



Office of Mental Health

Capital Awards for Crisis Residential Programs for Children and Adults

Questions and Answers

January 15, 2020

Designated Contact/Issuing Officer

1. May we contact Local Government Units (LGUs) directly, or must the Designated Contact/Issuing Officer, Carol Swiderski, be part of the contact/call?

Ms. Swiderski will not be part of this communication; the applicant should contact the LGU directly.

Key Events/Timeline

2. What is the anticipated start date for funding/activity? It is listed as TBD on page 5, Section 2.2. Alternatively, when does OMH anticipate having an anticipated start date?

This RFP is for capital funding. Each project progresses at its own pace therefore a set start date for the capital contract cannot be determined overall. Staff from the Bureau of Housing Development and Support and the Field Offices will work with awardees to make steady progress.

3. What is the timeframe for starting services?

Please refer to the State's response to question 2 for information regarding anticipated start

Eligibility

4. Could these funds be used to convert an existing children's CR into a Children's Crisis Residence program?

Yes. However, these closures are subject to PAR approval.

5. Who should the letter of support be addressed to? Someone at OMH or the CEO of the applicant agency?

The letter of support should be addressed to the applicant agency and uploaded with the submission in the Grants Gateway.

6. Is the RFP only for current OMH certified Crisis Residential Program providers or can any Article 31 provider in good standing could apply, and if awarded the agency will be able to submit a PAR application for OMH approval as a Crisis Residential Program provider?

Article 31 providers that meet the criteria under Section 2.5 of the RFP (Eligible Agencies) may apply. OMH licensure as a crisis residential program provider is not a prerequisite.

7. Can an agency that does not currently have an OMH contract apply?

Yes.

Disqualification Factors

8. As an article 31 and 32 clinic; could we provide ambulatory detox at an Intensive Crisis Respite facility?

This service provision needs to be described in the applicant's program model and will be evaluated at time of licensure.

Grants Gateway

9. In cases throughout the Grants Gateway where an applicant chooses to upload a response instead of using the textbox, is the applicant correct in understanding that it is allowed to exceed the 4,000-character restriction by whatever amount is needed within its uploaded document to answer the question in full (while being as concise as possible).

Yes, but it is cautioned that the response must be succinct and speak strictly and only to the question being asked. OMH reserves the right to review and score based on the appropriateness of the response provided.

10. Where within the Grants Gateway portal would OMH prefer that Applicants upload relevant Deed(s) demonstrating site control?

The RFP does not require submission of a Deed. As Section 4.3.3 / Award Notification states, if awarded it would be provided as part of the PAR process or the site control can be described in writing in response to question 1b (Executive Summary).

11. Is there an MB limit on combined files being uploaded into the Grantee Document folder?

Nothing is to be uploaded into the Grantee Document folder. All uploads must be made in response to the question posed and placed in the appropriate upload space for that question. The limit is 10MB.

12. If a feasibility study has been conducted, may it be attached as a pre-submission upload or in the grantee document folder? Will this be looked upon favorably by OMH in their application evaluation process?

There are two placeholders provided on the Pre-Submission upload page for any extraneous (not required and/or not a required component of a response to a question) documents. Scoring/points will not be given consideration for any such extraneous document.

13. In program specific questions, may uploads for each question exceed 4,000 characters?

Refer to the States response for Question 9.

Capital-Based Budget

14. It seems the incorrect form was uploaded for the Appendix A1 - Capital Budget Narrative. It is labeled "Appendix B1 – Budget Narrative". Please clarify.

The form itself is correct, unfortunately, it was titled incorrectly. This form is to be used. Evaluators will know that it is specific to the Capital Budget.

15. Is asbestos abatement an allowable cost for a proposed rehabilitation project?

Yes.

16. Section 2.9.9 – Are costs to relocate clients during facility renovations an allowable expense?

OMH would consider funding relocation costs on a limited basis.

17. Section 2.9.3, 4.1 and 4.3 – The regional units and funding amount targets calculate to \$250,000 per unit for 12 units within the New York City region. The allowable costs in Section 2.9.2 include percent increases for contingency and costs for administration. Preliminary budget estimates for our project exceed the per unit cost target with the addition of contingency and administration costs. Per Section 4.1 and 4.2, 26 points are awarded for the fiscal score. Will proposals that exceed the target \$250,000 per unit be scored lower than proposals that meet or are less than the target cost per unit?

There is no established cost per unit. The minimum award amounts per region are intended to distribute the funding regionally. The unit targets are an estimation of the number of potential units for each region.

18. Can any of the Capital funds be used to partially support oversight and supervision of implementing the capital project (Project Management) by staff of the applicant, particularly in managing the selected contractor. If so, what category of the budget would this go under?

Yes, applicants may propose to include an owner's representative to assist in oversight of the construction process. Section 2.9.3 of the RFP indicates that owner's representative costs should be included in the "Other" expense category in the Grants Gateway budget.

19. If an Applicant is planning on building a new separate but physically adjoining Residential Crisis Support space onto an existing large-house structure that will continue to serve as a neighboring Congregate Treatment residence, does OMH consider such a design and building project to fall under the "construction of new facility(y)/(ies)" description/sub-category of activity (vs. "rehabilitation of existing building(s)") that are mentioned on page 4 of the RFP in section 1.1 "Purpose of the Request for Proposal" (all of the land is already owned by the Applicant, so it would not be an "acquisition" project)? With regard to the "Allowable Costs" table on RFP page 9, would this construction of a new multi-room annex onto an existing structure allow/require a 10% contingency or a 5% contingency?

Considering that the project seems to primarily involve expanding the footprint of the existing building, it should be considered new construction. Therefore, a 5% contingency should be applied.

20. Are these capital funds available to create new respite programs or to upgrade existing respite facilities?

Yes.

21. Page 9 of the RFP that addresses design amount – which is listed as 10% of contingency. Please clarify as that seems low. IF a project is \$2,000,000 then contingency would be \$200,000 and 10% of that would be \$20,000 for design fee. That sounds very low. Did you mean 10% of the renovation budget?

That section of the RFP refers to “additional” architect’s fees. Please refer to OMH’s current architect’s fee schedule below. The fees are based upon the construction/ rehabilitation cost.

OMH Architect’s Fee Schedule

COST RANGE	FORMULA FOR CALCULATION OF BASIC FEE
Up to \$999,999	15% of Cost
\$1,000,000 to \$3,999,999	\$150,000 + (8% of Cost Over \$1,000,000)
\$4,000,000 to \$5,999,999	\$350,000 + (6% of Cost Over \$4,000,000)
\$6,000,000 to \$7,999,999	\$495,000 + (4.5% of Cost Over \$6,000,000)
\$8,000,000 to \$9,999,999	\$600,000 + (4% of Cost Over \$8,000,000)
\$10,000,000 to \$12,999,999	\$700,000 + (3% of Cost Over \$10,000,000)
\$13,000,000 to \$15,999,999	\$800,000 + (2.5% of Cost Over \$13,000,000)
\$16,000,000 and Up	To Be Negotiated

Workplan and Objectives

22. Is the work plan portion of the RFP worth points?

No.

Term of Contract

23. Based on page 10, Section 2.9.4 of the RFP that capital contracts will be approved for a five-year term. Are applicants allowed to undertake and complete the funded work at any point along that 5-year timeline?

In order for OMH to execute a capital contract the Bureau of Housing Development and Support staff will work with awarded applicants assess the feasibility of the project, develop a cost estimate and submit a request for funding to the Division of the Budget. Once DOB has approved, staff will work with the awarded applicant to enter into a contract through the Grants Gateway. This capital contract will have a five-year term and once approved it is expected the applicant will be ready to start the actual development. It is expected that awardees diligently pursue the advancement of their project toward completion throughout the contracting and development process.

Acceptance of Terms and Conditions

24. Will the Capital Awards for Crisis Residential Programs for Children and Adults grants awards require property liens?

Yes, a State Aid Grant Lien will be required.

25. Is there commitment to this funding, and building the program, if it is decided not to pursue it after the RFP is submitted? Is there a financial risk by replying to this RFP?

There is no financial risk assumed simply by submitting an application or receiving an award. An award may be declined at any time prior to receiving funds under an executed contract.

Method for Evaluating Proposals

26. Page 16 of the RFP, Section 4.1 indicates that the Financial Assessment section 5.4.5 may receive up to 26 points. However, the Grants Gateway portal (per screen capture below) indicates that this section is worth 30 points. Which is correct?

The RFP document on the OMH website is correct, there are 26 points assigned to the Financial Assessment section 5.4.5, the build in the Grants Gateway is incorrect, there will only be a maximum of 26 points awarded in this section.

Awarding Contracts

27. Are there dollar limits per project and/or per bed?

There are no award per project or per bed limits per se. Each request will be scored in part based on cost effectiveness and evaluated in view of OMH's experience with administering capital funds. OMH reserves the right to approve or reject any aspect of the proposed scope of work, which extends beyond the initial award.

Initial Awards and Allocations

28. It appears that the recently released RFP for capital funding for crisis residential programs does not include available funding for the North Country of New York State (page 17 of the RFP). Would you please confirm that this is the case? If so, would you please share why?

This is not the case, OMH has different regional definitions than the Regional Economic Development Councils. Clinton, Essex, Franklin, Hamilton, Jefferson, Lewis, and St. Lawrence Counties are in the Central New York Region. Please see: <https://www.omh.ny.gov/omhweb/aboutomh/fieldoffices.html>

29. Please clarify is there is a firm deadline for the operational, staffed launch of the Crisis Residential Program (i.e., a particular calendar date or a specific number of days following completion of the capital construction or rehabilitation funded by this grant)?

OMH is interested in establishing a network of crisis residential programs as soon as practicable. The actual operational dates will vary by project. It is expected that a project would become operational immediately following the completion of construction (assuming issuance of an Operating Certificate by OMH and a Certificate of Occupancy by the local municipality).

Funding

30. Now that the RFP for Crisis Residence capital funds has been released, when will the DRAFT rates being proposed to CMS be shared with the provider community? Logically, providers cannot respond to the RFP without being able to let their Boards of Directors

meet their fiduciary obligations of evaluating the fiscal viability of investing in a building project.

Attached (below) please find DRAFT Medicaid per diem rates (pending any necessary State and Federal approvals). These rates may be used as a reference, however any final rates paid under Medicaid Managed Care will be determined via contracts with Managed Care Organizations.

Proposed Rate Code Description	Downstate	Upstate
Residential Crisis Support (RCS) ¹	\$576.09	\$512.72
Intensive Crisis Residence (ICR) ²	\$913.30	\$812.84
Children's Crisis Residence ³	\$911.10	\$810.88

1. 1:4 Paraprofessional to client/Length of stay should not exceed 28 days.
2. 1:8 Paraprofessional & RN to client/24 hr. Psychiatric on call/ Length of stay should not exceed 28 days
3. 3:8 Paraprofessional to client/ Length of stay must not exceed 21 days without clinically appropriate MCO and/or field office extension authorization.

No assurance is made by OMH to provide operating funding to meet all program expenses.

31. We reviewed the Capital Crisis Residence RFP but are trying to figure out if this would be fiscally viable for us to pursue. The primary reason is that we do not know what the rates will be. Is there any chance that OMH would be able to provide us with the proposed rates? Anything that could guide us would be very helpful.

Please refer to the State's response to question 30 for information on proposed Medicaid rates.

No assurance is made by OMH to provide operating funding to meet all program expenses.

32. Have the children's crisis residential rates been released yet?

Please refer to the State's response to question 30 for information on proposed Medicaid rates. No assurance is made by OMH to provide operating funding to meet all program expenses.

33. What funding would a provider use for Crisis Beds operating if not ESSHI?

Funding sources may include but are not limited to: grants, Medicaid Managed Care, private pay clients, local aid and any other anticipated revenue.

Please refer to the State's response to question 30 for information on proposed Medicaid rates.

34. Are the youth served in the crisis residence eligible for Medicaid? If not, can you give an example of what revenue stream is used to support the program operations since OMH funds only the Capital?

Admission to a crisis residence doesn't deem an individual Medicaid eligible nor does it impact an individual's Medicaid eligibility.

Please refer to the State's response to question 30.

35. "Applicants are expected to identify potential sources for operating funding to demonstrate fiscal sustainability. No assurance is made by OMH to provide operating funding to meet all program expenses."

Will OMH provide funding to support a portion of operating costs?

Could providers bill Medicaid for the services outlined in the Licensed Crisis Residential Programs similar to the rehabilitative service rate provided to adults living in Community Residences? Or should providers negotiate agreements with all MMC's for reimbursement?

Please refer to the State's response to question 30 for information on proposed Medicaid rates.

Please refer to the State's response to question 24 for information on Program Development Grants.

Providers will be required to negotiate with insurers for reimbursement of their enrollees.

No assurance is made by OMH to provide operating funding to meet all program expenses.

36. What will the options be for funding operations? Will it be from net deficit funding or will there be a Fee for Service billing code?

Please refer to the State's response to question 30 for information on proposed Medicaid rates.

Please refer to the State's response to question 42 for information on Program Development Grants.

Providers will be required to negotiate with insurers for reimbursement of their enrollees.

No assurance is made by OMH to provide operating funding to meet all program expenses.

Funding sources may include but are not limited to: grants, Medicaid Managed Care, private pay clients, local aid and any other anticipated revenue.

37. When will the state rates be released? Appendix C Crisis Residence Interim Program Guidance mentions staffing recommendations. The state rates will determine if the staff composition is sustainable and the level of staff able to be funded (example: and RN on staff). Will the state rates be released before the application is due?

Please refer to the State's response to question 30 for information on proposed Medicaid rates.

38. When will the DRAFT rates being proposed to CMS be shared with the provider community? To develop a realistic operating budget, the following will need to be understood – a) Will there be a "Days Care" rate"? Contract rate; b) What rate will Medicaid Managed care pay?; c)What if a youth is not Medicaid eligible?; and, d) What will the local aid (local MH) pay?

Please refer to the State's response to question 30 for information on proposed Medicaid rates.

39. The funding in this RFP is only for start-up programs and not existing programs, correct?

No, this capital opportunity also applies to existing crisis residential programs that, in order to preserve or expand a program, need to acquire new property, construct a new facility and/or for rehabilitation of an existing building.

40. There is funding to run a Residential Crisis Support/Children's Residence Program I have property for lease to a nonprofit and it is ideal space for program like this and want to reach out to a known organization?

This RFP provides capital funding only. OMH providers can be located at The Mental Health Program Directory found on the OMH website at:
<https://my.omh.ny.gov/bi/pd/saw.dll?PortalPages>

41. Will this capital funding be paired with any type of ongoing operational funding?

No, not at this time.

42. If a nonprofit were looking to start a crisis residential program for children or adults is there currently funding available to start and run such a program? If yes, where is the funding from - city? state?

Regarding start-up funding, as detailed in Section 5.3 Funding “In addition, applicants are eligible for Program Development Grant (PDG) funds to assist with the establishment of new crisis residential programs. PDG funds of up to \$8,499 per bed are to be used for start-up costs such as furnishings, equipment, staff training, initial staffing costs. Note that PDG budget requests will not be submitted as part of this application process. OMH staff will work with successful applicants to develop and approve a PDG budget following subsequent awards. Proposals under this RFP may include durable goods (e.g. installed equipment or furniture) as part of the proposed capital budget.”

As noted above, OMH staff will work with applicants to develop a PDG budget following awards. The grant funding per unit will not exceed \$8,499 per unit.

Please refer to the State’s response to question 30 for information on proposed Medicaid rates.

No assurance is made by OMH to provide operating funding to meet all program expenses.

Funding sources may include but are not limited to: grants, Medicaid Managed Care, private pay clients, local aid and any other anticipated revenue.

43. The RFP references awarding central NY with \$4 million for 30 units. Is that per provider or per bed?

OMH has allocated \$4 million to the Central New York region which is estimated to fund 30 units.

44. Is there any reimbursement information which will help plan the scale of the program for ongoing sustainability?

Please refer to the State’s response to question 30 for information on proposed Medicaid rates.

45. How are these services billed for individuals not on Medicaid and does commercial insurance require prior authorization?

This RFP is exclusively for capital funding and does not provide operating funds. Applicants are expected to identify potential sources for operating funding to demonstrate fiscal sustainability. No assurance is made by OMH to provide operating funding to meet all program expenses.

It is the sole responsibility of the applicant to develop an Operating Budget using the State’s Budget Template. Applicants should identify all sources of income for reimbursement under the proposed crisis program(s). Funding sources may include but are not limited to: grants, Medicaid Managed Care, private pay clients, local aid and any other anticipated revenue. The Operating Budget will include a detailed description of the program’s financial sustainability (see [Appendix B](#)).

No provisions to the award under this RFP govern commercial insurance requirements for prior authorization.

46. Is there an RFP coming out that will provide operating funds for the program?

No

47. If Medicaid funds will support operations, what are the rates?

Please refer to the State's response to question 28 for information on proposed Medicaid rates.

48. Can a model be operated that includes a certified peer worker residing in the residence (part of his/her compensation)?

No.

49. Can capital funds be used for the conversion of a transitional house to a crisis residential facility?

Yes, subject to the approval of the agency licensing the transitional house, if any.

50. If the funding guidance is not released within a reasonable amount of time, can providers use CR budgets as a guide for budget portion?

Rehabilitation in Community Residences budgets should not be used as a reference in establishing an operating budget.

Please refer to the State's response to question 30 for information on proposed Medicaid rates.

Please refer to the State's response to question 42 for information on Program Development Grants.

51. For clients who are not enrolled in Medicaid Managed Care but are on Medicaid, will there be a FFS rate?

State Plan 20-0001 will establish Children's Crisis Stabilization and Residential Support services as a State Plan FFS benefit, pending CMS approval, and State FFS rates will be published once approved.

52. Will property pass through be available for a crisis residence? Is there an expectation that OMH contracting funding may be available to supplement the program and potentially assist with ongoing property related costs?

Property pass through will not be available for a crisis residence.

Please refer to the State's response to question 42 for information on Program Development Grants.

53. Is it acceptable for an applicant's projected total annual revenue (100%) enabling the operation of the proposed new Residential Crisis Support program to come from Medicaid and/or contracts with Medicaid Managed Care Organizations? Or is a broader mix of income sources required?

Applicants are expected to identify potential sources for operating funding to demonstrate fiscal sustainability. No assurance is made by OMH to provide operating funding to meet all program expenses.

It is the sole responsibility of the applicant to develop an Operating Budget using the State's Budget Template. Applicants should identify all sources of income for reimbursement under the proposed crisis program(s). Funding sources may include but are not limited to: grants, Medicaid Managed Care, private pay clients, local aid and any other anticipated revenue. The Operating Budget will include a detailed description of the program's financial sustainability (see Appendix B).

54. Is it still OMH's intention to promulgate suggested rates? If so, what are they?

Please refer to the State's response to question 30 for information on proposed Medicaid rates.

55. If new projects are allowed, is it expected that these programs will be financially self-sufficient through Medicaid and other billings, or will agencies be offered new net deficit funding? Will start-up funding be available to hire and train staff at least three months before opening a program?

Applicants are expected to identify potential sources for operating funding to demonstrate fiscal sustainability. No assurance is made by OMH to provide operating funding to meet all program expenses.

It is the sole responsibility of the applicant to develop an Operating Budget using the State's Budget Template. Applicants should identify all sources of income for reimbursement under the proposed crisis program(s). Funding sources may include but are not limited to: grants, Medicaid Managed Care, private pay clients, local aid and any other anticipated revenue. The Operating Budget will include a detailed description of the program's financial sustainability (see Appendix B).

Please refer to the State's response to question 30 for information on Program Development Grants.

56. Has OMH established a base rate or recommended base unit cost for the Intensive Crisis Residence and the Residential Crisis Support Programs? If so, what are they? If not, when does OMH expect to release information on funding and rates for providers of Residential Crisis Programs?

Please refer to the State's response to question 30 for information on proposed Medicaid rates.

57. Have the MCOs agreed upon a base rate for the Intensive Crisis Residence and the Residential Crisis Support Programs? If yes, what are they?

Please refer to the State's response to question 30 for information on proposed Medicaid rates.

58. Appendix C Crisis Residence Interim Program Guidance states "Crisis residences are expected to be licensed by OMH and contracted with MMCOs to be reimbursed under the Medicaid Managed Care Crisis Intervention Benefit". From this statement, are we to believe we have to partner with MMCOs in order to receive payment for individuals staying at the crisis residence? What happens if an individual doesn't have health insurance or has Medicaid but not managed care?

Yes, Medicaid Managed Care Organizations reimburse adults under the 1115 Crisis Intervention benefit. Applicants are expected to identify potential sources for operating funding to demonstrate fiscal sustainability. No assurance is made by OMH to provide operating

funding to meet all program expenses. Funding sources may include but are not limited to: grants, Medicaid Managed Care, private pay clients, local aid and any other anticipated revenue.

59. Will OMH be setting crisis respite rates for the Children's Crisis Residential program? The current available rate is the HCBS per diem crisis rate. What does this mean for youth that are not HCBS eligible? If there is no Children's Crisis Residential respite rate, is the expectation that an organization will negotiate rates with each MCO?

Please refer to the State's response to question 30 for information on proposed Medicaid rates. Providers will be required to negotiate with insurers for reimbursement of their enrollees.

Dormitory of the State of New York (DASNY)

60. If the property is already covered by DASNY debt, can new debt be issued for a part of the property?

Yes.

61. If the proposed project space is leased, what is an acceptable term of the lease for amortization purposes? Is a 5-year lease, with the right to renew for 5 years, acceptable? If a 15-year minimum is required, can it be a 5-year lease with two 5-year renewal options?

A renewable lease for a lesser term than the bond amortization, typically 25 years, would not be acceptable and would be cause for an award to be rescinded. However, leases may be structured with renewable terms, so five 5 years terms, or 10/15, or a variation thereof, would be acceptable. OMH Counsel's Office will review all proposed leases.

62. If a bank holds a lien on the property to be developed, can capital funds be applied for while a lien is in place?

There is no specific prohibition against properties with an existing lien. However, if the proposal does not include the retirement of the lien as an acquisition cost, OMH may not be able to subordinate its lien.

63. Section 4.3.3 (last paragraph) – What happens if the program becomes financially non-viable or is closed for other programmatic reasons before the end of the DASNY amortization period? Who repays the remainder of the DASNY bond?

How the discontinuation of a licensed program with remaining DASNY debt is resolved is very fact-specific. For instance, a program may be transferred to alternate provider, the property may be sold and the proceeds applied to the DASNY debt, etc.

64. If the proposal includes converting an existing Community Residence Property that has existing MCFFA/DASNY debt service requirements, how will the remaining debt service be handled?

Typically, the remaining debt would continue to be paid through the existing mechanism. New bond debt associated with the award under this RFP would be paid by OMH. However, the specifics of each situation must be considered on a case-by-case basis.

65. For a new site, can the funds be applied to upgrade a property the agency secures through a long-term lease agreement, e.g., 20 years? If so, can the agency submit a proposed lease agreement, schematic plans, and a scope of work?

Yes, a site secured through a long-term lease is acceptable, provided that the term of the lease is commensurate with the bond amortization, and the State's investment may be secured. A proposed lease, schematics and a scope of work are acceptable components in an application. Acceptance of the lease is subject to OMH legal review.

66. Can this property be a long-term leased site?

Yes, see answer to Question 65.

67. What type of lien will be placed on the property if it is a leased site and what will the landlord have to sign?

A State Aid Grant Lien and/or leasehold mortgage will be required to secure the State's investment against a leased property.

Introduction

68. Section 5.1 page 19 (final paragraph) – “Selected applicants will be expected to pursue all potential funding avenues to ensure financial viability of the program”. Does this mean that the provider agency can continue to receive block grant funding for DSS beds?

There is no prohibition against TANF Block Grant funding, provided it does not impose requirements that conflict with the crisis program regulations.

Executive Summary

69. Is it acceptable to co-mingle youth populations, i.e. youth in foster care who reside in a residential treatment program and eligible youth under this RFP? Example: Can OMH crisis residential youth receive group counseling, recreational services, etc. along with the residential foster care youth?

No, programs and the children served by them, must be physically and programmatically separate. There is no ability to co-mingle youth populations across residential settings in the provision of services.

70. Is this just OMH kids? Where are the referrals coming from? What is the referral mechanism?

This RFP is designed to support capital needs for residential crisis programs intended to serve either adults or children experiencing a behavioral health crisis. The applicant is expected to discuss referral sources and the role of the program in the Behavioral Health System within the program's community, county or region. See section 5.4.1 Executive Summary questions 1c. and 1d.

71. Should applicants upload the required LGU letter of support as an attachment to response 1d or do you prefer it is uploaded in grantee document folder or elsewhere.

Nothing is to be uploaded into the Grantee Document folder. All uploads must be made in response to the question posed and placed in the appropriate upload space for that question.

72. What is needed to demonstrate site control?

Site control typically takes the form of a deed, conditional contract for sale, option agreement, or long-term lease.

73. If we are pursuing a site but because of length of getting the award and the contracts we lose the site, can an alternate site be substituted?

Potentially. However, the alternate site, cost, scope of work, etc. must conform substantially to the original scored application. Further, OMH may rescind its commitment if a suitable alternate site is not identified within a reasonable, agreed upon timeframe.

Implementation

74. Question 3a on page 22 of the RFP indicates, “Provide any linkage agreements or Memorandums of Understanding (MOU) with referral sources, if available. Question: are applicants allowed to include currently in-force referral-focused MOU that were drawn up and signed in advance of this RFP & proposal, or must all MOU provided be tailored to this specific initiative and signed/dated between the RFP release date and due date? Are signed Letters of Commitment (LOC) or Memoranda of Agreement (MOA) allowed to be included in lieu of MOU in some cases?

Current MOUs can be included as can LOCs and MOAs.

75. Question 3a on page 22 states, “Include the process for referrals and interface with referral sources including but not limited to: OMH Field Offices, Single Point of Access/State Plan Amendment, Health Homes, Mental Health Practitioners, Comprehensive Psychiatric Emergency Program, School Counselors, Managed Care Organizations (MCO’s), Mobile Crisis, Emergency Departments, Clinics, Local Hospital Systems, Law Enforcement, Self-Referrals, etc.” This question also indicates, “Provide any linkage agreements or Memorandums of Understanding (MOU), if available.

Is OMH expecting/wanting to receive signed MOUs from the OMH Field Office itself (a branch of this funder) and from the Single Point of Access, or is OMH intending instead to receive MOUs related to whatever subset of the above comma-separated list the applicant already has in-hand (or can readily obtain by the proposal deadline)?

OMH is expecting the applicant to explain the referral process in the community and include MOUs from entities such as Health Homes, Mental Health Practitioners, Comprehensive Psychiatric Emergency Program, School Counselors, Managed Care Organizations (MCO’s), Mobile Crisis, Emergency Departments, Clinics, Local Hospital Systems, Law Enforcement, Self-Referrals, etc., as applicable.

76. Question 3b on RFP page 22 indicates, “State your commitment to serve individuals that meet admissions criteria regardless of special population status, including, but not limited to LGBTQ individuals, individuals who are dually diagnosed, individuals who are homeless and/or individuals with a justice involved history”. Can you please elaborate on OMH’s expectations regarding how individuals experiencing homelessness are intended to be served with funds from this particular program, specifically given the maximum length of stay of 28 days? Can those individuals be served with referrals (to other community program) only (rather than admission into this Crisis Respite Support program)?

Based on experience in the field—is that if someone is allowed/required to enter this Crisis Respite program without a realistic discharge plan that includes a known home to return to, a non-profit agency will be setting those homeless clients up without any resources to promote their longer-term success, and we'll also be diverting scarce Crisis Respite Support resources needed by other local individuals with SMI who do have a permanent home to return to, and who will most benefit from Crisis Respite. Please advise.

We expect individuals admitted to crisis residential programs will have viable discharge plans. Homeless individuals may not be summarily excluded from admission due to their housing status. Note that a person residing in an emergency shelter that experiences a mental health crisis is considered homeless.

77. A similar, but slightly different request for clarification. Question 3b on RFP page 22 indicates, “State your commitment to serve individuals that meet admissions criteria regardless of special population status, including, but not limited to LGBTQ individuals, individuals who are dually diagnosed, individuals who are homeless and/or individuals with a justice involved history.”

At the same time, page 19 of the RFP states, “The goal of this RFP is to fund selected agencies that will provide needed crisis and transitional services to individuals with a serious mental illness to prevent or delay hospitalization, and/or to assist in providing step-down services to individuals who are discharged from the hospital but require a higher level of support and services than can be provided in their permanent residency.”

Likewise question 3e on RFP page 22 indicates, “Describe discharge procedures, including the agency’s approach to facilitate an individual’s return to a pre-crisis level of functioning...” Based on experience, homeless individuals typically would/could not enter a Respite program like this with a “pre-crisis” level of functioning available for them to “return to.” These individuals often need a longer term, case-management level of support.

Since the Crisis Respite Support funding, based on experience, is meant to serve people who do have a permanent home, and is not meant to pay for transitional housing service or to provide case-management to individuals experiencing homelessness, is an applicant allowed to choose to include in its Crisis Respite Support admissions criteria only individuals who have a permanent/safe place to return to after completion of the maximum/allowable 28 days in Crisis Respite? If so, then can the Applicant’s statement in response to 3b exclude “individuals who are homeless” or in some way qualify that statement? The reason is: while an agency can link people experiencing homelessness to resources in the community that may eventually help with transitional and permanent housing pursuit, it often takes a very protracted (many months) time with local housing shortages to find an affordable apartment for someone who is homeless, and doing that work is beyond the budget and scope of what this grant supplies. If an applicant is not allowed to exclude persons experiencing homelessness from admissions into this program, how should such applicants proceed upon expiration of the 28-day Crisis Respite limit? Please clarify, and please resolve the apparent discrepancy between RFP pages 19 and 22.

Admission to a crisis residence and admission criteria should identify the behavioral health crisis episode and the ability to resolve the crisis within projected time frames. There are no

restrictions to discharge to a shelter or other living situation with a longer-term plan and connection to support services. Crisis residence programs are meant to serve any individual experiencing a behavioral health crisis.

78. Are all certified and uncertified programs eligible to refer?

There are no specific limitations on referrals based on prior living situation. Appropriate referrals should be based on the needs of the individual and the appropriateness of the program and services.

79. Can we refer our own existing clients?

Yes. Also, please refer to the State's response to question 78.

80. If the Crisis beds are part of a location with other beds (CR), do the minimums and maximums change?

No. The crisis residence will be considered a separate program and will operate based on their license.

81. The RFP states, "OMH expects the length of stay to be no more than 28 days in the Intensive and Residential Support programs." Can an individual stay no more than 28 days per calendar year or consecutively?

Consecutively.

82. For question 3a (pg. 22), are applicants allowed to upload any number of relevant MOUs? And are they allowed to do so using the Grantee Document Folder?

The MOUs are to be scanned and uploaded as one PDF document in response to the question (3a). No documents are to be uploaded in the Grantee Document folder as they do not become part of the application and will not be reviewed and/or scored.

83. For question 3a (pg. 22), does OMH want applicants to separately describe interactions and specific points of contact with each referral source named in the list that begins with OMH field offices and ends with Self-referrals? In other words, is OMH wanting 14 separate paragraphs or can they be aggregated in a single descriptive paragraphs about the applicant overall process for referrals?

A succinct, detailed response is accepted. Separate paragraphs for each referral source is not necessary.

84. For any question in Grants Gateway that requires both a narrative response and an attachment (for example 3c, RFP p22), is it allowable for Applicants to use the upload button and attach a PDF narrative response to the question (because it exceeds the 4,000-character limit of the textbox) and then upload the required attachment (i.e., copy of individual assessment tools; sample of ISP) using the Grantee Document Folder? As an alternative (if desired), in response to such a question, is the applicant instead allowed to upload a single PDF document at the single-upload spot associated with the specific question (e.g., 3c) that includes BOTH the full narrative response AND all of that question's required attachment(s), each clearly labeled and combined in a single uploaded file?

The response should be provided as a single PDF document at the upload placeholder associated with the specific question that includes both the full narrative response and the question's required attachments.

85. For question 3f, RFP p22, for the instruction to “Attach policies and procedures for the proposed program, including but not limited to those identified in Part 589.6 of NYCRR,” our agency’s Residential Crisis Support policy manual—which will apply to the new program with only a few small adjustments—comprises 18 topics/chapters and hundreds of pages. Question: Does OMH / Grants Gateway accept “.zip” files as an upload format? If an applicant is allowed to combine all of the chapters into a single “.zip” or “.PDF” file, what is the maximum file size an applicant is allowed to upload in response to question 3f?

No zip files can be uploaded/accepted into the Grants Gateway application. The maximum file size for response is 10MB.

86. Question 3b on RFP page 22 indicates, “State your commitment to serve individuals that meet admissions criteria regardless of special population status, including, but not limited to LGBTQ individuals, individuals who are dually diagnosed, individuals who are homeless and/or individuals with a justice involved history”. Among other admissions criteria, are the following two admissions criteria allowable as a means of assuring the sought high-quality “home-like” environment (RFP p21) of the program and the safety of all residents and staff: (1) “Applicants must not pose a serious threat to themselves or to others. Criminal histories of applicants will be carefully reviewed on an individual basis, assessing for the likeliness/potential future violence or activity.” And (2) “Acceptance may be contingent upon the agreement of the applicant to adhere to suggested recommendations which could include a partial hospitalization program. If the applicant has been unable to maintain sobriety, acceptance may also require the successful completion of a rehabilitation and/or detox program.”

It is the applicant’s responsibility to “State your commitment to serve individuals that meet admissions criteria regardless of special population status...” The applicant’s proposed admission criteria will be evaluated during the review process.

87. Does OMH have a preferred format/form for the linkage agreements/MOUs requested by this RFP?

No.

88. Program specific questions 3a and 3g ask for linkage agreements or Memorandums of Understanding (MOU) with referral sources. Since the Crisis Residence is not currently operating, would a letter of support be acceptable?

Yes, also see the response for question 82.

89. For the question 3.f. in section 5.4.3 of the RFP: Would a table of contents suffice in response to a request for organizational policies and procedures for the proposed program? It seems premature to develop and provide program policies and procedures especially given a lack of formal program guidance from OMH. What is the minimum information you require?

For an existing program policies, and procedures must be provided. For a program under development a table of contents will suffice but must demonstrate an understanding of the purpose and services of the program.

Agency Performance

90. Question 4a on page 23 of the RFP indicates, “Describe the agency’s experience providing services to individuals with a serious mental illness and/or people in behavioral health crisis, including effective linkages to community providers and activities and helping these individuals (achieve their rehabilitation transition individuals) into the community, including procedures and support the narrative with any relevant and recovery goals.” This part of the sentence is unclear. Question: Should the parenthesized word “individuals” be removed?

It should read, “helping these individuals (achieve their rehabilitation transition) into the community...”

91. What is meant by an “OMH provider in good standing”?

In order to be in good standing with OMH and/or an LGU, the organization needs to be a current OMH provider (and/or crisis services provider through an LGU) that is not under any form of sanction, violation of licensure, breach of contract, or similar serious contractor performance issue.

If you are not a current OMH provider, you would need to demonstrate you have a provider relationship with the LGU. Given the language of the RFP, in section 2.5 Eligible Agencies the applicant needs to provide a Letter of Support from the LGU as part of the application.

92. For Question 4c, referenced on page 23 of the RFP and presented in Grants Gateway with 4,000-character textbox and/or a file-upload opportunity, is OMH intending that the applicant use that space (and/or upload field) to make a case that highlights the agency’s own assessment of its organizational competency, addressing the same variables named in this question that OMH will be reviewing during its assessment/internal review of the applicant? (Or is Question 4c just a placeholder that will be completed entirely by OMH via its internal review?)

OMH expects the applicant to highlight its own assessment and competency.

93. For question 4c, regarding OMH internal review, could you clarify what information applicants are expected to provide in response?

Applicants that hold current OMH contracts are not expected to submit a response to Question 4.c. OMH’s process for internal review of agency performance is presented for informational purposes. Those applicants that do not currently hold an OMH contract must respond to Question 4.d. in lieu of OMH’s internal review of agency performance.

94. Does experience with the Behavioral Health Population under OCFS Licensure satisfy any/all parts of sections 4a-c on page 23 of the RFP (particularly 4c) of the application?

Yes. As stated in section 5.4.4 Applicants that do not hold a current OMH contract but hold a contract with a Local Government Unit (LGU) or other entity, must note their agency’s ability to serve the contractually agreed upon target population. See question 4d.

Applicants will be scored on EITHER 4c or 4d as applicable. NOTE - depending on status of being an OMH provider or not, will determine whether to respond to question C or D. For the question that does not apply to your circumstance, please include "Not Applicable" in the response box.

95. If the agency does not have an OMH contract, but has an OPWDD contract with NYS Start, would they be eligible to apply?

Yes. As stated in section 5.4.4 Applicants that do not hold a current OMH contract but hold a contract with a Local Government Unit (LGU) or other entity, must note their agency's ability to target the contractually agreed upon target population. See question 4d.

Financial Assessment

96. For questions 5a, 5b, and 5c, each of which offer a 250-character textbox alongside the button to upload the required, respective templates, are applicants expected to type a short-contextualized introduction within the textbox AND also attach the required completed template documents via the upload button? Is an applicant allowed to type text in that box if the applicant feels this will help reviewers further understand the attachment[s]? (Is there a reason that these three questions are the only ones in Grants Gateway with a 250-character limit, while the rest all have a 4,000-character limit?)

These questions are specific to the budget and require specific forms that must be completed and uploaded. 5a is the Capital budget that must be completed through the Budget Properties Page, 5b is the Budget Narrative that must be uploaded for the Capital Budget, the template to be used is found on the Pre Submission Upload page, and 5c is the required upload of the budget template for the Operating Budget, also found on the Pre Submission Upload page.

The system "forces" the choice of a response type, so it was decided to use the 250-character limit. No short-contextualized response is required. The budget narrative should be used to detail the budgets.

97. Question 5b on page 23 of the RFP (and in Grants Gateway) indicates, "The Applicant must complete a Budget Narrative (Appendix A1), which provides detailed explanation and justification for the cost estimates provided in the Capital Budget completed in Grants Gateway..." However, when we click on the appropriate template associated with what is called Appendix A1 in Grants Gateway, the document template that comes up has the title "Appendix B1: Budget Narrative". Question: Are the template for Appendix A1 and Appendix B1 the exact same template (a blank, unstructured textbox within a Word Document)? Are applicants supposed to manually replace the title "Appendix B1" with "Appendix A1" when filling out the form to justify the costs in the Capital Budget?

Please refer to the State's response to question 14.

98. Will the awardees be required to pay prevailing and/or union wages for the capital work completed through the RFP?

Prevailing wage and/or union wages are only required when the property the project is located on is state owned or other publicly-owned property.

99. Where can guidelines regarding prevailing wages for contractors be found?

Please refer to the State's response to question 98 for information regarding prevailing wage.

100. Is the project subject to prevailing wage – ie, will it have to bid out as a union labor project?

Please refer to the State's response to question 98 for information regarding prevailing wage.

101. Can funds be utilized on a building project that will have a crisis bed designated but also be for other certified residential space? If yes, are there any changes to the budget format or narrative pieces in order to distinguish between the costs and space for the Crisis versus the Certified Residential beds?

Note that Part 589 regulations establish a minimum of three beds for Residential Crisis Support and Intensive Crisis Residence programs. A crisis program may be co-located with another certified residential program, provided that the crisis program is programmatically and physically separate. A project that includes other certified residential space would be eligible conceptually. The applicant's budget narrative should present the scope and costs of the entire project and distinguish the costs and scope applicable to the crisis program. There is no separate budget format provided for such projects. The budget should include in the "Grant Funds" column only the costs associated with the crisis program, for which funding is being requested. The "Other Funds" column should be used to indicate amounts for any applicable funding necessary for the project other than the funds requested under this RFP.

102. How specific does the plan for funding operations need to be?

Reviewers need to be able to assess program viability; details that support the sustainability are necessary.

103. Is there a timeframe to draw down the funds? If so, what is it?

The timeframe to draw down funds is project-specific and will depend upon various factors, including, but not limited to the contracting process, design, acquisition (if applicable), and construction. No funds will be advanced prior to the execution of a contract and State Aid Grant Lien, following the approval of the Division of Budget, Office of the Attorney General, and Office of the State Comptroller.

HCBS

104. Can HCBS services be provided and billed for, for a client already enrolled in HCBS services during their stay in the crisis residence?

Yes.

Definitions

105. Children's Crisis Residential – RFP states 8 units is the maximum. Please define "unit". Is a "unit" one bed or may a "unit" have multiple beds?

A unit is one bed.

Regulations

106. The proposed space will only accommodate 9 single bedrooms. However, it is anticipated the need for these Intensive Crisis beds to be far greater than the supply. Would it be possible to receive a waiver which would allow for several double (rather than single) bedrooms in order to accommodate demands for this service? These double bedrooms would only be used at times of increased demand.

With respect to double occupancy PART 589 Operation of Crisis Residence states: (1) Single bedrooms shall be at least 90 square feet (exclusive of closets) and a multiple bedroom shall provide at least 75 square feet per recipient. (i) No more than one adult shall occupy a bedroom. (ii) No more than two children shall share a bedroom. (iii) No bedroom shall be located below grade. Additional “Design and Space Requirements” can be found in Section 589.13 of the regulation governing the operation of Crisis Residences:
https://www.omh.ny.gov/omhweb/policy_and_regulations/adoption/adoption-part-589.pdf

If the proposed space is inadequate or technically infeasible, an alternative suitable location should be considered.

107. Can Telehealth be used in place of onsite professional staff for evaluations and assessments?

Yes, if it is approved by OMH and comports with 596 regulations.

108. Will the program run under an operating certificate (certified program) and if so, what review process will be in place for the regulatory approval for the sites that are offered?

Yes, OMH will review each program to ensure conformance with the regulations prior to issuing an Operating Certificate. With regard to the physical space, the proposed drawings will be reviewed by a consultant architect to ensure conformance with the applicable regulations, fire protection standards, building codes, etc. prior to approval by OMH. Additionally, staffing, budget and operational policies and procedures will be reviewed.

109. What, if any, are the Physical Plant requirements for room sizes and room types available (ie: kitchens, common spaces, # of bathrooms)?

Refer to the States answer for question 106.

110. Are there a minimum and maximum number of Crisis units per location? Does it vary between Adult or Children program types?

Both the Residential Crisis Support Program and Intensive Crisis Residence shall not have fewer than 3 beds and shall not exceed 16 beds. A Children’s Crisis Residence Program shall not exceed 8 beds. Additional “Certification” information can be found in Section 589.5 of the regulation governing the operation of Crisis Residences:
https://www.omh.ny.gov/omhweb/policy_and_regulations/adoption/adoption-part-589.pdf.

111. Section 2.5 – Children’s Crisis Residence programs currently operate under 14 NYCRR Part 594. Are those programs eligible under this RFP?

Yes.

112. Please define this language which relates to nursing staff needed from §589.8 Staffing in further detail or provide an example:

(h) Additional requirements for children’s crisis residence programs:

(3) Adequate volume of registered professional nursing staff on duty to ensure the continuous provision of treatment services in accordance with their scope of practice.

The Children's Crisis Residence is expected to provide nursing staff in accordance with the needs of the participants within the program. The program must provide nursing services; however, the volume of nursing staff is to be determined by the program.

113. Page 17 of the RFP – Does submitting an application for this RFP commit applicants to complying with/obtaining licensure through OMH Regulation Part 589 of 14 NYCRR, or would it be required if the application is successful and the applicant completes the contracting process?

Successful applicants who enter the contracting process will be required to obtain licensure through Part 589 of the 14 NYCRR. Funds awarded pursuant to the RFP are for residences that will be licensed pursuant to 14 NYCRR Part 589.

114. If we increase or change the number of beds in an existing licensed community residence, would the change require notification under Section 41.34 of the mental hygiene law, Padavan Law?

No, crisis programs funded under this RFP are not considered residences that would require community notification.

115. Does the agency have to notify the municipality of the site under the Padavan law – Mental Hygiene Law 41.34?

No. See answer to Question 114.

116. Part 589.6 of the NYRCC indicates, “(1) Onsite direction shall be delegated to an individual who shall be known as the director... and (2) The director shall be employed by the crisis residence program as a full-time employee.” For a smaller (3-bed) residential crisis support program, is the applicant required to dedicate 1.0 FTE time of the director to only this program or, for efficiency and effectiveness, can that person also be/remain in charge of other, complementary NYS-licensed residential programs on the spectrum of behavioral health-related housing administered by the applicant agency?

Yes. Final published regulation 589.6 (g) states:

- (1) Onsite direction shall be delegated to an individual who shall be known as the director and who shall meet the qualifications specified in section 589.8(d) of this Part.
- (2) The director shall be employed by the agency as a full-time employee.

Miscellaneous

117. Would OMH provide a letter of support allowing an agency to apply for capital funds for the construction of a crisis/respite care program within an OMH-owned facility?

OMH would consider such a proposal but would not provide a letter of support to itself.

118. Can there be shared staff across the three crisis programs?

It would seem unlikely that one agency would provide all three crisis programs, but yes, they can share staff, but staff may only work in one program per shift.

119. Can the two adult programs share space or have swing beds?

A crisis residence may be housed in a building with other programs, however; it must be within spaces that are physically and programmatically separate.

120. Will an additional RFP be posted shortly for the expansion of existing service contracts or for new contracts? How should organizations expect to support the increased need for support services as a result of the development of new crisis residential programs? If awarded, what is OMH recommending organizations do to support this need once new crisis residential programs are developed?

No, there will not be an additional RFP.

121. Can the crisis residence be located in the same building as an article 31 clinic?

A crisis residence may be housed in a building with other programs, however; it must be within spaces that are physically and programmatically separate.

122. Can an individual with a primary SUD diagnosis be admitted in the crisis residence?

The purpose of the crisis residence is to provide short-term residential support to persons exhibiting symptoms of mental illness who are experiencing a psychiatric crisis. The admission to the residence must be identified as symptoms of mental illness. A diagnosis is not necessary for admission to the crisis residence.

123. Can there be shared staff between the crisis residence program and other agency programs, for example, outpatient clinic?

Yes, but staff may only work in one program per shift.

124. What is the typical length of time to complete an OMH licensing application process?

The typical length of time to complete the EZ-PAR process is 30 to 60 days. The typical length of time to complete a Compressive PAR is 90 days.

125. Are State operated Crisis beds closing? If so, is this the expected referral pool?

The referral pool is individuals in the community who are experiencing a mental health crisis. The RFP is intended to establish or expand community crisis residential programs and is unrelated to State Operated programs.

126. If interested in establishing two residences which will serve three individuals in each, can it be applied to have two residences? If so, would it be two separate applications, or can one application be submitted for the two sites?

Yes. Two different applications are required.

127. The proposed property is currently an occupied multi-floor transitional house. Residents would be moved permanently to another transitional residence in order to convert the building to a crisis residential facility. Is this permitted?

Yes, subject to the approval of the agency funding or licensing the transitional house, if any.

128. It will be proposed to use these capital funds to convert a 2-family home with 5 OMH supported housing beds into an adult crisis residential facility. The current residents will be permanently moved into another facility. Is this permissible?

Yes.

129. Attachment A-MWBE Requirements, II.A. states 30% participation goal: 16% MBE and 14% WBE. Section 3.5 of the RFP states: 16% MBE, 14% WBE, and 6% SDVOB: a total of 36% participation goal. Which guidance is correct?

The language presented in the RFP: 16% MBE, 14% WBE and 6% SDVOB, is correct.

130. NYS OMH released a letter in August 2018 titled “Agency Position Development: Ligature Risk”. The noted intent was to establish guidance to address ligature risks in terms of mitigation for existing risks and eventual removal for inpatient treatment settings. The letter outlines the agency’s position for inpatient units (Art. 28, 31 hospitals and State-operated Psychiatric Centers), for clinic settings, in residential treatment facilities (RTF), and in mental health specialty outpatient settings (Day Treatment, Partial Hospital Programs, and State-operated Community Residences). What is the agency’s position relative to non-State-operated new or renovated crisis programs under Article 589? Facilities that adhere to NYS OMH Patient Safety Standards Guidelines require more costly items from a limited vendor pool. Further, renovated facilities may not meet this guidance, which may indicate that providers should construct a new facility as opposed to renovations.

Crisis residences are not an inpatient treatment setting.

131. Will youth be attending school in their home district? Would agency need to provide? Would they not be in school for a period of time?

A determination would need to be made on whether it is appropriate for the child to attend school during their admission. If it is determined to be appropriate, the district of residence is responsible programmatically and fiscally for the provision of education, unless the child is in the custody of DSS in accordance with Education Responsibilities for School-Age Children in Residential Care.

132. Can LGUs support more than one applicant?

Yes.

133. For the proposed Residential Crisis Support program—which will add an adjoining separate structure with 3 crisis beds—is it acceptable for an existing supervisor (at address of proposed site) to serve as the director/supervisor for the Crisis program (budgeted at a fractional FTE, but responsible/on-call 24/7), with the understanding that this person will be employed full-time by our agency? This person could balance the needed amount of oversight time, respectively, to each of these licensed residences on the same property?

Yes.

134. Are applicants required to be connected to an Article 31 Clinic or similar entity?

No. Pursuant to 14 NYCRR Section 589.7(e), Crisis Residences are required to have agreements with other community-based providers for purposes of service continuity and integration.

135. With regard to anticipated awards, the State anticipated funding a total number of “units” per region. How is the State defining a “unit”? For example, the 30 units in the Central Region?

Each unit is for one individual.

136. If a crisis residence has a period of time when no one is being served, must the scheduled staff remain on site, or may they be redeployed to another site so long as access to the facility for a new admission is still available?

If the crisis residence is empty, staff may be deployed to other sites, provided that 24-hour access to the facility for a new admission is maintained.

137. Is it the expectation of OMH that peer services be on-site 24/7?

No.

138. Is it the expectation of OMH that admissions be accepted 24/7?

Yes.

139. How many Children’s Units are targeted within the NYC region, by borough? How many Children’s Units are targeted within the Long Island region, by county?

Beds are targeted based on the region and include both children and adult beds. The NYC region is targeted for \$30 million and 120 units, the LI region is targeted for \$6 million and 40 units.

There are no specific unit targets for the types of residences (Residential Crisis Support, Intensive Crisis Residence and Children's Crisis Residence) within regions, boroughs, or counties.

140. Can a Children’s residence in one borough or county accept referrals from another borough or county?

Yes.

141. Which, if any, type(s) of referral sources are preferred for MOUs?

MOUs should be based on the need of the community and the resources available.

142. Is there a per unit or per project cap on the capital funding that can be applied for?

No.

143. Could this crisis residence facility be utilized for both the OMH Crisis Residence and the OCFS/HCBS Crisis Respite/Full Day Planned Respite simultaneously? If so, can these populations be co-mingled?

No.

144. What is the average number of days from submission of OMH request for licensure (Comprehensive PAR) to approvals?

Please refer to the States response for question 124.

145. Can an agency pursue multiple OMH licenses simultaneously?

Yes.

146. Does OMH, or to OMH's knowledge, do the MCOs have a geographic preference for program location? If so, please provide details.

Applicants should work with their MCOs to determine geographic preferences.

147. It is our understanding that OMH has engaged in discussions with MCOs regarding Crisis Residential Programs. What has OMH learned about the payers' interest in these services?

Applicants should work with their MCOs to determine interest in services.

148. When will Intensive Crisis Residence and the Residential Crisis Support program services become a mainstream Medicaid benefit in NYS?

The crisis intervention benefit is currently included in the 1115 waiver.

149. When will OMH release detailed "guidance" on the Intensive Crisis Residence and the Residential Crisis Support Programs?

Program Guidance is currently under development and will be released prior to the implementation of the Medicaid Managed Care benefit.

150. Can an existing Short-term Crisis Respite Center be licensed under the new regulations? If so, please describe the timeframe and process for licensure. What are OMH's intentions regarding net deficit funding for existing respite programs?

Yes, if it meets the standards described in Part 589. No net deficit funding changes are anticipated at this time.

151. Can a Crisis Residential program serve clients from multiple counties or is it limited to serving clients from the county in which it is located?

Yes.

152. Does the entire project need to be ADA compliant? For example, can two be done – 4 bed units separately certified in a building with the ground floor being 4 ADA compliant beds and the second floor having a 4-bed unit that is not ambulatory?

The design will be subject to review by OMH's consultant architect for licensing, fire protection and accessibility requirements. The extent of accessible units required may depend on the extent of construction. For example, new construction involving 5 or more units must design and construct 5 percent of the dwelling units, or at least one unit, whichever is greater, to be accessible for persons with mobility disabilities. An additional 2 percent of the dwelling units, or at least one unit, whichever is greater, must be accessible for persons with hearing or visual disabilities. All common areas, and entrance thereto must also be accessible. OMH encourages applicants to consider the needs of the population to be served in determining the extent of accessible units beyond minimum standards.

153. Does the 8 unit maximum defined as 8 people per crisis residence?

Yes.

154. Please define and give examples of Local Government Unit.

The Local Governmental Unit (LGU), is the Directors of Community Services (DCS) in each county has a statutory authority and responsibility for oversight and cross-system management of the local mental hygiene system to meet the needs of individuals and families affected by mental illness, substance use disorder and/or developmental disability in their communities.

155. Program implementation will involve collaboration with the Center for START Services in program design and implementation. Based at the University of New Hampshire it is an evidence-based model – providing crisis response and mitigation to people with IDD and co-occurring mental health diagnosis. The Center for START Services will be contracted to provide technical support and consultation – would this model be permissible within the framework of the RFP?

This RFP does not govern or limit an applicant's ability to consult with other vendors regarding program development. The proposed model must meet the requirements for licensing under 589.