Solicitation Information
October 10, 2017

RFP# 7566483

TITLE: Center of Excellence for Treatment of Opioid Use Disorders

Submission Deadline: November 7, 2017 @ 10:00 AM Eastern Time (ET)

PRE-BID/ PROPOSAL CONFERENCE: No

Questions concerning this solicitation must be received by the Division of Purchases at david.francis@purchasing.ri.gov no later than **October 20, 2017 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 Division of Purchases' website as an addendum to this solicitation. It is the responsibility of all interested parties to download this information.

BID SURETY BOND REQUIRED: No

PAYMENT AND PERFORMANCE BOND REQUIRED: No

David J. Francis, Interdepartmental Project Manager

Applicants must register on-line at the State Purchasing Website at www.purchasing.ri.gov

Note to Applicants:

Proposals received without a completed RIVIP Bidder Certification Cover Form attached may result in disqualification.

THIS PAGE IS NOT A BIDDER CERTIFICATION COVER 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) is soliciting proposals from qualified firms to provide treatment and recovery support services through a certified Center of Excellence for the Treatment of Opiate Use Disorders in accordance with the terms of this Request for Proposals ("RFP") and the State's General Conditions of Purchase, which may be obtained at the Division of Purchases' website at www.purchasing.ri.gov.

The initial contract period will begin approximately January 1, 2018 for one year. Contracts may be renewed for up to four additional 12-month periods based on vendor performance and the availability of funds.

This is a Request for Proposals, not a Request for Quotes. Responses will be evaluated on the basis of the relative merits of the proposal, in addition to cost; there will be no public opening and reading of responses received by the Division of Purchases pursuant to this solicitation, 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 RFP are solicited. However, proposals which depart from or materially alter the terms, requirements, or scope of work defined by this RFP may be rejected as being non-responsive.

3. All costs associated with developing or submitting a proposal in response to this RFP or for providing oral or written clarification of its content, shall be borne by the vendor. The State assumes no responsibility for these costs even if the RFP is cancelled or continued.

4. Proposals are considered to be irrevocable for a period of not less than 180 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 in the proposal.

6. 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. 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.

7. The purchase of goods and/or services under an award made pursuant to this RFP will be contingent on the availability of appropriated funds.

8. Vendors are advised that all materials submitted to the Division of Purchases for consideration in response to this RFP may be considered to be public records as defined in R. I. Gen. Laws § 38-2-1, *et seq*. and may be released for inspection upon request once an award has been made.

   Any information submitted in response to this RFP that a vendor believes are trade secrets or commercial or financial information which is of a privileged or confidential nature should be clearly marked as such. The vendor should provide a brief explanation as to why each portion of information that is marked should be withheld from public disclosure. Vendors are advised that the Division of Purchases may release records marked confidential by a vendor upon a public records request if the State determines the marked information does not fall within the category of trade secrets or commercial or financial information which is of a privileged or confidential nature.

9. 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.

10. By submission of proposals in response to this RFP vendors agree to comply with R. I. General Laws § 28-5.1-10 which mandates that contractors/subcontractors doing business with the State of Rhode Island exercise the same commitment to equal opportunity as prevails under Federal contracts controlled by Federal Executive Orders 11246, 11625 and 11375.

    Vendors are required to ensure that they, and any subcontractors awarded a subcontract under this RFP, undertake or continue programs to ensure that minority group members, women, and persons with disabilities are afforded equal employment opportunities without discrimination on the basis of race, color, religion, sex, sexual orientation, gender identity or expression, age, national origin, or disability.

    Vendors and subcontractors who do more than $10,000 in government business in one year are prohibited from engaging in employment discrimination on the basis of race, color, religion, sex, sexual orientation, gender identity or expression, age, national origin, or disability, and are required to submit an "Affirmative Action Policy Statement."

    Vendors with 50 or more employees and $50,000 or more in government contracts must prepare a written "Affirmative Action Plan" prior to issuance of a purchase order.

    a. For these purposes, equal opportunity shall apply in the areas of recruitment, employment, job assignment, promotion, upgrading, demotion, transfer, layoff, termination, and rates of pay or other forms of compensation.

    b. Vendors further agree, where applicable, to complete the "Contract Compliance Report" (http://odeo.ri.gov/documents/odeo-eeo-contract-compliance-report.pdf), as well as the "Certificate of Compliance" (http://odeo.ri.gov/documents/odeo-eeo-certificate-of-compliance.pdf), and submit both documents, along with their Affirmative Action Plan or an Affirmative Action Policy Statement, prior to issuance of a purchase order. For public works projects vendors and all subcontractors must submit a "Monthly Utilization Report" (http://odeo.ri.gov/documents/monthly-employment-

utilization-report-form.xlsx) to the ODEO/State Equal Opportunity Office, which identifies the workforce actually utilized on the project.

For further information, contact the Rhode Island Equal Employment Opportunity Office, at 222-3090 or via e-mail at Krystal.Waters@doa.ri.gov .

11. In accordance with R. I. Gen. Laws § 7-1.2-1401 no foreign corporation has the right to transact business in Rhode Island until it has procured a certificate of authority so to do from the Secretary of State. This is a requirement only of the successful vendor(s). For further information, contact the Secretary of State at (401-222-3040).

12. In accordance with R. I. Gen. Laws §§ 37-14.1-1 and 37-2.2-1 it is the policy of the State to support the fullest possible participation of firms owned and controlled by minorities (MBEs) and women (WBEs) and to support the fullest possible participation of small disadvantaged businesses owned and controlled by persons with disabilities (Disability Business Enterprises a/k/a "DisBE")(collectively, MBEs, WBEs, and DisBEs are referred to herein as ISBEs) in the performance of State procurements and projects. As part of the evaluation process, vendors will be scored and receive points based upon their proposed ISBE utilization rate in accordance with 150-RICR-90-10-1, "Regulations Governing Participation by Small Business Enterprises in State Purchases of Goods and Services and Public Works Projects". As a condition of contract award vendors shall agree to meet or exceed their proposed ISBE utilization rate and that the rate shall apply to the total contract price, inclusive of all modifications and amendments. Vendors shall submit their ISBE participation rate on the enclosed form entitled "MBE, WBE and/or DisBE Plan Form", which shall be submitted in a separate, sealed envelope as part of the proposal. ISBE participation credit will only be granted for ISBEs that are duly certified as MBEs or WBEs by the State of Rhode Island, Department of Administration, Office of Diversity, Equity and Opportunity or firms certified as DisBEs by the Governor's Commission on Disabilities. The current directory of firms certified as MBEs or WBEs may be accessed at http://odeo.ri.gov/offices/mbeco/mbe-wbe.php. Information regarding DisBEs may be accessed at www.gcd.ri.gov.

For further information, visit the Office of Diversity, Equity & Opportunity's website, at http://odeo.ri.gov/ and *see* R.I. Gen. Laws Ch. 37-14.1, R.I. Gen. Laws Ch. 37-2.2, and 150-RICR-90-10-1. The Office of Diversity, Equity & Opportunity may be contacted at, (401) 574-8670 or via email Dorinda.Keene@doa.ri.gov

13. HIPAA - 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

SECTION 2. BACKGROUND

Agency Context

Per RI General Law Title 40.1, the Director of the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) is empowered as the State Mental Health Authority and as the Co-Single State Authority for Substance Abuse with the Executive Office of Health and Human Services for the purposes of determining the Maintenance of Effort for the substance abuse education, prevention and treatment programs as a result of the state consolidating the behavioral health Medicaid funding. The Office of Facilities and Program Standards and Licensure, within the Department, is responsible for the licensing of behavioral health, developmental disabilities and traumatic brain injury programs for the State of Rhode Island.

The Division of Behavioral Healthcare Services (DBH) maintains the overall responsibility for planning, coordinating and administering a comprehensive State-wide system of mental health promotion and substance abuse prevention, intervention and treatment activities. The Division's Units provide a comprehensive approach to attainment of six overarching goals. These goals are consistent with those of SAMHSA's National Behavioral Health Quality Framework. They are:

1. Promote the most effective prevention, treatment and recovery practices for behavioral health disorders
2. Assure behavioral healthcare is person, family and community centered
3. Encourage effective coordination within behavioral healthcare and between behavioral healthcare and primary care and other healthcare, recovery and social supports
4. Support communities to use best practices to enable healthy living
5. Make behavioral healthcare safe by reducing harm caused in delivery of care
6. Foster affordable, high quality behavioral healthcare through a new and recovery-oriented delivery model

Goals of the Services

In September of 2016, the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) applied for and was awarded the Medication Assisted Treatment Prescription Drug and Opioid Addiction (MAT-PDOA) grant to assist in the response to the overdose crisis through expanding/enhancing access to mediation-assisted treatment services for persons with opioid use disorder that are seeking or receiving MAT. The principal goal of the program is to provide rapid initiation and ongoing treatment for individuals with Opioid Use Disorders (OUD) in high risk areas across the state with a focus on high need populations and communities that are disproportionately affected.

Current Service Outcomes

As of July, 2017, there were 5,466 individuals prescribed Methadone and another 4,335 that were prescribed buprenorphine (source: http://preventoverdoseri.org/medication-assisted-therapy/). Various Medication Assisted Treatment services are available through Methadone Treatment Programs, Buprenorphine waivered physicians and nine (9) Centers of Excellence locations for the treatment of Opiate Use Disorders. Centers of Excellence (COE) in this context are specialty centers that meet certification standards ,utilize evidence-based practices for providing treatment

to and coordinating care of individuals with moderate to severe Opioid Use Disorders and ensure timely access to Medication Assisted Treatment. COEs serve as a resource to providers, including primary care providers, so they can gain practical experience in the treatment of opioid use disorders and therefore ongoing necessary care can be more readily attained by individuals in the community.

Expected Service Outcomes

BHDDH is seeking applications that propose to open a COE in an underserved area of the state with a high burden of overdose morbidity and mortality. Applicants are encouraged to review the data available on www.PreventOverdoseRI.org, which has information on the distribution of overdose fatalities from 2014 to 2016. On the map, click on the "Rate" toggle at the bottom to view the towns/cities with the highest overdose rates. It is expected that consideration of epidemiological data will not be the only factor in determining where a new COE is located. In addition to need, applicants should propose to open a COEs in a location where it will be supported with existing clinical infrastructure.

Outcomes related to this procurement include the following long term and intermediate outcomes:

End Service Outcome Areas

- Admissions to Medication Assisted Treatment
  Measure: # admissions
- Integrated care/treatment
  Measure: # clients receiving integrated care
- Overall Health
  Measure: % of individuals that report improved overall health at 6 month follow up
- Criminal Justice status
  Measure: % of individuals that report no arrests in the past 30 days at 6 month follow up
- Illicit opioid drug use
- *Measure: % individuals that report decreased use of substances in the past 30 days at 6 month follow up*
- Prescription opioids used in a non-prescribed manner
  Measure: % individuals that report decreased non-prescribed use in the past 30 days at 6 month follow up

Intermediate Service Outcomes Areas

- Community provider knowledge of Medication Assisted Treatment
  Measure: % of individuals who have demonstrated improvement in knowledge
- Access to peer recovery services and other recovery supports
  Measure: # and % of individuals receiving services after referral
- Collaborations with housing, employment/education programs and other support services
  Measure: # of organizations that enter into formal written agreement to improve collaboration
- Availability of Waived physicians within the community
  Measure:# of waivered physicians

Target and priority populations:

- Individuals with Opiate Use Disorders

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SECTION 3: SCOPE OF WORK AND REQUIREMENTS

General Scope of Work

To enroll and provide Medication Assisted Treatment and support services to 200 unique individuals over a one year period. Provide access within fourty-eight (48) hours Saturday through Thursday and within seventy-two (72) hours for referrals made on Friday. The successful vendor must be fully licensed and in compliance with the rules and regulations of the licensing Department at BHDDH, must be accredited by one of the recognized accreditation bodies (The Joint Commission, CARF or COA) and maintain compliance with all applicable state and federal statutes including Federal Confidentiality laws found in 42 CFR Part II. The successful vendor must meet all applicable certification standards and best practice guidelines pertaining to the programs and clinical services offered through the Center of Excellence (COE).

Specific Activities / Tasks

1. Apply to become a Center of Excellence within two (2) weeks of purchase agreement award.
2. Conduct screening and a physical assessment to determine diagnostic criteria for opioid use disorder relative to MAT, including determination of opioid depedence, any history of substance use disorder treatment,or elevated risk of relapse.
3. Conduct biopsychosocial assessments which include American Society of Addiction Medicine (ASAM) criteria
4. Develop comprehensive, individualized treatment plan for patients receiving services, including a referral to community providers after the stabilization period. The plan will need to include building, educating and documenting the individual's knowledge around recovery support services in the community.
5. Provide recovery support services, including peers, supported employment and housing
6. Utilize the state Prescription Drug Monitoring Program (PDMP) for each new patient admission and recheck every 90 days.
7. Establish and implement a plan to mitigate the risk of diversion and ensure the appropriate use/dose of medication by patients
8. Ensure that urine toxicology screens are completed
9. Ensure patients with a history of multiple relapses will have access to the appropriate level of care and treatment and continue to monitor, coordinate and stabilize as needed for the entire 6 months
10. Stabilize patients enrolled in the COE and provide access information and encouragement to potentially transfer back to community-based providers within a 6-month period. Provide follow up on those transferred to community care.
11. Work with RI-MAT PDOA Project Director to educate and train Primary Care Physicians (PCPs) on in office based treatment of OUD
12. Conduct baseline, six month and discharge Client Outcome interviews
13. Collect and report required data to the Behavioral Health Online Data Base at a minimum of once per month. See Appendix C- RI-BHOLD (Behavioral Health On-Line Data) Collection Form
14. for the data input form.
15. Participate in all evaluation activities associated with the grant.

Performance Targets
100% of patients will have an individualized treatment plan
100% of patients will complete toxicology screens
100% of patients will be outreached for 6 month follow up client outcome interview
80% of patients will complete 6 month follow up client outcome interview
100% of patients will be made aware of appropriate recovery support services
25% of physicians in the community will be outreached to for educational purposes
4 community providers will enter into a formal written agreement to demonstrate collaboration and/or integration of care

SECTION 4: PROPOSAL

A. Technical Proposal

Narrative and format: The proposal should address specifically each of the following elements:

1. Capability, Capacity, and Qualifications of the Offeror
    a. Describe Offeror's previous experience with delivering the services requested or with similar scopes of work.
    b. Describe Offeror's information technology infrastructure, staffing, and operational practices for managing client, program, fiscal, and billing data and information. BHDDH seeks proposals that demonstrate resources and ability to securely and accurately collect, store, analyze, and share data in accordance with confidentiality requirements
    c. Describe Offeror's practices for required data collection, insuring data quality and submission of data or reports as required or requested by BHDDH.
    d. Describe the physical infrastructure in place to support service delivery.
    e. Describe Offeror's financial management and internal control practices.
    f. Describe Offeror's ability to properly invoice for services rendered. BHDDH seeks proposals that describe practices to ensure invoices to the Department are accurate and timely, and supported by required documentation, and demonstrate ability to reconcile claims and resolve discrepancies between amounts billed and services rendered.
    g. Demonstrate compliance with all state and federal regulations and statutes, including but not limited to licensing regulations.

2. Staff Qualifications
    a. Describe qualifications and experience of key staff who will be involved in this project, including their experience in the field.
    b. (add requirement of job descriptions, cv or resumes).

3. Proposed Approach

    a. Service Methodology

        i. Describe the specific service, program or intervention the Offeror proposes to provide. BHDDH seeks proposals with detailed information on service components, intensity and duration of service, frequency and setting service, and population served.

ii. Describe how the proposed service fits into and/or connects with the array of services provided by the Offeror, other community organizations, BHDDH, educational institutions, or other entities. BHDDH seeks proposals that demonstrate robust program linkages to related services, supports, and resources that collectively increase the likelihood of achieving successful outcomes.

a. Feasibility of Success

i. Describe why the proposed service model is likely to cause the achievement of desired outcomes for the target population. BHDDH seeks proposals that cite specific rigorously-designed, replicated, and peer-reviewed research – or, for locally-developed programs, a well-constructed theory of change supported by the best available research – that credibly supports causal links between services delivered and achievement of desired outcomes. Provide URLs or other details sufficient for verification of cited research.
ii. Describe the Offeror's prior experience delivering the proposed service to the described target population. BHDDH seeks proposals that reflect successful track record of effectively delivering services similar to those proposed to clients similar to those of the target population.
iii. Describe how the Offeror will assess performance related to delivery of services as proposed and insure that they are delivered in a manner consistent with the service model. BHDDH seeks proposals that offer comprehensive fidelity monitoring strategies and demonstrate that data and feedback on services and performance are systematically analyzed and regularly used to share learnings, remedy performance deficits, and inform performance improvement.

c. Sustainability

i. Describe how the services or outcomes would be sustained at the conclusion of the award period. Do not include cost information but rather a description of the approach or strategy to be implemented.

4. Workplan

a. Please describe in detail how the requested services (key tasks) will be performed including staffing patterns (including level of effort), staffing ratios for service delivery, supervision and administration.
b. Describe for which components of the proposed service the Offeror intends to be primary provider, and for which, if any, and with whom the Offeror intends to subcontract, and describe any relationships established with other organizations that will have a significant role in the development, delivery, or evaluation of services. BHDDH seeks proposals that demonstrate the existence of any necessary organizational relationships, and describe the nature of such relationships, including but not limited to contractual and/or financial obligations.
c. Please provide a graphic depiction (table or chart) that describes time frames for completion of key tasks, deliverables and lead parties for year 1 of implementation. This may be appended as attachment or included in the body of the proposal.

B. Cost Proposal

Detailed Budget and Budget Narrative:

Provide a cost proposal for fees charged for the Year-One (12-Month Budget) services outlined in this proposal using Appendix B. Budget Form-Reimbursement line item budget with cost categories and supplemental information- AND include a budget narrative that provides detailed information on each cost category listed on the budget form.

Any contract resulting from the proposal will be cost reimbursement. Please insure that any charges to the contract are included in the cost proposal. The general guidance below describes the items that should generally be contained in the cost category.

1) Salaries

This line is meant to capture salaries of individuals who are employed directly by the applicant. Provide the name of employee (if available), position/title, full time equivalency (FTE) status or level of effort/percentage of time on the contract service and total amount of salary to be charged under the contract.
Describe key responsibilities of each of the positions funded (1-2 sentences).

2) Fringe Benefit

Describe the fringe benefit rate and how it is calculated. Fringe is usually expressed as a percentage of salary.
Describe the amount of fringe associated with the position/title described in salaries.
Make sure that the fringe charged to the contract reflects the percentage of time described for the position. For example, if staff is 100% on the contract, then 100% of their fringe can be charged to it. If the position is 50% on the contract, only 50% of their fringe is charged to the contract.

3) Contractual Services

Describe all services associated with the contract that are obtained by contract, memorandum of understanding/agreement, purchase order or other procurement mechanisms.

4) Travel

Briefly describe the nature of local travel undertaken for contracted service (for example: Mileage reimbursement at .56/mi for personal vehicle. Mileage is associated with attendance at required contract meetings, attending trainings and workshops, monitoring implementation of contract services).

5) Conference

Describe any travel out of state to attend conferences, training or meetings.

6) Postage/Office Supplies/Printing

Costs for postage and office supplies are included in this category. For large scale print jobs exceeding a cost of $500, please provide a brief description of the types of print materials that are required.

7) Telephone/Cable/Internet

Telephone and internet use related to the project may be charged if its' use is exclusively in support of the contract. Cable television is not chargeable to the contract. If telephone and

internet come as a bundle or package of services from a provider, only the monthly cost of telephone and internet can be charged. If use of these services are not exclusive to the contract, it should be included under the overhead-indirect line.

8) Information System

If the contract requires use of an information system to submit data, the costs or fees associated with its use should be captured on this line.

9) Property Rent

Include costs for any property or equipment rental necessary for administration of the project. If the property (either space or equipment) is rented specifically for the contract, then it is appropriate to charge on this line, otherwise it can be captured under the overhead –indirect line.

10) Heat & Utilities

Include costs such as heat and electric in this line. If the heat and utilities are specifically attributable to contract it is appropriate to include the costs in this line, otherwise it can be included under overhead - indirect line.

11) All Other

Include any other major costs necessary for the contracted service but not otherwise covered by the categories 1-10 in this category. Client incentives associated with follow up data collection are capped at $30 per person.

12) Agency Overhead-Indirect

Other costs necessary to the administration of the project, but not otherwise captured in other direct cost lines may be included in this category. Generally, overhead or indirect charges cannot exceed 10% of the direct cost budget unless there is a federally approved, indirect cost rate.

C. ISBE Proposal

See Appendix A for information and the MBE, WBE, and/or Disability Business Enterprise Participation Plan form(s). Bidders are required to complete, sign and submit these forms with their overall proposal in a sealed envelope. Please complete separate forms for each MBE, WBE and/or Disability Business Enterprise subcontractor/supplier to be utilized on the solicitation.

SECTION 5: EVALUATION AND SELECTION

Proposals shall be reviewed by a technical evaluation committee ("TEC") comprised of staff from State agencies. The TEC first shall consider technical proposals.

Technical proposals must receive a minimum of 55 (79%) out of a maximum of 70 points to advance to the cost evaluation phase. Any technical proposals scoring less than 55 points shall not have the accompanying cost or ISBE participation proposals opened and evaluated. The proposal will be dropped from further consideration.

Technical proposals scoring 55 points or higher will have the cost proposals evaluated and assigned up to a maximum of 30 points in cost category bringing the total potential evaluation score to 100 points. After total possible evaluation points are determined ISBE proposals shall be evaluated and assigned up to 6 bonus points for ISBE participation.

The Division of Purchases reserves the right to select the vendor(s) or firm(s) ("vendor") that it deems to be most qualified to provide the goods and/or services as specified herein; and, conversely, reserves the right to cancel the solicitation in its entirety in its sole discretion.

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

Criteria	**Possible Points**
Capability, Capacity, and Qualifications of the Offeror	10 Points
Staff Qualifications	10 Points
Proposed Approach	25 Points
Work Plan	25 Points
Total Possible Technical Points	**70 Points**
Cost proposal*	30 Points
Total Possible Evaluation Points	**100 Points**
ISBE Participation**	6 Bonus Points
Total Possible Points	**106 Points**

*Cost Proposal Evaluation:
The vendor with the lowest cost proposal shall receive one hundred percent (100%) of the available points for cost. All other vendors shall be awarded cost points based upon the following formula:

(lowest cost proposal / vendor's cost proposal) x available points

For example: If the vendor with the lowest cost proposal (Vendor A) bids $65,000 and Vendor B bids $100,000 for monthly costs and service fees and the total points available are thirty (30), Vendor B's cost points are calculated as follows:

$65,000 / $100,000 x 30= 19.5

**ISBE Participation Evaluation:

a. Calculation of ISBE Participation Rate

1. ISBE Participation Rate for Non-ISBE Vendors. The ISBE participation rate for non-ISBE vendors shall be expressed as a percentage and shall be calculated by dividing the amount of non-ISBE vendor's total contract price that will be subcontracted to ISBEs by the non-ISBE vendor's total contract price. For example if the non-ISBE's total contract price is $100,000.00 and it subcontracts a total of $12,000.00 to ISBEs, the non-ISBE's ISBE participation rate would be 12%.

2. ISBE Participation Rate for ISBE Vendors. The ISBE participation rate for ISBE vendors shall be expressed as a percentage and shall be calculated by dividing the amount of the ISBE vendor's total contract price that will be subcontracted to ISBEs and the amount that will be self-performed by the ISBE vendor by the ISBE vendor's total contract price. For example if the ISBE vendor's total contract price is $100,000.00 and it subcontracts a total of $12,000.00 to ISBEs and will perform a total of $8,000.00 of the work itself , the ISBE vendor's ISBE participation rate would be 20%.

b. Points for ISBE Participation Rate:

The vendor with the highest ISBE participation rate shall receive the maximum ISBE participation points. All other vendors shall receive ISBE participation points by applying the following formula:

(Vendor's ISBE participation rate ÷ Highest ISBE participation rate

X Maximum ISBE participation points)

For example, assuming the weight given by the RFP to ISBE participation is 6 points, if Vendor A has the highest ISBE participation rate at 20% and Vendor B's ISBE participation rate is 12%, Vendor A will receive the maximum 6 points and Vendor B will receive (12% ÷ 20%) x 6 which equals 3.6 points.

General Evaluation:

Points shall be assigned based on the vendor's clear demonstration of the ability to provide the requested goods and/or services. Vendors may be required to submit additional written information or be asked to make an oral presentation before the TEC to clarify statements made in the proposal.

SECTION 6. QUESTIONS

Questions concerning this solicitation must be e-mailed to the Division of Purchases at david.francis@purchasing.ri.gov no later than the date and time indicated on page one of this solicitation. No other contact with State parties is permitted. Please reference **RFP # 7566483** on all correspondence. Questions should be submitted in writing in a Microsoft Word attachment in a narrative format with no tables. Answers to questions received, if any, shall be posted on the Division of Purchases' website as an addendum to this solicitation. It is the responsibility of all interested parties to monitor the Division of Purchases website for any procurement related postings such as addenda. If technical assistance is required, call the Help Desk at (401) 574-8100.

SECTION 7. PROPOSAL CONTENTS

- Proposals shall include the following:

a. One completed and signed RIVIP Bidder Certification Cover Form (included in the original copy only) downloaded from the Division of Purchases website at www.purchasing.ri.gov. *Do not include any copies in the Technical or Cost proposals.*

b. One completed and signed Rhode Island W-9 (included in the original copy only) downloaded from the Division of Purchases website at http://www.purchasing.ri.gov/rivip/publicdocuments/fw9.pdf**.** *Do not include any copies in the Technical or Cost proposals.*

c. Two (2) completed original and copy versions, signed and sealed Appendix A. MBE, WBE, and/or Disability Business Enterprise Participation Plan. Please complete separate forms for each MBE/WBE or Disability Business Enterprise subcontractor/supplier to be utilized on the solicitation. *Do not include any copies in the Technical or Cost proposals.*

d. 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 and as appropriate, resumes of key staff that will provide services covered by this request).

a. One (1) Electronic copy on a CD-R, marked "Technical Proposal - Original".
a. One (1) printed paper copy, marked "Technical Proposal -Original" and signed.
b. Four (4) printed paper copies

e. Cost Proposal - A separate, signed and sealed cost proposal reflecting the hourly rate, or other fee structure, proposed to complete all of the requirements of this project.

f. One (1) Electronic copy on a CD-R, marked "Cost Proposal -Original".
- One (1) printed paper copy, marked "Cost Proposal -Original" and signed.

g. Four (4) printed paper copies

- Formatting of proposal response contents should consist of the following:

7. Formatting of CD-Rs – Separate CD-Rs are required for the technical proposal and cost proposal. All CD-Rs submitted must be labeled with:
    - Vendor's name
    - RFP #
    - RFP Title
    - Proposal type (e.g., technical proposal or cost proposal)
    - If file sizes require more than one CD-R, multiple CD-Rs are acceptable. Each CD-R must include the above labeling and additional labeling of how many CD-Rs should be accounted for (e.g., 3 CD-Rs are submitted for a technical proposal and each CD-R should have additional label of '1 of 3' on first CD-R, '2 of 3' on second CD-R, '3 of 3' on third CD-R).

Vendors are responsible for testing their CD-Rs before submission as the Division of Purchase's inability to open or read a CD-R may be grounds for rejection of a Vendor's

proposal. All files should be readable and readily accessible on the CD-Rs submitted with no instructions to download files from any external resource(s). If a file is partial, corrupt or unreadable, the Division of Purchases may consider it "non-responsive". USB Drives or any other electronic media shall not be accepted. Please note that CD-Rs submitted, shall not be returned.

8. Formatting of written documents and printed copies:
    - **a.** For clarity, the technical proposal shall be typed. These documents shall be single-spaced with 1" margins on white 8.5"x 11" paper using a font of 12 point Calibri or 12 point Times New Roman.
    - **b.** All pages on the technical proposal are to be sequentially numbered in the footer, starting with number 1 on the first page of the narrative (this does not include the cover page or table of contents) through to the end, including all forms and attachments. The Vendor's name should appear on every page, including attachments. Each attachment should be referenced appropriately within the proposal section and the attachment title should reference the proposal section it is applicable to.
    - **a.** The cost proposal shall be typed using the formatting provided on the provided template.
    - **c.** Printed copies are to be only bound with removable binder clips.

SECTION 8. PROPOSAL SUBMISSION

Interested vendors must submit proposals to provide the goods and/or services covered by this RFP 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, shall not be accepted.

Proposals should be mailed or hand-delivered in a sealed envelope marked "**RFP# 7566483 Excellence for Treatment of Opioid Use Disorders "** 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 shall not be accepted. Proposals misdirected to other State locations or those not presented to the Division of Purchases by the scheduled due date and time shall be determined to be late and shall not be accepted. Proposals faxed, or emailed, to the Division of Purchases shall not be accepted. The official time clock is in the reception area of the Division of Purchases.

SECTION 9. CONCLUDING STATEMENTS

Notwithstanding the above, the Division of Purchases reserves the right to award on the basis of cost alone, to accept or reject any or all proposals, and to award in the State's 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.

If a Vendor is selected for an award, no work is to commence until a purchase order is issued by the Division of Purchases.

The State's General Conditions of Purchase contain the specific contract terms, stipulations and affirmations to be utilized for the contract awarded for this RFP. The State's General Conditions of Purchases can be found at the following URL: https://www.purchasing.ri.gov/RIVIP/publicdocuments/ATTA.pdf.

APPENDIX A. PROPOSER ISBE RESPONSIBILITIES AND MBE, WBE, AND/OR DISABILITY BUSINESS ENTERPRISE PARTICIPATION FORM

- **Proposer's ISBE Responsibilities (from 150-RICR-90-10-1.7.E)**

1. Proposal of ISBE Participation Rate. Unless otherwise indicated in the RFP, a Proposer must submit its proposed ISBE Participation Rate in a sealed envelope or via sealed electronic submission at the time it submits its proposed total contract price. The Proposer shall be responsible for completing and submitting all standard forms adopted pursuant to 105-RICR-90-10-1.9 and submitting all substantiating documentation as reasonably requested by either the Using Agency's MBE/WBE Coordinator, Division, ODEO, or Governor's Commission on Disabilities including but not limited to the names and contact information of all proposed subcontractors and the dollar amounts that correspond with each proposed subcontract.

2. Failure to Submit ISBE Participation Rate. Any Proposer that fails to submit a proposed ISBE Participation Rate or any requested substantiating documentation in a timely manner shall receive zero (0) ISBE participation points.

3. Execution of Proposed ISBE Participation Rate. Proposers shall be evaluated and scored based on the amounts and rates submitted in their proposals. If awarded the contract, Proposers shall be required to achieve their proposed ISBE Participation Rates. During the life of the contract, the Proposer shall be responsible for submitting all substantiating documentation as reasonably requested by the Using Agency's MBE/WBE Coordinator, Division, ODEO, or Governor's Commission on Disabilities including but not limited to copies of purchase orders, subcontracts, and cancelled checks.

4. Change Orders. If during the life of the contract, a change order is issued by the Division, the Proposer shall notify the ODEO of the change as soon as reasonably possible. Proposers are required to achieve their proposed ISBE Participation Rates on any change order amounts.
5. Notice of Change to Proposed ISBE Participation Rate. If during the life of the contract, the Proposer becomes aware that it will be unable to achieve its proposed ISBE Participation Rate, it must notify the Division and ODEO as soon as reasonably possible. The Division, in consultation with ODEO and Governor's Commission on Disabilities, and the Proposer may agree to a modified ISBE Participation Rate provided that the change in circumstances was beyond the control of the Proposer or the direct result of an unanticipated reduction in the overall total project cost.

- **MBE, WBE, AND/OR Disability Business Enterprise Participation Plan Form:**

Attached is the MBE, WBE, and/or Disability Business Enterprise Participation Plan form. Bidders are required to complete, sign and submit with their overall proposal in a sealed envelope. Please complete separate forms for each MBE, WBE and/or Disability Business Enterprise subcontractor/supplier to be utilized on the solicitation.

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS
DEPARTMENT OF ADMINISTRATION
ONE CAPITOL HILL
PROVIDENCE, RHODE ISLAND 02908

MBE, WBE, and/or DISABILITY BUSINESS ENTERPRISE PARTICIPATION PLAN
Bidder's Name:
Bidder's Address:
Point of Contact:
Telephone:
Email:
Solicitation No.:
Project Name:

This form is intended to capture commitments between the prime contractor/vendor and MBE/WBE and/or Disability Business Enterprise subcontractors and suppliers, including a description of the work to be performed and the percentage of the work as submitted to the prime contractor/vendor. Please note that all MBE/WBE subcontractors/suppliers must be certified by the Office of Diversity, Equity and Opportunity MBE Compliance Office and all Disability Business Enterprises must be certified by the Governor's Commission on Disabilities at time of bid, and that MBE/WBE and Disability Business Enterprise subcontractors must self-perform 100% of the work or subcontract to another RI certified MBE in order to receive participation credit. Vendors may count 60% of expenditures for materials and supplies obtained from an MBE certified as a regular dealer/supplier, and 100% of such expenditures obtained from an MBE certified as a manufacturer. This form must be completed in its entirety and submitted at time of bid. **Please complete separate forms for each MBE/WBE or Disability Business Enterprise subcontractor/supplier to be utilized on the solicitation.**

Name of Subcontractor/Supplier:					
Type of RI Certification:	□ MBE □ WBE □ Disability Business Enterprise				
Address:					
Point of Contact:					
Telephone:					
Email:					
Detailed Description of Work To Be Performed by Subcontractor or Materials to be Supplied by Supplier:					
Total Contract Value ($):		Subcontract Value ($):		ISBE Participation Rate (%):	
Anticipated Date of Performance:					

I certify under penalty of perjury that the forgoing statements are true and correct.

Prime Contractor/Vendor Signature	**Title**	**Date**
Subcontractor/Supplier Signature	**Title**	**Date**

Appendix B. Budget Form

12- Month Budget

Contract Agency: _____

Contract Service: _____

Category /Item	Proposed Budget	Other Funds	Total Budget
[col. 1]	[col. 2]	[col. 3]	[col. 4] col 4 = col 2 + col 3
1) Salaries			
2) Fringe Benefit			
3) Contractual Services			
4) Travel (in state)			
5) Conference (out of state)			
6) Postage/Office Supplies/Expenses			
7) Telephone/Cable/Internet			
8) Information System			
9) Property Rent			
10) Heat & Utilities			
11) All Other			
12)Agency Overhead-Indirect			
TOTAL	**$0.00**	**$0.00**	**$0.00**

Notes,

1. A separate Program Budget is required for each contract service, e.g. outpatient services, prevention services or, residential services.
2. Attached Supplementary Information Pages must be completed for Items 1, 2, 3 & 11.
   Also, narrative should be provided as necessary to describe any item; supporting narrative must be provided to describe Item #12, Agency Overhead/Indirect
3. It is understood and agreed that the amounts indicated above in Col 2 for the several line items are estimates of expenditures to be incurred by the Contractor in the performance of this Agreement and to be claimed by the Contractor for reimbursement under this Agreement. It is further understood and agreed that actual variations shall not in themselves be cause for disallowance of reimbursement by BHDDH; provided, however, that the contractor shall notify and obtain the approval of the contract officer, in writing, if expenditures to be claimed for reimbursement in a line item above vary or are projected to vary by 10 percent or more from the approved budget. Further, that unless permission of the contract officer shall have been obtained in advance, no expenditure shall be claimed by the Contractor for reimbursement by BHDDH under this agreement if such expenditure shall have been incurred in a line item category not listed above. Budget transfers between Expense Categories (1) and (2) are exempt from the 10 percent ceiling and do not require the prior approval of the contract officer.

for departmental use	
Action/Disposition	
Reviewer	Date

APPENDIX B. BUDGET FORM Supplemetary Information

Item # 1 Salary Costs					
Position Title	# of Positions	Total Annual Salary [contract year earnings]	Salary Chargeable to Program		
			BHDDH	Other	Combined
Total Salaries		N/A	**$0.00**	**$0.00**	**$0.00**

Item # 2 Fringe Benefits & Other Personnel Costs	Fringe Benefits Chargeable to Program		
	BHDDH Share	Other Funds	Combined
Total Fringe Benefits	**$0.00**	**$0.00**	**$0.00**

Item # 3 Contractual Costs (list each contract consultant service)	# of Hours	Hourly Rate	Consultants Chargeable to Program		
			BHDDH Share	Other Funds	Combined
Total Consultant Costs		N/A	**$0.00**	**$0.00**	**$0.00**

Item #11 All Other (list each cost item)	Other Costs Chargeable to Program		
	BHDDH Share	Other Funds	Combined
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
			$0.00
Total Other Costs	**$0.00**	**$0.00**	**$0.00**

if additional space is required, complete on additional page(s); enter grand total for each category on final page

Appendix C : RI-BHOLD (Behavioral Health On-Line Data) Collection Form

The following is an:___Admission ___Current Update ___Discharge Today's Date_____/_____/ _____

For each of the following items, please circle, check, or enter only one response per item, unless otherwise indicated. Additional instructions for specific items are on the back of the second page of this document.

BASIC CLIENT DEMOGRAPHICS

CLIENT REC #: _____

SSN_____-_____-_____

RACE/ETHNICITY *(circle Yes, No, or Unknown for each option):*

Y / N / Unk Native Alaskan/ Amer. Indian
Y / N / Unk Asian
Y / N / Unk Hawaiian/ Pacific Islander
Y / N / Unk Black
Y / N / Unk White
Y / N / Unk Hispanic

DOB:_____/_____/ _____

GENDER: ___Male ___Female

VETERAN STATUS:

___ Active Duty ___No Service
___ Veteran ___Unknown

MARITAL STATUS:

___ Never Married ___Divorced
___ Now Married ___Widowed
___ Cohabitating ___Unknown
___ Separated

HIGHEST LEVEL OF EDUCATION:

___ Never Attended
___ Some Elementary School
___ Completed Elementary School
___ Some High School
___ Completed High School
___ Some Beyond High School
___ College Degree (Associates or Bachelors)
___ Graduate Degree (Master's, Doctorate, RN)
___ Unknown

ADMISSION INFORMATION

PROVIDER ID: _____

PROGRAM TYPE (*Chose only one):*

Mental Health

___ Inpatient Psychiatric Hospitalization
___ ER Diversion
___ Psych Stepdown
___ MHPRR
___ RICSOC
___ Other CSP
___ CAITS
___ GOP
___ Contact (receiving service pre-admission)

Substance Abuse

___ Inpatient Detox - Free Standing Medical
___ Detox Step Down
___ Respite
___ Residential - Transitional (<=30 days)
___ Residential - Short Term (<=90 days)
___ Residential - Long Term (<=180 days)
___ Halfway House
___ Recovery Housing
___ Day Treatment/ PHP
___ SA Intensive Outpatient
___ SA Outpatient
___ Outpatient Narcotic Maintenance
___ Outpatient Narcotic Detox
___ Continuing Care

FIRST TREATMENT DATE *(first face-to-face contact for current treatment episode at the provider)* :

_____/_____/ _____

ADMISSION DATE *(to current program type):*

_____/_____/ _____

REFERRAL SOURCE:

___ Self
___ Mental Health Care Provider
___ Substance Abuse Treatment Provider
___ Other Health Care Provider
___ Hospital Emergency Room
___ Federal or State Social Services Agency
___ Shelter for the Homeless / Abused
___ School System (e.g., counselor, etc.)
___ Employer/ Employee Assistance Program
___ Other Community Referral
___ Court System (complete COURT REFERRAL)
___ Unknown

COURT REFERRAL:

___ NA (REFERRAL SRC is not "Court System")
___ Civil
___ Court

COURT REFERRAL *(continued):*

___ Adult Drug Court
___ Family Drug Court
___ Juvenile Drug Court
___ Adult Diversion
___ Juvenile Diversion
___ Prison
___ Youth Corrections
___ Probation/Parole
___ DUI / DWI
___ Other
___ Unknown

OF ARRESTS IN 30 DAYS prior to admission:

_____ *(enter "99" if Unknown)*

IN 30 DAYS prior to admission, how often did the client attend a voluntary self-help group for SA recovery?

___ NA (client is a MH client only)
___ None
___ 1-3 times in past month
___ 1-2 times in past week
___ 3-6 times in past week
___ Daily
___ Unknown

CURRENT CLIENT INFORMATION

RI CITY / TOWN OF RESIDENCE *(if in Rhode Island, check first option and enter name of city/town) :*

___ _____
___ Out of State
___ Unknown

ZIP CODE *(corresponds to city/town listed above):*

___ ___ ___ ___ ___ *(enter "99999" if unknown or out of state.)*

RESIDENTIAL ARRANGEMENT

___ Private residence/household
Public Housing/Section 8
___ Residential (e.g., grp home or supervised apt.)
___ Assisted Living Facility
___ Nursing Home
___ Other Institutional Care (e.g., Long Term Hospital)
___ Foster Home
___ Incarcerated in Jail or Correctional Facility
___ Sober Housing

RESIDENTIAL ARRANGEMENT *(continued):*

___ Shelter, transient, no permanent address
___ Homeless, street/outdoors, park
___ Unknown

FAMILY SIZE *(include client in the count):*

_____ *(enter "99" if Unknown)*

MONTHLY HOUSEHOLD INCOME:

_____ *(enter "999999" if Unknown)*

CLIENT REC #: _____ *2014*

CURRENT CLIENT INFORMATION *(continued)*

EMPLOYMENT STATUS:
- ___ Employed: Full Time (35+ hours/week)
- ___ Employed: Half Time (20-34 hours/week)
- ___ Employed: Part Time (<20 hours/week)
- ___ Armed Forces
- ___ Volunteer
- ___ Unemployed (laid off or looking for work)
- ___ School or Job Training
- ___ Homemaker
- ___ Inmate or Resident of Institution
- ___ Retired
- ___ Disabled
- ___ Unknown

EMPLOYMENT TYPE:
- ___ NA (not employed full, half, or part time)
- ___ Competitive
- ___ Supported
- ___ Transitional
- ___ Other
- ___ Unknown

PAYMENT SOURCES (*enter 1 for "primary", 2 for "secondary" and 3 for "tertiary" source of pay*):
- ___ NA (none, free care)
- ___ Personal, Self Pay
- ___ Commercial/Private Insurance

PAYMENT SOURCES *(continued):*
- ___ Medicaid
- ___ Medicare
- ___ DBH
- ___ Grant (e.g., Federal, VA, etc.)
- ___ Drug Court
- ___ Other State Agency (e.g., DCYF, ORS)
- ___ Military (e.g., VA, CHAMPUS/TRICARE)
- ___ Other (e.g., worker's comp, etc.)
- ___ Unknown

CONTRACT ID #: _____

CURRENT DIAGNOSES & CO-OCCURRING CONDITIONS

AXIS I DIAGNOSES
- PRIMARY: _____. _____
- SECONDARY: _____. _____
- TERTIARY: _____. _____

AXIS II DIAGNOSES
- PRIMARY: _____. _____
- SECONDARY: _____. _____

GAF SCORE (*enter "0" if Unknown)* :
_____

AXIS IV *(choose Y, N, or Unk for EACH):*
- Y / N / Unk Probs w/ primary support group
- Y / N / Unk Probs related to social environ.
- Y / N / Unk Education problems
- Y / N / Unk Occupational problems
- Y / N / Unk Housing problems
- Y / N / Unk Economic problems
- Y / N / Unk Problems w/ access to health care services
- Y / N / Unk Problems with legal system
- Y / N / Unk Other psychosocial and environmental problems

CO-OCCURRING *(choose Y, N, or Unk for EACH):*
- Y / N / Unk MH / SA Issues
- Y / N / Unk Developmental Disability
- Y / N / Unk Pregnant
- Y / N / Unk Smoking
- Y / N / Unk Hypertension
- Y / N / Unk Hepatitis
- Y / N / Unk Life Threatening Viral Illness
- Y / N / Unk Hypercholesterolemia
- Y / N / Unk Obesity
- Y / N / Unk Diabetes
- Y / N / Unk Asthma
- Y / N / Unk Chronic Obstr. Pulm. Disease (COPD)

CURRENT SUBSTANCE ABUSE

SUBSTANCE(S) OF ABUSE *(enter 1 for "primary", 2 for "secondary" and 3 for "tertiary" drug of choice):*
- ___ NA (No Substance Abuse)
- ___ Alcohol
- ___ Cocaine/Crack
- ___ Marijuana - Hashish
- ___ Heroin
- ___ Non-Prescription Methadone
- ___ Oxycontin
- ___ Other Opiates & Synthetics
- ___ PCP
- ___ Other Hallucinogens
- ___ Methamphetamine (ice)
- ___ Other Amphetamines
- ___ Other Stimulants
- ___ Benzodiazepine
- ___ Other Tranquilizers
- ___ Barbiturates
- ___ Other Sedatives or Hypnotics
- ___ Inhalants
- ___ Over the counter
- ___ Steroids
- ___ GHB Gamma Hydroxybutyrate
- ___ Ecstasy
- ___ Unknown

ROUTE OF ADMINISTRATION (*for Primary SA):*
- ___ NA (no primary substance of abuse)
- ___ Oral
- ___ Smoking
- ___ Inhalation
- ___ Injection
- ___ Other
- ___ Unknown

FREQUENCY OF USE (*for Primary SA):*
- ___ NA (no primary substance of abuse)
- ___ No past month use
- ___ 1-3 times in past month
- ___ 1-2 times per week
- ___ 3-6 times per week
- ___ Daily
- ___ Unknown

ROUTE OF ADMINISTRATION (*for Secondary SA):*
- ___ NA (no secondary substance of abuse)
- ___ Oral
- ___ Smoking
- ___ Inhalation
- ___ Injection
- ___ Other
- ___ Unknown

FREQUENCY OF USE (*for Secondary SA):*
- ___ NA (no secondary substance of abuse)
- ___ No past month use
- ___ 1-3 times in past month
- ___ 1-2 times per week
- ___ 3-6 times per week
- ___ Daily
- ___ Unknown

ROUTE OF ADMINISTRATION (*for Tertiary SA):*
- ___ NA (no tertiary substance of abuse)
- ___ Oral
- ___ Smoking
- ___ Inhalation
- ___ Injection
- ___ Other
- ___ Unknown

FREQUENCY OF USE (*for Tertiary SA):*
- ___ NA (no tertiary substance of abuse)
- ___ No past month use
- ___ 1-3 times in past month
- ___ 1-2 times per week
- ___ 3-6 times per week
- ___ Daily
- ___ Unknown

AGE AT FIRST USE *(enter "98" if not applicable/no Substance of Abuse, and "99" if unknown):*

Primary: _____ Secondary: _____ Tertiary: _____

CLIENT REC #: _____

DISCHARGE INFORMATION

DISCHARGE DATE *(from current program):*

_____/_____/ _____

LAST FACE-TO-FACE CONTACT DATE *(for current program):*

_____/_____/ _____

IN 30 DAYS prior to discharge, how often did the client attend a voluntary self-help group for SA recovery?

___ NA (client is a MH client only)
___ None
___ 1-3 times in past month
___ 1-2 times in past week
___ 3-6 times in past week
___ Daily
___ Unknown

REASON FOR DISCHARGE

___ Completed treatment - no referral required
___ Internal transfer - to another program episode at agency
___ External transfer - to another provider
___ Discharged, additional services advised
___ Client discharged before completed treatment / against advice /no contact within 30 days
___ Discharged due to inability to pay for services
___ Discharged for other non-compliance issues (e.g., rule infractions)
___ Discharged to corrections due to incarceration
___ Client deceased
___ Unknown

REFERRAL AT DISCHARGE

___ NA / None
___ Mental Health Care Provider
___ Substance Abuse Treatment provider
___ Other Health Care Provider
___ Federal or State Social Services Agency
___ Shelter for the Homeless / Abused
___ School System (e.g., counselor, Student Assistance Program, etc.)
___ Employer/ Employee Assistance Program
___ Other Community Referral
___ Court / Criminal Justice System
___ Unknown

OF ARRESTS IN 30 DAYS PRIOR TO DISCHARGE FROM PROGRAM: (*enter "99" if Unknown):*

___ ___

CLIENT INFORMATION at DISCHARGE

RESIDENTIAL ARRANGEMENT at DISCHARGE:

___ Private residence/household
___ Public Housing/Section 8
___ Residential (e.g., grp home or supervised apt.)
___ Assisted Living Facility
___ Nursing Home
___ Other institutional care (e.g., Long Term Hospital
___ Foster Home
___ Incarcerated in Jail or Correctional Facility
___ Sober Housing
___ Shelter, transient, no permanent address
___ Homeless, street/outdoors, park
___ Unknown

EMPLOYMENT STATUS at DISCHARGE:

___ Employed: Full Time (35+ hours/week)
___ Employed: Half Time (20-34 hours/week)
___ Employed: Part Time (<20 hours/week)
___ Armed Forces
___ Volunteer
___ Unemployed (laid off or looking for work)
___ School or Job Training
___ Homemaker
___ Inmate or Resident of Institution
___ Retired
___ Disabled
___ Unknown

EMPLOYMENT TYPE at DISCHARGE:

___ NA (not employed full, half, or part time)
___ Competitive
___ Supported
___ Transitional
___ Other
___ Unknown

GAF SCORE at DISCHARGE (*enter "0" if Unknown)* :

_____

SUBSTANCE OF ABUSE at DISCHARGE

SUBSTANCE OF ABUSE at DISCHARGE *(enter 1 for "primary", 2 for "secondary" and 3 for "tertiary" drug of choice):*

___ NA (No Substance Abuse)
___ Alcohol
___ Cocaine/Crack
___ Marijuana - Hashish
___ Heroin
___ Non-Prescription Methadone
___ Oxycontin
___ Other Opiates & Synthetics
___ PCP
___ Other Hallucinogens
___ Methamphetamine (ice)
___ Other Amphetamines
___ Other Stimulants
___ Benzodiazepine
___ Other Tranquilizers
___ Barbiturates
___ Other Sedatives or Hypnotics
___ Inhalants
___ Over the counter
___ Steroids
___ GHB Gamma Hydroxybutyrate
___ Ecstasy
___ Unknown

FREQUENCY OF USE (*for Primary SA):*

___ NA (no primary substance abuse at discharge)
___ No past month use
___ 1-3 times in past month
___ 1-2 times per week
___ 3-6 times per week
___ Daily
___ Unknown

FREQUENCY OF USE (*for Secondary SA):*

___ NA (no secondary substance abuse at discharge)
___ No past month use
___ 1-3 times in past month
___ 1-2 times per week
___ 3-6 times per week
___ Daily
___ Unknown

FREQUENCY OF USE (*for Tertiary SA):*

___ NA (no tertiary substance abuse at discharge)
___ No past month use
___ 1-3 times in past month
___ 1-2 times per week
___ 3-6 times per week
___ Daily
___ Unknown

SUPPLEMENTAL INSTRUCTIONS FOR COMPLETION OF DATA COLLECTION FORM

This form is to be collected on all clients served at your agency at the time of program admission and discharge, and updated every 6 months a client remains in treatment. If a client transfers programs within your provider, a discharge should occur from the old program/PID and a new admission record completed to the new program/PID. All fields are required for all clients unless otherwise indicated. See RIBHOLD Data Dictionary for further details

	TYPE of COMPLETION	Check all that apply. Regardless of Type of Completion, always complete the Basic Client Demographics. If it's a program Admission, complete pages 1-2. If Update, complete any/all field values that have changed. If it's a program Discharge, complete page 3.
	TODAY's DATE	Enter date of data collection/form completion
CLIENT	CLIENT REC #	Provider-defined client record number that uniquely identifies clients within your provider, across admissions.
CLIENT	SSN	If a client does not have a SSN available, check the box indicating same at data entry and one will be constructed for them. Update with actual SSN as soon as possible
CLIENT	DOB & GENDER	Required fields, cannot be unknown or blank
CLIENT	RACE/ETHNICITY	Answer Yes or No separately for each racial/ethnic category.
ADMISSION	PROVIDER ID (PID)	Code used to identify the primary location of client program admission/treatment.
ADMISSION	PROGRAM TYPE	Select only one. If a client is admitted to more than one program, a separate data collection form should be completed for each admission. However, in general a client cannot be admitted to more than one MH, or more than one SA program simultaneously within a provider (exceptions for narcotic maintenance/recovery house).
ADMISSION	FIRST TREATMENT DATE	First face-to-face contact with the PROVIDER (not just the PID) for the current episode of treatment. If a client is transferring to a new PROGRAM or a different PID within your PROVIDER, this should contain the client's original first treatment date at your PROVIDER.
ADMISSION	ADMISSION DATE	Date of admission to the current PROGRAM type. Leave blank for CONTACTs.
ADMISSION	COURT REFERRAL	Complete only if the Referral Source is "Court System," otherwise select NA
ADMISSION	SELF-HELP GROUP at ADMISSION	This field is optional for clients admitted to a MH PROGRAM type who may have a co-occurring SA issue.
CURRENT CLIENT INFORMATION is to be captured at admission and updated at least every 6 months afterwards while the client remains active.		
ADMISSION & CURRENT	RI CITY/TOWN and ZIP	Should reflect where the client currently resides, not the community of origin of the client.
ADMISSION & CURRENT	FAMILY SIZE	Count of all family members living in the household who are depending on the monthly income recorded for that household. The count always includes the client.
ADMISSION & CURRENT	MONTHLY HOUSEHOLD INCOME	Includes monthly household revenue generated by client and any other household member who has some financial responsibility for the client and lives in the same household. Optional for clients who are self-pay (or have private insurance) that covers 100% of their care, otherwise it is required.
ADMISSION & CURRENT	EMPLOYMENT STATUS	If more than one option applies, select the one highest on the list that is applicable (e.g., if client is employed part time and a student, check Employed: Part Time)
ADMISSION & CURRENT	EMPLOYMENT TYPE	Complete only if EMPLOYMENT STATUS is Employed: full, half, or part. Otherwise select "NA."
ADMISSION & CURRENT	PAYMENT SOURCES	If DBH is a pay source, always enter it as "1 - primary". In general, enter only one number next to each applicable PAYMENT SOURCE (e.g., if a client has double insurance coverage, select "Commercial" only once). "NA" or "Unknown" options may have more than one number entered next to them.
ADMISSION & CURRENT	CONTRACT ID#	This field is only completed for some clients who have DBH as a primary pay source (e.g., SSTAR-contracted services, SA outpatient contracts, SA residential services, ACI slots, or ATR slots).
ADMISSION & CURRENT	CURRENT DX & CO-OCCURRING	These fields are to be completed for all clients, regardless of PROGRAM type
ADMISSION & CURRENT	SUBSTANCES of ABUSE & related ROUTE, FREQUENCY, AGE at FIRST USE	These fields are to be completed for all clients with a substance abuse issue (SA PROGRAM admits and MH PROGRAM admits with co-occurring SA issue). For "MH-only" clients, enter "NA/not applicable" values for these fields.
DISCHARGE INFORMATION is required of all PROGRAM discharges and transfers to other PIDs/PROGRAMS, except CONTACTs (for which it is optional).		
DISCHARGE	DISCHARGE DATE	If a client is being transferred from one PID/PROGRAM to another, the DISCHARGE DATE on the first record should be the same as the ADMIT DATE on the next record.
DISCHARGE	SELF-HELP GROUP at DISCHARGE	This field is optional for clients discharged from a MH PROGRAM who have a co-occurring SA issue.
DISCHARGE	REASON for DISCHARGE	If a client is being transferred from one PID/PROGRAM to another, the REASON for DISCHARGE is "Internal transfer"
DISCHARGE	EMPLOYMENT STATUS at DISCHARGE	If more than one option applies, select the one highest on the list that is applicable (e.g., if client is employed part time and a student, check Employed: Part Time)
DISCHARGE	EMPLOYMENT TYPE at DISCHARGE	Complete only if EMPLOYMENT STATUS at DISCHARGE is Employed: full, half, or part. Otherwise
DISCHARGE	SUBSTANCES of ABUSE at DISCHARGE & related FREQUENCY of USE	These fields are to be completed for all clients with a substance abuse issue (SA PROGRAM discharges and MH PROGRAM discharges with co-occurring SA issue). For "MH-only" clients, enter "NA/not