Enhanced Step-Down Program- Mental Health and Intellectual and/or Developmental Disabilities (ESD-MH/IDD)
Statewide
RFP#OMH118
Questions & Answers

Eligible Agencies

Q1. Will a joint proposal with two partnering agencies be considered?

A1. The Enhanced Step-Down Program is operated as a single program with a single Program Director and shared staffing. OMH will consider a proposal which includes a subcontractor; however, the applicant must demonstrate seamless service delivery without additional steps for individuals served. This includes use of a shared electronic health record, co-location of staff as appropriate, and an MOU which clearly outlines each entity's roles and responsibilities. Such sub-contracted relationships must be clearly explained in the Proposal Narrative. Proposals may lose points if applicants fail to provide sufficiently detailed responses regarding both entities on questions related to Agency Performance (6.2) and Implementation and Readiness (6.5). It is noted that OMH will only contract with a single vendor, and the primary contractor will be responsible for all deliverables.

Q2. Are lead applicants permitted to propose subrecipients/subcontractors?

A2. See question and answer #1.

Q3. Does the agency need to have Article 16 services in order to be eligible or can one apply without having a clinic as long they have an established behavioral supports department with a licensed clinician?

A3. The agency does not need to have an Article 16 program in order to be eligible. Eligibility criteria are outlined in section 2.4 of the RFP.

Q4. For the purposes of determining eligibility, what qualifies as an OMH-or OPWDD-certified "clinical" service?

A4. Eligible applicants must operate clinical services that are licensed, certified, or funded by OMH or OPWDD. This includes:

- Article 31 Mental Health Outpatient Rehabilitation and Treatment Services (MHOTRS) Programs and Certified Community Behavioral Health Clinics (CCBHCs)
- Personalized Recovery Oriented Services (PROS) Programs
- Assertive Community Treatment (ACT) Teams
- Partial Hospitalization Programs
- Continuing Day Treatment (CDT) Programs

- Inpatient Psychiatric Units
- OMH-Hosted Community Oriented Recovery and Empowerment (CORE) Community Psychiatric Support and Treatment (CPST) Providers

OPWDD funded, certified or authorized services, including:

- Residential Habilitation
- Intensive Behavioral Services
- Article 16 Clinic Services
- Crisis Services for Individuals with Developmental Disabilities (CSIDD)

Q5. Can applicants apply for pathway #1 or pathway #2 or must they apply for both?

A5. OMH is seeking a vendor to provide the full Enhanced Step-Down Program, which includes both the Specialty CTI Team and the TRS, serving individuals in both pathways.

Program Operations (General)

Q6. Page 6 of the RFP indicates "Anticipated Contract Start Date" of 04/01/2025. Page 33 of the RFP indicates, "One award will be made for each Specialty CTI Team for a five-year period starting 01/01/2025." Which date should Applicants plan toward as the start of the contract?

A6. The anticipated contract start date is 4/1/2025.

Q7. RFP page 29 indicates, "OMH intends to fund projects that can demonstrate an ability to provide the appropriate need based ESD services and will be able to complete the capital project for the Transitional Residential Setting in a timely manner" (bold added). Is it reasonable to project, based on past similar experiences and the Long Island housing and property markets, that "a timely manner" could be approximately 1 year after the CTI component and services are launched (to occur within 3 months of contract start)?

A7. Reasonable timelines may vary based on the specific details of each project. OMH will work with awardees to ensure projects are progressing as required. Regardless of the timeline to open the Transitional Setting, the awardee is expected to begin coordinating with hospitals and providing the Specialty CTI component within 3 months of the contract start date.

Q8. Is there a minimum/max number of people the agency is expected so support at one time, or throughout the duration of the contract?

A8. Agencies must demonstrate their capacity to provide ESD services to up to 30 individuals at a time, with up to 5 at any given time in the Transitional Residential Setting.

Q9. What would be the requirements for hiring staff? What would be the min/max number of people we would serve? Are we required to accept every referral received?

A9. ESD Programs are expected to hire staff as described in Section 5.3.4 of the RFP. The Specialty CTI Team will have a capacity to serve 30 individuals and the TRS will have a capacity to serve 5 individuals. Providers are not required to accept every referral received.

Q10. Page 36 of the RFP (Narrative Prompt 6.1.16), indicates, "Describe your collaboration with the Local Government Unit (LGU), including previous collaboration and any specific collaboration on this proposal. In your response describe how you will work with the Director of Community Services to facilitate care for individuals served by the ESD Program. Question: Are applicants / awardees allowed to focus tightly and serve just one county within the awarded region? If so, would a demonstration of collaboration with the LGU be limited to just that one target county… or must applicants – to receive top consideration for award – work across multiple counties / LGUs in the awarded region?

A10. Teams must work with DCSs and local hospital/provider systems to identify need within the identified region and work to their capacity.

Q11. Western NY region includes serval municipalities and distinct sub-regions. Will the awardee need to be able to cover the entire geography?

A11. Correct. See question and answer number 10.

Q12. RFP (Section 5.1, "Introduction") page 21 indicates, "Note that because of the specialty focus of ESD Programs, awardees are encouraged to consider partnering with more than one (1) hospital/facility, based on local need." RFP p21 also indicates, "…each ESD 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) or more in areas where there are multiple hospital systems within their awarded location. This relationship must include a Memorandum of Understanding (MOU). The MOU should outline a coordinated process for regular communication… [etc.]."

RFP page 35, Proposal Narrative / 6.1 Description of Program, prompt #6 indicates, "Provide at least one (1) letter of support from the hospital(s) listed… with signatures from the hospital executive C-suite."

Question: Are applicants correct in understanding that the referenced MOU is not required to be submitted with this application, but instead (per our understanding of 6.1, prompt #7) will be developed in the early stages of project implementation?

A12. That is correct. Only a letter of support from the hospital(s) is required with this application. The MOU will be completed with the hospital(s) and awarded program during the early stages of implementation.

Q13. During implementation, if more than one hospital is engaged, will OMH accept multiple MOUs (one between the Applicant and each hospital) or will OMH prefer a single MOU across all hospitals and the Applicant?

A13. If more than one hospital is engaged, OMH requires MOUs for each hospital and the awarded program.

Q14. In response to 6.1, prompt 6, may OMH/reviewers award more points to an applicant in a high-population area that exceeds the requirement and includes letters from more than one hospital versus an applicant in the same area that merely meets the requirement and includes a single letter from one supportive hospital?

A14. High-population area applicants and multiple letters of support do not receive additional points for these areas. However, not providing a letter of support will result in losing points.

Q15. Is there a max on letters of support?

A15. No. However, multiple letters of support are encouraged if the program anticipates relationships with multiple hospitals. Only one letter of support is required and will result in the loss of points if not provided. Applicants will not earn additional points for more than one letter of support.

Q16. The RFP on page 23, indicates, "For individuals currently enrolled in a Care Coordination Organization (CCO), ESD staff will collaborate with the resident's Care Coordinator to implement their individual safeguards or individual plan of protective oversight as outlined in their 'Life Plan.' Does the term "Life Plan" (capitalized in the RFP) refer to an evidence-based element of the ESD model itself or is this a more generic descriptor of the type of Individualized Support / Service Plans (ISPs) that CCOs and Health Home Care Managers often co-develop with and for their clients?

A16. Note that this sentence applies to the subset of ESD recipients currently enrolled in a Care Coordination Organization (CCO). 'Life Plan' here refers to the specific document developed in collaboration with care managers. See: https://opwdd.ny.gov/providers/what-life-plan

Specialty CTI

Q17. Aside from the TRS component how is this different from other CTI RFP's that are pending?

A17. This Specialty CTI RFP focuses specifically on adults with moderate to severe behavioral issues associated with co-occurring mental health (MH) disorders and intellectual and/or developmental disabilities (I/DD). The Specialty CTI Team will provide enhanced clinical services that are not available through standard CTI; for example, the Specialty CTI Team will provide diagnostic psychological evaluations, IQ testing, and short-term counseling and psychotherapy services.

Q18. On RFP, pages 23, 25, and 37, the underlined hyperlink containing the phrase "CTI Manual for Workers and Supervisors (2021)", links to an 88-page document, supported by VA QUERI PII / VA Grant Per Diem Case Management Program, focused on "Homeless-experienced veterans", related to supervisors in a veteran-oriented program. Later, only on page 23, a hyperlink within the phrase "which can be found here" links to a 52-page manual co-authored by the Silberman School of Social Work / Hunter College. Both are 2021 documents.

Question: Should applicants pay attention only to the 52-page document (in conjunction with the 20-page "Critical Time Intervention (CTI) Manual" from 5/17/2002 referred to on page 23) or is the 88-page document (focused on veteran programming) intended to guide/inform applicants for this grant?

A18. Both documents are intended to guide and inform applicants for this grant. While the ESD Program is not targeted to the veteran population, many of the principles and practices outlined in the document would apply regardless of target population.

Q19. The Staffing Pattern only includes one Care Manager. Is that meant to be the person handling the 30 CTI cases at one time?

A19. The caseload of the Specialty CTI Team will be shared between the CTI Team Leader, Care Manager, Behavior Intervention Specialist, and Nurse. Additional guidance will be provided to awarded providers.

Transitional Residential Setting

Q20. Regarding TRS locations: Can the location of the TRS housing be in an adjacent region to where services/clients are located if transportation-accessible? For example, can a lower Westchester (Hudson valley region) or Nassau (Long Island region) TRS location be used to New York City program/clients or must the TRS location be within the 5 boroughs of NYC? Are there specific requirements to make this scenario acceptable?

A20. No. The TRS must be located in the region it will directly serve.

Q21. Is the TRS component limited to only 5 single rooms set up?

A21. Correct

Q22. At what point post award does the TRS have to be operational? How much capital funding is being offered?

A22. There is no set timeframe for which the TRS must be operational. OMH will work with awardees to site and develop the program in the most expedient manner.

Q23. RFP page 27 indicates, "The TRS will provide… skill building (habilitation and rehabilitation)." Are applicants free to use their own operational definitions of "habilitation" and "rehabilitation" or does OMH have a definition of these terms in the specific context of this ESD grant? (The term "habilitation" is not used in the 2002 or 2021 guidance documents.)

A23. Habilitation and rehabilitation are approaches to skill building for individuals with disabilities. Broadly speaking, habilitation is intended to support individuals with building or improving new skills, and rehabilitation is intended to restore skills or functioning lost due to the individual's disability. Individuals with co-occurring mental health conditions and intellectual/developmental disabilities may benefit from both habilitation and rehabilitation. Applicants may refer to habilitative and rehabilitative services provided by their organization when referencing skill building services.

Q24. Can you please define [what t]he residential coordinator is and how that is different than the clinician working in the program?

A24. The Residential Coordinator is a licensed mental health professional responsible for daily clinical oversight of the residential program, including training and supervision for direct support professionals (DSPs). The 0.5 FTE clinician will not have management responsibilities or primary responsibility for training or supervision of DSPs.

Q25. What is considered "secured outdoor space"?

A25.The term “secured” was included in error. There must be outdoor space associated with the site. For the purposes of this program, the proposed location must include a space outside that is safely set apart from a road, public parking lot, or other structure/condition that poses a risk to safe enjoyment of the space.

Q26. The grant references secure outdoor space, please define secure.

A26. See question and answer number 25.

Q27. Can TRS beds be co-located with other OMH or OPWDD certified residential programs?

A27. TRS beds may be in a building with another OMH program, or OPWDD program, but it must be a separate and distinct space/program. In other words, the TRS beds cannot be co-mingled with any other certified residential capacity.

Q28. The staffing ratios are different from day to evening. Is the expectation that the individuals be involved in external day programs?

A28. The day and evening ratios are the same (3:5), while the overnight staffing ratio is 2:5. There is no requirement for involvement in external day programs.

Q29. The requirement for TRS residents to self-administer medication with supports and the ADL standards may preclude some people from entering the TRS. Is there flexibility in this requirement?

A29. No, not at this time.

Q30. TRS 24/7 monitoring. Would it be allowable for a person living in the TRS to leave the house on their own, for example, for a family visit if assessed to be safe?

A30. Yes.

Q31. The TRS setting requirements of 5 single bedrooms, enclosed outdoor space, meeting/office space, space for people to be alone such as a sensory room, and to be fully accessible would be very challenging in NYC and very expensive. Does the housing aspect of the proposal fully cover the cost for this type of property?

A31. Yes.

Q32. What is the expectation for the TRS fire protection system? Is it smoke and CM detectors or is it a hard-wired system?

A32. TRS programs will need to comply with NFPA 101 Life Safety Code Chapter on new Board and Care facilities.

Q33. Are there any specific needs for zoning, or can this be zoned as an R1 residential setting?

A33. Zoning requirements will be reviewed post award as each municipality may have different requirements.

Q34. Will the TRS be considered a congregate care setting with the agency collecting program fees from residents?

A34. No.

Q35. Would allowing continuous waiver enrollment for individuals within the Transitional Residential Setting (TRS) be considered? Without waiver enrollment it will be challenging to coordinate timely transitions from the TRS to traditional OPWDD services. Having a smooth process for placement in the OPWDD system will help prevent the residences from being backlogged and it will expand the reach of this program.

A35. Rules related to waiver enrollment and duplicative services are directed by Medicaid and waiver language (i.e., the waiver is a contract), and cannot be unilaterally changed by a state agency or other entity.

Q36. What happens if the person is not ready to transition to the community after 6 months at the Transitional home?

A36. The average length of stay is expected to be approximately 6 months, though providers will have flexibility to ensure a positive discharge outcome.

Q37. Is there an expectation that the provider provide housing once the individual transitions from the transitional home? Or can they seek residential elsewhere?

A37. Each individual admitted to the Transitional Residential Setting will be engaged in a process of person-centered planning to determine their needs and preferences related to permanent housing placement. This will include full consideration of the housing options for which they are eligible, whether or not the ESD provider operates that level of housing. ESD programs will work closely with their LGU and other housing providers in their region to place individuals in a variety of settings.

Systems Navigation (Connection to Long-term Housing &Supports)

Q38. How will OMH's and OPWDD's separate policies and procedures for facilitating housing among their primary-served populations be reconciled (and/or operated jointly) for this ESD/TRS program's participants to reduce obstacles, maximize options, and open clear pathways to long-term housing solutions?

A38. OMH and OPWDD are committed to working with ESD providers to facilitate access to appropriate residential supports/services to ensure this program remains transitional. Changes to policies and procedures, if any, would be made in forthcoming guidance.

Q39. RFP page 2 indicates, "The average length of stay [in the Transitional Residential Setting] is expected to be approximately 6 months, though providers will have flexibility to ensure a positive discharge outcome." (underline added) Question: Toward supporting positive discharge outcomes (including for individuals who cannot move back in with family or afford traditional housing – but who are not technically "homeless"), what specific long-term housing programs do OMH and OPWDD envision and recommend that grantees (and served individuals) pursue? (On Long Island,

especially, where apartment-inventory is exceptionally low vs. State average, what guidance and potential solutions do OMH and OPWDD recommend?)

A39. Awarded vendors should have a thorough understanding of the housing options available in their local communities through multiple systems, including but not limited to OMH and OPWDD. Enhanced Step-Down Programs will employ a person-centered planning approach to identifying appropriate housing options, including but not limited to the full spectrum of licensed and funded housing available through OMH and OPWDD.

Q40. Question: toward helping grantees and clients assure a positive discharge outcome, will OMH allow individuals served by this ESD / TRS program to access unlicensed OMH permanent Supportive Housing program openings? (i.e., Will OMH and OPWDD authorize / direct the local SPOA/SPA(s) to enable this program's participants, upon discharge from TRS, to be eligible, qualified, considered, and/or prioritized for such permanent OMH Supportive Housing, regardless of how or whether the individual is enrolled in particular OPWDD services, and based strictly on such person's diagnosed behavioral health condition(s), subject only to the overall eligibility rules of such OMH permanent Supportive Housing programs)?

A40. Individuals enrolled in the ESD Program will need to meet the eligibility criteria for the level of housing they are discharged to. There has been no change in the eligibility criteria for OMH or OPWDD housing and residential programs.

Q41. What long-term permanent housing solutions are OMH and OPWDD recommending grantees consider after the 6 months in TSR?

A41. Each individual admitted to the Transitional Residential Setting will be engaged in a process of person-centered planning to determine their needs and preferences related to permanent housing placement. ESD programs will work closely with their LGU and other housing providers in their region to place individuals in a variety of settings. This may include but is not limited to the full continuum of licensed, certified, and funded housing and residential services available through OMH and OPWDD.

Q42. What long-term housing may OPWDD facilitate and/or make available for participants graduating from the TRS portion of this program?

A42. Those supported by the ESD will be considered for all appropriate housing options available to the person as considered and explored by the CTI team at the time of discharge. This program does not include the creation of any new long-term housing opportunities through OMH or OPWDD at this time.

Q43. For situations in which older-adult parents bring their adult-children to psychiatric inpatient care and then are unwilling or unable to take those adult children back into their home upon hospital discharge, will SP[O]A and OPWDD work together to help provide prioritized access to long-term housing opportunities?

A43. At this time, there is no prioritized access to long-term housing for individuals engaged in the ESD Program. The application and designation process for accessing long-term housing opportunities through OPWDD is well established and is applied fairly and consistently to all applicants throughout the state.

Q44. Local providers on Long Island have noted a trend whereby older-adult parents of individuals with IDD and behavioral health issues bring their adult-children to a hospital for inpatient psychiatric admission (due to behavioral health issues of their adult-children that are overwhelming to them). When the hospital stay is over, many of these parents are no longer willing to take their adult-children into their homes. What long-term housing does OMH/OPWDD recommend is available after 6 months of TSR?

A44. See question and answer #43 above.

Q45. Will those participants who are suspected to have IDD have their application fast tracked through OPWDD's front door?

A45. No, applications will not be “fast tracked.” Those who are suspected of meeting eligibility criteria for OPWDD and determined likely to benefit from OPWDD services will have eligibility pursued through the CTI team. The eligibility process through OPWDD is a well-established process and is fair and consistent for all applicants across the state, regardless of what programs or services the person has previously received.

Q46. For individuals that go through pathway #1 and use the CTI service but not the TRS, can OPWDD pre-qualify those individuals with High Needs funding?

A46**.** No. The requirements for accessing High Needs Funding from OPWDD as well as the referral process are well-established and consistent for all applicants throughout the state, regardless of which programs a person may have accessed previously.

Q47. How is “disenrollment” from the waivers going to affect services and process?

A47. Disenrollment from a specific waiver generally means the person is no longer able to receive services that are directly funded through that waiver. Disenrollment must occur when a person is seeking a service through another funding source that is considered a duplicative service with the current waiver they are enrolled under. Planned disenrollments are common occurrence in several situations, especially with accessing time limited services through a different funding source (e.g., a different waiver), and the person is usually re-enrolled with minimal delay once the time limited service concludes (i.e., a time limited RTF stay).

Staffing Requirements, Qualifications, Credentials

Q48. Considering there's a shortage of psychiatrists, will the use of a psychiatric nurse practitioner be acceptable if unable to find a psychiatrist?

A48. The 0.05 FTE psychiatrist is intended to be available to consult with the team, provide support on individual cases, and liaise with other existing psychiatric and medical providers. In cases where efforts were made and no Psychiatrist could be recruited immediately, OMH may consider the use of an experience Nurse Practitioner in Psychiatry to meet the FTE requirement if the applicant is able to adequately describe the availability of and access to an experienced consulting psychiatrist.

Q49. Can you clarify the qualifications and minimum requirements for the Program Director, CTI Team Leader, Behavior Intervention Specialist, Residential Clinical Coordinator, and Clinician?

A49. The ESD Program overall must employ at least one FTE Licensed Clinical Social Worker (LCSW), or Licensed Psychologist *and* the Specialty CTI Team must have the capacity to provide diagnostic psychological evaluations, including IQ testing and comprehensive assessments for autism spectrum disorder. Programs have flexibility to decide the specific role that staff with these qualifications/credentials may fill based on their experience, skills, and interests (e.g., Program Director, CTI Team Leader, Behavior Intervention Specialist, etc.).

The Program Director, CTI Team Leader, Residential Clinical Coordinator, and Clinician must be licensed or permitted mental health professionals, as defined below:

- Creative arts therapist: An individual who is currently licensed or possesses a permit to practice as a creative arts therapist issued by the New York State Education Department;
- Mental health counselor: An individual who is currently licensed or possesses a permit to practice as a mental health counselor issued by the New York State Education Department;
- Marriage and family therapist: An individual who is currently licensed or possesses a permit to practice as a marriage and family therapist issued by the New York State Education Department;
- Nurse practitioner: An individual who is currently certified to practice as a nurse practitioner issued by the New York State Education Department;
- Physician: An individual who is currently licensed to practice medicine issued by the New York State Education Department;
- Physician assistant: An individual who is currently registered to practice as a physician assistant issued by the New York State Education Department;
- Psychoanalyst: An individual who is currently licensed or possesses a permit to practice as a psychoanalyst issued by the New York State Education Department;
- Psychologist: An individual who is currently licensed or possesses a permit to practice as a psychologist issued by the New York State Education Department;
- Registered nurse: An individual who is currently licensed or possesses a permit to practice as a registered professional nurse issued by the New York State Education Department; and
- Social worker: An individual who is either currently licensed or permitted to practice as a licensed master social worker (LMSW) or as a licensed clinical social worker (LCSW) issued by the New York State Education Department.

Programs will need to be aware of clinical supervision requirements and scope of practice laws and regulations established by the Office of Professions to ensure that licensed and permitted staff are working within their scope of practice.

The Behavior Intervention Specialist must be an LCSW or Licensed Psychologist or must meet the following qualifications if supervised by a licensed psychologist, LCSW, or psychiatrist:

- at least a master's degree from a program in a clinical or treatment field of psychology, social work, school psychology, or applied psychology as it relates to human development and clinical interventions, and documented training in assessment techniques and behavior support plan development; or
- a national board certification in behavior analysis (BCBA) or a New York State Applied Behavior Analyst (LBA) license; or,
- a New York State license in mental health counseling (LMHC).

For example, if the program employs a Licensed Psychologist as the Program Director, a Licensed Behavior Analyst (LBA) may be employed in the role of Behavior Intervention Specialist under the supervision of the Program Director.

Q50. Are Board Certified Behavior Analysts (BCBAs) considered Licensed Mental Health Counselors?

A50. Licensed Mental Health Counselors (LMHCs) are individuals who are currently licensed as a mental health counselor by the New York State Education Department (SED). Licensed Behavior Analysts (LBAs) are individuals who are currently licensed as a behavior analyst by SED. Changes to Education Law that took effect on November 22, 2022, allow individuals to apply for a New York State Applied Behavior Analyst (LBA) license based on certification from an acceptable national certifying body. As a result, individuals with relevant certification from the Behavior Analysis Certification Board (BACB)* may apply for an LBA license on that basis. LMHC and LBA are separate licenses, each with their own defined scope of practice.

Q51. Are master level licensed Board-Certified Behavior Analyst considered under the grant as "licensed professionals"?

A51. No. Please see questions and answers #49-50 above for additional information on the distinction between the BCBA and LBA and staff qualifications.

Q52. Is there flexibility in the requirement that the Program Director, CTI Team Leader and Residential Clinical Coordinator ALL be licensed? The recruitment and expense may be very challenging.

A52. The cost of these professionals has been factored into the program fiscal model. However, programs may employ mental health professionals with a permit from SED as outlined above in question X. The applicant's organizational infrastructure, including recruitment strategies should be described in their proposal.

Technology, Data, & Reporting

Q53. Can you specify the requirements for an eligible electronic health record? The RFP states that OMH will have the ability to access the EHR.

A53. The requirements for an eligible electronic health record are described in section 5.3.2 of the RFP. As described in the RFP, applicants who do not have EHRs that support the HL7 FHIR® standard (R4 or higher) can also securely submit data files to NYS OMH using a secure file transfer method.

Q54. The RFP includes the requirement that "programs must use data such as PSYKES": will programs that do not already have access to PSYKES be given access? Will programs be given access to other sources such as CHOICES (OPWDD)?

A54. A number of factors impact which providers are able to access databases like PSYCKES and CHOICES, including their Medicaid enrollment status. OMH and OPWDD will consider access to these sources for any awardees who do not currently have access. If OMH is unable to provide access to PSYCKES, a provider's non-access will not impact their scoring or eligibility for the award. OMH will collaborate with the awardee to establish appropriate, secure data sharing arrangements.

Capital Development, Budget, & Funding

Q55. RFP p33, indicates in Section 5.5, Operating Funding, that "The ESD Program (Specialty CTI and TRS) will be fully funded by Net Deficit Funding, or state aid, until such time as another funding mechanism has been determined by the state. Question: Are applicants correct in understanding that for the purposes of this program, "Net Deficit Funding" and "state aid" are interchangeable terms (as they have sometimes been in past RFPs), or are these two separate funding sources?

A55. Yes, the two terms can be viewed as synonymous.

Q56. Does the definition of "state aid" include the $100,000 in "Start-Up Funds," referenced on RFP p34?

A56. Start-up funds will be issued as a non-recurring payment and is separate from ongoing State aid as otherwise outlined in the RFP.

Q57. What is the nature of the capital funding associated with this program – will it cover both property acquisition and mortgage servicing?

A57. Capital funding is available for acquisition, construction, and/or rehabilitation. Debt service funding will be paid by OMH on behalf of the provider.

Q58. RFP Section 4.4 (Award Notification), page 19 indicates, "The capital funding is made available as interest free construction financing, and it must be repaid with a Dormitory Authority of the State of New York (DASNY) bond mortgage. OMH would in turn fund the annual debt service for this mortgage. The Applicant must agree to an Assignment Agreement allowing OMH to make payments directly to DASNY on behalf of the Applicant." [bold added] Question: Does the "debt service" (to be covered / funded) by OMH include all principal payments until the mortgage is paid off?

A58. Yes.

Q59. Are applicants correct in understanding that they themselves are not required to pay or budget for any matching funding (for any part of the loan or mortgage payments / principal that will be due… i.e., for any part of the OMH-approved acquisition, construction, and/or rehabilitation/restoration activities to be undertaken as an Awardee in creating the Transitional Residential Setting)?

A59. Yes, applicants are correct in this understanding.

Q60. Understanding that this is considered "interest-free" construction financing, should applicants' budget (only) to cover mortgage insurance that is often required by lenders as part of a monthly mortgage payment, or will such insurance be covered in the payments that OMH makes directly on behalf of the Applicant?

A60. Applicants need not budget for mortgage insurance.

Q61. The RFP on p34 indicates in Section 5.6, Capital Funding for the TRS, that "Program Development Grant (PDG) funds will also be available as part of this contract to assist with developing the new program funded by OMH." Question: Can OMH please clarify (1) what the PDG funds may be used for; (2) how such funds are distinct from (or included in) the other funding streams "State Aid", "Capital Funding," and/or "Start-Up" funding indicated in the RFP; and (3) how applicants should incorporate PDG funds in their submitted budget and/or budget narrative? (Is the specific dollar-amount associated with PDG to be determined?)

A61. Program Development Grant (PDG) funds, which are distinct from any other funding referenced in this RFP, may be used for any start-up costs for the TRS including but not limited to furniture, office supplies, and staffing. PDG funds should not be included in the budget or budget narrative. The current PDG rate is $9,677/bed.

Q62. The RFP, on page 14 (Section 3.6), establishes "an overall goal of 0% for SDVOB participation." Section 3.5 does not appear to establish a numerical (or zero) goal for Minority and Women Owned Business Enterprises (M/WBE). Is there an established numerical goal for M/WBE for this grant? If so, are applicants correct (per interpretation of RFP page 13) to conclude that any MWBE Utilization Plan (or associated waiver) does not need to be submitted as part of this grant application (and would instead be submitted only post-award announcement, along with the executed contract documentation)?

A62. There are no MWBE goals for this RFP, so the MWBE goal is also 0%.

Q63. Where can we find the Appraisal and Feasibility report?

A63. OMH will order both the appraisal and feasibility report after awards are made. OMH will provide awardees with the necessary documentation to request these studies.

Q64. In reference to 5.6 Capital funding for TRS – If the organization has its own resources available for the construction of the project and does not need to take on a mortgage will reimbursement be made directly to the organization; or is a mortgage required in order to have the construction covered by the grant?

A64. Reimbursement will initially be made to the awarded agency via interest free construction financing. However, financing must be repaid with a Dormitory Authority of the State of New York (DASNY) bond mortgage. OMH will pay the debt service on this mortgage on the provider's behalf.

Q65. Is there a capital funding formula that is to be followed through OMH Bureau of Housing based on 5 people being supported? If so, what is that formula, if not, is there a cap?

A65. There is no specific formula or cap. OMH will work with agencies to develop a capital budget post-award.

Other

Q66. Section 3.5- Could you please clarify what the overall goal for MWBE utilization is. As an example, there is a 0% goal for SDVOB participation.

A66. There are no MWBE goals for this RFP, so the MWBE goal is also 0%.