



*Delaware Health  
And Social Services*

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**DIVISION OF MANAGEMENT SERVICES**

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PROCUREMENT

PSC#747

WOMEN/CHILDREN RESIDENTIAL TREATMENT PROGRAM

FOR

DIVISION OF SUBSTANCE ABUSE AND MENTAL HEALTH

Date Due: MAY 23, 2007  
11:00 AM

ADDENDUM # 1

PLEASE NOTE

ABOVE

THE ATTACHED SHEETS HEREBY BECOME A PART OF THE  
MENTIONED BID.

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## Questions and Answers:

1. **Attachments:** There are a number of missing attachments and a couple that appears to be mis-labeled. Will the announced revision clear this up (sorry - just to get the questions on the table)? **A revised RFP is being sent via email to pre-bid meeting attendees.**
2. **Area Coverage:** There is a statement on page 19: “The proposals must clearly indicate that they are in response to RFP number **PSC – 0747** and indicate the county covered on the response. A separate proposal, with both Technical and Business Components, must be submitted for each coverage area being proposed.”

It is acceptable to offer a single facility to cover the whole state of Delaware as long as outreach and aftercare are provided to the whole state? **Not only acceptable but required. The above language has been corrected in the revised RFP.**

3. **Attachments:** There are a couple of instances where the RFP asks for a rather extensive package of material (e.g., especially personnel policies, resumes and job descriptions). Should these be placed completely in the body of the proposal or summarized in the body and included as an attachment? **Resumes and job descriptions are required in the technical proposal. The personnel policies and procedures have to be made available upon request of the reviewers but should not be included in the proposal.**
4. **Start up Costs:** Can you give us any guideline for startup costs. For example, since the vendor will not fully incur the first 2 or 3 months of operating expenses, can the vendor propose those 2 months of budget dollars for renovations, equipment, furniture and furnishings, computers and software, phones and communications equipment, staff recruitment and training, and other specific budgeted start –up expenses? **The first operating budget request is to include monies requested for start up expenses – and not necessarily associated with dollars in the regular operating budget, but it needs to be clearly identified as such.**
5. **Indirect Rate:** Based on page 102 of the RFP, is the indirect rate allowable up to 12%? **Yes.**
6. XV. General Instructions for Submission of Proposals, Page 21, K. Contract Termination Clause, gives both parties the right to terminate for any reason, upon 30 days notice. **Would DSAMH consider only permitting termination for default or unavailability of funds during the first year of the contract?** **Termination clauses are clearly covered by the boilerplate contract that is included in the rfp.**
7. **What adjustments will be made if the program capacity is more than 10; specifically will the \$950,000 maximum be raised?** (B. Performance Measures and Payments, page 30, 1. Utilization). **The applicant must propose a program that can be operated within the budget guidelines specified in the RFP. If it costs more to increase**

capacity, don't propose it. But, capacity can often be increased by a small number of beds without increasing overall program costs beyond what is allowed by the RFP.

8. Page 10, C Available Funding, states that the contract will be renewable for a minimum of an additional 4 years, as long as there is sufficient funding and performance is satisfactory. General Conditions, page 17, j. states that the contract will be eligible for at least 2 additional years renewal. These two statements seem to conflict. **Can DSAMH please indicate which statement is accurate regarding the number of renewal years?** The contract will be renewable for a minimum of 5 additional years as long as sufficient funding is available and performance is satisfactory." The information in the general conditions section is boilerplate.
9. Page 11, Length of Treatment, states that DSAMH will pursue opportunities to conduct formalized research on the program model proposed by the applicant. **Will this require the contractor to collect additional data or conduct any follow up with the client after discharge (other than what might be in the proposal)?** If a formal research project is established, the provider will be expected to work with DSAMH and the researcher(s) to determine what data will be required during treatment to conduct the study appropriately. The provider will not be expected to do follow up work with the client after treatment for research purposes without making suitable budget amendments."-
10. Core Services ,the second page 9, G. Program Evaluation, states the successful applicant will be required to submit data on the performance and outcome measures that will be established in conjunction with the Federal Substance Abuse Prevention and Treatment Block Grant. **Will the data items that the contractor will be required to collect be determined by the time the program begins? If not, is it correct that any new or additional data items the contractor will be asked to collect once the performance and outcome measures are determined will not be retroactive requirements?** As with all DSAMH contracts, the contractor for this program will be expected to report any data items required by the federal government for compliance with substance abuse and mental health block grant reporting requirements. Refer to the Consumer Reporting Form for the current requirements. If the federal government adds new data elements in the future, the contractor will be expected to collect and report them."
11. Core Services, second Page 7, 5) b) requires the program provide screening for learning disabilities and other developmental delays and i) requires the program provide screening for learning and developmental disabilities. **Can these services be coordinated with other community resources/providers or must they be directly provided by the contractor? THEY CAN BE COORDINATED, ALTHOUGH I WOULD HOPE THAT SOME PRELIMINARY SCREENING COULD OCCUR GIVEN THE PROFESSIONAL LEVEL OF STAFFING.**
12. Core Services, second Page 7-8 Comprehensive Services for Children requires the program provide or coordinate daycare supervised by either a staff person or a trained parent responsible for her own children. **Is a day care license required for the program? Who provides the after-school tutoring and the developmentally appropriate services for pre-school-aged children?** Day care may be provided through arrangements with a licensed day care provider in the community (thereby, an opportunity for the children to interact with other children than those in the treatment program) or at the treatment program, as long as the program becomes licensed to provide this service. Children should receive all education and educationally related services the same way that others living in the community receive them (i.e., in public schools, community based programs, etc.). A trained parent is one who has received child care training from licensed child care staff and is responsible to watch only her own children.

13. Core Services, second Page 9, F. Staffing and Staff Qualifications states that Clinical supervisors are required to enroll in the Clinical Supervision Project sponsored by the DSAMH Training Office. **Can DSAMH provide more information regarding this project? Where is the training held? Are there additional costs associated with the training? How many hours/sessions are required?** This has been offered by the Training Office in the past at no cost to funded providers.
14. General Conditions, page 17, I contains inventory and property records requirements. According to c. First Year Start Date, page 34, funding for the first 2 months only is cost reimbursement. **Since the contractor is expected to utilize other funds to support the program, who owns property and equipment used in the program? Capital items purchased through a cost reimbursement budget will belong to the state.**
15. B. Performance Measures and Payments, page 31, 4. Psychotropic Medications states that the agency will have access to the CMHC pharmacy for psychotropic medications. **Will use of the CMHC pharmacy be at no cost to the agency? Yes, as long as our guidelines are followed and sufficient funding remains available to DSAMH to make this service available”.**
16. B. Performance Measures and Payments, page 33, Rules, 3. states that days in treatment will be calculated from the CRF criteria for date of admission and date of discharge (the date of admission is billable and the date of discharge is not billable). **Though the date of discharge is not billable, does it still count in the determination of retention days? As discussed at the pre-bid meeting, only rules 1 and 2 apply to this program and the remainder were eliminated in the revised rfp.**
17. Program Evaluation, second page 9, section G: the program “will be required to submit data on a monthly basis to the DSAMH Management Information Systems Unit utilizing a format designed by the DSAMH Management Information Systems unit...” **What is the data that must be submitted and can the DSAMH MIS Unit accept this data in electronic format? As with all DSAMH funded programs, this program must report monthly data on the Consumer Reporting Form (CRF) – see the CRF for specifics. DSAMH prefers electronic submission.”** It’s not negotiable.
18. **What amount of funds are allocated for start-up?** The applicant must propose a start up budget as stated in the RFP.
19. On page 5 under program design - Can the treatment phase run simultaneous to the orientation phase or do we need to wait the 3-4 weeks? It would seem to be clinically contradictory for a client to be in more than one phase at the same time. The times are recommended and can be adjusted for clinical need – however, it is expected that most clients will require 3 to 4 weeks in the orientation phase.
20. Page 5 under treatment phase - Who qualifies as an "escort"? For activities listed in the second paragraph (e.g., job interviews) is an escort required? An escort should be used whenever the client leaves the building until the client has demonstrated that they can safely leave the facility and return on their own without “deviating”, submitting to cravings to pick up, etc
21. Page 6 - Do the religious/clergy activities to be held on site or off site? The program should allow clients to have their clergyperson visit them at the program. When they reach the stage where they are allowed to attend events outside of the facility, clients should be allowed to attend the religious service of their choice that is within a reasonable distance from the facility – escorts should be used as mentioned above.

22. Page 6 under core services - Are the psychiatric services to be provided on site by staff or off site through collaborations and or referrals? The distinction here on page 6 is between what we expect the program to offer themselves and what on page 7 they can either offer themselves or in collaboration with others. What they need to offer on page 6 as the co-occurring services that should be available on site. If they need more intensive mental health treatment, the client may be in the wrong program.
23. Page 7 under ancillary services - for the medical/dental services - Should these be included in our budget or are the women covered via another source? If only a portion are, is there an estimate as to the percentage of women/children with coverage The program should employ adequate health care staff (i.e., some combination of doctor, nurse practitioner and/or nurse), at least on a part-time basis, to handle routine physical examinations, medical problems and wellness care. Clients should be referred to specialists as needed
24. Page 8 - What constitutes a "trained parent"? . A trained parent is one who has received child care training from licensed child care staff and is responsible to watch only her own children
25. Page 8 - As I recall, the children's' medical/dental care should be covered through the state, is this correct? We do not pay for medical/dental care beyond what is mentioned above. Children will need to be seen by a pediatrician and other specialists as needed in the community. All available funding resources need to be maximized to pay for this out-of-facility medical/dental care. –
26. Page 10 - Accreditation - Do you have a listing of the "other accrediting agencies approved by DSAMH?" Only JCAHO and CARF are currently approved by DSAMH.
27. Page 15 - Is there existing documents which would outline the current/reasonable ranges for qualified clinicians? Applicants should propose staffing patterns that include clinicians qualified/credentialed to provide the services they propose to offer, and who meet the qualifications spelled out in the DSAMH Licensing Standards. Applicants should propose budgets that pay competitive salaries to recruit and retain these professionals.
28. Page 23 - Can you provide a copy of the Department of Health and Social Services Policy Memorandum 46? Sent via email to pre-bid meeting attendees.
29. Page 25 - What are the general timeframes for licensure (e.g., do we have to be in operation for a period of time?) Programs must obtain a provisional license before they open their doors for service.
30. Page 31 - For successful completion it refers to the requirement for abstinence. Does this equate to a zero tolerance policy for relapse or if a women relapses, can she be retained in the program? Addiction is a chronic disease that must be continually attended to or relapse will occur, just as it does in other chronic diseases. As such, relapse is part of the recovery process. The expectation is that clients will achieve and maintain abstinence from all non-prescribed drugs, including alcohol, while in a residential treatment program. If the client relapses while on pass for various reasons outside the facility, the program should deal with the situation as they would deal with relapse for any other chronic disease. In this context, zero tolerance policies are not appropriate. Lastly, the program needs to establish policies that clearly distinguish between relapse and bringing drugs/alcohol into the facility, an action that jeopardizes the safety of other clients as well as their own.

A revised RFP has been distributed to attendees of the pre-bid meeting