



- Q1. Section 1.2: Required Licensure/Certification/Credential: Pg 8. If an applicant possesses a current vendor contract with multiple counties through DHR to provide Medicaid Rehab services, will such contract(s) be sufficient as licensure (Child Care Facility License) for the purpose of this proposal?**
- R1. No. Refer to Amendment 1 on the department's website, under Quick Links, scroll to Request for Proposals and Click the title (In-Home Intensive Services) RFP.**
- Q2. Section 1.2: Required Licensure/Certification/Credential: Pg 8. Is a Residential Child Care Facility License required if applicant is not a placement facility but one who focuses on the Intensive in home provision? If so, is collaboration required since one of DHR' s roles is placement through the ISP and court process?**
- R2. See R1 above.**
- Q3. Section 5.0: Cost Proposal: Paragraph 1: Pg 28. What is the 15 % match related to the preservation case reimbursement rate of \$1520 stated?**
- R3. Please Refer to Amendment 2.**
- Q4. Section 5.0: Cost Proposal: Paragraph 1: Pg 28 If a vendor chooses the "to bill Medicaid Option", does billing constitute a direct bill or a medicaid rehab billing process?**
- R4. A Medicaid Rehab billing process.**
- Q5. Section 5.0: Cost Proposal: Pg 28: "(Should there be an option to bill medicaid)" Does this statement refer to the Non-medicaid and Medicaid rates of \$1970 and \$1355 on the same page or to only the preservation cases reimbursed at \$1520 with a 15% match?**
- R5. Refer to Amendment 2 to this RFP. An option to bill Medicaid is available for IHS only when reunification is the service goal. Due to funding stream, Medicaid is not a billing option when preservation is the service goal for the family.**
- Q6. Section 5.0: Cost Proposal: Paragraph 1: Pg 28 Can you clarify rates for Preservation versus Reunification services and Medicaid versus non-medicaid options?**
- R6. Please refer to Amendment 2 in the RFP.**



**Q7. Section 5.0: Cost Proposal Pg 28: If we choose Medicaid billing should we have a Mental Health license or would we invoice through DHR?**

**R7. Vendors will bill through Medicaid as instructed.**

**Q8. Section 3.10 Aftercare: Pg 21: the RFP states Aftercare is a period of three months. It also states during the aftercare period, if a child re-enters care, it will be at no additional cost to the Department. Does this mean the Vendor will be paid for services during the aftercare period as long as the child does not re-enter care?**

**R8. No, Aftercare is post case closure and is not subject to reimbursement.**

**Q9. Section 3.10 Aftercare: Pg 21: the RFP states Aftercare is a period of three months. It also states during the aftercare period, if a child re-enters care, it will be at no additional cost to the Department. Does this mean the Vendor has to provide services to the child while in care without payment for services?**

**R9. The Department is paying for IIHS that lead to permanency outcomes for the child/family. The expectation is that the vendor's services will successfully achieve that outcome by service closure. If the child must re-enter care within a three month window, the vendor has to provide IIHS services at their expense.**

**Q10. Section 4.2.5.3.4 Aftercare Pg 26: Is the Vendor paid for services after children and families are discharged from the program?**

**R10. Aftercare is a non-reimbursable service**

**Q11. Section 5.0 Cost Proposal Pg 28: Are all preservation cases paid at \$1,520 per month regardless of the number of hours of service provided?**

**R11. This contract has a fixed rate reimbursement mechanism. Providers will receive a fixed rate per month regardless of the number of hours of service provided for cases with a preservation goal.**

**Q12. Section 5.0 Cost Proposal Pg 28: Are all preservation cases paid at \$1,520 per month regardless of the number of children and adults receiving services?**

**R12. Refer to R11 above. The service unit is the family not individuals.**

**Q13. Section 5.0 Cost Proposal Pg 28: How is the 15% match calculated?**



**R13. Refer to Amendment 2 to this RFP. Match expectation will be against the total amount billed for IIHS when preservation is the permanency goal. For example, if the provider bills for 10 units of service (\$15,200), the match computation will be 15% x \$15,200. This amount will be subtracted from the \$15,200 as match provided by the vendor.**

**Q14. Section 5.0 Cost Proposal Pg 28: Is the 15% deducted from the \$1,520, therefore Vendor would receive \$1,292 per month?**

**R14. Yes, Refer to R13 above.**

**Q15. Section 5.0 Cost Proposal Pg 28: Is the rates listed under Non-Medicaid and Medicaid for reunification services as opposed to the rate above for preservation services?**

**R15. Medicaid cannot be billed for IIHS when preservation is the permanency goal. It can be billed when reunification is the permanency goal.**

**Q16. Section 5.0 Cost Proposal Pg 28: Are we to submit a budget detail and narrative in addition to Appendix E:Cost Proposal?**

**R16. As deemed necessary by vendor. Please refer to Amendment 4 for revised form (Appendix E.)**

**Q17. a. Section 5.0 Cost Proposal Pg 28: If we are to submit a budget, will you provide a form to use?**

**b. Section 5.0 Cost Proposal Pg 28: If we are to submit a budget, do we submit one for each region we propose to serve?**

**R17.No, use the cost proposal form in Appendix E to select your proposed regions. Please Refer to Amendment 4 for revised form.**

**Q18. Section 5.1 Method of Payment Pg 28: If we are receiving a flat rate as noted under Section 5.0, then why is it mentioned that Administrative Costs must not exceed 10%?**

**R18. Please refer to Amendment 4.**

**Q19. Section 6.0 Evaluation Criteria Pg 29: Cost Proposal is 20% of the evaluation, however the Appendix E: Cost Proposal doesn't ask for a rate or cost of any kind. How is the cost evaluated?**

**R19.Please refer to Amendment 4.**



**Q20. Section 1.8.3 Cost Proposal Forms Pg 11: Per Section 5.0 we are being paid at a flat rate, so all Vendors will bill at the same rates, so how will Vendor's cost be used extensively during proposal evaluations?**

**R20. Refer to R19.**

**Q21. Section 5.0 Cost Proposal Pg 28: Is there a funding maximum?**

**R21. Funding is based strictly on the units/slots obtained through this RFP process and the number of families served per month within the slot allocation. This may vary for IIHS when the permanency goal is reunification and Medicaid is billed. In this case maximum billing will be determined by services/frequency detailed in the ISP.**

**Q22. 5.0 COST PROPOSAL, first paragraph, states, "A state/local match equaling 15% of the cost is required to secure the federal funds."**

**Please clarify: Does the 15% match requirement also apply to the Family Reunification reimbursable rate of \$1600 per month (cannot bill Medicaid)?**

**R22. No. The match rate applies only to IIHS services provided to families where preservation is the permanency goal.**

**Q23. Regarding 4.2.5.4. Revolving Door Policy, found on page 26 of 37, which states that " Vendors must attest that . . . [none] of the vendor's trustees, officers, directors, agents, servants or employees is a current employee of the Department, and none of the said individuals have been employees of the Department in violation of the revolving door prohibitions contained in the state of Alabama ethics laws", can you please clarify the Department's understanding of how this ethics laws would apply to a former employee of DHR? . . . specifically addressing:**

- 1) the length of time since a prospective employee had been separated from employment by the Department;**
- 2) the position held by the former DHR employee;**
- 3) whether or not the former DHR employee had performed any licensing service with private vendors;**
- 4) whether the former DHR employee had any involvement in negotiating, or supervising, a DHR contract with a private vendor;**
- 5) whether the former DHR employee had provided services in partnership with the private vendor, even in the absence of licensing or contracting responsibilities;**
- 6) whether the former DHR employee was to be employed in a different region from their employment by the Department;**



7) whether the former DHR employee could conceptually be serving clients formerly served while working for the Department even if not a service to be provided under this contract; and 8) the intersection of all these various factors. Item #8 regarding the intersection of the factors is to seek clarification regarding which of the many possible factors take precedence in regards to the others. In other words, if the length of time one must be separated is three years, but there is also a prohibition against having worked in a position to license a private vendor, which of those is primary? . . . if someone worked in licensing, but has been separated from the Department for 5 years does that mean he or she is not subject to the prohibition of employment since it has been over three years? Or, likewise, if a worker from Montgomery County was formerly a Food Stamps worker and had had no contact of any sort with any vendor and had nothing to do with any contract, but could, conceivably encounter a client in the new project that had once been approved for Food Stamps, would that worker be eliminated from employment on the Project?

**R23. Please review the State of Alabama's Revolving door policy referenced in the Alabama code in Section 36-25-13. ([www.ethicsalabama.gov](http://www.ethicsalabama.gov))**

**Q24.a. Section 1, pg. 8, 1.3 Should the "licensed" part of the last sentence be deleted?**

**b. Pg. 10 Section 1.6.8 – Secretary of State – Do you have a form # for this verification? If**

**c. Pg. 11 Section 1.8.1 – May we submit the electronic copy on a flash drive instead of a CD/DVD?**

**R24. a. Refer to Amendment 2.**

**b. Refer to the Secretary of State's website, [www.sos.state.al.us](http://www.sos.state.al.us). print the form verifying status.**

**c. Yes.**

**Q25. Section 3, Pg. 17 3.5 – "worker must be accessible... via telephone, cell phone, pager system and email." Is a pager still required?**

**R25. No, however the vendor must be accessible 24/7, 365 days per year by whatever means.**

**Q26. Section 4,**

**Pg. 24 4.2.4 – does this change due to Amendment #1?**

**R26. There is no licensure requirement.**



**Q27. Section 5,  
Pg. 28 5.1 – please explain Administrative cost.**

**R27. Please refer to Amendment #4.**

**Q28. Out of home care Placement: Is it the intention that the providers of IIHS will be responsible for securing and paying for any out of home placements for preservation cases that necessitate a removal (with the exception of intensive residential placements, placements for sexual offender treatment, etc)? If so, will the provider be required to maintain a designated number of foster homes available for this contract? If DHR initiates a removal, what is the timeframe and process for finding a placement? (this question is not based upon a particular section of the RFP, but based upon the original cost proposal which I understand has been revised. The original cost proposal referenced out of home room and board)**

**R28. Providers will not be responsible for securing and paying for out of home placements for IIHS cases where preservation is the goal. It will be the provider's responsibility to work with the child/family and county DHR staff to ensure that the child spends a minimal amount of time in the out of home placement. It is expected that the provider will be involved in any removal decisions/plans as part of the ISP team when the removal is not due to an emergency decision.**

**Q29. In-Home Referrals: Will referrals for in-home services come from investigators or the DHR in-home unit? If a case is from an investigator, will the provider be held harmless if a removal is necessitated within a short period of time? (Section 3.5 Service Delivery, page 17)**

**R29. Referral protocol may vary slightly from county to county, it should not be dissimilar to current placement practice. If the vendor is unable to provide services please see section 3.9 of this RFP.**

**Q30. Differential Response: How does the department anticipate the referrals for IIHS differing from the referrals for FOCUS (short term in home services)? What criteria constitutes immediate crisis response v. initiation within 24 hours? ( Section 3.5 Service Delivery, page 17)**

**R30 While the IIHS combines elements from both FOCUS and Continuum of Care, it is a separate, stand alone RFP. Referrals to the vendors will be dictated by the contents of Section 3.5 of the RFP document. The first two paragraphs of that section detail identification and referral process. If the County protocol has identified the case as one that needs immediate attention, they will so inform the vendor and work closely with them on case initiation.**



**Q31. Criteria, Safety Assessment, and Hand Off:** With regard to appropriateness of referrals, what exclusionary criteria will the department have for families? For example, will families with active substance abuse problems (in which the family refuses treatment) be considered for referral to IIHS? What Safety Assessment and protocols is DHR utilizing to assess appropriateness for in-home services v. removal? What is the timeframe for DHR to provide adequate information to the provider so as to assure a proper referral acceptance? (Section 3.5 Service Delivery, page 17 and 18)

**R31. DHR will assess whether the case is appropriate for IIHS services. If that assessment indicates that the family can benefit from the provision of IIHS, a referral will be made. The vendor can accept or reject the referral (see 3.9).**

**Q32. Outcomes:** If it is not safe for children to remain with/ return to their family and the IIHS provider worked with a relative for permanent placement, would this be considered a successful outcome? Additionally, could the IIHS provider include permanency with a relative for preservation cases as an outcome measure? (Section 3.11 Outcomes, page 21)

**R32. Yes, assuming that was the permanency goal in the ISP.**

**Q33. Case Assignment and Ratios:** Will a case be required to be assigned to both a therapist and a family support worker? Does every case have to have a therapist? (Section 3.2 and 3.3 Staff, page 16 and 17)

**R33. No. Individual case needs will determine whether a therapist is needed on the case. The vendor's decision is to determine how to provide the most effective services to the family to achieve the desired outcome in the least amount of time. The means by which the vendor accomplishes this will be determined by the vendor and the ISP team.**

**Q34. Contracting Capacity:** Would the department consider contracting with one agency to provide this service in a single region so as to allow that agency the opportunity to develop quality, sustainable services? Is there a minimum of slots in a region that DHR would expect a provider to handle? Maximum? (Section 1.0 Project Overview, page 7)

**R34. No. Decisions will be made based on the quality of the responses. There is no established minimum number of slots in a region that the RFP asks any one vendor to offer/provide. It is expected that all slots per region will be allocated.**



**Q35.Training: What training requirements will DHR require of the provider? Will providers have access to the DHR-sponsored ACT training (or other training related to safety and risk assessment offered by DHR) (Section 4.2.5.1.5 Staff Performance Evaluations and Training, page 25)**

**R35.This section pertains to trainings that must be provided by the vendor. Vendors will not have access to DHR Trainings, etc.**

**Q36. Transportation & Visitation: For children in out-of-home care status, what is typical for a visitation requirement, such as number of visitation in a given week, that the provider will be asked to provide? Will the Provider have access to the DHR transportation aides (if DHR still employees transportation aides in some counties)? (Section 3.6 Core Services, page 18)**

**R36. Visitation expectations will be individualized and based on the needs of the particular child/family and the ISP process. No, the providers will not have access to DHR transportation aides.**

**Q37. DHR Reports: For reports to be issued to DHR, is there a standard template or report form? (Section 3.6 Core Services, page 19)**

**R37. Reporting forms will be provided to selected vendors.**

**Q38. Medicaid: Is it DHR's preference that providers be Medicaid-certified? If a provider is not yet Medicaid-certified, would DHR support a provider to become certified throughout the term of the contract so as to leverage Medicaid later? (Amendment 2, Cost Proposal)**

**R38. Two options are provided to the vendors for reimbursement, both a Medicaid and non-Medicaid option. The choice is strictly the vendors.**

**Q39. Payment Timeliness: As DHR will not pay providers until reimbursement from the Medicaid agency, how long do Providers anticipate getting paid upon approval of an accurate, authorized, and approved invoice? (Amendment 2, Cost Proposal)**

**R39. Billing will be processed upon receipt of an approved invoice from the vendor. Funds for services that are specific to Medicaid Rehab billings will be paid when monies are received from Medicaid for those services.**

**Q40.Pg. 11 Section 1.8 Submitting a Proposal**



**QUESTION: Pg. 11 Section 1.8.3 Cost Proposal Forms states that Vendors must respond to this RFP by utilizing the cost proposal forms found in Appendix E.**

**The form in Appendix E only asks for the number of Non-Medicaid and Medicaid slots for each region.**

- i. Is there no budget required for this submission?**
- ii. If a budget is required, is there a specific budget format/form that needs to be used, and would the format need to be submitted per region? Please specify.**

**R40. Please refer to Amendment 4 for revised form (Appendix E.)**

**Q41. Pg. 16 Section 3.0 Scope of Project**

**QUESTION: Are evidence based or informed practices required? If no, are they evaluated higher?**

**R41. Yes, refer to section 1.0 of this RFP.**

**Q42. Pg. 19 Section 3.7.1 DHR Roles**

**QUESTION: Once the case has been accepted, is that when Letter D of Section 3.7.1 page 19 goes into effect? Thus it's possible for the IIHS provider to meet the family prior to a formal introduction by DHR as described in Letter D of Section 3.7.1 page 19?**

**R42. This section speaks to the role of the DHR worker. This would be the general practice for scheduling an initial face-to-face visit. It does not preclude a more expedited approach if the situation calls for it. In either case it would be the responsibility of the DHR worker to schedule/facilitate the visit.**

**Q43. Pg. 20 Section 3.7.2. Roles of IIHS Workers**

**QUESTION: Will obtaining a letter of suitability on a prospective employee suffice as "coordinating with DHR on the suitability of the various candidates" as stated in Section 3.7.2 page 20?**

**R43. No.**

**Q44. Pg. 20 Section 3.7.2 Roles of IIHS Workers**

**QUESTION: Letter G references that the IIHS agency may coordinate pulling together information to complete the CFA. Can you clarify coordinate and who is responsible for the completion of the CFA?**

**R44. The Department is responsible for completion of the CFA. The vendor maybe asked to contribute knowledge relevant to the process.**



**Q45. Pg. 21 Section 3.9 Reject/Eject Policy**

**QUESTION: IIHS workers are required to contact families within 24 hours of the DHR referral to conduct an initial assessment of family needs and strengths per Section 3.5 page 17. Once the assessment has been conducted, does the IIHS provider have the discretion to accept the family as a case, keeping in mind the Reject/Eject Policy in Sect.3.9 page 21?**

**R45. Yes.**

**Q46. Pg. 21 Section 3.10 Aftercare: "If a child must enter care during this time, it will be at no additional cost to the department."**

**QUESTION: Please define "care" and who is expected to provide and/or pay the care. Please also define "time" – what length of time is expected?**

**R46. The RFP identifies the Aftercare period as three months post closure of the case.**

**Q47. Pg. 21 Section 3.11 Outcomes**

**QUESTION: Will DHR provide data as needed for outcome collection**

**R47. The provider is expected to have sufficient information available to track outcomes.**

**Q48. Pg. 22 Section 3.13 Tracking**

**QUESTION: What happens if a family is not able to be located at 3 -24 months post-discharge?**

**R48. Vendor must make attempts to meet the requirements in 3.13 and must update/inform the referring county of all attempts.**

**Q49. Pg. 28 Section 5.0 Cost Proposal Questions**

- a. **QUESTION: What qualifies as the "match"? Is the match only for preservation cases?**
- b. **QUESTION: This section lists rates for services, however, Section 5.1 says payment will be cost reimbursement. Please clarify payment – rates or cost reimbursement?**
- c. **QUESTION: Please clarify the rates listed as they vary from the preservation rate and the reunification rate listed in the first paragraph.**
- d. **QUESTION: Would there be anything that would be unallowable to use as a match for Preservation, and will we need to be reporting on the match amounts periodically?**
- e. **QUESTION: For Reunification, is it possible to exceed the slots proposed between Medicaid/Non-Medicaid? For example, could we get more Non-**



**Medicaid slots than proposed and less Medicaid? And if that is the case, will DHR pay for the services that would have been directly billed to Medicaid for those exceeding slots?**

- R49.** a. Refer to Amendment 2 of this RFP. Yes  
b. Fixed rate for IIHS. If billed for services with the goal of reunification, then reimbursement would be at the approved Medicaid rates for those services.  
c. Refer to answer to a. above  
d. Refer to answer to a. above  
e. Slot totals to vendors will not change nor can they be exceeded. The vendor elects the number of those slots awarded to be Medicaid/Non-Medicaid.(Refer to Amendment 4).

**Q50. Pg. 28 Section 5.1 Method of Payment**

**QUESTION:** This section states that “payment for services provided pursuant to this procurement will be made on a cost reimbursement basis.” The “cost reimbursement” language contradicts the rate structure in section 5.0. Please clarify if this is a rate-based program or cost reimbursement- based program.

**R50. Payment on these contracts will be made on a fixed rate basis, not cost reimbursement.**

**Q51. 12. Pg. 29 Section 6.0 Evaluation**

**QUESTION:** The Vendor Qualifying Information (A – G) adds up to 325 points but the possible points listed is 300. Is there an error?

**R51.Refer to Amendment 4.**

**Q52. Pg. 34 Appendix D Certificate of Compliance**

**QUESTION:** If applying for multiple regions/counties, which county should put used on the certificate of compliance form? The location of an office? Or, do we submit multiple certificates?

**R52. Yes, vendors will have to submit multiple certificates.**

**Q53. Pg. 35 Appendix E: Cost Proposal**

a. **QUESTION:** Is this the only budget form required? Does an actual budget have to be submitted?

**R53. Yes, refer to Amendment 4.**

**Q54. Pg. 35 Appendix E Cost Proposal**



**QUESTION: It appears that the Regions start repeating themselves.**

**For example, Central Alabama is listed first, followed by East Alabama, etc., and ends with West Central Alabama. But, then just under West Central Alabama, the regions start over with Central Alabama. Was this just a typo, or was there a reason for this repetition?**

**R54. Refer to Amendment 4.**

**Q55. Amendment #2; Section 5.0 Cost Proposal: If vendor is not Medicaid certified for billing is \$1520 (minus the match) and \$1600 the allowable monthly billing amount?**

**R55. Refer to Amendment 2.**

**Q56. Page 16; Section 3.2 Number of Staff per Treatment Team: The RFP speaks to Therapists. Is it mandatory to employ a therapist or can you have a treatment team made up of Family Support Workers and a supervisor?**

**R56. The RFP does not require the inclusion of therapists on the treatment team. However, if a therapist is needed to meet the needs of child/family then one must be provided.**

**Q57. Page 16; Section 3.2 Number of Staff per Treatment Team: Is a full-time supervisor required by the grant?**

**R57. Yes.**

**Q58. Section 1.0, page 7 Project Overview w/Physical Presence  
The RFP states vendors may propose more than one region but must provide assurances that they will have a physical presence in the region required to bid on a region? Please define physical presence and explain when the vendor must establish a physical presence?**

**R58. Physical presence in the region may be addressed by the vendor's plan to serve all counties in the region in a fair and equitable manner. It might entail having staff based in a given county, or within a reasonable commute so that families may be served in a timely manner and at the frequency warranted. For example, if the vendor had bid for slots in the Southwest Alabama cluster and had their primary physical location in Gulf Shores, it would be expected that vendor describe their plan for serving referrals from Choctaw County effectively. If the plan for serving a region is accepted, it must be fully operational by 10/01/16.**

**Q59. Section 1.0, page 7 Project Overview /Evidence-Based  
What is the Department's definition of a nationally recognized**



evidence-based program? If the definition is that it has to be evidence-based, can the Vendor also create our own model based on a national model?

**R59. It is anticipated that the vendor will research the subject and base their proposal on material that is found in evidence-based programs for intensive in home services that have been successful when implemented.**

**Q59. Section 1.6, page 9 Mandatory Requirements  
Will the department provide all required forms in Microsoft word Format?**

**R59. Yes.**

**Q60. Section 1.8.3, page 11 Cost Proposal Forms  
Will the vendor also need to submit a budget with the cost proposal form found in Appendix E? Will the Department provide instructions for Appendix E?**

**R60. No, the vendor must use the revised form in (Appendix E) to submit their proposed cost. Refer to Amendment 4.**

**Q61. Section 3.5,page 17 Service Delivery  
The RFP states, "IIHS staff are required to contact families face-to-face within 24 hours... from time of referral" but in Section 3.7.1, letter D the RFP states "Within 48 hours of service acceptance the DHR worker will contact the family and the IIHS provider to schedule a face to face in-home initial visit as soon as possible but not to exceed 4 working days." What is the correct time frame for making the initial visit?**

**If a Vendor does not have any openings, is the Vendor expected to place newly referred families who do not need crisis intervention on a waiting list?**

**According to the RFP, if a child is placed out-of-home during a preservation case, the Vendor will continue to work with the family towards reunification. When this occurs, will the original preservation case be closed and will a new case be opened for reunification purposes? If the original case is not closed, is the Vendor still required to close the case within the original 6-9 month timeframe?**

**R61. a. Section 3.5 Service Delivery notes that IIHS staff is required to contact families face-to-face within 24 hours (immediately if an emergency) from the time of the referral. Section 3.7.1 refers to the role of the DHR worker and the 48 hours after acceptance is the time frame for the worker to make the referral to the IIHS vendor. Although the remainder of 3.7.1 D notes**



that the initial visit should be scheduled within 24 hours, that visit should occur within four working days maximum.

b. Yes, however referrals can be made to any other providers serving the region if immediate services are needed.

c. No, the permanency goal will change to reunification and services may be modified, but the family is still the open case and worked on within the original time frames for service authorization.

**Q62. Section 3.9, page 21 Reject/Closure Policy**

What is the Department's definition of a successful closure?  
How often is the closure rate monitored? Monthly, quarterly, or annually?

**R62. The Department's definition of successful closure occurs when, the case is closed by the county department with the goal of reunification or preservation is attained. Vendor activity on cases assigned will be monitored monthly.**

**Q63. Cost Proposal**

Is the vendor allowed to split slots between Medicaid and Non-Medicaid per region?

**R63. Refer to Amendment 2.**

**Q64. 1.8 SUBMITTING A Proposal**

1.8.1 P.11 Will the Intensive In-Home proposal be accepted by the department prior to July 7, 2016? What is meant by –two business (Monday-Friday) days prior to the due date?

**R64. Yes. Proposals can be hand-delivered, two days prior to the due date between the hours of 9:00a.m.-12:00p.m. (Section 1.81 pg. 9)**

**Q65. SECTION 3: SCOPE OF PROJECT**

**3.5 SERVICE DELIVERY**

1. P. 17. Second paragraph. Denotes a referral must be seen within 24 hours of the initial referral from DHR. Will you clarify the time frame that an IIHS worker is to make the initial face to face contact? Under 3.7, the statement reflects a 48 hour time frame including the IIHS worker's initial visit as soon as possible and not to exceed 4 days.
2. P. 17, Second paragraph. Explain the process expected for the facilitation of an intake assessment meeting at the time of the initial referral to be completed by the DHR Worker. What are the Medicaid requirements for an intake assessment meeting?



3. **P.17. Third paragraph. Should a situation arises where as an IIHS Vendor not have an opening slots, what will be the logistics for a vendor serving families outside of its region.**
4. **P. 17. Third paragraph. What is meant by this sentence “families needing crisis intervention will not be placed on the waiting list until the crisis has been stabilized”? What is the criteria for a referral that is initiated due to a crisis versus a referral that is more focused on increasing safety and reducing the probability of out of home placement?**
5. **P. 17. Fourth paragraph. Does the contact made by the IIHS Supervisor to DHR referral worker pertains to non-crisis referrals in the vendor’s anticipation of an opening?**
6. **P. 17. Fifth paragraph. The term “mental health consultation” seems to be used to describe the provision of services by the IIHS workers. When billing Medicaid for the reunification cases, this term is used to document services from one professional to another professional (as it relates to the client/family’s condition). Will there be a list to determine the Medicaid services allowed depending on the credentials of the workers?**
7. **P.17. Ninth paragraph. Given the time could range from 6 to 9 months for each family, does this mean Vendor will potential serve fewer families on an annual basis**

**R65. 1. Refer to R61.**

2. **Chapter 105 of the Alabama Medicaid Manual, details services that can be provided under the Rehabilitation Services. The requirements for intake assessment are as noted for intake evaluation. This service will be billed by county DHR staff. The provider is expected to have either their own assessment or CFA provided by the county in order to comply with Medicaid requirements.**
3. **It is anticipated that multiple vendors will be responsive to needs for each region. If one vendor does not have an opening another vendor will be approached. Decisions to exceed slot levels in a region will be made on a case by case basis by the Resource Management Division.**
4. **The county DHR offices will make the decisions relevant to the timing of any referrals for the services.**
5. **The vendor is responsible for contacting the DHR worker within two days of an “anticipated” opening.**



**6. Medicaid services to be provided will be driven by the ISP process. If these services are indicated and authorized, the vendor must comply with the Department's and Medicaid's requirements as to appropriate credentialing, caps, etc., for service provision.**

**7. Yes.**

**Q66. 3.7.2 ROLES OF IIHS WORKERS**

**Item: E**

- 1. What will be the process for coordinating with DHR on the suitability of a candidate? Does this mean the CAN investigation and the criminal background check?**

**R66. Yes, the process in coordinating with DHR on the suitability of a candidate is complying with the criminal history background check and CAN Registry.**

**Q67. 5.0 COST PROPOSAL**

**This question is to clarify the process of Medicaid billing for therapy session when the referral is in the family name versus the child's name? If there is not a clinical diagnosis, will the family or child be eligible for Medicaid billing?**

**Will there be an opportunity to attend a pre-proposal conference to clarify additional questions?**

**R67. Medicaid billing is authorized only for those cases that have reunification identified as the permanency goal. As such, it can only be billed for identified individuals that meet the criteria for said billing and for services approved in the ISP. With few exceptions, this will be the identified child/youth that is being reunified.**

**No.**