



**Solicitation Information  
January 28, 2014**

**RFP# 7548426**

**TITLE: Hospital Emergency Room Diversion**

**Submission Deadline: February 27, 2014 at 10:00 AM (ET)**

**PRE-BID/ PROPOSAL CONFERENCE: No  
MANDATORY:**

If YES, any Vendor who intends to submit a bid proposal in response to this solicitation must have its designated representative attend the mandatory Pre-Bid/ Proposal Conference. The representative must register at the Pre-Bid/ Proposal Conference and disclose the identity of the vendor whom he/she represents. A vendor's failure to attend and register at the mandatory Pre-Bid/ Proposal Conference shall result in disqualification of the vendor's bid proposals as non-responsive to the solicitation.

**DATE:**

**LOCATION:**

Questions concerning this solicitation must be received by the Division of Purchases at [David.Francis@purchasing.ri.gov](mailto:David.Francis@purchasing.ri.gov) no later than **February 7, 2014 at 10:00 AM (ET)**. Questions should be submitted in a *Microsoft Word attachment*. Please reference the RFP# on all correspondence. Questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

**SURETY REQUIRED: No**

**BOND REQUIRED: No**

David J. Francis  
Interdepartmental Project Manager

Applicants must register on-line at the State Purchasing Website at [www.purchasing.ri.gov](http://www.purchasing.ri.gov)

**Note to Applicants:**

Offers received without the entire completed four-page RIVIP Generated Bidder Certification Form attached may result in disqualification.

**THIS PAGE IS NOT A BIDDER CERTIFICATION FORM**

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## **SECTION 1: INTRODUCTION**

The Rhode Island Department of Administration/Division of Purchases, on behalf of the Rhode Island Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH), hereinafter referred to as the Department, Division of Behavioral Healthcare Services (DBH), is soliciting proposals from qualified firms to develop and operate a three-year pilot of the Sobering Treatment Opportunity Program (STOP), in accordance with the terms of this Request for Proposals and the State's General Conditions of Purchase, which may be obtained at the Rhode Island Division of Purchases Home Page by Internet at <http://www.purchasing.ri.gov/>.

STOP will serve chronic alcohol dependent individuals who are intoxicated without emergent medical conditions who can be safely diverted from hospital emergency rooms because they do not have emergency medical conditions.

The initial contract period will begin approximately May 1, 2014 for one year. Contracts may be renewed for up to two additional 12-month periods based on vendor performance and the availability of funds.

This is a Request for Proposals, not an Invitation for Bid. Responses will be evaluated on the basis of the relative merits of the proposal, in addition to price; there will be no public opening and reading of responses received by the Division of Purchases pursuant to this Request, other than to name those offerors who have submitted proposals.

## **INSTRUCTIONS AND NOTIFICATIONS TO OFFERORS:**

1. Potential vendors are advised to review all sections of this RFP carefully and to follow instructions completely, as failure to make a complete submission as described elsewhere herein may result in rejection of the proposal.
2. Alternative approaches and/or methodologies to accomplish the desired or intended results of this procurement are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this RFP will be rejected as being non-responsive.
3. All costs associated with developing or submitting a proposal in response to this RFP, or to provide oral or written clarification of its content shall be borne by the vendor. The State assumes no responsibility for these costs.
4. Proposals are considered to be irrevocable for a period of not less than 120 days following the opening date, and may not be withdrawn, except with the express written permission of the State Purchasing Agent.
5. All pricing submitted will be considered to be firm and fixed unless otherwise indicated herein.
6. Proposals misdirected to other state locations, or which are otherwise not present in the Division at the time of opening for any cause will be determined to be late and will not be

considered. For the purposes of this requirement, the official time and date shall be that of the time clock in the reception area of the Division.

7. It is intended that an award pursuant to this RFP will be made to a prime vendor, or prime vendors in the various categories, who will assume responsibility for all

Aspects of the work. Joint venture and cooperative proposals will not be considered. Subcontracts are permitted, provided that their use is clearly indicated in the vendor's proposal and the subcontractor(s) to be used is identified in the proposal.

8. All proposals should include the vendor's FEIN or Social Security number as evidenced by a W9, downloadable from the Division's website at [www.purchasing.ri.gov](http://www.purchasing.ri.gov).
9. The purchase of services under an award made pursuant to this RFP will be contingent on the availability of funds.
10. Vendors are advised that all materials submitted to the State for consideration in response to this RFP will be considered to be Public Records as defined in Title 38, Chapter 2 of the General Laws of Rhode Island, without exception, and will be released for inspection immediately upon request once an award has been made.
11. Interested parties are instructed to peruse the Division of Purchases website on a regular basis, as additional information relating to this solicitation may be released in the form of an addendum to this RFP.
12. Equal Employment Opportunity (G.L. 1956 § 28-5.1-1, et seq.) – § 28-5.1-1 Declaration of policy – (a) Equal opportunity and affirmative action toward its achievement is the policy of all units of Rhode Island state government, including all public and quasi-public agencies, commissions, boards and authorities, and in the classified, unclassified, and non-classified services of state employment. This policy applies to all areas where State dollars are spent, in employment, public services, grants and financial assistance, and in state licensing and regulation.
13. In accordance with Title 7, Chapter 1.2 of the General Laws of Rhode Island, no foreign corporation, a corporation without a Rhode Island business address, shall have the right to transact business in the State until it shall have procured a Certificate of Authority to do so from the Rhode Island Secretary of State (401-222-3040). This is a requirement only of the successful vendor(s).
14. The vendor should be aware of the State's Minority Business Enterprise (MBE) requirements, which address the State's goal of ten percent (10%) participation by MBE's in all State procurements. For further information visit the website [www.mbe.ri.gov](http://www.mbe.ri.gov)
15. Under HIPAA, a "business associate" is a person or entity, other than a member of the workforce of a HIPAA covered entity, who performs functions or activities on behalf of, or provides certain services to, a HIPAA covered entity that involves access by the business associate to HIPAA protected health information. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits HIPAA protected health

information on behalf of another business associate. The HIPAA rules generally require that HIPAA covered entities and business associates enter into contracts with their business associates to ensure that the business associates will appropriately safeguard HIPAA protected health information. Therefore, if a Contractor qualifies as a business associate, it will be required to sign a HIPAA business associate agreement.

16. In order to perform the contemplated services related to the Rhode Island Health Benefits Exchange (HealthSourceRI) , the vendor hereby certifies that it is an “eligible entity,” as defined by 45 C.F.R. § 155.110, in order to carry out one or more of the responsibilities of a health insurance exchange. The vendor agrees to indemnify and hold the State of Rhode Island harmless for all expenses that are deemed to be unallowable by the Federal government because it is determined that the vendor is not an “eligible entity,” as defined by 45 C.F.R. § 155.110.

## **SECTION 2: BACKGROUND AND OVERVIEW**

### **Background**

In 2010, the RI General Assembly created the Special Senate Commission to Study Cost Containment, Efficiency and Transparency in the Delivery of Quality Patient Care and Access by Hospitals. Included in this Commission’s work was the recommendation that specified a need to create more behavioral health interventions. As a result of this recommendation, the RI Senate passed S875, creating a Special Commission to Study Emergency Department Diversion, which gathered experts in the substance abuse field, ED staff, department directors, medical professionals, provider CEOs, insurance providers and first responders, who examined current research and data of non emergent ED usage, alternatives and opportunities.

Inherent in the study were universal themes, which identified:

- The current system’s failure to appropriately and cost effectively transport and treat individuals with non emergent behavioral health issues;
- The devastating impact to both the individual and the system when budget cuts undermine service provisions; and
- The importance of examining and changing laws that prevent alternatives to screening and treating non emergent behavioral health issues in locations other than the hospital emergency departments.

Utilization of the hospital emergency department services for individuals with chronic alcohol dependence for non emergent medical needs is not only a system failure but also a medical care failure to the individual. Better alternatives and more effective approaches can be utilized with a commitment to changing our current system of care. This includes developing an alternative approach of delivering supportive, comprehensive services that provide a continuum of care for chronic alcohol-dependent individuals and are proven to reduce re-admissions and move individuals toward meaningful treatment and recovery.

The findings of the Special Senate Commission have led to the recommendation of the establishment of the Sobering Treatment Opportunity Program (*STOP*) program and the

development of the scope of services detailed in this Request for Proposal.

The Special Senate Commission Findings:

- Emergency departments currently face an over utilization of high cost, high levels of non emergent behavioral healthcare usage that could be appropriately treated in alternative settings;
- Municipalities face significant costs and personnel stressors for transporting individuals with non urgent behavioral health and /or substance use disorders to emergency room departments;
- Patients and providers face significant treatment access issues: patient obstacles and third party limitations, budget and resource limitations;
- Our state system currently provides funding for alternative stabilization units for those diagnosed with psychiatric disorders but limits eligibility criteria through regulations, significantly reducing access to those with active substance use disorders in need of services;
- Current Department of Health state Ambulance Advisory Council protocols for individuals with behavioral health and/or substance use disorders prevent Emergency Medical Technicians from transporting individuals to settings other than a hospital emergency department;
- Coordination among health care providers and the delivery system is fragmented for individuals with behavioral health and/or substance use disorders, lacking a continuum of comprehensive, integrated emergency services; and
- Nationally, there are demonstrated models that provide quality care for individuals with behavioral health and/or substance use disorders outside of hospital emergency departments that document improved health outcomes.

The Senate Commission made the following Recommendations to address the inappropriate transportation to, and utilization of, hospital emergency departments for chronic alcohol dependent individuals who are intoxicated without emergent medical conditions:

1. Amend existing RI alcohol statute to make it more flexible.
2. Create state-wide care partnerships to enhance patient-centered systems of care to include on-demand services, 24-hour triage center programs, mobile outreach transportation teams, and telephone triage system for substance use disorders/behavioral health issues.
3. Support opportunities through Health Homes Medicaid enhanced funding to include on-demand, substance use and/or behavioral healthcare and transitions to community supports.
4. Pilot program with evidence based suicide/mental health assessment tools and training for first responders, healthcare professionals to determine appropriate placement in ER or diversion program.
5. Support the development of a pilot program with protocols for Emergency Medical Services (EMS) transports to alternative facilities. The Department of Health is ultimately responsible for this aspect of the program.

6. Support opportunities to enhance or reinvest savings for best practice housing models that include supportive services and employment/training linkages.
7. Support the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals in exploring opportunities for funding the alternative program.

## **Overview**

In Providence, and throughout the State, there has been a historic overreliance on municipal emergency transport vehicles and hospital emergency rooms as a source of treatment for individuals with non-emergency conditions and behavioral health issues. Current regulations require that emergency patients be transported by licensed ambulances staffed by licensed EMTs to a hospital, including those patients who happen to be intoxicated and collapsed in a public area. This practice is considered both wasteful and an inappropriate use of a high level of emergency transportation and medical care for non-emergency situations. This is currently occurring at a time when municipalities and hospitals have diminishing resources to appropriately serve the public.

With so many inappropriate non-emergency runs, the municipalities are seeking ways to effectively address this issue to make available more emergency transport capacity for true emergencies without frequently calling other cities and towns for back-up, and to achieve savings. In addition, hospital emergency departments seek to reduce overcrowding from non-emergency cases, in part, by supporting a system whereby individuals who are suffering from severe intoxication could be managed at a more suitable location, where they could be encouraged to seek appropriate follow-up treatment and have better coordinated access to other community-based resources and supports.

In the 2012 legislative session, the General Assembly approved legislation, S2561 Sub A to make the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals responsible for presenting a proposal for a three-year pilot program to divert individuals impaired by substance abuse related issues to an alternative treatment program outside of the hospital emergency department. The Department of Health will collaborate with the municipality involved to coordinate and develop transportation options for these individuals to the pilot program. Once approved by the Governor and the General Assembly, and adequately, this pilot program will begin to serve as a resource for emergency transport and hospital EDs to better serve this target population. This Request for Proposals will detail the requirements of the program, facility and services needed to develop and implement the *Sobering Treatment Opportunity Program (STOP)*, serving a specific geographic area as defined by the pilot, in response to this situation.

## **SECTION 3: SCOPE OF WORK**

### **General Scope of Work**

The proposed three-year pilot program, suggested to be called the “*Sobering Treatment Opportunity Program*” or “*STOP*”, will be initially developed to serve individuals, 18 years of age or older, in a specific geographic area as defined by the pilot. Overseen by BHDDH and managed by the successful bidder, the STOP program will be a collaborative effort of the Fire

and Police Departments of the City; RI Hospital and the Emergency Medicine physicians who staff the Emergency Department of the hospital; the Department of Health EMS Services; existing substance abuse and behavioral healthcare agencies that provide detoxification, treatment, care coordination and support services; homeless service providers who provide a range of transitional housing options for individuals struggling with substance abuse and in various stages of recovery; and the organizations that develop employment opportunities for recovering individuals. Statutes that affect transportation, approved facilities and mandatory treatment of this population will need to be addressed as part of the STOP program implementation.

### **RI General Laws**

S 2561 Sub A established a pilot emergency department diversion program that amended 23-1.10-20 to create more flexibility by allowing, but not requiring, individuals to be transported to an alternative community-based pilot ER setting and for evaluations to be performed by medical staff, other than physicians. The statute did not alter the comprehensive and coordinated care for the treatment of alcoholics and intoxicated persons as set forth in section 23-1.10-6. Emergency room physicians, emergency medical technicians (EMTs), police and providers who have traditionally treated these individuals will need to be oriented on the revised and/or newly enforced statutes to facilitate the use of the alternative treatment program and emergency commitments, as appropriate.

*RI General Laws 23-1.10-10: Treatment and services of intoxicated persons and persons incapacitated by alcohol-* requires that intoxicated persons be brought to an approved treatment facility for emergency treatment (affiliated with or part of the medical services of a hospital)... and shall be examined by a licensed physician as soon as possible. S 2561 Sub A creates flexibility in the statute for the pilot facility to an alternative facility that would need to qualify as an approved treatment facility for persons to be transported to, outside of a hospital emergency department, and staffed by qualified individuals other than exclusively licensed physicians, who can monitor the residents and help them move through the continuum of care towards recovery.

*RIGL Chapter 23, Section 23-1.10-11: Emergency commitment-* establishes a process for Emergency Commitment for intoxicated persons, which can be utilized for: “(1) an intoxicated person who has threatened, attempted, or inflicted physical harm on himself or herself or another and is likely to inflict physical harm on himself or herself or another unless committed, or (2) is incapacitated by alcohol”... As per the statute, a certifying physician, spouse, guardian, relative or any other responsible person can make a written application for commitment to the administrator of the approved facility for not more than ten (10) days. The Department, with the assistance of appropriate clinical providers, will develop the standards for consideration and review for these commitment requests. This existing statute, although potentially helpful for some of the current chronic alcoholic population, has not been used, primarily because there is no “approved public treatment facility for emergency treatment”, as per the statute, that can provide a secured treatment environment. The proposed program would need to be designed to fulfill that status. The program would need to be able to secure those individuals who fall into the committed category and still have the flexibility to serve those who do not warrant mandated treatment.

*RIGL Chapter 23, Section 23-1.10-12: Involuntary commitment of alcoholics-* establishes a process for longer term Involuntary Commitment of Alcoholics. This process, which involves a

petition to the district court, can be utilized for those individuals who have the same risks of danger to themselves or others as described in the Emergency Commitment statute, along with the risk of continuing to suffer abnormal mental, emotional or physical distress, continuing to deteriorate in ability to function independently if not treated, and inability to make a rational and informed choice as to whether or not to submit to treatment. This commitment can continue for a stated period of time as long as the likelihood of harm to him/her or others continues to exist. The Department will evaluate the appropriateness of increased use of this statute after a period of evaluation of the experience of the program.

### **Existing Substance Abuse Treatment and Recovery System**

Applicants should be aware of current addiction treatment capabilities and services in place in Rhode Island to coordinate and collaborate in the development, implementation and ongoing operation of the *STOP* program, and to encourage individuals to seek treatment for their addiction. BHDDH has a full continuum of addiction treatment services related to alcohol, drug and prescription medication misuse and abuse available to those in need. Funding for addictions treatment is provided through the federal Substance Abuse Prevention Treatment Block Grant (SAPTBG) Block Grant, state general revenue dollars, Medicaid and other federal grants such as the Access to Recovery Program. As of January 1, 2014 a whole new population of single adults will become eligible for Medicaid as part of the expansion population. Their eligibility will be based solely on income, or lack thereof. It is anticipated that most of the clients to be served by the *STOP* program will be part of this expansion population and the successful provider will be expected to make use of the expanded funding by assisting clients to apply for benefits through the Medicaid portal.

Addiction treatment programs include inpatient detoxification services, outpatient detoxification, and detox step-down beds which provide an opportunity for continued stabilization while an individual prepares for reintegration into the community or a residential treatment setting. The General Outpatient Program (GOP) for the indigent and uninsured provides drug-free outpatient services for alcohol, drug dependent and addicted persons. The GOP works with five prime contractors - organizing services in their respective service areas which encompass general outpatient, intensive outpatient and partial hospitalization levels of care. New contracts require these providers to establish strong linkages with recovery support service providers in their communities including recovery coaching through peers. BHDDH also funds residential treatment services for adults and adolescents.

The BHDDH funded residential treatment system ranges from transitional programs with a 7-14 day length of stay to short-term residential (30 – 90 days) to long-term care programs of up to 180 days, and includes working half-way houses. Five of the adult residential providers are now women-only facilities, and include a program where children are able to stay with their mothers while they are in treatment. This new system actually decreased the total number of treatment beds available, but has an expectation to increase the number of unique individuals served through more effective level of care transitioning, and the incorporation of recovery oriented services which includes newly funded recovery houses.

BHDDH functions as the federally-mandated State Opioid Treatment Authority. The Department provides funding for the uninsured in eight of the twelve authorized OTP programs. It is anticipated that use of heroin and synthetic opioids will continue to be a significant issue in the

State of Rhode Island. Because of this, funded treatment slots will continue to be filled beyond capacity. These slots are supported by the use of costs not otherwise matchable (CNOMS) through the Medicaid 1115 Waiver.

The 2013 BHDDH budget proposal called for the creation of Medicaid-supported Health Homes for Medicaid-funded opioid treatment clients. This initiative is designed to provide stronger linkages between opioid treatment providers and the patients' medical service delivery systems; assign primary responsibility for the oversight of health care and wellness promotion to the Health Home team of the OTP; improve transitions between levels of care; improve access to necessary healthcare services; address chronic disease self management needs and provide support and education to patients and their families. Concepts from this program can be utilized by the *STOP* program for its population. The applicant is strongly encouraged to have access to an electronic health records (EHR) system to foster real-time communication between treatment providers at the various stages of the continuum.

A primary focus for BHDDH addiction treatment system is the incorporation of recovery principles into its service delivery system. Recovery-oriented systems support person-centered and self-directed approaches to care that build on the strengths and resilience of individuals, families and communities, encouraging them to take responsibility for their sustained health, wellness and recovery. BHDDH's movement in this area has been guided by the recommendations of the Governor's Council on Behavioral Healthcare, Recovery Oriented System of Care Committee. Development and enhancement of a recovery-oriented system of care (ROSC) has been furthered by the recent receipt of three grants: The Access to Recovery, the Transformation Transfer Initiative and the Employment Development Initiative. In September of 2007 and again in September 2010, the Department was awarded an Access to Recovery grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). The Access to Recovery (ATR) allows clients to choose among substance abuse clinical treatment and recovery support service providers, expands access to a comprehensive array of clinical treatment and recovery support options (including faith-based programmatic options), and increases substance abuse treatment capacity. Since 2007, the Rhode Island ATR has served over 2600 clients, providing clinical treatment and recovery support services resulting in positive, measureable outcomes. The ATR program has resulted in significant improvements in abstinence rates and decrease in arrest (or re-arrest) rates, 5 to 7 months post-admission. Both the TTI and the EDI involved the training and placement of peers to provide support for individuals with mental health disorders. These programs have been very successful at supporting Health Home services and employment initiatives at clubhouses and recovery centers.

The Department continues to implement the Transition from Prison to Community Program. This program provides residential or intensive outpatient substance abuse treatment services to parolees for whom these services are a required condition of parole. This funding has increased capacity at residential treatment programs and allowed inmates, who were previously waiting in prison for a state-funded residential bed to become available, to have quicker access to treatment. All referred parolees receive a standardized assessment by a Licensed Chemical Dependency Professional and are then referred to the appropriate clinical setting. Additional funding for this initiative was obtained through Byrne/Jag and contracted through The Providence Center. These funds increased the overall residential beds available for this program and provided recovery support services following successful completion of treatment. While the residential portion of

Byrne/Jag funding has been exhausted, the Department continues to support recovery services for this population.

Prevention services are provided through 35 contracts with municipalities funded through the Rhode Island Substance Abuse Prevention Act. Through these programs, residents of all of the state's 39 municipalities are exposed to public education and other strategies designed to change community norms, prevent alcohol and other drug use, reduce retail purchases of alcohol by children and youth, and arrest the progression from initial substance use to abuse and dependency.

### **Medicaid 1115 Reapplication**

As part of the reapplication to CMS, the STOP Program included requesting authorization to use member incentives to encourage clients to engage in ongoing substance abuse treatment, upon discharge from STOP. In addition, the state seeks a waiver of Section 1902 (a)(10)(B) to offer services in an alternative setting to authorize providing STOP services to any qualified Medicaid beneficiary, regardless of delivery system enrollment (*Rhode Island 1115 Research and Demonstration Waiver Project No. 11-W-00242/I Addendum July 10, 2013*).

### **Transportation**

Although transportation of individuals to the STOP program is outside of the scope of this RFP, the Department will work with HEALTH to identify the necessary legislative authority and rules and regulations and practices including but not limited to 23-4.1-7: Standards for ambulance license and *Rules and Regulations Relating to Emergency Medical Services [R23-4.1EMS]* are addressed to ensure patient safety, protocols and standards are adequately addressed to ensure that transportation is part of the overall STOP program.

### **Screening:**

When clients are referred to the STOP program staff will screen individuals for health issues beyond alcohol or substance abuse and, if appropriate and permissible based on established clinical protocols, accept the individuals into the STOP program instead of hospital EDs. As part of the screening, staff will be directed to utilize general criteria based on a pilot study of EMTs' field assessment of intoxicated patients' need for ED care<sup>1</sup>. The study indicated that the answer to all of the listed questions about the individual should be "No" to be considered appropriate for the STOP program alternative to the ED:

- Complaint other than alcohol intoxication?
- Age younger than 18 years?
- Abnormal vital signs (as defined in the protocols)?
- Abnormal pulse oximetry?
- Any sign of trauma?
- Any sign of illness?
- Any sign of environmental emergency?
- Abnormal blood sugar (as defined in the protocols)?

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<sup>1</sup> Cornwall AH, Zaller N, Warren O, et al. A pilot study of emergency medical technicians' field assessment of intoxicated patients' need for ED care. *The American journal of emergency medicine*. 2012;30(7):1224–8. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/22056060>

- Aggressive/confrontational?
- Other findings of concern?

As experience with the program and patients builds, some of the criteria may be modified through coordination with the hospital physician staff, based on the capacity of the *STOP* program and treatment staff.

### **Program Values and Services**

Individuals who are caught in a cycle of inebriation and hospitalization need four critical supports to help them recover from this cycle and move towards leading productive and fulfilling lives:

- Medical stabilization and access to integrated healthcare services, including quick access to detoxification services and treatment services that are highly effective in engaging people who are often alienated from mainstream systems.
- Direct access to transitional housing, which supports lifestyle change until they can access residential treatment and, eventually, permanent housing.
- The development of peer relationships that nurture and support personal transformation and recovery in a respectful environment.
- Attainment of income through employment or accessing benefits which will often require assisting clients to obtain “proofs” or legal documentation.<sup>2</sup>

Additionally, programmatic and treatment values should be established as the foundation of the *STOP* program. Safety of the clients and staff should be a priority. Clients should be treated with respect and dignity and not encounter the social stigma that occurs with these conditions. Prevention and early intervention should be utilized as often as possible. Treatment settings should be the right services at the right time in the most cost effective and accountable manner, leading to positive outcomes. Harm reduction and motivational counseling should be utilized to encourage clients to agree to participate and continue in treatment and recovery services. Care coordination and transition assistance should be provided throughout the client’s involvement in the program.

It is recommended that the ED Physician’s group at RI Hospital and medical interns and residents from Brown University Medical School be engaged to provide medical support and staff for daily rounds and ongoing coordination at the facility to monitor medical issues, prescribe medications, perform minor primary care services, and facilitate transfer to the hospital, whenever necessary.

As communicated to the Department by the ED Physicians Group, presence of any of the following signs or symptoms of the impaired individual will be grounds for immediate transport to the hospital ED and should be incorporated into the applicant’s profile of services:

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<sup>2</sup> Food stamps, SSI, SSDI and Medicaid/Medicare require clients to have proof of RI residence, original birth certificate, photo ID, and a social security card.

- Complaints in addition to alcohol intoxication
  - Head Trauma
  - Significant other trauma
  - Chest pain
  - Acute abdominal pain (does not include chronic daily abdominal pain)
  - Hematemesis (bloody vomit)
  - Suicidality or Homocidality
  - Belligerent or threatening behavior
- Abnormal vital signs
  - Systolic blood pressure >180 or <90
  - Pulse >115 or <50
  - Oxygen saturation <92%
  - Temperature >99.9 F or < 97.0 F
  - Blood glucose <75mg/dL(if able to drink juice) or <80 mg/dL if unable to drink juice or >200 (without a history of diabetes) or >300 (with a history of diabetes)
- Abnormal physical exam findings
  - New trauma to the head or face
  - Cervical spine midline tenderness
  - Laceration requiring suture closure
  - Significant abdominal tenderness to palpation
  - GCS <13 (This will exclude patients with excessive somnolence)
  - Focal neurologic findings (i.e. new weakness)
  - CIWA (alcohol withdrawal score) >10<sup>2</sup>

For individuals without serious medical conditions that require a hospital setting, community-based detoxification with affiliated services would be appropriate. Peer specialists/recovery coaches should be utilized to help engage clients to consider treatment and guide them through the steps of participation, recovery and ongoing support services in the program. It is important that clients feel cared for and engaged in their care. However, the question of enabling unhealthy behavior is also a concern. A number of these clients have regularly refused ongoing treatment and support. Voluntary engagement in treatment is always preferred; therefore, policies must be developed to create incentives to get individuals to make use of the service opportunities that are available through the *STOP* program. Some examples of incentivizing policies would be to require individuals, who go to the program three or four times in a four-day period, for example, to sign a pledge to participate in treatment and support the next time they need help. Vouchers for food, clothing, housing, etc., have also been effective. The judicial system has a history of recommending treatment for individuals involved in the criminal justice system as a part of their judgments. While these clients are typically involved in misdemeanor level infractions that call them to the attention of the police (public nuisance, disorderly conduct, etc.), there is still a precedent for recommending treatment as part of one's plea.

Although voluntary engagement into the treatment and recovery program is always the preferred method, most clinicians and many clients consulted leading to the recommendations for this project, have indicated that mandatory treatment may be the most effective way to engage certain clients who have not been sober for a lengthy period of time. Due to excessive alcohol use and dependence, these individuals may have incurred a serious impact on brain functioning and the associated behaviors related to brain impairment. Thus, these clients would need to maintain

sobriety for a significant period of time to be able to understand what it would be like to be sober and to regain better brain, behavioral and physical functioning. To that end, mandatory treatment would be warranted. As per the identified statutes, this would be appropriate for individuals who are deemed to be a danger to themselves or others because of their potential of becoming inebriated again and dying from alcohol poisoning, hypothermia, head or other trauma from falling or accidents, or from driving under the influence. Typically, these clients may be out of immediate danger when they achieve reduced inebriation, but if they are released to continuously engage in the same addictive behavior, they are once again a danger to themselves and society. Therefore, there is a rationale for the option to mandate treatment although the cost of a locked facility may prohibit a vendor from being able to provide this option with the dollars available. Furthermore, some concerns about client's civil rights that arose during hearings about the proposed project make this option something that might require further investigation.

Housing, employment and ongoing support benefits are the critical components of achieving and maintaining sobriety and fostering meaningful recovery. Since most of the frequent, chronically alcohol-dependent individual utilizers of the emergency department services are homeless, in order to reap the benefits of the services described, housing must be part of the equation. It is recommended that operating subsidies and rental vouchers be created for this population, enabling affordable housing projects and market rate landlords to assist lower income individuals (including the homeless and disabled). Types of services available in the community, which need to be addressed and coordinated, that would be helpful to this population include, but are not limited to, the following:

Housing:

- Housing location programs
- Housing First and other community-based housing programs
- Section 8, Rhode Home, Shelter Plus Care
- Rental classes and other educational programs on successful housing retention
- Veteran's Housing Assistance programs
- Veteran's community outreach and housing programs
- Public Housing Authorities

Employment:

- State employment support agencies and programs like ORS, Ticket to Work and DLT
- Community-based training and employment programs
- Community-based placement programs
- Integration with Governor's plans to increase employment in the State

Benefits:

- SSI/SSDI Outreach, Access and Recovery (SOAR)
- Benefits Specialists (from CMHOs)
- Veteran's Benefits Administration
- The Point/Options Counseling and other programs through Medicaid/Medicare

## **Physical Space**

The *STOP* program will need to have adequate physical space where individuals can safely go to achieve short-term sobriety or safe reduction in inebriation and be engaged by peers and substance abuse treatment providers. The capacity of the initial clinical observation phase of the *STOP* program, based on the volume of chronic alcoholic clients projected from emergency transports and emergency department admissions of chronic alcoholic individuals, is recommended to be appropriately staffed to accommodate 15 individuals for a period of approximately 24-48 hours. The program will need to be operational 24/7 and have the capacity in house or connections to medical detoxification for those that need it and are willing to participate. Full time security will be necessary to ensure the safety of clients and staff. It would be helpful to have a kitchen where food can be prepared and fluids can be stored to help clients regain sobriety.

The space should be designed to include a separate area for congregate and private meeting rooms for group and private engagements with care coordinators, peers and treatment providers and to encourage provision of detoxification services. This area can also be used by professionals who could help clients with substance abuse treatment, relapse prevention, coping skills, employment, housing, benefits, education, exercise, family re-integration and general skill building during the day. By making this type of environment available to other homeless individuals, or those at risk of homelessness who have employment, training and educational needs, blended funding and collaboration could be promoted with the Office of Housing and Community Development and community-based providers of these services.

Preferably, the site used for the *STOP* program will have, or be connected to, a diverse set of day program opportunities that can serve as an alternative to consuming alcohol, and help break the daily cycle of chronic inebriation and required acute recovery services. Blending funding and sharing space with homeless service providers seeking to provide day programs, intake, assessment and referrals for their clientele to community based services, would also create service coordination and financial efficiencies. If the space is large enough to accommodate a health clinic, further safety and wellness could be facilitated with clients.

## **Transitional Housing Capacity**

Since housing is such a critical factor in maintaining treatment gains and assisting in recovery, a second separate area with a capacity for 15-20 individuals should be created, in-house or outsourced, to provide transitional housing for 20-30 days to individuals who have “graduated” into sobriety and could benefit from this level of community service and support. After which, other housing options, such as permanent, supportive, subsidized or mainstream housing can be arranged. This is also important for engaging individuals to pursue treatment, because the existing transitional housing capacity in the state is not sufficient for immediate placement. Some residential treatment programs require 30 days of sobriety before admission, or have wait times before entry due to being filled to capacity. Recovery Houses/sober houses often require 30 days of sobriety before admission. The transitional housing component of the Program can provide housing until such time that the client can access residential treatment, or if appropriate, recovery housing. By co-locating these services, financial efficiencies for staffing and space can be maximized and an individual needs-based and responsive system of care can be provided.

## **Data Collection**

Currently, RI Hospital is collecting data (mostly demographic, utilization and insurance, etc.) on this population. The Department will ask the vendor to collect this demographic, utilization and insurance data as well, along with data that reports source of referral to the program, and referrals made from the program; summaries of clinical findings on assessment and care coordination; housing, employment and veteran status; outcome measures and follow-up care with tracking of sobriety, treatment, housing and employment status 30, 90 and 180 days out of the program. The Department will also work with the vendor to determine actual costs, and cost savings (deferred costs, etc.) of this program and other categories to present in its annual report to the General Assembly and Governor.

## **Program Funding**

The amount of funding allocated to this program by the legislature is \$250,000. This is for a one year trial. Future funding for the program will be dependent upon the legislature, as this is not part of BHDDH's regular budget. Rather than relying on the funding available for this project through this RFP, applicants should consider ways to braid funding by taking advantage of federal, state and private resources. Many of the private agencies and community non-profits are receiving funding to address the issues STOP is trying to address; but there are silos, specific funding requirements that limit flexibility and a general lack of coordination. Structural problems like this in the system cannot be solved without long-term structural solutions; therefore a key component of this program will be a reinvestment of cost savings into housing, employment and recovery services that are integrated into the community. Therefore, this program must show net cost savings.

Some examples of ways to leverage funding are using the ACU Medicaid rate to cover much of the clinical treatment that needs to be done at the STOP program. Applicants should work with the Office of Housing and Community Development and the Housing Resource Commission to access rental subsidies, collaborate with the Department of Labor Training and the Office of Rehabilitative Services to provide employment and training. Applicants could also use federal grant funding to supplement the Medicaid funding to treat and provide case management to these individuals. If possible, applicants should enroll clients in health homes. Applicants should also work with private foundations to seek funding to evaluate the program for cost savings or to fund innovative aspects of the program.

## **SECTION 4: TECHNICAL PROPOSAL**

Narrative and format: The separate technical proposal should address specifically each of the required elements:

All proposals must include the components listed below to be considered for this award.

- **Executive Summary** (Not to Exceed One Page)
- **Table of Contents:** The table of contents shall be broken down by primary proposal components, including appendices, with corresponding page numbers

- **Narrative:**

**ORGANIZATIONAL EXPERIENCE (10 Points):**

1. For the applicant agency and each possible subcontracting agency, a brief paragraph describing similar projects undertaken.
2. Letters of agreement mutually signed by the agency and any subcontractor must be appended. These letters will not count towards the total narrative page limit.
3. A description of the business background of the applicant (and all proposed subcontractors).
4. Applicant's experience in developing and implementing substance abuse treatment and recovery programs.

**STAFF EXPERIENCE AND CREDENTIALS (10 Points):**

1. Applicants will provide specific detailed information on agency experience, credentials and how this experience will benefit in implementing the *STOP* program. This section must include a brief synopsis of job responsibilities for each staff position.
2. Applicants will provide a protocol for staff supervision and project oversight on a daily, weekly and monthly basis in this section.
3. Applicants shall include identification of the staffing pattern, by lead and subcontractor agencies, proposed to provide the required program services and capabilities.
4. Applicants will describe collaborative efforts to be undertaken that will allow them to meet the requirements of this program. MOUs or Letters of support should be included in the appendix for all subcontracts or collaborations.

**WORK PLAN/ PROJECT DESIGN (40 Points):**

1. Applicants will describe the agency's understanding of the State's requirements, including the results intended and desired.
2. The Work Plan/Project Design should address all of the components described under Scope of Work, as well as any technical issues that will or may be confronted in implementing the initiative.
3. Applicants shall include a specific plan outlining how all services will be developed, provided and monitored.

Applicants for the pilot *STOP* program for individuals 18 years of age or older in a defined geographic area as established by the pilot, should propose services and capacities to develop and

implement the following features of the program summarized below and also described above in Section 3, Scope of Work:

### **STOP Program Services**

- The *STOP* program will be a 24 hour/7 days per week licensed service that will function as an “approved public treatment facility”, which will intake individuals, transported by the program or self transported to the facility, to provide initial and ongoing clinical assessment, medical clearance, case management, peer support, administrative, maintenance and security services, while monitoring up to 15 clients recovering to achieve a reasonable reduction in inebriation.
- The staffing for this component includes sufficient clinical (RNs, case managers, and residential assistants), security, and administrative staff, necessary to accommodate this population and capable of providing a secure environment and staffing for a mandated treatment capacity.
- The capacity should exist to perform a screening for mental health issues as well.
- The ability to make appropriate referrals for clients needing extended behavioral health treatment, housing, community supports, benefits and employment beyond those services provided within the *STOP* program, are critical capabilities that should be presented.
- Arrangements should be established with the RI Hospital ED Physician’s group, or another comparable physician group, to perform daily medical rounds in the program for clinical issues that may warrant transfer to the hospital.
- The program will need to present the in-house capacity, or connections, to offer timely medical detoxification for those that need it and are willing to participate.
- The program should have the capability of having food available for this population and the ability to wash or replace clothing as appropriate and necessary.

### **Physical Space**

- The *STOP* program will need to have adequate and appropriate physical space to serve a capacity of 15 individuals and staff to achieve short-term sobriety or safe reduction in inebriation and be engaged by peers and substance abuse treatment providers. Length of stay in this component of the program is estimated to be approximately 24-48 hours.
- The facility should be located in, or convenient to, a defined geographic area as established by the pilot.
- Full time security will be necessary to ensure the safety of clients and staff. The facility will need to be designed and equipped to provide a secured treatment area for those individuals who are mandated to treatment.
- It would be helpful to have a kitchen where food can be prepared and fluids can be stored to help clients regain sobriety.

- The space should be designed to include a separate area for congregate and private meeting rooms for group and private engagements with care coordinators, peers and treatment providers and to encourage provision of detoxification services.

### **Transitional Housing Capacity**

- A second separate area with a capacity for 15-20 individuals should be created, in-house or outsourced, to provide transitional housing for 20-30 days to individuals who have “graduated” into sobriety and could benefit from this level of community service and support.
- Case managers should be included to provide, as appropriate, housing options, such as permanent, supportive, subsidized or mainstream housing. By co-locating these services with the *STOP* program services, financial efficiencies for staffing and space can be maximized and an individual needs-based and responsive system of care can be provided.

### **DATA COLLECTION (10 Points):**

1. Applicants shall include a specific plan for collecting and tracking treatment and referral data on the clients engaged with the *STOP* program as indicated in this RFP.
2. Applicants shall include a description of the applicant’s provision of electronic health records and engagement with the RI Health Information Exchange—Currentcare.
3. Applicants shall include a description of their ability to maintain the confidentiality of personal protected information.
4. The Department will ask the vendor to collect client demographic, utilization and insurance data, along with data that reports source of referral to the program, and referrals made from the program;
5. Data should be collected including summaries of clinical findings on assessment and care coordination; housing, employment and veteran status;
6. Data including outcome measures and follow-up care with tracking of sobriety, treatment, housing and employment status 30, 90 and 180 days out of the program should be collected.
4. The Department will also work with the vendor to determine actual costs, and cost savings (deferred costs, etc.) of this program and other categories to present in its annual report to the General Assembly and Governor.

### **SECTION 5: COST PROPOSAL**

Detailed Budget and Budget Narrative:

Applicants must provide a detailed, line-item budget for the cost of this project using Appendix A: Budget Form. Applicants must include a table of what will be charged to the project itself, what will be offered in kind (if anything), and what resources will be leveraged. For example if the staffing patterns for this proposal require a Registered Nurse, and the applicant anticipates

that 100% of that nurse’s time on the project will be covered by Medicaid or other insurances as opposed to the \$250,000 of state funding provided through this RFP. When this occurs it should be reflected in the budget table as leveraged resources, and described in a budget narrative that explains the rationale for each line item in the budget.

Finally, an estimate of what costs will be billed to Medicaid through existing Medicaid-enrolled clients and what will be billed to clients enrolled in Medicaid expansion will need to be provided with an explanation of how that estimate was developed. The higher the number of expansion clients included in the estimate the better the cost proposal; therefore it would behoove applicants to demonstrate in their workplan how they will ensure that clients seeking services at their facility will gain enrollment in Medicaid or other insurance plans while in their care. Appendix A: Budget Form provides a format for budget tables.

**SECTION 6: EVALUATION AND SELECTION**

Proposals will be reviewed by a Technical Review Committee comprised of staff from state agencies. To advance to the Cost Evaluation phase, the Technical Proposal must receive a minimum of 60 (85.7%) out of a maximum of 70 technical points. Any technical proposals scoring less than 60 points will not have the cost component opened and evaluated. The proposal will be dropped from further consideration.

Proposals scoring 60 technical points or higher will be evaluated for cost and assigned up to a maximum of 30 points in cost category, bringing the potential maximum score to 100 points. The Department of Health reserves the exclusive right to select the individual(s) or firm (vendor) that it deems to be in its best interest to accomplish the project as specified herein; and conversely, reserves the right not to fund any proposal(s).

Proposals will be reviewed and scored based upon the following criteria:

<b>Criteria</b>	<b>Possible Points</b>
Organizational Experience	10 Points
Staff Experience and Credentials	10 Points
Quality of the Workplan/Project Design	40 Points
Data Collection	10 Points
<b>Total Possible Technical Points</b>	<b>70 Points</b>
Total Cost (see A and B below)*	30 Points
A. Highest dollars leveraged annually	15 Points
B. Greatest number of treatment days provided annually	15 Points
<b>Total Possible Points</b>	<b>100 Points</b>

\*The highest dollars leveraged annually and the greatest number of treatment days provided annually will each receive 15 of the 30 cost points. Other bids will receive a percentage of the 30 points based on the formula below.

**A. Highest dollars leveraged annually:**

$$\begin{aligned} & (\text{Bidder's dollars leveraged/highest dollars leveraged}) * 15 \\ & + \\ & (\text{Bidder's number of treatment days provided annually /greatest number} \\ & \quad \text{of treatment days provided annually}) * 15 \end{aligned}$$

For example: If the bidder with the highest dollars leveraged (Vendor A) includes \$100,000 of leveraged funds in their proposal and Vendor B includes \$65,000, vendor B's cost points are calculated as follows:

$$\$65,000 / \$100,000 * 15 = 9.75$$

**B. Greatest number of treatment days provided annually:**

If the bidder with the greatest number of treatment days provided annually (Vendor A) says that they will provide 10,000 treatment days annually and Vendor B says that they will provide 500 treatment days annually, vendor B's cost points are calculated as follows:

$$500 / 1000 * 15 = 7.5$$

Applicants may be required to submit additional written information or be asked to make an oral presentation before the technical review committee to clarify statements made in their proposal.

**SECTION 7: PROPOSAL SUBMISSION**

Questions concerning this solicitation may be e-mailed to the Division of Purchases at [david.francis@purchasing.ri.gov](mailto:david.francis@purchasing.ri.gov) no later than the date and time indicated on page one of this solicitation. Please reference **RFP # 7548426** on all correspondence. Questions should be submitted in a Microsoft Word attachment. Answers to questions received, if any, will be posted on the Internet as an addendum to this solicitation. It is the responsibility of all interested parties to download this information. If technical assistance is required to download, call the Help Desk at (401) 574-9709.

Offerors are encouraged to submit written questions to the Division of Purchases. **No other contact with State parties will be permitted.** Interested offerors may submit proposals to provide the services covered by this Request on or before the date and time listed on the cover page of this solicitation. Responses received after this date and time, as registered by the official time clock in the reception area of the Division of Purchases will not be considered.

Responses (**one (1) original plus four (4) copies**) should be mailed or hand-delivered in a sealed envelope marked “**RFP# 7548426 Hospital Emergency Room Diversion**” to:

RI Dept. of Administration  
Division of Purchases, 2nd floor  
One Capitol Hill  
Providence, RI 02908-5855

NOTE: Proposals received after the above-referenced due date and time will not be considered. Proposals misdirected to other State locations or those not presented to the Division of Purchases by the scheduled due date and time will be determined to be late and will not be considered. Proposals faxed, or emailed, to the Division of Purchases will not be considered. The official time clock is in the reception area of the Division of Purchases.

**Responses shall include the following:**

1. One completed and signed four-page R.I.V.I.P generated bidder certification cover sheet (included with the original proposal only) downloaded from the RI Division of Purchases Internet home page at [www.purchasing.ri.gov](http://www.purchasing.ri.gov).
2. One completed and signed W-9 (included with the original proposal only) downloaded from the RI Division of Purchases Internet home page at [www.purchasing.ri.gov](http://www.purchasing.ri.gov).
3. **A separate Technical Proposal** describing the qualifications and background of the applicant and experience with and for similar projects, and all information described earlier in this solicitation. The Technical Proposal is limited to six (6) pages (this excludes any appendices). As appropriate, resumes of key staff that will provide services covered by this request.
4. **A separate, signed and sealed Cost Proposal** using Appendix A: Budget Form reflecting the hourly rate, or other fee structure, proposed to complete all of the requirements of this project.
5. A copy of the most recent independent certified audit(s) and any accompanying management letters issued as part of the audit.
6. In addition to the multiple hard copies of proposals required, Respondents are requested to provide their proposal in **electronic format (CD-Rom, disc, or flash drive)**. Microsoft Word / Excel OR PDF format is preferable. Only 1 electronic copy is requested and it should be placed in the proposal marked “original”.

**CONCLUDING STATEMENTS**

Notwithstanding the above, the State reserves the right not to award this contract or to award on the basis of cost alone, to accept or reject any or all proposals, and to award in its best interest.

Proposals found to be technically or substantially non-responsive at any point in the evaluation process will be rejected and not considered further.

The State may, at its sole option, elect to require presentation(s) by offerors clearly in consideration for award.

The State's General Conditions of Purchase contain the specific contract terms, stipulations and affirmations to be utilized for the contract awarded to the RFP. The State's General Conditions of Purchases/General Terms and Conditions can be found at the following URL:

<https://www.purchasing.ri.gov/RIVIP/publicdocuments/ATTA.pdf>

**APPENDIX A: BUDGET TABLES**

**BUDGET**

NAME OF AGENCY: \_\_\_\_\_

FEDERAL EMPLOYER IDENTIFICATION NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/TOWN: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ FAX: \_\_\_\_\_

EXECUTIVE DIRECTOR: \_\_\_\_\_

TIME OF PERFORMANCE: FROM \_\_\_\_\_ TO \_\_\_\_\_

**BUDGET SUMMARY**

**COST CATEGORY**

**AMOUNT**

- |    |                                      |       |
|----|--------------------------------------|-------|
| 1. | PERSONNEL                            | _____ |
| 2. | CONSULTANT AND SUB CONTRACT SERVICES | _____ |
| 3. | TRAVEL                               | _____ |
| 4. | SPACE                                | _____ |
| 5. | SUPPLIES                             | _____ |
| 6. | EQUIPMENT                            | _____ |
| 7. | OTHER COSTS                          | _____ |

**TOTAL FUNDS REQUESTED:**

\$0.00

ATTACHMENT 1- BUDGET FORM (2 of 5)

<b>PERSONNEL REQUEST FROM STATE DOLLARS*</b>								
A	B	C	D	E	F	G	H	I
POSITION TITLE	EMPLOYEE NAME	TOTAL ANNUAL SALARY	TOTAL ANNUAL FRINGE BENEFITS	% APPLIED TO PROJECT	SALARY ON PROJECT  (Column C x E)	FRINGE BENEFITS ON PROJECT  (Column D x E)	TOTAL PERSONNEL COST ON PROJECT  (Column F + G)	SOURCE OF OTHER** FUNDS
<b>TOTAL→</b>								
<p>* ROUND TO NEAREST DOLLAR</p> <p>** INDICATE FUNDING SOURCE IF EMPLOYEE COST IS SHARED</p>								
							<b>ENTER ON PAGE 1 LINE 1</b>	

ATTACHMENT 1- BUDGET FORM (3 of 5)

<b>BUDGET DETAIL FROM STATE DOLLARS</b>		
CONSULTANTS & SUB CONTRACT SERVICES	TYPE, NAME, HOURLY RATE, NUMBER OF HOURS, ETC	COST
	Enter on page 1, line 2	
TRAVEL	PURPOSE, RATE, NUMBER OF MILES, ETC	COST
	Enter on page 1, line 3	
SPACE	DESCRIPTION	COST
	Enter on page 1, line 4	
SUPPLIES	DESCRIPTION	COST
	Enter on page 1, line 5	
EQUIPMENT	PURCHASE, LEASE, RENTAL	COST
	Enter on page 1, line 6	
OTHER COSTS	DESCRIPTION	COST
	Enter on page 1, line 7	



ATTACHMENT 1- BUDGET FORM (5 of 5)

<b>BUDGET DETAIL LEVERAGED/IN KIND</b>		
CONSULTANTS & SUB CONTRACT SERVICES	TYPE, NAME, HOURLY RATE, NUMBER OF HOURS, ETC	COST
	Enter on page 1, line 2	
TRAVEL	PURPOSE, RATE, NUMBER OF MILES, ETC	COST
	Enter on page 1, line 3	
SPACE	DESCRIPTION	COST
	Enter on page 1, line 4	
SUPPLIES	DESCRIPTION	COST
	Enter on page 1, line 5	
EQUIPMENT	PURCHASE, LEASE, RENTAL	COST
	Enter on page 1, line 6	
OTHER COSTS	DESCRIPTION	COST
	Enter on page 1, line 7	