Department of Homeless Services

REQUEST FOR PROPOSALS

Subway Outreach Program

EPIN: 07120I0002

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

Basic Information

RFP Release Date	November 7, 2019
Proposal Due Date	December 10, 2019 by 2:00pm
Pre-Proposal Conference	Date: November 19, 2019 Time: 2:00pm to 4:00pm Place: 150 Greenwich Street (4 World Trade Center), 37th Floor Bid Room, New York, NY 10007 Please note security at 150 Greenwich Street requires that all visitors provide identification (with picture) to be admitted into the building. To expedite security processing, please send an email to accoprocurements@hra.nyc.gov with the names of the individuals expected to attend from your organization no later than the day before the Pre-Proposal Conference. **Please include RSVP and the title of the RFP in the subject line of the email.** Please arrive at least fifteen (15) minutes early to ensure adequate time for security procedures. In addition, proposers should bring a copy of the RFP that will indicate the purpose of the individuals' visit to the building.
Anticipated Contract Term	July 1, 2020 to June 30, 2023 with one 3-year renewal option
Agency Contact Person	Cinnamon Warner: accoprocurements@hra.nyc.gov
Anticipated Funding and Payment Structure	• Anticipated annual maximum available funding: $22,834,512 • Anticipated total maximum available funding: $68,503,536 • Anticipated number of contracts: 1 • Anticipated Payment Structure: Line-item reimbursement
Minimum Provider Qualifications	• The proposer must have a 501 (c) (3) IRS Determination letter to be eligible to propose.
Questions Regarding this RFP	• Questions regarding this RFP must be transmitted in writing to the Agency Contact Person. • Questions received prior to the Pre-Proposal Conference will be answered at the conference. • Substantive information/responses to questions addressed at the conference will be released in an addendum to the RFP to all organizations that are prequalified to propose to this RFP through the HHS Accelerator system, unless in the opinion of the Agency, the question is of a proprietary nature.
Subcontracting	Subcontracting is permissible under the following conditions: • The proposer should identify any proposed subcontractor in the proposal. • Agency assumptions as set forth in the Program Expectations and other sections of this RFP apply equally to any proposed subcontractor(s). • All contractors and subcontractors shall be subject to DHS approval before expenses are incurred and payments made.

Proposal Submission Instructions

General Guidelines	• All Proposals must be submitted utilizing the Procurement Tab of the HHS Accelerator system at www.nyc.gov/hhsacceleratorlogin by providers with approved HHS Accelerator Applications, including Business Application and required Service Application(s) for the areas listed in the Services and Providers Tab. • Proposals received after the Proposal Due Date and Time are late and shall not be accepted, except as provided under New York City's Procurement Policy Board Rules, Section 3-16(o)(5). • Please allow sufficient time to complete and submit Proposals, which includes entering information, uploading documents and entering log-in credentials. The HHS Accelerator system will only allow Providers to submit Proposals prior to the Proposal Due Date and Time. • Providers are responsible for the timely electronic submission of proposals. **It is strongly recommended that Providers complete and submit their Proposals at least 24 hours in advance of the Proposal Due Date and Time.** • Resources such as user guides, videos, and training dates are listed on at www.nyc.gov/hhsaccelerator. For more information about submitting a proposal through the HHS Accelerator system, please contact help@mocs.nyc.gov.	
Proposal Details		
Basic Information	• Subway Outreach Program	
Provider Contact	• Select member of your organization who will be primary contact	
Funding Request	• Enter the total funding request	
Proposal Documents		
Required Documents	**Document Type**	**Description**
	Proposal	Completed Structured Proposal Form (Attachment D)
	Key Staff - Resumes	Resumes and/or description of qualifications for key staff positions
	Organizational Chart	Program organizational chart showing how the proposed services fit into the Proposer's organization
	Budget	Completed Proposal Budget Summary (Attachment C)
	Doing Business Data Form	Completed Doing Business Data Form (Attachment B)
	IRS Determination Letter [501(c)3]	501(c)(3) Internal Revenue Service determination letter. All proposers must submit a copy of their IRS 501(c)(3) Determination Letter at the time of proposal. Failure to do so shall result in a determination that the proposal is non-responsive.
Optional Documents	Consortium/Subcontractor Agreement	If applicable, Consortium/Subcontract agreement.
	Medical Linkage Agreements	Medical linkage agreements from medical organizations providing services that support the achievement of program participants' service plan goals

	Community Linkages and Partnerships	Linkage agreement from other community-based organizations providing services that support the achievement of program participants' service plan goals
	Financial Audit Report	Financial Audit Report or Certified Financial Statement or letter explaining why no financial statement is currently available

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

Section 1 – Program Background

The Department of Homeless Services (DHS) works to prevent homelessness before it occurs, addresses street homelessness, provides shelter, and assists New Yorkers in transitioning from shelter and street homelessness to permanent housing. DHS collaborates with non-profit partners to provide temporary shelter and services that homeless New Yorkers need to achieve and maintain housing permanency. In April 2016, Mayor de Blasio announced a major restructuring of homeless services in New York City by creating an integrated and streamlined management structure for DHS and the Human Resources Administration (HRA) under the Commissioner of the Department of Social Services (DSS). In February 2017, the Mayor announced his comprehensive plan to turn the tide on homelessness, neighborhood by neighborhood. The plan's guiding principle is community and people first, and giving homeless New Yorkers, who come from every community across the five boroughs, the opportunity to be sheltered closer to their support networks and anchors of life, including schools, jobs, family, medical care, houses of worship, and communities they called home in order to more quickly stabilize their lives. Learn more about how DHS is turning the tide on homelessness, neighborhood by neighborhood, at nyc.gov/tide.

DHS is committed to developing a continuum of services specifically designed to meet the service needs of individuals experiencing homelessness who are on the street and seeks to administer resources and services designed to achieve the ultimate goal of housing placement. Our core focus is on bringing people in from the streets and subways, one person at a time, and supporting them to remain off of the streets and subways. Success depends on building trust with individuals who have fallen through every social safety net and are distrustful of government and service providers because of past experiences. As noted by United States Department of Housing and Urban Development (HUD) in its 2004 Report on Strategies for Reducing Homelessness https://www.huduser.gov/Publications/PDF/ChronicStrtHomeless.pdf, "outreach and engagement are the first steps involved in connecting with street homeless people, bringing them off the streets, and linking them with other portions of the service system. Most individuals experiencing chronic homelessness are unlikely to connect with even the best housing programs unless these first contacts are effective".

Outreach teams currently provide street outreach and housing placement services to homeless individuals on the street, in the subway system, and in public places, many of whom may have severe and persistent mental illness and or substance use disorders. Outreach teams are a primary referral source into Safe Havens and Stabilization Beds and are required to prioritize the use of transitional housing options for the chronic and vulnerable street and subway homeless clients. Outreach teams would also work to refer clients to Drop-In Centers, which are DHS-contracted facilities open 24 hours a day / 7 days a week offering necessities to individuals experiencing homelessness such as warm meals, laundry services and showers. Outreach teams are divided into five catchment areas in New York City: (1) Manhattan, (2) The Bronx, (3) Staten Island, (4) Brooklyn/Queens and (5) the Metropolitan Transportation Agency (MTA) subway system. This RFP is for the MTA subway system and its 472 subway stations. A single primary contractor would be designated by DHS as the single point of accountability for individuals experiencing homelessness that are on the street or those perceived to be street homeless in the MTA subway system. The single primary contractor can be either a consortium of not-for-profit organizations with a lead agency, or a single not-for-profit organization[1]. The outreach teams would also work closely with drop-in centers, safe havens, shelters, other outreach teams, community partners, the State and the MTA, and other external stakeholders throughout the city. Moving a client to permanent housing, a Drop-in Center, stabilization bed, safe haven, or shelter, and coming out of the MTA subway system and off the streets, is a targeted outcome and a potentially life-saving result for someone living on the streets or subway.

[1] For the purposes of this RFP, the terms "contractor", "proposer" and other like terms shall mean the proposer team either as a consortium or a single proposer.

Section 2 – Program Expectations and Proposal Instructions

A. Target Population and Experience

1. Program Expectations

a. The target population consists of individuals, 18 years of age or older who are living on the streets and/or in the MTA subway system. This includes anyone who is confirmed as unsheltered homeless on the street or MTA Subway System; street and subway clients in transitional housing (Safe Havens, Stabilization Beds, Drop-in Centers, and Shelter), permanent housing or other transitional placements.

b. The contracted outreach team would be flexible in working with the variety of behaviors and situations an individual experiencing homelessness may present. Some of these may include but are not limited to: hoarding; lack of personal hygiene; self-isolation; serious mental illness; substance use disorders, including alcohol and opioid dependence, and injection drug use; and medical conditions, such as diabetes, heart disease, hypertension, cellulitis, poor dentition, infestation with lice or other parasites, or ailments of the feet that need to be addressed.

c. The contractor would have successful experience:

i. Providing two or more years of successful experience in providing social services and referrals to individuals experiencing homeless who are on the street or other like populations. Proposers with less than two (2) years of experience can participate in the program by partnering in a consortium in which there is a lead provider with a minimum of two (2) years of experience. The lead provider must be pre-qualified in the relevant service areas through HHS Accelerator.

ii. Providing harm reduction models that have proven effective in reaching individuals experiencing homelessness who are on the street. Harm reduction uses a set of practical strategies aimed at reducing negative consequences associated with addiction and substance use.

iii. Interfacing with healthcare providers, hospitals, and libraries when dealing with individuals experiencing homelessness; and

iv. Placing clients into appropriate permanent settings.

d. The contractor would have successful experience collaborating with:

i. Ambulatory or inpatient detoxification services, as well as residential treatment services.

ii. Drop-in Centers, Safe Havens, and Shelters.

2. Proposal Instructions

a. Complete Section A of Attachment D: Structured Proposal Form, questions 1-4.

b. If applicable, attach a consortium/subcontractor agreement.

3. Evaluation

a. This section will be evaluated based on the proposer's, and subcontractor's, if applicable, successful relevant experience in serving the target population based on the criteria in this section. It is worth a maximum of **10 points** in the Proposal Evaluation.

B. Outreach Program Implementation and Approach

1. Program Expectations

a. Program Cooperation

i. Upon request of DHS, in recognition that the Subway Outreach Program is funded by the City of New York, the contractor would place on all contract related materials a statement or other program identifier acknowledging that the program is funded by the City of New York and/or identifying such contractor as being a NYC HOME-STAT subway outreach contractor.

ii. DHS reserves the right to require the contractor's staff to wear clothes approved by the DHS in coordination with the contractor when interacting with the public, and to have vehicles painted a certain color and/or with DHS approved branding.

b. Outreach Strategies

i. The contractor would develop a strategy for ensuring outreach workers visit all stations as per

a service need level agreed upon with DHS and MTA.

ii. The contractor would devise a specific strategy for engaging clients at the end of the line terminal stations, which would include collaboration with law enforcement and/or MTA partners. The contractor would also include a description of how their outreach teams would ride trains to engage clients who remain there.

c. Field Outreach

i. Field outreach and case management services would be the focus of the program, which would require staffing levels that reflect this emphasis.

ii. The contractor would seek out individuals experiencing homelessness throughout the MTA subway system. This would include all areas of subway stations and within subway cars not prohibited by the MTA.

iii. When a potential client (as defined in Section 2, A. 1.a.) is identified and engaged, a clinical assessment would be conducted prior to a referral to a resource facility (e.g. shelter, Drop-in Center, etc.).

iv. Outreach workers would continue to engage individuals refusing services as they are encountered in the field until trust is established.

v. The contractor would work closely with the DHS Street Homeless Solutions' program staff in terms of the overall direction, coordination, and management of the program and for ensuring that goals are achieved, including providing rapid outreach deployment at DHS's direction.

vi. The contractor would also work closely with the State and the MTA, New York City Department of Health and Mental Hygiene (DOHMH), the New York Police Department (NYPD) including the Department's Homeless Outreach Unit, Health and Hospitals Corporation (HHC) and other relevant partners to coordinate resources regarding the program.

vii. The contractor would develop deployment strategies with the approval of DHS program staff in consultation with agency liaisons, using field observations, 311 calls, customer correspondence such as complaints, and referrals from letters, email, and phone calls. The contractor should be responsive to the deployment needs of DHS.

viii. The contractor would ensure the provision of subway system outreach 24 hours a day, 7 days a week, including the provision of the appropriate amount of outreach conducted between 8 PM and 7 AM and during the rush hours. The minimum number of case management and outreach worker hours in the subway system, or other activities directly related to providing outreach in the subway, would be based upon the Homeless Outreach Population Estimate (HOPE) count numbers.

ix. The contractor would provide outreach and social services on a 24/7 basis. The contractor would place emphasis on evening and overnight outreach when clients are in known locations as well during the rush hours.

x. The contractor would utilize evidence-based practices for all services provided to this population. Case management and outreach staff would be expected to receive training in motivational enhancement therapy, trauma informed care, CPR, opioid overdose prevention, behavioral health first aid, cultural competencies, de-escalation techniques, a variety of harm reduction practices and placement data entry. Training for new staff members should be included within two weeks of hire. The contractor would submit their full training curriculum to DHS at the outset of the contract and thereafter when any changes are made.

xi. The contractor would be active and participatory with Homeless Outreach & Mobile Engagement Street Action Teams (HOMESTAT):

a. Respond to 311 calls within 1 hour, subject to emergencies, and communicate resolutions to appropriate staff

b. Participate in client counts, as directed

c. Place clients on the HOME-STAT By-Name List

d. Work with DHS to improve data system integration
e. Participate in case conferencing and other program level reviews

xii. For each client, the contractor would be responsible for the completion of all relevant paperwork and applications for entitlements such as (but not limited to) Medicaid, cash assistance, SSI/SSDI, and veterans' benefits.
xiii. The contractor would participate in follow-up case planning and conferencing for all clients placed in detoxification programs, hospital inpatient settings, addiction treatment centers, alcohol crisis centers, and other short-term transitional settings.
xiv. The contractor would document in the DHS system of record each time a client is admitted to an emergency department, hospital-based detox, or hospital in-patient unit (medical or psychiatric) to ensure better coordination of discharge planning.
xv. The contractor would adhere to protocols for responding to extreme weather conditions (such as Code Red for extreme heat or Code Blue for extreme cold).
xvi. The contractor would participate in deploying resources as needed for the annual Homeless Outreach Population Estimate ("HOPE").
xvii. The contractor would participate in DHS/DOHMH/HRA/Health and Hospitals Corporation (HHC) initiatives to improve the health of the homeless population, including overdose prevention, other harm reduction initiatives, and rapid HIV testing, if requested.
xviii. The contractor would be available at all times, to assist in the identification of a decedent, brought to a hospital or city morgue. The contractor would follow protocols not only in identification of the body, but also in contacting next of kin and reporting the death as a priority 1 to the DHS Agency Medical Director's Office, Serious Incident Unit, and program staff.
xix. The contractor would provide office space and appropriate equipment for the staff required for this program.
xx. The contractor would establish how many staff would work per shift, including the number of van drivers and the skill level of each staff person. The contractor would submit a staff schedule to DHS for review and approval and would coordinate with DHS staff when staffing changes are to be made.

d. Overnight Terminal Initiative
i. The contractor would target 37 MTA end of line subway stations to serve individual experiencing chronic homelessness who ride the train overnight.
ii. The contractor would coordinate an end of line strategy with the NYPD, State and the MTA; would concentrate resources overnight; and would develop a schedule of terminal visits on a monthly basis.
iii. The contractor would follow the established protocol for engaging clients at end of the line subway stations. The protocol is as follows: when a train reaches the last stop on the subway line the train conductor makes an announcement that all customers must leave the train; NYPD would ask that all passengers exit the train the contractor then offers services to all individuals perceived as experiencing homelessness as they leave the train.
iv. The contractor would use this approach to maximize the opportunity to speak with individuals experiencing homelessness on the trains. At the end of the line stops there are fewer customers, train layover periods are longer, and service delays are least problematic. This approach creates opportunities to encourage clients to accept transitional and or permanent opportunities.

e. Station Outreach
i. The contractor would conduct outreach at stations where there is homeless activity. Stations are visited more or less frequently based on the number of individuals experiencing homelessness as observed during HOPE, by the program, MTA station staff, or customer complaints.
ii. While the contractor would serve all individuals experiencing homelessness in the subway

system, the contractor would focus their resources most intensely on individuals who are spending a significant amount of time in the system.

iii. The contractor would be responsible for responding to 311 calls and other calls from the public regarding individuals experiencing homelessness in the MTA subway system. The contractor would respond to a call within 1 hour, subject to emergencies.

iv. For each client, the contractor would be responsible for the completion of all relevant paperwork and applications for entitlements such as Medicaid, public assistance benefits, SSI/SSDI, and veterans' benefits.

v. The contractor would participate in follow-up case planning and conferencing for all clients placed in detoxification programs, hospital inpatient settings, addiction treatment centers, alcohol crisis centers, jails and other short-term transitional settings.

vi. The contractor would work with DHS program staff to ensure appropriate discharge planning from all facilities where client is transitionally placed.

vii. The contractor would submit appropriate housing packages for clients within 90 days of receipt of required housing documents.

viii. The contractor would be required to present a plan to ensure continuity of service provision if the contract transitions to another provider in order to guarantee that existing knowledge and resources are optimally utilized and to ensure that clients do not experience a disruption in services rendered.

ix. The contractor would adhere to Code Red and Code Blue and other extreme weather conditions protocols, including the submission of vulnerable client lists in advance of each season (i.e. summer and winter).

f. Subway Car Outreach

i. The contractor would be expected to conduct routine outreach in subway cars with the NYPD.

ii. The contractor would propose an approach and a schedule for conducting this outreach, with a focus on evenings.

iii. In conjunction with the NYPD, the contractor would engage and offer services to individuals who they believe are experiencing homelessness. If the individual is willing to accept services, the contractor would offer transport to transitional, permanent, hospital and other settings.

g. Diversion

i. The contractor would assist the NYPD with the program to divert clients from criminal justice system involvement. When the NYPD contacts the contractor regarding an individual who may be eligible for the Diversion Program, the contractor would check such individual's eligibility for the program and, where such individual is eligible, dispatch an outreach team to complete an assessment and offer follow up services.

2. Proposal Instructions

a. Complete Section B of Attachment D: Structured Proposal Form, questions 5-10.

3. Evaluation

a. This section will be evaluated based on the quality of the proposed plan to operate the program based on the criteria in this section. It is worth a maximum of **25 points** in the Proposal Evaluation.

C. Health Care Services

1. Program Expectations

a. Contractor Responsibilities

i. The contractor would report the revenues which they received in reimbursement from Medicaid or other insurances to DHS or the shelter contractor and would subtract the reimbursement amount from their monthly invoice. Medical contractors would receive a 5% bonus, up to $100,000 per year, for reimbursements they receive from billing Medicaid and other insurances. If used, a Memorandum of Understanding (MOU) or subcontract would be subject to the review and approval of DHS. The contractor is required to utilize the same scope of service as outlined in the RFP for all subcontracted medical services.

ii. Preferably, medical services would be provided 35 hours-per-week, 6 days-per-week. At a minimum, services would be provided, 14-20 hours-per-week, 2-3 days-per-week, depending on the number of outreach clients and budget.
iii. Assess clients in the field to determine if they are in need of immediate medical or behavioral health intervention and provide services as needed and if possible, in the street.
iv. If the client is determined to be in imminent risk to self or others, staff would call 911.

b. Emergency Removal
   i. The contractor will employ qualified behavioral health staff who will be trained and authorized by the DOHMH, pursuant to New York State Mental Hygiene Law §9.37 https://www.nysenate.gov/legislation/laws/MHY/9.37 and/or §9.58 https://www.nysenate.gov/legislation/laws/MHY/9.58, to remove individuals deemed to require psychiatric evaluation. The contractor shall respond to calls regarding client removals under §9.37 and/or §9.58 on a 24/7 basis, 365 days per year. Once a removal occurs, staff would travel with the client to the hospital to ensure that the client is evaluated and admitted to the hospital, if applicable. For each client removed under these procedures, the contractor would advocate for admission and follow up with hospital staff and participate in discharge planning when the client is stable. The qualified health or behavioral health professional on the contractor's staff or sub-contractors hired for these purposes would attend DOHMH training to become credentialed prior to the contract start date (or, if hired subsequent thereto, promptly after being hired and assigned to perform services under this program).

c. Assessment
   i. The contractor would make all efforts to complete a medical history and physical, which includes a screening for psychiatric and substance use disorders, is available for each client. The behavioral health screening would include the DAST-10, AUDIT-C, PHQ-9, questions regarding any history of mental illness, and suicidal/homicidal ideation. If all the screenings are negative and the client does not present any concerning behavior, the client would not be referred for a more comprehensive behavioral health assessment.
   ii. The contractor would ensure that the relevant information from all assessments and client encounters are entered in Street Smart, the DHS system of record for Outreach Contractors/Providers.

d. Primary Care
   i. The contractor would ask about a primary care provider during the completion of the medical assessment.
   ii. If client has a primary care provider, the contractor would communicate with the primary care provider (PCP) and share a copy of the assessment and continue on-going communication with the PCP via the case manager or a patient navigator to verify that the client is receiving needed care.
   iii. If the client doesn't have a primary care provider, the contractor would link all active clients to a community-based PCP, preferably a nearby Homeless Federally Qualified Health Center ("FQHC"), as appropriate according to the client's managed care plan. If the client does not have health insurance or refuses care in a traditional clinical setting, the client would be offered on-going medical care and follow-up services by the outreach medical provider. If necessary, clients would be assisted in changing Medicaid Managed Care Plans or their PCP, as per protocols developed for NYC homeless populations.
   iv. The contractor would provide clinical services according to standard clinical guidelines, including preventive and screening services according to the US Preventive Services Task Force, whenever possible. This includes complete and age appropriate history and physical examination; routine and age appropriate laboratory tests; and all age appropriate immunizations, including flu vaccine during the flu season (https://www1.nyc.gov/assets/doh/downloads/pdf/chi/chi-35-5.pdfht) and pneumococcal, tetanus, and hepatitis A and B vaccines. The hepatitis A vaccine would be particularly

encouraged.

v. Clients would be assessed for chronic diseases common in the population (hypertension, cardio-vascular disease, etc.) and offered health promotion and treatment.
vi. The contractor would provide episodic care or assist the client in accessing urgent care as needed.
vii. The medical provider would handle all consult requests from the outreach team and communicate with outside providers and hospitals as needed, including managing visits to, and admissions and discharges from emergency departments. As needed, the medical provider would request a consult with the DHS office of the medical director if assistance and support are needed to manage an issue with a hospital, following the DHS medical consult procedure and using the consult request form.
viii. The contractor would assist clients in receiving dental and podiatric care as needed.
ix. The contractor would link clients to specialty care for any issues uncovered during initial comprehensive clinical assessments, including podiatry care, as needed.
x. The contractor would arrange for access to pharmacy services.
xi. The contractor would make condoms available.

e. Behavioral Health Services
   i. The scope of behavioral health services would include screening and assessment, psychiatric evaluation, stabilization, referral and linkage to community-based treatment, and substance use disorder and follow-up services with the treatment provider, if any. For clients who are unable to use community-based treatment services, the contractor and/or its sub-contractor would provide treatment services on site.
   ii. The contractor would attempt to help clients access psychiatric medications or obtain medications directly for the client and attempt to administer monthly intramuscular (IM) medication when indicated.
   iii. For clients with co-occurring behavioral health and substance use disorders, the contractor would stabilize the clients and provide supportive services including harm reduction and health promotion to reduce the frequency and duration of both drug/alcohol and/or psychiatric hospitalizations. The contractor would also provide substance use education, prevention and treatment activities, e.g., group interventions, linkages to community-based services, and peer support.
f. Harm Reduction and Ancillary Services
   i. The contractor would be or become a NY State certified Opioid Overdose Prevention Program directly or via their medical provider and would provide training to outreach staff as naloxone administration trainers and responders so that outreach teams have sufficient staff trained as Certified Overdose Prevention Responders to cover all shifts at all times. The contractor would identify an Overdose Prevention Champion who would train or coordinate training for staff and clients. The contractor would inquire about history of drug overdose for all clients and provide naloxone training as a priority to all clients with a history of drug overdose and their acquaintances. The contractor would make naloxone available at ALL times. This training includes how to identify signs of opioid overdose and how to administer naloxone intranasally.
   ii. The contractor would offer or facilitate access via agreements with outside organizations to syringe exchange programs and harm reduction services.
   iii. The contractor would provide directly or via MOU medication for addiction treatment for opiate dependence and alcohol dependence, and refer to detoxification services, and residential rehabilitation.
g. Response to Emergencies
   i. The contractor would develop and implement an appropriate and effective plan for emergency response and for transferring clients to and communicating with affiliated hospitals or clinics for treatment when necessary, including an on-call system for phone/email

coverage 24hrs/7 days a week.

ii. The medical provider would assist outreach teams in managing urgent cases, primarily via phone or email consults. True medical emergencies would be managed by calling 911. If the client is refusing medical treatment and EMS agrees not to transport the client to the emergency department (ED), outreach staff can request that EMS call their 24-hour telemetry physician on call at 718-899-5062. The physician would evaluate the situation and explain the potential risks to the client if the client does not receive medical intervention. The outreach staff would also inform their medical director.

iii. For clients who need to be taken to the ED, the medical providers would discuss directly with EMS regarding client's condition and needs and would provide a written referral to psychiatric or medical ED (including copies of medical records and a summary of the situation). The Medical Director would talk to the ED staff as needed to ensure all relevant information is communicated to the ED. The medical provider would follow-up by phone call on the same day to verify plans and discuss with hospital staff.

iv. The medical provider would be responsive to the hospital staff and take responsibility to communicate with the hospital and avoid inappropriate discharges. The medical provider would follow the DHS institutional referral procedure for clients admitted to the hospital and being discharged to shelter and review referrals within the designated timeframes if requested by the outreach provider. Only referrals that may be inappropriate for discharge may need to be reviewed by the medical provider.

v. During Code Blue, the medical director would work closely with outreach staff to advocate for admission to hospitals for clients that meet criteria for Emergency Removal.

h. Additional Care Specific to Outreach Clients

i. Best Practice: each new client would be offered a tuberculosis test, preferably the QuantiFERON® blood test (QFT), and if not, a Tuberculin Skin Test (TST).

ii. If a client receives a medical assessment, a TB test should be included. Clients with a positive QFT or TST should receive a chest X-ray. Those with an abnormal chest X-ray would be immediately reported to the NYC Department of Health and Mental Hygiene (DOHMH) Bureau of TB Control for follow-up.

iii. Clients diagnosed with tuberculosis would be assisted with transportation to a DOHMH TB clinic for care and for Directly-Observed Therapy ("DOT") services. DOT can also be provided on-site, in collaboration with or through DOHMH Bureau of TB Control.

iv. Relevant infectious disease screening would be offered, including HIV and hepatitis C and B testing. Clients with HIV should be referred to both HRA's HIV/AIDS Services Administration (HASA) and a Ryan White care coordination program, and those with hepatitis C would be linked to a hepatitis C comprehensive care provider.

v. The contractor would maintain a list of medically vulnerable clients in Street Smart or other data systems that are created by DHS and would submit this list to DHS upon request.

vi. The contractor would cooperate with DHS, the Office of the Chief Medical Examiner (OCME) and the NYC DOHMH on communicable disease containment, outbreak investigations, response to a client's death, natural or man-made emergency, or other crises.

vii. Clinical staff would provide training sessions to outreach staff on topics related to identifying and understanding behavioral health symptoms, behavioral health treatment, psychotropic drugs and side-effects, substance use and harm reduction, crisis prevention and intervention, as requested. The provider would coordinate, as necessary, completion of a psychiatric screening evaluation, psychosocial summary, SSI/SSD application, 2010e (supportive housing application), M11Q or other documents needed to facilitate diversion from a Safe Haven, and if indicated, referrals to outside programs or psychiatric clinics.

i. Legal Requirements

i. The contractor would ensure that staff to follow infection control guidance.

ii. The contractor would ensure that all clients sign HIPAA-compliant releases of information,

including for the release of information to DHS.

j. Care Coordination
   i. The contractor would provide oversight, coordination of care, and liaise, on behalf of clients, with hospital Emergency Department and in-patient unit staff, visiting nurse services, dialysis centers, Health Homes, managed Medicaid care managers, and the DHS Office of the Medical Director.
   ii. The contractor would coordinate with all other providers or teams serving the clients, including but not limited to DOHMH and its Mobile Crisis, Assertive Community Treatment (ACT) teams, and Intensive Mobile Treatment (IMT) Teams; hospital social workers and medical/psychiatric staff, in compliance with DHS hospital discharge protocols; and with DHS.
   iii. The medical provider would work with DOHMH to facilitate AOT orders and access outpatient behavioral health services as needed, including completing a Single Point of Access (SPOA) application.
   iv. A care coordinator would promote health and wellness among clients through education and enhancement of motivation to initiate and maintain services.

k. Other
   i. The contractor would collaborate with DHS on surveys and program review as needed to understand the needs of the population in order to design better services.

2. Proposal Instructions

a. Complete Section C of Attachment D: Structured Proposal Form, questions 11-18.

3. Evaluation

a. This section will be evaluated based on the quality of the proposed plan to operate the program based on the criteria in this section. It is worth a maximum of **10 points** in the Proposal Evaluation.

D. Supportive Services and Partnerships

1. Program Expectations

a. The contractor would establish referral relationships with appropriate community resources.
b. The contractor would establish a strong relationship with Safe Havens, Drop-In Centers, and Shelters to ensure referred clients receive ongoing and continuous care.
c. The contractor would offer the following supportive services directly or indirectly through subcontracting arrangements with other qualified organizations:
   i. Referrals for clients to needed community-based resources
   ii. Create linkages and relationships with local hospitals
   iii. Follow up with community-based service providers to ensure that referred clients are participating in the service and that services remain available
d. The contractor would make referrals to ambulatory or inpatient detoxification services, as well as residential treatment services, for clients who require these services and are interested in receiving such treatment. The contractor is strongly encouraged to include an exploration of harm reduction models that have proven effective in reaching these populations.
e. Staff accompaniment by van, public transportation or other appropriate means of transporting clients to appointments and placements is required. The appropriate vehicular insurance, where applicable, is required.
f. Staff would accompany clients into their placements and/or appointments and must provide a warm hand off.
g. If a client is in imminent danger, the contractor would contact and bring in for assistance Police, EMS, and/or any on-site medical/psychiatric staff, as applicable.
h. The contractor would attend meetings requested by DHS. Medical staff, under employment or subcontract with the contractor, would attend meetings for medical contractors, as expected by DHS.
i. In instances where an Assisted Outpatient Treatment (AOT) order is being sought or enforced for clients with mental illness, who, in view of their treatment history and present circumstances are unlikely to survive safely in the community without supervision; the contractor would collaborate with

DHS and/or DOHMH-funded AOT teams, and assist in following all procedures and protocols, identified in the DHS Kendra's Law Protocol, as well as any revised regulations over the contract term. For more information on Kendra's Law, see NY Mental Health Law §9.60 et seq (https://law.justia.com/codes/new-york/2012/mhy/title-b/article-9/9.60/).

j. The contractor would assist in the identification of a deceased street homeless individual by going to the NYC Office of the Chief Medical Examiner (OCME) offices/morgues or by viewing a photograph of the decedent, supplied by OCME. The contractor would comply with DHS procedures that outline the contractor's role in identifying a decedent, contacting next of kin, and completing a DHS Priority Incident Report.

k. The contractor would collaborate with DHS where DHS asks for their assistance in assessing a client for a removal as authorized under section 9.58 of the New York State Mental Health Law (https://law.justia.com/codes/new-york/2012/mhy/title-b/article-9/9.58/). When an individual is determined to be at risk of harm to themselves or others, the outreach team would accompany such individuals to the hospital for an evaluation.

l. DHS Street Homeless Solutions is currently developing model of practice across their programs, including for outreach. As such, the awarded contractor would be required to adhere to the Model of Practice. Some elements of the Model of Practice would be incorporated into the final contract with the contractor.

2. Proposal Instructions

a. Complete Section D of Attachment D: Structured Proposal Form, questions 19-21.

b. Attach the following:

   i. Linkage agreements or letters of intent. Broadly worded referral agreement letters or letters of support will not be sufficient.

3. Evaluation

a. This section will be evaluated based on the quality of the proposed approach to offer supportive services to clients and establishing partnerships with community resources based on the criteria in this section. It is worth a maximum of **10 points** in the Proposal Evaluation.

E. Housing Placement Services

1. Program Expectations

a. The contractor would adhere to a clear plan for expediting the placement of clients into permanent housing or long-term transitional settings in order to promote their recovery and re-integration into meaningful community life.

b. The contractor would be expected to use a "housing first" approach wherever feasible.

c. Housing First is a proven method of ending all types of homelessness and is the most effective approach to ending chronic homelessness. Housing First offers individuals (and families) experiencing homelessness immediate access to permanent affordable or supportive housing. Without clinical prerequisites like completion of a course of treatment or evidence of sobriety and with a low-threshold for entry, Housing First yields higher housing retention rates, lower returns to homelessness, and significant reductions in the use of crisis service and institutions. (United States Interagency Council on Homelessness - https://files.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf).

d. DHS recognizes placement into permanent supportive housing and other permanent housing as the best outcome for clients who are unsheltered within the MTA transit system. The contractor would be expected to assist each client to move into permanent housing. If transitional steps are required (e.g., Drop-In Center or Safe Haven placement), the contractor would be expected to continue to work with the client to achieve permanent housing at the conclusion of the transitional steps. This includes working collaboratively with the Drop-In Center or Safe Haven staff to prepare the client for permanent housing.

e. The contractor would be expected to identify both long term transitional and permanent housing

placement options for client placement. The contractor would be expected to have at least two full time staff members responsible for identifying placement resources, expediting client placements and providing follow up as needed.

f. The contractor would adhere to DHS processes for placement into DHS Safe Haven beds and maintain full occupancy to the greatest extent possible. (see Attachment E - FY20 Safe Haven Allocations Procedure & Operating Guidelines for DHS Contracted Outreach Beds)
g. The contractor would be responsible for procuring and leasing stabilization bed resources. Stabilization beds are low threshold beds for high functioning street homeless clients. Clients should be chronic street homeless and be able to care for him or herself. Case management is provided by outreach teams on site or scheduled office visits.
h. The contractor would be expected to ensure stabilization beds procured within budgeted allowances and beds procured are being utilized.
i. The contractor would create an individualized and comprehensive plan for each client, detailing all services and steps necessary to achieve placement in permanent housing or a long-term transitional setting. The contractor would consider the unique service needs of each individual and construct a housing plan that would assist the client in meeting the best outcome possible.
j. The contractor would work with the client to determine preferences for type of housing and geographic location.
k. The contractor would be responsible for the completion of all relevant housing applications and paperwork for each client such as the HRA Supportive Housing application (2010e), SPOA, city-funded vouchers for market rate housing, and any other appropriate resources.
l. The contractor would engage in other efforts to expedite and ensure housing placement, such as escorting clients to all services and other appointments, assisting clients in gathering required documentation and preparing and escorting clients for housing interviews.
m. The contractor should have a written plan for each client placed in a stabilization bed to transition them successfully into permanent housing or a long-term transitional placement and should maintain and enter case notes in the DHS system of record.
n. The contractor would be required to should continue to provide case management services to clients who are in transitional placement sites. They would coordinate with on-site case managers at Safe Havens or other programs to assist in seeing a client through to permanent housing.
o. For each client placed in permanent housing, the contractor would initially maintain periodic contact with the client and establish a schedule for gradually phasing out services entirely, once the client has been stably housed for approximately six months to one year ("aftercare"). Aftercare should be in place for at least three months and can extend for as long as the contractor deems necessary.

2. Proposal Instructions

a. Complete Section E of Attachment D: Structured Proposal Form, questions 22-25.

3. Evaluation

a. This section will be evaluated based on the quality of the proposed approach to case management and housing placements for outreach clients. Stronger consideration will be given to proposals that would provide both transitional and permanent supportive housing units for homeless individuals sleeping in the streets and subways, including proposing to provide scattered site and congregate supportive housing. It is worth a maximum of **20 points** in the Proposal Evaluation.

F. Data Monitoring and Reporting

1. Program Expectations

a. The contractor would use appropriate case record maintenance and recording protocols, in accordance with accepted social work practice and applicable laws and regulations.
b. The contractor would use the DHS StreetSmart database system, and/or any other data and tracking system developed by DHS to track all homeless individuals engaged, and all clients entering the program as well as services received, case notes, incident reports, and any other DHS data requested.
c. The contractor would ensure that all the relevant information is collected on the forms provided by

DHS or their own forms or EMR, as long as the information needed by DHS is entered into Street Smart is collected.

d. The medical provider would establish a quality management system and implement clinical indicators, developed and provided by DHS.
e. The medical provider would send a copy of the indicators monthly to DHS and review the performance indicators with their relevant staff.
f. DHS would maintain a list of top priority data fields and the contractor would, on a monthly basis, review caseload to ensure that all known data for priority fields is filled in.
g. The contractor would maintain documentation of all engaged unsheltered individuals, prospect and caseload clients, daily activity reports, and priority incidents.
h. The contractor would report on clients served and activities, using tools designed and provided by DHS.
i. The contractor would report on clinical services, referrals and relevant outcomes as defined by DHS.
j. Monthly reports are due by the 15th day of the following month.
k. DHS would monitor the contractor and evaluate service delivery based on site visits, unannounced participation in outreach, and ongoing data and service reporting. DHS reserves the right to terminate and/or bring in additional vendors if the contracted services are not provided according to the requirements expressed in the RFP.
l. DHS expects all providers to meet performance targets, recognizing that homelessness is driven by a range of citywide, statewide, regional, national, and global economic and socio-political factors, as well as broader deinstitutionalization at every level of government and nationwide behavioral health and substance use challenges.
m. The contractor would be responsible for meeting percentage and numerical targets that measure progress towards the following outcomes:
    i. Verifying subway homelessness and adding individuals experiencing verified subway homelessness onto the By-Name List and the caseload.
    ii. Placing as many outreach caseload clients as possible into transitional settings
    iii. Preparing as many outreach clients as possible for permanent housing through housing package production
    iv. Placing as many outreach caseload clients as possible into permanent settings
    v. Reducing returns to the streets and subways for outreach clients
n. The contractor would submit daily reports to DHS that capture by shift and team the locations visited (time in / time out), general observations, and clients observed, contacts and placements and joint outreach activities.
o. The contractor would conduct Quality Assurance reviews and submit reports to DHS, as indicated below:
    - Submit monthly visit logs
    - Randomly select and review 10 percent of visit logs for accuracy
    - Review and submit proof that existing staff are trained in CPR and Opioid Overdose Prevention on a quarterly basis
    - Review and submit a quarterly report on placement data
    - Monitor submissions of the daily report
    - Monitor compliance with the updated performance metrics
    - Monitor monthly reporting on calls received via 311
p. The contractor would submit a plan describing the protocol they will follow to monitor and ensure that outreach teams are conducting assigned site visits or are logging a valid reason for not visiting scheduled sites. The contractor would provide monthly reports documenting when a call (via 311 or hotline) was sent to an outreach team, the time the team responded, the name of the station, and the outcome of the call.

2. <u>Proposal Instructions</u>

a. Complete Section F of Attachment D: Structured Proposal Form, questions 26-28.

3. Evaluation

a. This section will be evaluated based on the quality of the proposed approach to manage data and reporting based on the criteria in this section. It is worth a maximum of **15 points** in the Proposal Evaluation.

G. Staffing Plan

1. Program Expectations

a. The contractor would provide an overall staffing model that would reinforce a low-threshold service setting to provide the necessary supports for engaged unsheltered individuals, prospect and caseload clients to achieve the outlined goals and objectives of the program. Such a model should include outreach specialists, housing specialists, case managers, as well as clinical and operational staff to accommodate the volume of engaged unsheltered individuals, prospect and caseload clients.

b. The contractor would ensure that the staffing plan has adequate field outreach coverage and includes a contingency plan for all shifts.

c. The contractor would identify and designate a senior medical provider staff member who has at least 5 years of experience providing services for people experiencing homelessness and is an MD as the Medical Director for the outreach team.

d. The contractor would employ clinical staff who can be trained and authorized by DOHMH pursuant to Mental Hygiene Law §9.37 and/or §9.58 to remove individuals deemed to require psychiatric hospitalization under the Mental Hygiene Law. Staff hired for these purposes should have significant experience executing psychiatric removal procedures. Contractors will be expected to respond to calls regarding client removals under §9.37 and/or §9.58 throughout the MTA subway system on a 24-hour basis, 365 days per year. Once a removal occurs, staff would travel with the client to the hospital to ensure at minimum that an evaluation is completed and would advocate for admission. The contractor would communicate and report all removals to the DHS Agency Medical Director and program staff. A minimum of 1 staff with 9.58 authority should be on-call per shift.

e. Case management services would include the following: clinical interventions including referrals to treatment, coupled with permanency planning, with the primary goal of placing clients into permanent housing and/or long-term transitional settings, and providing aftercare once they are in such settings. Case management efforts may also include but are not limited to: the completion of clients' HRA supportive housing application (including all required evaluations and documentation), assistance with entitlement applications, enrollment in behavioral health and/or substance use treatment services, and placement into transitional and long-term supportive housing, including safe havens, long-term substance use treatment programs, and DHS shelters.

f. The contractor will provide crisis intervention, off-site clinical back-up, and removals to hospitals by teams which will operate on a 24 hour/7 day per week basis pursuant to Mental Hygiene Law Sections §9.37 and §9.58. The contractor would create a strategy for initiating placement during the overnight period in all boroughs or providing stop-gap services until placement can be initiated during business hours for low demand/transitional placement.

g. The contractor would ensure that all staff are regularly trained in motivational enhancement therapy, trauma informed care, CPR, use of naloxone and/or opioid overdose prevention, behavioral health first aid, cultural competencies, de-escalation techniques, harm reduction practices, universal precautions, and other areas designated by DHS. DHS requires that staff have sufficient experience and knowledge in working with the street homeless population.

h. The contractor would provide a staffing structure that would ensure that the program maintains a consistent level of operations 24 hours a day, 7 days a week.

i. The contractor's staff would include a sufficient number of administrative, supervisory, and casework staff to effectively provide the requisite services. In addition, the contractor would employ an adequate number of fiscal staff to provide fiduciary oversight and to ensure the appropriate distribution of funds.

j. Casework and outreach staff would be qualified to react appropriately to client situations, manage crises, and to develop strong linkages to community-based resources for accessing substance use, behavioral health, medical and other needed services.
k. Staff would be qualified to evaluate clients upon admission for level of intoxication, intervene appropriately during crises, assess which clients require behavioral health and/or substance use services, interact with other above ground street outreach teams on all client issues, share best practices, and ultimately assist the client in achieving housing permanency.
l. The contractor's staffing models, job descriptions and hires, including the Program Director, would be subject to the approval of DHS.
m. The contractor would maintain a client to staff ratio that allows a significant and consistent amount of time to work with clients who are participating in an alternate housing search and receiving case management services. It would also allow time for strengths-based motivational work with clients who are moving at a slower pace toward housing.

2. Proposal Instructions

a. Complete Section G of Attachment D: Structured Proposal Form, questions 29-30.
b. Attach the following:
    i. An organization chart specifically for the proposed program, indicating lines of supervision and showing how proposed services will fit into the proposer's organization.
    ii. Resumes and/or descriptions of the qualifications of proposed program staff. If resumes are not available, include the intended job descriptions with qualification requirements. Specify administrative, managerial and clerical positions and indicate whether staff members work full-time or part-time.

3. Evaluation

a. This section will be evaluated based on the quality of the proposed staffing plan to operate the program based on the criteria in this section. It is worth a maximum of **5 points** in the Proposal Evaluation.

H. Budget Management

1. Program Expectations

a. It is anticipated that the payment structure for the contracts awarded from this RFP would be based on line item budget reimbursement.
b. The contractor's costs would enable the effective delivery of services described in this RFP.
c. The proposed budget represents the annual cost to provide services for the proposed program.
d. The contractor would adopt strict fiscal controls to ensure finances are managed appropriately, including proper separation of duties, grant management to ensure sound financial controls, and financial transactions are authorized and documented appropriately.
e. The total maximum available funding for this contract is $68,503,536 for 3 years ($22,834,512 annually).

2. Proposal Instructions

a. The budget should be constructed so that client services and direct care staff are prioritized.
b. Complete Section H of Attachment D: Structured Proposal Form, question 31.
c. Attach your most recent Financial Audit Report or Certified Financial Statement; or a letter stating why no report or financial statement is currently available.
d. Proposers should include in their proposal document, a Budget Narrative that fully describes how they will plan for and manage budgets for this program, based on the program expectations outlined throughout this RFP and consistent with the proposed program design. Budget narrative should include:
    i. Justification for each cost item with a description of how the budget will support the proposal, including the identification and justification of all personnel and Other than Personnel Services (OTPS), including administrative costs and fringe benefits:
        - For Personnel Services, include titles of all personnel to be employed by the proposer

under the proposed contract, as well as the salaries and fringe to be provided to such personnel.

- For operation, utilities and other support expenses, list each item and explain how the costs (of each one) were determined.
- For contracted services, list the associated cost included in the funding request, explaining how the cost of the assigned work for the program was calculated.
- If it is a non-program service purchased from a vendor, describe the nature of the service, why it is needed, and how the costs relating to its purchase were determined. If obtained through a subcontractor, separate medical and psychiatric budget.

ii. If applicable, description of how in-kind contributions or other sources of funding will be used to leverage additional services.

3. <u>Evaluation:</u>

a. This section will be evaluated based on the quality of the proposed approach to manage the program budget based on the criteria in this section. It is worth a maximum of **<u>5 points</u>** in the Proposal Evaluation.

Section 3 – List of Attachments

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

- Attachment A – General Information and Regulatory Requirements
- Attachment B – Doing Business Data Form
- Attachment C – Proposal Budget Summary
- Attachment D – Structured Proposal Form
- Attachment E – FY20 Safe Haven Allocations Procedure & Operating Guidelines for DHS Contracted Outreach Beds
- Attachment F – Outreach to Safe Haven Referral Form

Section 4 – Basis for Contract Award and Procedures

A. Proposal Evaluation

All proposals received by DHS will be reviewed to determine whether they are responsive or non-responsive to the requirements of this RFP. All proposers must submit a copy of their IRS 501 (c) (3) Determination Letter. Failure to do so shall result in a determination that the proposal is nonresponsive. Proposals which DHS determines to be nonresponsive will be rejected. DHS Evaluation Committees will evaluate and rate all remaining proposals based on the Evaluation Criteria outlined in this RFP. DHS reserves the right to conduct interviews and site visits, or to request that proposers make presentations, as deemed applicable and appropriate. Although DHS may conduct discussions with proposers submitting acceptable proposals, it reserves the right to award contracts on the basis of initial proposals received, without discussions; therefore, the proposer's initial proposal should contain its best programmatic terms.

B. Contract Award

A contract will be awarded to the responsible proposer whose proposal is determined to be the most advantageous to the City, taking into consideration the factors or criteria which are set forth in this RFP. Proposals will be ranked in descending order of their overall average technical scores and DHS will establish a shortlist through a natural break in scores for technically viable proposals. An award will be made to the highest rated vendor whose proposal is technically viable and whose prices do not exceed the conditions set forth in the RFP. However:

- DHS reserves the right to skip over one or more proposals to ensure appropriate geographic distribution of awards; or to ensure appropriate capacity of the vendor; or to promote the best interests of the City.
- DHS reserves the right to award less than the full amount of funding requested in the best interests of the City.
- DHS reserves the right to award contracts to more than one vendor to ensure adequate coverage of the system and to ensure adequate linkages to housing or similar facilities.
- DHS reserves the right, prior to contract award, to determine the length of the initial contract term and each option to renew, if any.
- DHS reserves the right, prior to contract registration and during the term of the contract, to change the program service size, program type, and/or model depending on the needs of the system.
- DHS reserves the right to make all necessary changes to the scope of services of the contract(s) to be awarded from this RFP. Should a change to the scope of services be required, the contractor(s) will ensure a smooth transition to the new program model where relevant, including the potential transfer of existing clients to more appropriate program settings.
- DHS reserves the right to implement a performance incentive/disincentive program at any time with reasonable notice to its contractors to ensure the work being done is cost-effective and incentivizes DHS goals and objectives.
- Greater consideration would be given to providers who have experience providing integrated medical and behavioral health services.

Contract Awards shall be subject to timely completion of contract negotiations between DHS and the selected proposer(s) and a determination of both vendor responsibility and administrative capability.