Critical Time Intervention Teams (CTI Teams)
Downstate
Questions & Answers

Q1. If our organization is not currently authorized to bill Medicaid, can we still apply for this RFP?

A1. Enrollment in the Medicaid program is not required to apply, however enrollment to the Medicaid program will be required at the time of transition to Medicaid.

Q2. Is the total amount indicated of $1,012,570 for downstate, with net deficit funding for one year or over five years?

A2. The amounts provided in RFP section '5.4 Operating Funding' are annual figures, unless otherwise noted. For example, monthly figures are provided in parentheses after the annualized State aid amounts for full program funding, with monthly figures used to prorate State aid funding upon Medicaid State Plan approval. The ongoing annual net deficit funding per team is labeled as such in the RFP. The funding mix in a given year will depend on the timing of Medicaid State Plan Approval.

Q3. If Medicaid does not approve billing, what is the range for an annual budget?

A3. The full annual (and monthly) figures provided in RFP section '5.4 Operating Funding' as follows:

- Downstate $1,217,259 ($101,438)

These figures are indicative of the State modeled annual (and monthly) revenue of a mature CTI program from all payors.

Q4. Is there an anticipated breakdown of funding by the number of agencies to be funded?

A4. Please refer to the response to Question 3.

Q5. Staten Island was excluded from the NYC pool. Can you advise why Staten Island was excluded and if there will be plans for a proposal that includes Staten Island in the future?

A5. The areas chosen for the RFP was based on different data points. The areas with the highest needs in regard to hospital/ER/CPEP discharges were prioritized. We do not yet know the locations for the next RFP.

Q6. What does the "XXXX" in parentheses placeholder stand for on page 30 of the RFP (under item 4.v.)?

A6. This placeholder was supposed to refer back to section 1.1 that outlines the catchment area of NYC and Long Island.

Q7. The instructions in Grants Gateway indicate that for any question, applicants have a choice to either type content into the 4,000-character limit textbox or type "See Attached" and then attach and upload a file. However, it looks like none of the question-prompts in Grants Gateway are accompanied by an upload button except for the two relating to uploading the Budget (Appendix B) and the Budget Narrative (Appendix B1). Should applicants assume that they do not have the option to upload responses and type "See Attached" for all the remaining question-prompts? Also, will applicants be submitting via Grants Gateway... or via SFS?

A7. For this RFP, we are not allowing any uploads. The instructions are a generic thing and must have been missed to take that piece out. Answers need to be typed in question box with 4,000-character limit. New RFPs will be in SFS but ones already out in the gateway are remaining in gateway and will complete entire process in the gateway. This RFP was entered into Grants Gateway and therefore will be completed in Grants Gateway.

Q8. Is street-outreach allowed as part of this program's funded activities (to reach the sub-segment of population who are homeless or unstably housed)? or should funded outreach be limited to hospitals, jails, and other institutions?

A8. There will not be street outreach for these CTI Teams. CTI teams will be working with hospital settings, including ER, CPEPs, and other crisis services. For these teams specifically, we are looking for connections and engagement during times in transition (discharge, ER, CPEP, crisis services). Subsequent RFPs will be looking at specialized populations.

Q9. Would OMH expect the MOU to be uploaded with and included in the application submission (along with the letter(s) of support from hospital(s) or can the MOU be submitted post-award? Where in Grants Gateway should the letter(s) and/or MOU(s) be uploaded? Did you want those submitted in the Grantee Document Folder?

A9. OMH understands that MOUs take more time to execute and therefore are not needed to submit with the RFP proposal. They would be expected after the team has been awarded. However, letters of support from hospitals must be submitted with the RFP proposal. Letters can be uploaded to the Grantee Document Folder.

Q10. Will the slide deck from the CTI Teams Bidders Conference be sent out after the meeting?

A10. The presentation will not be sent out, but rather was uploaded in OMH procurement page along with both recordings from the LI and NYC presentation and can be found **here**.

Q11. For new CTI teams, can/should applicants' budget for an additional allocation in the amount of four-months' worth of annual State Aid (in addition to the full 12-month State Aid allocation) in the first year? (This would be separate from -- and in addition to -- the $100K start-up, from Net Deficit Funding, and service dollars, correct?)

A11. Ramp-up funding will only be applicable to programs that begin operation within four months of the transition to Medicaid billing and will be prorated as necessary. Please note that

the full 12-month State Aid allocation will also be prorated to coincide with the start of Medicaid billing.

Q12. Are MOUs required at submission? Or will letters of support be sufficient (with MOU's required later)? Given that most if not all hospitals will require significant legal review of MOUs, even as we already partner w/all major hospital systems in our region, and these legal teams may take weeks or months (longer than the entire application window) to complete and approve an MOU.

A12. OMH understands that MOUs take more time to execute and therefore are not needed to submit with the RFP proposal. They would be expected after the team has been awarded. However, letters of support from hospitals must be submitted with the RFP proposal.

Q13. Currently, Grants Gateway does not appear to have spaces to upload proof of notification of LGUs of intent to apply. Where should these be uploaded? And, if they should all be combined with MOUs/LOSs into a single PDF and submitted, where should these be attached?

A13. It is not required to submit proof of communication with the LGU, but if you want to submit something, it is encouraged and can be uploaded to the Grantee Document Folder.

Q14. Would OMH like applicants to assume for the purposes of developing the Year 1 budget (and annual budget over 5 years) that funding will be in the amount of State Aid... or would OMH like applicants to assume that in Year 2 or Year 3, for example, the amount of funding will change to the Medicaid-reimbursement model that has been mentioned and anticipated?

A14. As a definitive start date for Medicaid billing cannot be provided, it is recommended for providers to choose a date on or after 10/1/24 for the effective start date of Medicaid billing, the date used is at each provider's discretion.

Q15. Regarding capacity, will a team serve 130 individuals annually, or maintain a case load of 130 at any given time?

A15. CTI teams will maintain an average caseload of 130 at any given time. When looking at timeframes, each individual will be provided services for a 9–12-month timeframe, which includes engagement in hospital/ER setting.

Q16. For the young adult exception, are these individuals 16 years or older that are emancipated? Do they have the capacity to provide informed consent?

A16. CTI teams may serve any individuals who are 16 yo or older, it will be up to the team and agency's comfort/knowledge to serve this population because of these nuances. Not everyone would have to serve this population but if they have ability to do so, then they can.

Q17. What is meant by "Mental Health Professional"?

A17. Team Leader's will need to be a Licensed Professional of Healing Arts (LPHA) and Mental Health Professional is defined as an individual with a minimum of a Master's degree in the human services field. OMH will consider qualifications that include experience working with the identified populations as in forthcoming guidance.

Q18. Will this be submitted through Grants Gateway or SFS?

A18. Any RFPs posted into Grants Gateway will be completed in Grants Gateway, including this RFP.

Q19. In the RFP, it was stated that the admin rate is capped at 10%. Other RFPs recently release capped admin rate at 15%. Is 10% accurate and if so, any chance this will be modified?

A19. Clarification to the RFP that up to 15% can be used for admin and over-head.

Q20. In the RFP it states that all eligible CTI Team members are expected to obtain & maintain 9.58 certification. Only RN's and certain social workers are eligible for that certification. Must teams fill some positions with this level of professional staffing?

A20. Based on the team composition, there will be at least one staff who is eligible.

Q21. Is ramp-up funding (and start-up funding) in addition to operating funding in year one? I.e., ~300k-$400k on top of the ~$400K for downstate in the initial four months of the program?

A21. Please refer to the response to Question 11.

Q22. The prompt 6.6.a.4.v. appears unfinished. Can you clarify that prompt on p30?

A22. The sentence should have referred back to Section 1.1 which outlines the catchment area, meaning Long Island and NYC. “Efforts to adequately engage underserved foreign-born individuals and families in the project’s catchment area as identified in (Section 1.1),

Q23. In preparing budget, when should we reflect a shift to Medicaid? Or should we build budget based on NDF and just adjust later?

A23. Please refer to the response to Question 14.

Q24. What is the expected timing of the CTI State Plan Amendment (SPA)?

A24. OMH will be submitting SPA sometime this year. We are not able to identify when CMS will review and approve but we are working towards an anticipated timeframe of early fall. This timeline may vary.

Q25. Can OMH explain the decision not to allow NICRA for A&OH? We’re concerned about the viability of a 10% cap in this highly inflationary environment.

A25. Please refer to the response to Question 19.

Q26. When services are covered under Medicaid, how will they be paid?

A26. Eligible services, duration and quantity of service, reimbursement amounts, rate/modifier/procedure codes, and billing frequency details are being developed for this service. Providers will be required to be Medicaid enrolled upon the transition to Medicaid billing and able to submit claims through eMedNY or managed care plans as appropriate.

Q27. Is it advised/expected that applicants will ramp up the 10 total team members of the CTI model, as total participants ramp-up during Year 1, or are you expecting the 10 staff

to hit the ground running at the same time? (We will aim to remain in integrity of the model, but wanted to get your expectation on staff ramp-up timing: first four months, perhaps?)

A27. The implementation plan includes OMH working closely with teams as they develop. This is a new program, so we want to make sure we work closely with agencies towards implementation. There is no expectation you hire all staff as you begin, the expectation is a ramp up approach.

Q28. In NYC counties with multiple awards (2) how will the work of two awardees be coordinated when potentially working with the same hospital or hospitals?

A28. The expectation is that these relationships are already being built prior to proposal submission. This should be part of the conversations happening prior with the hospitals.

Q29. Since IPAs are eligible applicants, can the IPA apply on behalf of multiple providers operating in multiple counties? How will awards be made if individual providers, be they members of the applying IPA or not, are also applying for an award? Could an IPA potentially be awarded most or all of the 9 teams?

A29. IPAs would be applying on behalf of providers in their network. If multiple boroughs counties, they should submit a proposal for each county/borough of interest. Scoring will be based on highest in each location. IPAs should notify their network of submission of proposal, if one of the networked providers is interested in applying separately, they would submit their own proposal.

Q30. How would a proposal be considered if it is multi-borough where our organization has sites?

A30. Submit based on location of proposed team and hospital. If crossing over boroughs and are interested in a team in each borough, submit one proposal for each.

Q31. If someone is homeless, how are they assigned to a borough? What team would they be assigned to? What if they move around a lot and frequently go to hospitals in different counties, etc.?

A31. This would be part of the work in developing policies with the hospitals. Agencies will want to work that out and how to best manage based on need. One suggestion could include linking up with other CTI teams in other boroughs.

Q32. How is Mental Health Professional defined for staffing requirements? Is this referring to licensed professionals?

A32. Team Leader's will need to be a Licensed Professional of Healing Arts (LPHA) and Mental Health Professional is defined as an individual with a minimum of a Master's degree in the human services field. OMH will consider qualifications that include experience working with the identified populations as in forthcoming guidance.

Q33. Is the capacity 130 over the course of the year or is the 130 expected to be maintained throughout the year once the program ramps up?

A33. CTI teams will maintain an average caseload of 130 at any given time. When looking at timeframes, each individual will be provided services for a 9–12-month timeframe, which includes engagement in hospital/ER setting.

Q34. Does OMH intend to contract with an entity to function as a hub for the purposes of receiving & managing referrals, quality assurance, program review and reporting functions?

A34. No, OMH does not plan to contract with an entity to function as a hub.

Q35. Can you share what the payment model will be (e.g., Medicaid PMPM)? If it will be paid PMPM, what is the estimated rate? What are the service requirements to be able to bill?

A35. Please refer to the response to Question 26.

Q36. Will deficit funding be adjusted based on adequacy of Medicaid reimbursement to cover program costs?

A36. While the State will continue to evaluate the program, State Aid funding commitments beyond the amounts outlined in RFP section '5.4 funding' cannot be made. The funding mix in a given year will depend on the timing of Medicaid State Plan Approval.

Q37. Will undocumented individuals and non-Medicaid eligible persons be eligible for CTI?

A37. Yes.

Q38. Could you provide more detail regarding the staffing ratio of 9.58? Which staff are included/excluded in the calculation?

A38: The 9.58 requirement is related to transportation and evaluation and has specific requirements. The staffing ratio should be based on a weighted caseload, the CTI Manual for Workers and Supervisors, 2021 can be referenced for further detail.

Q39. Is the expected Medicaid revenue based on a fully operational team that is seeing a full capacity roster of participants? Are there any details you can share about the billable model so that we can take this into account for our decision-making?

A39. The figures provided in RFP section '5.4 Operational Funding', under "the ongoing annual Medicaid" are indicative of the State modeled annual (and monthly) Medicaid revenue of a mature CTI program. Average annual mature CTI program caseloads are outlined in the RFP by team type/region.

Q40. Can the state include in the RFP a condition that all teams work with the NYC Dept of Homeless Services closely, have an MOU with the Dept, and participate in coordinating discharges and ED visits.

A40. The RFP is already issued and there is no plan to require a MOU. CTI Teams will be expected to work with all community supports for individuals transitioning from hospital or CPEP/ER settings, including shelters when applicable.

Q41. Will agencies be responsible for establishing referral arrangements with non-hospital-based sources or might there be a SPOA?

A41. CTI teams will be responsible for working with hospitals for referral process directly to the team. Hospital referrals must be prioritized.

Q42. Is the Team Leader expected to provide a certain percentage of direct service? Is there a staff/client ratio limit?

A42. Although the Team Leader should provide direct care service, we have not defined what that direct service ratio is expected to be. It is an important part of team culture for the Team Leader to provide direct care.

Q43. Regarding the payment again, in Year 1, just to be sure I understand, there will not be Medicaid billing, just state direct funding.

A43**.** A definitive start date for Medicaid billing cannot be provided as it is dependent upon CMS review and approval. Please refer to the response to Question 11 for additional clarification. The state will work closely with teams and keep them informed.

Q44. Can you include possible exclusions for people enrolled with SOS, Pathway Home, etc.

A44. Absolutely we will take this into consideration. We are currently in discussions around co-enrollment.

Q45. Follow-up on collaboration with DHS: RFPs have been known to be amended when there is a compelling reason. I would appreciate that amendment, unless you think that adding this clause at time of contract with the awardees will be possible.

A45. The RFP is already issued and there is no plan to require a MOU with DHS. CTI Teams will be expected to work with all community supports for individuals transitioning from inpatient hospitals, ERs/CPEPs, including shelters when applicable.

Q46. How much ramp up time to implement the Medicaid billing once approved?

A46. This will be dependent on when Medicaid rolls out. We will work closely with awarded teams to provide proper notice, additionally there required notification to MCOs.

Q47. Are there any word limits total proposal or sections?

A47. The Grants Gateway has a 4,000-character limit on each answer. Attachments are only allowed for the budget questions.

Q48. The RFP says that "a critical aspect of this program is the partnership between CTI Teams and Hospitals", but the list of target populations includes individuals coming from other institutions and conditions. What is the expectation about developing multiple referral relationships beyond the hospitals where a MOU has been established, e.g., correctional institutions, transition age youth in residential programs? Or will there be some type of SPOA for referrals not coming?

A48. The expectation of the CTI teams first and for most is to work directly with the hospital system, including inpatient, ERs, and CPEPs. Hospital referrals must be the focus of these CTI teams. Target populations for the hospital to consider referring to CTI, are individuals considered high need and referenced in the RFP (cite?) It is not anticipated that there will be SPOA for CTI.

Q49. Are agencies required to work with all these target groups or is the expectation that we will pick a particular target group?

A49. The target population referenced in the RFP is include examples of high need populations that CTI teams will prioritize and hospitals will refer to CTI.

Q50. Can a client who is in one of the target population groups be enrolled in another program within the agency, e.g., someone being discharged from the hospital or correctional setting with a history of poor transitions? Can the agency program make the referral, or must it be generated by the discharging agency?

A50. Individuals being discharged from the hospital (inpatient, ER, CPEP) and meets the target population may be served, regardless of services within your agency they may be receiving as long as it is not a similar or duplicative service. The discharge plan and referrals are initiated by the discharging facility, however, the expectation is that the CTI staff are involved in the discharge planning and bring their expertise around community supports available.

Q51. What about individuals with dual dx who are leaving detox or inpatient drug/alcohol rehabilitation with a history of rapid relapse?

A51. The expectation of the CTI teams is to work directly with the hospital system, including psychiatric inpatient, ERs, and CPEPs. Hospital referrals must be the focus of these CTI teams.

Q52. Will there be any guidelines/restrictions about co-enrollment with other programs, esp. those that bill Medicaid?

A52. Yes, this information will be forth coming.

Q53. Will undocumented individuals and people who are not Medicaid eligible be eligible for this service? Any other criteria that might make someone ineligible for referral?

A53. Yes, undocumented individuals and those without Medicaid that meet the target population criteria are eligible for CTI services. There are not specific ineligibility criteria outlined.

Q54. Are there any section or total proposal word limits on responses?

A54. The Grants Gateway has a 4,000-character limit on each answer. Attachments are only allowed for the budget questions.

Q55. Are you able to provide details on how you came to the expected Medicaid Revenue per team once the SPA is approved. Specifically:

-Expected % of Medicaid clients served based upon the 130 census; and were there different assumptions on % of Medicaid clients in different phases of model at any particular time?
-What Rates were utilized to determine revenue and will the rates differ based upon which phase of the CTI model a person is in?
-Will services be billed monthly?

A55. Please refer to the response to Question 26.

Q56. I wanted to clarify if Staten Island providers are eligible to apply for this grant? The RFP spoke of 9 CTI teams, but Staten Island was not in the initial proposed catchment area. Will there be an expansion of the initial model? Would Staten Island providers have to include another Borough as part of their catchment if they applied or be a part of an IPA or agency that serves another Borough and Staten Island?

A56. CTI Team locations for this RFP are as follows: Queens 1 CTI Team; Kings 2 CTI Team; The Bronx 2 CTI Team; Manhattan 2 CTI Team; Suffolk 1 CTI Team; Nassau 1 CTI Team. There will be additional teams that will be RFPd, but the location of those teams is not yet known.

Q57. Will applicants need to include CTI training costs in their start up budgets, or will OMH be providing CTI training for free?

A57. OMH plans to provide CTI training, details forthcoming. Agencies may want to consider any additional training they may need to provide.

Q58. Will applicants need to include 9.58 training and certification costs in their start up budgets, or will OMH be providing 9.58 training for free?

A58. Agencies will work with LGU/DOHMH for 9.58 training and certification.

Q59. What is the expected timeframe to ramp up to a caseload of 130 clients?

A59. There is not identified time frame, the state will work with teams further upon award. Ramp up will be based on determined budget model and costs.

Q60. Can applicants articulate a plan for placing a CTI team in one hospital initially (with an MOU), with a plan to ramp up to additional hospitals (with additional MOUs) within the award period?

A60. Each CTI Team must have a well-defined working relationship with at least one (1) local Article 28 and/or Article 31 hospital (e.g., inpatient psychiatry units, emergency department and/or CPEP) for the purposes of the proposal submission. However, we would expect agencies to partner with more than one hospital in areas where they may be higher demand. This can occur after awarded, however, you will want to indicate your plan in the proposal.

CTI Teams should consider partnering with more than one (1) hospital/facility, based on local need. CTI Teams should consider where additional relationships with hospitals in their county/borough may be needed, as well as with hospitals in nearby counties/boroughs where

individuals may go to receive psychiatric inpatient services but return to county/borough where CTI Team is located.

Q61. Can our CTI team receive referrals from other hospitals that we do not have an MOU with (yet)? Or can our CTI team only receive referrals from the hospital we have an official MOU with?

A61. Each CTI Team must have a well-defined working relationship with at least one (1) local Article 28 and/or Article 31 hospital (e.g., inpatient psychiatry units, emergency department and/or CPEP) for the purposes of the proposal submission. However, we would expect agencies to partner with more than one hospital in areas where they may be higher demand. Depending on this relationship, it may or may not require a MOU. CTI Teams should consider partnering with more than one (1) hospital/facility, based on local need. CTI Teams should consider where additional relationships with hospitals in their county/borough may be needed, as well as with hospitals in nearby counties/boroughs where individuals may go to receive psychiatric inpatient services but return to county/borough where CTI Team is located.

Q62. In Section 5.1.1. It says, "Applicants must notify the LGU(s) of their intent to apply." Does the state require proof of this notification, and if so, what qualifies as proof? Who is the LGU contact for NYC?

A62. There is no specific required proof of this notification for the proposal submission. Department of Health and Mental Hygiene (DOHMH) is the local government unit in NYC.

Q63. Is there an opportunity to apply for the CTI RFP for Staten Island?

A63. CTI Team locations for this RFP are as follows: Queens 1 CTI Team; Kings 2 CTI Team; The Bronx 2 CTI Team; Manhattan 2 CTI Team; Suffolk 1 CTI Team; Nassau 1 CTI Team.

Q64. Where can we upload the letter of support required in question 6.4a? Currently, there's no upload button available for this question.

A64. Letters of support can be uploaded to the Grantee Document Folder.

Q65. Where can a draft of an MOU be uploaded in Grants Gateway?

A65. A MOU is not required to be submitted for the purposes of this proposal, however, a letter of support as defined in the RFP. **Provide a letter of support from the hospital(s) listed, including the hospital answers to the below three (3) questions and signatures from the hospital executive leadership.**

i. How will the hospital embed the CTI Team in discharge planning processes?
ii. How will the hospital ensure access for CTI Team staff to engage with individuals served while inpatient?
iii. What processes will be put in place to identify and refer individuals eligible for a CTI Team?

These documents can be uploaded to the Grantee Document Folder.

Q66. The RFP says that "Each CTI Team must have a well-defined working relationship with at least one (1) local Article 28 and/or Article 31 hospital…This relationship must include a Memorandum of Understanding (MOU)." Are we correct in understanding that

an applicant can secure a letter of support from a hospital(s) to enter into an MOU, but that the detailed MOU with the hospital(s) can be developed after the award? Hospitals in areas with multiple applicants may be reluctant to enter into MOUs prior to the award.

A66. That is correct. The MOU is not required for the purposes of the proposal, however, it will be required if awarded. For the purpose of the RFP, please submit a letter of support as outlined in the RFP. **Provide a letter of support from the hospital(s) listed, including the hospital answers to the below three (3) questions and signatures from the hospital executive leadership.**

iv. How will the hospital embed the CTI Team in discharge planning processes?
v. How will the hospital ensure access for CTI Team staff to engage with individuals served while inpatient?
vi. What processes will be put in place to identify and refer individuals eligible for a CTI Team?

Q67. The RFP says that "In order to support implementation of the hospital's person-centered discharge plan, the applicant must develop coordinated admission and transition plans with community providers." Is it required that applicants secure and submit with their applications linkage agreements with community providers that offer services the applicant organization does not provide, such as outpatient mental health services or supportive housing?

A67. There will not be an opportunity to provide or link additional documents for linkage agreements in the proposal. Agencies should clearly articulate this information where indicated as part of the response to this RFP.

Q68. What are the minimum qualifications for the 3 FTE Mental Health Professionals?

A68. Team Leader's will need to be a Licensed Professional of Healing Arts (LPHA) and Mental Health Professional is defined as an individual with a minimum of a Master's degree in the human services field. OMH will consider qualifications that include experience working with the identified populations as in forthcoming guidance

Q69. Is an MOU with a hospital required or only the support letter?

A69. Both, but the MOU is not required for the purposes of the proposal, however, it will be required if awarded. For the purpose of the RFP, please submit a letter of support as outlined in the RFP. **Provide a letter of support from the hospital(s) listed, including the hospital answers to the below three (3) questions and signatures from the hospital executive leadership.**

vii. How will the hospital embed the CTI Team in discharge planning processes?
viii. How will the hospital ensure access for CTI Team staff to engage with individuals served while inpatient?
ix. What processes will be put in place to identify and refer individuals eligible for a CTI Team?

Q70. The 5.2 "Objectives and Responsibilities" section of the RFP (pp20-21) includes a sentence that says, "Refer to Critical Time Intervention Manual (2002) and the CTI Manual for Workers and Supervision (2021) for more details." The same link appears on RFP pg19 (5.1, Introduction), pg24 (under 5.3.4., CTI Team Staffing), pg29 (under 6.5 Utilization Review). The link provided to the 2021 manual leads to a highly customized manual that

is specific to the special population of veterans. The document linked-to is titled, "MANUAL FOR CTI WORKERS AND SUPERVISORS IN VA GRANT AND PER DIEM'S CASE MANAGEMENT GRANT PROGRAM [all caps in title]". Is this the intended manual? Or was this link a typo and is OMH intending to link to a broader, more holistic CTI manual that is not specific to the VA / Veterans' population and programming?

If this above link is correct, this manual deviates from the model indicated in the RFP and in the 2002 manual. For example, specifically, page 7 of the 2021 manual says that each of "the three distinct phases" of the program is "approximately two months long," while the other sources indicate 3 months or 90 days per CTI phase.

(The CTI RFP p22 indicates: "Phase 1 Initiate Linkages -- Months one (1) to (3) post discharge," and p23 "Phase 2 Try Out - four (4) to six (6) post discharge" and p23 "Phase 3 Final Transfer of Support - Months six (6) to nine (9) post discharge.")

The "Two Month" timeframe is repeated many times in the 2021 document, i.e., on pg19 (re: Phase 1), pg21 (re: phase 2), and pg23 (re: phase 3). In addition, page 30 says, "Phase transitions should occur every two months and are not delayed for any reason, with very few exceptions." The included CTI Implementation Self-Assessment form (e.g., pg 76 of the 2021 manual) also includes such references to two months.

Will OMH allow APPLICANTS to choose either 2 or 3 months per phase (or "2-3 months") in their planned implementation?

In other cases where the RFP, 2002 manual, and 2021 manual conflict or contradict on any points beyond this matter, are APPLICANTS empowered to choose intuitively what works best (or is there a dominant guide to model-fidelity among these three)?

If a two-month-per phase assumption is intended, then Phases 1-3 combined would last ~6 months instead of ~9 months that is referenced in other sources.

Is a combined total of 6 months or 9 months intended by OMH for Phases 1-3?

Is it reasonable to assume a full one-year cycle when the Pre-CTI phase is included (since arranging housing is very unpredictable, and flexibility is required in real-life implementation)?

A70. Thank you for bringing this to our attention. The correct version of the document; CTI manual for Workers and Supervisors 2021; has been uploaded to the OMH Procurement Page here **Critical Time Intervention Teams (CTI Teams) Long Island/NYC**