider awarding additional programs to providers already awarded in the same competition.

For Therapeutic and Treatment Programs, awards will be made to the highest-rated providers in each competition pool whose proposals are technically viable, consistent with ACS's need for programmatic and geographic distribution and whose prices do not exceed the conditions set forth in the RFP. Providers will be limited to one program per competition. In the event that there are insufficient technically-viable proposals to meet the need in a competition, with the one-program limitation, ACS reserves the right to consider awarding additional programs to providers already awarded in the same competition. For each competition the program size is provided in **Table 2: Therapeutic and Treatment Programs Catchment Competitions and Funding.**

For All Recommended Contract Awards:

- If a proposer is eligible for more than one contract award, ACS may, in its sole discretion, determine, based on the proposer's demonstrated organizational capability, programmatic distribution, geographic distribution and the best interests of the City, how many and for which service types the proposer will be awarded a contract.
- ACS reserves the right to increase the number of families served if funding is available.
- ACS reserves the right to award less than the full amount of funding requested and to modify the allocation of funds among competitions in the best interests of the City.

- ACS reserves the right to shift service targets and areas in response to changes in demographics or service needs across communities.
- ACS reserves the right, prior to contract award, to determine the length of the initial contract term and each option to renew, if any.

ACS may, in its sole discretion, give greater consideration to proposals that offer to serve special populations and/or that bring existing program sites in the catchment area being proposed. ACS will consider these factors as well as the geographic distribution of services to meet the needs of all children and families that require services to enhance cost and time efficiency in start-up operations and to maximize the benefits of providers that have an existing presence in a particular community. The special populations are speakers of the following languages:

- American Sign Language
- Arabic
- Albanian
- Bengali
- Chinese languages, including Mandarin, Cantonese, and/or Fukienese/Amoy
- Haitian/Creole
- Hebrew
- Korean
- Mixtec
- Polish
- Punjabi
- Russian
- Urdu
- Yiddish
- Yoruba
- Any Special Populations or speakers of languages identified by proposers

Contract awards shall be subject to the timely completion of contract negotiations between ACS and selected proposers as well as a positive responsibility determination. Negotiations may include the following adjustments requested by ACS of proposers:

- Capacity reductions or increases as compared to the proposed capacity
- *Target population* to be served
- *Community district or catchment area or borough* to be served

The contract award shall also be subject to:

- Demonstration that the proposer has, or will have, by the conclusion of negotiations and the start of the contract, site control deemed sufficient by ACS of an appropriate program facility
- Model support organization application process - conditional awards will be made and awards will be subject to proposers' participation in this process

C. Planning Phase: ACS will work closely with the contractors selected to support start-up, implementation, fidelity, engagement, and evaluation. Once selected, contractors will participate in an intensive start-up development, planning, and engagement process with support from ACS. Contractors agree to participate in the below planning phase in partnership with ACS to plan for and implement the

models. This process will not exceed five (5) hours per week. For the planning phase, contractors will not receive payment for the time spent in negotiations.

Planning Phase (1-3 Months)

- Model-specific application to ACS and model support organization
- Develop monitoring and tracking system to assess progress toward evaluation metrics
- Develop job descriptions with approval of ACS and model support organization

D. Payment structure: Reimbursement will largely be cost-based (that is, based on contractors' spending against approved line-item budgets), with a portion of payment driven by performance using utilization, quality, and outcome metrics set by ACS. Such metrics may include staff training goals, client utilization and length of service targets, casework contacts, levels of parent engagement, post-services outcomes, increasing Advocate cases, and community outreach, among other measures. ACS reserves the right to modify the basis of reimbursement of the contract in the future. During the term of the contract awarded pursuant to this RFP (including any renewals), in the event the provider incurs additional or increased expenses related to a site used to provide services to youth and/or families (e.g., rent, property taxes, property insurance) or other fixed costs (e.g., health insurance, model support organization expenses), ACS, in its sole discretion, may modify the budget to provide additional funding to reimburse the provider for such additional or increased expenses. Additionally, during the term of the contract awarded pursuant to this RFP (including any renewals), ACS, in its sole discretion, may modify the budget to provide additional funding to address health and safety emergency needs. Finally, In ACS's sole discretion, in the event the contract awarded pursuant to this RFP is renewed, the provider may be provided a one-time increase to the budget at the time of the first renewal equal to the lower of: (a) the rate of two percent (2%), or (b) the percentage rate increase, as determined by the U.S. Bureau of Labor Statistics National Consumer Price Index for the Urban Consumers (CPI-U), for All Urban Consumers, All Items, New York-Northern N.J.-Long Island, NY-NJ-CT-PA area during the immediately preceding twelve (12) month period.