IPV-FAIR RFP
Questions and Answers:

1. **Implementation timeline - the RFP states that contracts will be looked at in June 2026, but will not start until January?**
   Answer: At this time, the start date for a new contract is slated to be January 1st, 2027. So, all programs that currently hold the contract will remain in place until that time.

2. **What happens with gap in service while the new contract?**
   Answer: Contracts will be extended and remain in effect until the RFP is completed, and new contracts begin.

3. **On p. 5 of the RFP (under 7a), it says "Subcontracting may be used to ensure that services are available throughout the region …". But on p.23 (under Service Requirements) it says: "The use of sub-contractors is not permitted for IPV Fair services." So, can subcontractors be used or not? If so, what, if anything, can they be used for?**
   Answer: The use of subcontracting is not permitted for IPV Fair service.

4. **The flow chart says there are 3 Family Navigators, but there are two other sections on staffing that say that there will be 2. Which is correct?**
   Answer: The contractor will maintain the following positions:
   - **One Full-Time Program Manager.**
   - **Three Full-Time Master's Level Clinicians,** of which **One Clinician shall be bilingual.**
   - **Two (2) Full-Time Family Support Navigators** holding a Bachelor's degree or possessing equivalent experience, of which **One Navigator shall be bilingual.**
   - **Program Manager** must have a Connecticut License (LCSW, LMFT, LMH, PhD) with no less than three (3) years management/supervisory experience and at least four (4) years providing direct services to families. Experience with intimate partner violence is required.

- **Masters level Clinicians:** Clinicians will be Master's level behavioral health professionals. Clinicians will have a graduate degree in social work, psychology, counseling, or a closely related field. Clinicians will be licensed. A minimum of two years' experience in a counseling setting is required.
- **Family Support Navigators:** The Family Support Navigator will have a Bachelor's degree (BA) in the human services field and/or high school diploma with at least three (3) years extensive experience providing direct services to families with complex needs.

5. **What are the weekend expectations?**

   Answer: Meet the needs of parents if they need weekend services. Please refer to answers in question 6.

6. **Can services be at any point on the weekends?**

   Answer: The program will ensure that flexibility exists with respect to service provision before 9:00 am and after 7:00 pm in order to best meet the needs of the families served. Providers should expect to have clinical sessions 4-5 nights a week and be available on weekends. All providers must include service coverage for all 52 weeks per year, 24 hours a day, 7 days a week for crisis intervention, including holidays, evenings and weekends. Virtual sessions are allowed on a case-by-case basis as agreed upon with the CPS team.

7. **What is the length of service? In the RFP, one place says four months, but in other places it says six.**

   Answer: The standard service duration is six (6) months, with extensions requiring approval through consultation with model developers, CT Children and Families IPV Specialists, and CPS.

8. **Is this RFP a re-procurement? If so, is there a list of current providers?**
   Answer: Yes, this RFP is a re-procurement. This is the link to the DCF IPV Fair Fact sheet that lists the current providers.
   ipv-fair-aim-fact-sheet_rev2022.pdf

9. **Can we have a list of providers who attended this meeting and those that submit a LOI.**
   Answer: Yes, the list will be posted after the LOI closing date.

10. **On page 9, there's a statement that says that there's an expectation of 80% of participants with identified substance use concerns will see a reduction in use upon discharge. My understanding is that we're not doing explicit substance use treatment within the IPV model. Later in the RFP, it seems to say if there are predominant substance use issues that we refer them out. Please clarify the expectation of whether we are or are not providing substance use treatment within the course of everything else that we need to do in this model now.**
    Answer: IPV fair will be providing co-occurring treatment. Substance use treatment will be a part of IPV fair. If participant is meeting ASAM criteria for level for 2.1 (intensive outpatient) or above. https://www.asam.org/asam-criteria/asam-criteria-4th-edition

11. **There is a statement saying that it is an in-home model or an outpatient clinical model. Is there a decision tree associated with when, around when each would be chosen? Or is that a clinical decision that the IPV team will make in conjunction with CCF?**
    Answer: After the first six weeks of the provider meeting twice per week with each family to complete assessments, clinicians will provide 1–3 sessions per week (45–60 minutes), and Family Navigators will continue at least one (1) session weekly. At least one (1) weekly clinical session and 1 weekly Family Navigator session will occur in the home. Navigators may provide

psychoeducation and Circle of Security parenting support when case management needs are minimal. If safety or confidentiality concerns prevent in-home sessions, meetings may occur at the provider's office or another agreed-upon location, with ongoing review during monthly Hub meetings between the contracted IPV Fair provider, the IPV Specialist and the CPS team to review all families receiving IPV Fair services.

12. **The list of required meetings, elements, participants, and frequency if that could be created in some way that's different than the narrative, it may be helpful for all of us. There are things that are called different names, so in one space it's called the case collaboration meeting. Currently it is called the hub meeting is there some sort of master list to ensure that we're all capturing and understanding? The required elements of the model.**

Answer: See charts.

A) Model Training & Ongoing Consultation

Component	Description	Duration	Cadence	Audience	Facilitator/Owner	Notes
Fathers for Change – Basic Training	Didactic + experiential model training	**2 days**	**Biannual**	New & existing IPV-FAIR clinicians; Family Navigators encouraged	**Dr. Carla Stover (Model Developer)**	Required annually for existing clinicians & FNs
Mothers and More – Training	Didactic + experiential model training	**1 day**	**Biannual**	New & existing IPV-FAIR clinicians; Family Navigators encouraged	**Dr. Carla Stover (Model Developer)**	Required annually for existing clinicians & FNs

Bi-weekly Consultation Calls (per agency)	Model fidelity + case consultation	**1 hour/call**	**2× per month**	Each of the **6 agencies**	**Dr. Stover**	**12 team consult hours/month** across agencies
Recorded Session Fidelity Review	Review of recorded treatment session for fidelity	**1 session per clinician**	**Annual**	Clinicians	**Dr. Stover**	One per clinician per year
Supervisors' Monthly Call	Reflective supervision & implementation	**1 hour**	**Monthly**	Program Managers/Supervisors	**Dr. Stover**	Required for all PM/Supervisors
All-Collaborative Monthly Call	Booster topics, fidelity, implementation	**1 hour**	**Monthly**	**All IPV-FAIR staff**	**Dr. Stover**	Required for all staff

B) Additional Training Requirements (CT Children & Families / DCF)

Course	Duration	Cadence	Audience	Owner
Circle of Security Parenting	Varies	As scheduled	Clinicians, FNs	DCF / Agency
DCF ABCD Child Practice Safety Model	Varies	As scheduled	Clinicians, FNs	DCF
DCF Mandated Reporter Training	~1–2 hours	**Annual / Onboarding**	All staff	DCF
DCF: "This Is CT Children and Families"	Varies	Onboarding	All staff	DCF
Advanced Series in IPV	Varies	As scheduled	Clinicians, FNs	DCF / Agency

Case Management for Families Impacted by IPV	Varies	As scheduled	Clinicians, FNs	DCF / Agency
Motivational Interviewing	1–2 days typical	As scheduled	Clinicians, FNs	DCF / Agency
PIE & Data Management System Training	~2–4 hours	**Annual refresher**	Data users	CCMC IPC

C) Preservice (5 Days) Agency Training — Prior to Service Initiation

Total: 5 days per agency before services begin; additional training as determined by the Department (DCF).

Module	Topics	Duration	Owner
IPV FAIR Core Training	IPV Family Assessment Intervention Response	Within 5-day block	DCF / Agency
Screening & Assessment	Caretaker/youth tools; Qualtrics/PIE data system	Within 5-day block	DCF / CCMC IPC
Engagement & Motivational Interviewing	Relationship-building, MI skills	Within 5-day block	DCF / Agency
Genograms	Family mapping and case formulation	Within 5-day block	DCF / Agency
Safety Planning	Risk assessment, safety protocols	Within 5-day block	DCF / Agency
Case Management	Coordination, referrals, documentation	Within 5-day block	DCF / Agency
Home Visits	Practice standards, safety, logistics	Within 5-day block	DCF / Agency
Fatherhood Initiative	Father engagement, support strategies	Within 5-day block	DCF / Agency

D) Supervision & Fidelity Requirements (IPVFAIR Model)

Activity	Audience/Role	Cadence	Duration	Owner	Purpose
Individual Clinical Supervision	Clinicians	**Minimum 1×/month**	**≥1 hour**	Supervisor	Model fidelity; case-specific interventions; staff development
Family Navigator Supervision	Family Navigators	**Biweekly**	**≥1 hour**	Supervisor	Model fidelity; case interventions; staff development
Consultation with Model Developer	Contractor (program teams)	**Biweekly**	**1 hour**	Dr. Stover	Case consultation; fidelity
Group Supervision	Clinical team	**1–2×/month**	**1–2 hours**	Supervisor	Case reviews; crises; successes; next steps
Monthly Team Supervision	Program team	**Monthly**	**≥1 hour**	Supervisor	Fidelity; org info; case review; open discussion
Annual Fidelity Session Review	Clinicians	**Annual**	1 recorded session	Dr. Stover	Formal fidelity monitoring
Monthly Supervisors' Meeting	PMs/Supervisors	**Monthly**	**1 hour**	Model Developers	Leadership alignment; implementation
Monthly ALL Collaborative Meeting	All IPVFAIR staff	**Monthly**	**1 hour**	Model Developers	Booster topics; fidelity; shared learning
Additional Supervision	As required	As needed	Varies	Supervisor / DCF /	As consistent with IPVFAIR model

				Model Developer	

13. **Is there's an extensive amount of training that's involved in this model and also attention to model fidelity.**

Answer: See question 12 for answer.

14. **Who is paying for ongoing supervision? Is that is that DCF or is that the provider?**

Answer: consultations cost are covered by DCF as part of Model development and fidelity. See question 12 for chart of break down.

15. **What are the expectations of the 24 hours support you envision that being? Through phone calls or do you feel that that you've been envisioned being more hands on in the hall?**

Answer: Contracted provider will have a crisis plan for each parent/caregiver which includes twenty-four hour, 7-day coverage for crisis intervention, including holidays, evenings and weekends.

16. **If this is a reprocurement, is it possible to have a list of who those providers are?**

Answer: Yes.

17. **What is the expectation for any third-party billing?**

Answer: The Contractor is required to enroll as a Medicaid provider with the Department of Social Services and to seek to negotiate a reimbursement rate from third party commercial payers for services offered through this contract. The Contractor is expected to bill for third party payment for participants covered by any government or private insurance program.

Refer to Medicaid guidelines for billing regarding Adult outpatient regulations. The rehab category of service benefit category only means that BH Clinics can provide services outside of the 4 walls of the clinic all other clinics regulations prior to this are in enforcement.
https://www.cga.ct.gov/ph/bhpoc/op/related/20190104_2019/20190104/DSS-NON%20LICENSED-Bulletin-DRAFT-01-03-2019.pdf

https://eregulations.ct.gov/eRegsPortal/Browse/RCSA/Title_17bSubtitle_17b-262Section_17b-262-855/
and in home treatment codes for billing and case management billing for adults.

18. **What is the expectation of providers having certain licenses because that would then allow for the app. Third party billing, if it was required.**

Answer: Please see information in Question 4 and question 17.

19. **On page 18, you talk about caseload capacity, and it says that there will be a minimum of eight caregiver pairs or 16 individuals. Please provide clarity. I would have the ability to work with eight pairs. 8 dyads, but in another part of the RFP you said that different clinicians should be assigned to the parent, the caregivers. Unless there was or if they thought they were going to be working together. Do you know what I mean? So, in one point you say a different clinician for each member of the dyad. But here in Page 18, it speaks to having the clinician handling 8 dyads.**

Answer: Each clinician and Family Navigator can be assigned up to 8 families(dyads) totaling 16 parent/caretakers. Assignment of separate clinicians to each parent/caretaker within the dyad will be determined in accordance with the treating clinician's clinical assessment and therapeutic recommendations. Page 19 of the RFP (Caseload Capacity).

20. **What has your experience been with third party billing given that it's predominantly in home and the focus of treatment is adults?**

Answer: Refer to question 17.

21. **Psychiatric coverage: for evaluations and medication consultation is the title of the section - can you clarify what the expectation is for the medication assisted treatment?**

Answer: Contractor to be able to provide treatment within their organization and or have partnerships in the community to meet the needs of both Psychiatric medication and medication assisted treatment for those in the service that need it.

22. **Are you looking for any of the IPV-FAIR clients who have substance use programs to have an ongoing relationship with the psychiatrists or an APRN?**

Answer: IPV-FAIR clients that need ongoing relationship with psychiatrist or APRN the contract will be responsible to ensure this support is received either through their agency or in partnership with other agencies.

23. **Page 7, #11 – Naming convention for Proposal and Budget – both say Proposal, and I know it is a typo but wouldn't hurt to have it documented that one should say Budget.**

Answer: Changes will be made to the RFP, and an amended RFP will be posted.

24. **Page 22, 1.(d) – It says to label the licensures 6A, 6B, 6C, etc. If it is Attachment 4, should they be labeled 4A, 4B, etc.?**

Answer: Please see the amended RFP.

25. **The RFP states the "Agency must provide documentation of all relevant DPH and children behavioral health licenses in accordance with the service being procured." Please provide direct guidance on exactly what type of DPH licensure is required.**

Answer: **Department of Public Health (DPH) License:** The Contractor will be required to establish and maintain all necessary licenses in order to provide clinical services as stated under Adult State Regulations **Section 17a-453a-4** and for Children **Section 17a-20-11.**

- **Substance Use Services:** Programs focusing on substance use for children must be licensed by the DPH. **Licensure Authority:** Programs serving clients under the age of 18 years for psychiatric conditions are licensed by DCF as Outpatient Psychiatric Clinics for Children.

26. **Is there any consideration for the staffing for the two regions that require coverage for three area offices as opposed to the other areas that have only two? It is notable that there is a requirement of cross assignment for families that come in as a pair and it will be challenging for staff to cover three area offices in the vast regions like region 3.**

Answer: Provider agencies may be required to implement cross-assignment arrangements in order to engage parents or caregivers who reside in separate households. Such circumstances may result from the dissolution of a caregiver relationship, the existence of an active restraining or protective order, or the implementation of a safety plan. These conditions may be present at the initiation of services or may emerge at any point during service delivery. Each provider agency is responsible for establishing and maintaining an internal coverage plan that ensures adequate service delivery within its designated catchment area. The development and management of such plans fall solely within the operational discretion of the agency, provided that coverage remains consistent with contractual and regulatory requirements

27. **Can you give more information on the 24-hour coverage expectation?**

Answer: Refer to answer to question 15.

28. **Is it anticipated that any of the services under the RFP are billable?**

Answer: Refer to question 17.

29. **Can you provide a list of current IPV providers across the State currently?**

Answer: There is a fact sheet that lists the providers.

30. **On page 4 the Notification to Bidders link does not function, can a new link be posted?**

Answer: Notification to Bidders link will be omitted. There will be an amended RFP posted.

31. **When Medicaid is billed for services is the expectation that the organization report back to the department how much Medicaid funding we receive. Will the contract dollars be reduced based on Medicaid funding to the organization?**

Answer: No contracting dollars will be reduced based on Medicaid funding.

32. **What is the annual capacity per site?**

Answer: Capacity and funding will be added to the amended RFP on page 3.

The daily average caseload per team (clinician & navigator) will be at minimum eight (8) caregiver pairs or (sixteen (16) individuals). The Contractor is expected to maintain capacity to annually serve between 96 caregiver pairs - 120 individuals dependent upon the length of service for the family (six (6) months).

33. **When you address question on subcontracting: On p. 5 it also says "a justification for sub-contracting and a detailed delineation of exactly what components of the service model the contractor versus the subcontractor will be providing must be included". Should this be an extra attachment?**

Answer: The IPV Fair contract does not allow subcontracting.

34. Are oral toxicology swabs acceptable form of testing?

Answer: The Contractor will use toxicology tests that meet current best practice standards including, where applicable, Clinical Laboratory Improvement Amendments (CLIA) waived tests and laboratory confirmation when needed. When conducting **urine** toxicology testing providers will use CLIA waived specimen collection cups that have been approved by the Department and are consistent with this program model. **Urine collection cups must include tests for specimen adulterants and/or contamination either directly such as by including temperature strips, PH, creatinine, and specific gravity readings or using other currently acceptable and valid practices. The Contractor is required to use CLIA waived tests for substances not identified in the collection cups. These substances include, but are not limited to alcohol, fentanyl, novel psychoactive substances and other synthetic substances.**

35. Is there consideration or flexibility on the service intensity of 2 to 3 visits per week for up to 8 families, which could be 16 individuals as 16 individuals twice a week would total 32 hours of direct care or 48 hours of direct care at 3 times per week. Those hours do not include travel.

Answer: Following the initial engagement meeting with the family, CPS worker, and provider team, the clinicians will meet with each caregiver twice weekly for the first six (6) weeks. Family Navigators will meet with each caregiver at least once weekly during this period. This intensive phase supports completion of assessments and development of treatment plans using Motivational Interviewing approach to build engagement and trust. After the initial six (6) weeks, session frequency will be adjusted based on family needs. Clinicians will provide 1–3 sessions per week…which has always been the standard in every IPV Fair contract (45–60 minutes), and Family Navigators will continue at least one (1) session weekly. At least one (1) weekly session will occur in the home. Navigators may provide psychoeducation and Circle of Security parenting support when case management needs are minimal.

36. **It is clear in the RFP that Dr. Stover will only be providing training twice per year. Can you provide some clarification on what happens with mid-season hires and how that gets managed? And also will trainings be live via webinar asynchronous?**

Answer: Please refer to training chart in question 12.

- In person, online and asynchronous trainings are all available.

37. **If we hire somebody and there are several months before she runs another training. Are we allowed to train our staff and get them up and running so that they're serving clients? Or is the expectation that Dr. Sover is the only one that can do that?**

Answer: Refer to Question 38.

38. **There is mention of the data management system and the PIE system in terms of data input from the cases. Is there duplicative entry in those two systems? Is there any capacity to batch and is there a capacity to use one system and not the other because of the data management piece of this or the data entry piece of this is already substantial and takes away from client care.**

Answer: Providers are required to enter data into both the DCF PIE system and the Qualtrics system. There is no capacity to batch.

39. **Is the part-time psychiatry a .5 FTE? What are you looking for in terms of a part-time psychiatrist?**

Answer: Psychiatric services are not required FTE however required to be able to refer within your agency or partner with agency in local area to meet the needs of the client timely.

40. The Notification of Bidders form is not used as part of the application, but if it is updated on CTSource within a month or two, do you need a new one?

Answer: No, the form needs to be updated and submitted onto CTSource annually.

41. The RFP asks for a certificate of Occupancy, if you lease your space what should we submit?

Answer: If you are leasing, you can submit documentation that has the dates of the occupancy.

42. Are we allowed to train our staff or is the expectation that Dr. Stover is only doing the training?

Answer: This question was answered in Question 37.

43. Is there consideration/flexibility that the bi-lingual clinician and specialists will need to cover the entire region and more specifically for regions that have three area offices?

Answer: The expectation is that every team have one Bilingual clinician and one Bilingual Family Navigator. Decision making is up to the agency on staff retention strategies. The department is open to hear what those strategies are.

44. Can you specify exactly how the referrals would be coming to us from DCF and will they only be DCF cases or will the community partner agencies, the CSF teams, be able to make referrals?

Answer: All referrals will be from the departments Intimate Partner Violence Specialist (gatekeeper) in consultations with CPS team. There is case by case decision on community partner agency receiving IPV- Fair. Priority to all DCF families involved for this service.

45. Has the Department received official notification from DPH that IPV-FAIR is a licensable program?

Answer: IPV-Fair is a clinic base providing co-occurring psychiatric/substance use treatment (outpatient/in home/community base treatment) program. *DPH does not license according to the name of the service but on the clinical/psychiatric/substance use treatment that is being provided.*

Please refer to DPH regulations on definitions and requirements for:

Private Freestanding Facilities for the Care or Treatment of Substance Abuse or Dependence

Connecticut General Statutes Section 19a-491 and/or 19a-506

Private Freestanding Psychiatric Outpatient Clinics for Adults

Connecticut General Statutes Section 19a-491 and/or 19a-506

https://portal.ct.gov/das/communications/uniform-licensing-application/regulations?language=en_US

46. In one part of the RFP, I know that you said there would be 8 caregiver peers to each clinician and then there was another part in the RFP that said if two parents were referred that the second parent would be getting a different clinician. Is that a standard rule or would that occur maybe in just cases that made sense?

Answer: Refer to Question 19.

47. You mentioned the expectation that they are licensed clinicians and, in the RFP, it says that there's a requirement that each clinician has at least two years of experience. When you're talking about licensed are you talking about independently licensed or are you talking about like LMSW, LPCA or LCSW?

Answer: IPV Fair Program Supervisors must be independently licensed -LCSW, LMFT), requiring 2 year of experience. Clinicians can be licensed associates -

LMFTA, LMSW, LPCA, **see links for further guidance:**
https://www.cga.ct.gov/2021/pub/chap_383b.htm
https://www.cga.ct.gov/2019/ba/pdf/2019HB-07132-R000557-BA.pdf
https://www.cga.ct.gov/2025/pub/chap_383c.htm

48. Are you saying with the staffing, the clinicians need to be LCSW's or MFT's? They cannot be associate license?

Answer: Refer to Question 47.

49. Can you provide a link to current providers? Fact Sheet does not have that information on the website.

Answer: This question is also listed above.

50. Can families be referred from FAR if they will not be keeping the case open for 120 days as stated as an exclusionary criteria?

Answer: The department will consider FAR cases on an individual basis in consultation with CPS team and IPV specialist.

51. Does the IPV model allow for subcontracting?

Answer: No.

52. Can families be referred from FAR if they will not be keeping the case open for 120 days as stated as an exclusionary criteria?

Answer: Refer to question 52.

53. Just to make sure, the $615,038.33 per contract funding is an annual amount, correct? So that would be $615,038.33 a year for three years.

Answer: Yes, that is correct.

54. There are two different outcomes listed - one on p 9 and the other on p 20 - which are the ones that we are required to meet that will be included on the contract?

Answer: Page 9 and Page20-21 were amended to reflect the same Program Outcomes.

55. Will you post the budget form?

Answer: Yes, the form will be posted.

56. Is the 24-hour crisis only provided by the IPV crisis team?

Answer: please refer to question 15. The Department looks forward to hearing your plan to address crisis for this population within the guidelines of the contract.

57. Can you clarify why the family specialist positions were not funded to create a matched team with the clinician and is there any flexibility with that?

Answer: please refer to staffing plan on page 27 chart for staffing pattern of RFP.

58. As the submission of this grant is via email, must the submission be marked "Original", as per page 6? Also, must the submission be 2-sided, as per page 27?

Answer: Only email submissions will be accepted and submissions do not have to be marked "Original". Also, submissions should be 1-sided. The RFP will be amended to show this information.

59. Can DCF confirm the total annual award amount?

Answer: $615,038.33 a year for three years. See page #5 for funding information/contract awards.

60. **Since the person using violence is included in IPV-FAIRs services (as per page 10), what type of safety training is included for the contractor's staff? Will DCF expect the person using violence to be served with in-home services by the contractor's staff? Under what circumstances are staff expected to conduct in-home visits when the person using violence is present? What safety protocols are required or recommended?**

Answer: Refer to question 12.

61. **Are there any circumstances under which a contractor may decline or defer a referral (e.g., safety concerns, clinical mismatch, or capacity limits)?**

Answer: Should the assessments indicate concerns of suitability of the program to meet the family's needs, the FAIR provider will initiate a discussion with the IPVS and CPS team to discuss concerns prior to any decision and/or disposition.

62. **What is the expected frequency and duration of services per family? What caseload per clinician does DCF consider realistic within this model?**

Answer: please refer to page 17 & 18 on Length of service and Pg 20-21 for case load of the RFP.

63. **At the bidder's conference, I believe DCF said that contractors would need to develop crisis plans regarding in-home services and 24/7 accessibility. Is that something that would be developed during the implementation phase of the grant? Or does such a plan need to be developed for the proposal?**

Answer: Refer to page 16 on Crisis intervention.

64. **What are the specific expectations for 24/7 crisis response, including required response times and whether in-person overnight/in-home responses are expected?**

Answer: Refer to page 16 on Crisis intervention.

65. **How much time monthly is the contractor's IPV-FAIR team expected to spend in trainings (such as those trainings listed on pages 18 – 20) and other grant-related meetings (such as those meetings listed on pages 15 – 16)? How much time monthly on fidelity monitoring for IPV-FAIR?**

    Answer: Refer to Answer in Question 12.

66. **This grant will require data collection/reporting through two web-based applications (Data Management System and the Provider Information Exchange [PIE]), as per page 21. Are those applications currently used by DCF—or are they different from other applications used by DCF for data collection/reporting? How much time monthly is the contractor's IPV-FAIR team expected to spend on data collection/reporting requirements?**

    Answer: Refer to answer question 40.

67. **Is the time spent by the contractor's IPV-FAIR team in trainings, meetings, and in data collection/reporting efforts fully supported by the grant?**

    Answer: Yes.

68. **What proportion of services (engagements listed on pages 12 – 16) are expected to be delivered in-home versus in a clinical setting? Are there minimum in-home requirements? Do virtual sessions factor in? Are contractors expected to provide direct services to the person using violence, and if so, in what format (individual, family, group)?**

    Answer: All virtual sessions are to be considered in concert with the CPS team for approval. This is an **in-home services**/clinic base treatment program understanding that there will be circumstances for clinic base due to safety concerns in the home.

69. **Are toxicology tests required of both caregivers for every referral (pages 13 - 14)? Or only if substance use is indicated for one or both caregivers? Are the child clients also expected to receive toxicology tests?**

Answer: Toxicology is **only for the caregivers** involved in the service. All adults enrolled will participate in toxicology as part of the assessment and treatment planning process.

70. **What level of psychiatric involvement (hours or FTE) is expected? Can those services be fully funded through the grant?**

Answer: Refer to question 40 for answer.

71. **How does DCF expect programs to maintain required staffing and continuous coverage with a 6.0 FTE team, particularly during staff vacancies or turnover?**

Answer: The department looks forward to hearing about agency's staff recruitment and retention plans.

72. **If a new organization replaces an existing IPV-FAIR contractor, what are the expectations for transitioning services from the existing contractor, including whether new contractors must immediately assume active cases?**

Answer: The department will support current contracted providers in transition and warm hand off to new services provider.

73. **Our organization has a 28.6% federally negotiated indirect rate. Can we claim that rate in our budget? If not, what percentage can applicants claim toward indirect in their budgets?**

Answer: Yes. The use of your rate restricts A/G to the Federal Requirement and cannot be combined with the State of CT regulations around calculation of A/G.

74. **Can you clarify why the family specialist positions were not funded to create a matched team with the clinician and is there any flexibility with that?**

Answer: Refer to question 58 for answer.

75. **Can families be referred from FAR if they will not be keeping the case open for 120 days as stated as an exclusionary criteria?**

Answer: Refer to question #52 for answer.

76. **Is there consideration/flexibility that the bi-lingual clinician and specialists will need to cover the entire region and more specifically for regions that have three area offices?**

Answer: Please see question #44.

77. **Is there consideration or flexibility on the service intensity of 2 to 3 visits per week for up to 8 families, which could be 16 individuals as 16 individuals twice a week would total 32 hours of direct care or 48 hours of direct care at 3 times per week. Those hours do not include travel.**

Answer: RFP has been updated and amended with correct calculations. Please refer to page 17 Length of services.

78. **Is there any consideration for the staffing for the two regions that require coverage for three area offices as opposed to the other areas that have only two? It is notable that there is a requirement of cross assignment for families that come in as a pair and it will be challenging for staff to cover three area offices in the vast regions like region 3.**

Answer: Please refer to question 26.

79. **On page 7, #11 – Naming convention for Proposal and Budget – both say Proposal, and I believe it is a typo but should one say "Budget"?**

Answer: Please see the amended RFP.

80. Page 22, 1. (d) – It says to label the licensures 6A, 6B, 6C, etc. If it is Attachment 4, should they be labeled 4A, 4B, etc.?

Answer: Please see amended.

81. The flow chart says there are 3 Family Navigators, but there are two other sections on staffing that say that there will be 2. Which is correct?

Answer: See question 4.

82. The proposal states that clinicians must be licensed. Would clinicians with provisional licenses also be eligible?

Answer: Yes for therapist positions. Supervisors are required to have an independent practitioner license.

83. Regarding the Service Provision section, it mentions that staff should have flexible schedules. Does this include required visits on Saturdays, or is that based on specific needs?

Answer: schedules are created based on client specific needs.

84. In the Case Management section, it states that providers should offer the Circle of Security to caregivers. Will training be provided for this curriculum?

Answer: Providers are given access to DCF Funded group.

85. Page 23 calls for a workforce attachment, is there a specific form that DCF wants?

Answer: There is no attachment, this question has been amended.

86. Exactly what IPV-Fair services can be billed for?

Answer: Refer to question 46.

87. Pg 12-13 is the expectation that when a biopsychosocial and diagnosis are completed these will be documented in PIE or somewhere that DCF will have access to?

- Answer: Records must be maintained on-premises in a lockable, secure area.

- **Agency Policies:** Agencies must have written policies regarding record protection, including procedures for removing records, releasing information, and maintaining records if the agency closes.

Records must be maintained in a manner that allows them to be accessible for review

In accordance to https://eregulations.ct.gov/eRegsPortal/Browse/RCSA/Title_19Subtitle_19-13Section_19-13-d75/#:~:text=(a)%20An%20agency%20shall%20maintain,(3)%20Patient%20care%20plans;

DPH regulations: https://portal.ct.gov/dph/public-health-hearing-office/regulations/public-health-code-medical-records-regulations?language=en_US

88. **We noticed that the RFP references different Family Support Navigator staffing levels across sections—specifically, the service flow chart on page 17 references 3.0 FTE Family Support Navigators per site, while the Staffing Model narrative and regional staffing tables list two (2) Full time Family Support Navigators per site. Could you please confirm the intended number of Family Support Navigator FTEs per site for this procurement?**

Answer: Refer to question 4.

89. **The RFP describes in home and clinic based outpatient services; however, in home outpatient services for adults are not eligible for Medicaid or other third party reimbursement. Could you please clarify the intended balance between clinic based and homebased interventions for parents/caregivers, and how this should be reflected in program design and budgeting?**

Answer: Refer to question 17.

90. **One of the stated program outcome goals is reduction in substance use. Beyond screening at intake and discharge and referrals when indicated, could you provide additional detail on what intervention components within IPVFAIR are expected to directly address substance use?**

Answer: Other interventions and training provided will be Motivational Interviewing, the use of Recovery supports as well see page 13 for assessment and screenings.

91. **The RFP notes that providers may assist with transportation as a way to reduce barriers to engagement. Could you clarify the expected frequency and scope of transportation support provided by IPVFAIR teams?**

Answer: Contractor to determine needs of family and meeting the needs of the client and what this looks like and in what capacity the agency can and will be able to support the individual.

92. **The RFP indicates offering trainings like Circle of Security. Should applicants build this cost into their budget, or are providers given access to DCF-funded groups?**

Answer: Providers are given access to DCF Funded group.

93. **The RFP indicates that providers must ensure access to psychiatric evaluations and medication consultation through a parttime psychiatrist or APRN and/or referral relationships. Could you please clarify the expected scope and average level of APRN/psychiatric time per site (e.g., standing weekly hours, on call consultation, episodic evaluation only), and whether this role is anticipated to be embedded and funded within the base contract or accessed primarily through referral arrangements?**

Answer: Refer to question 40 for answer.

94. **Billing / Medicaid Reimbursement**

Are current agencies providing the service billing for it successfully? Have there been any known issues with billing this program through Medicaid, given that it is an adult in-home behavioral health treatment model?

Answer: **Refer to question 17.**

adult co-occurring clinical services (treatment for both mental health and substance use disorders) are billable and covered under Medicaid in Connecticut (HUSKY Health). Services must be deemed medically necessary and provided by qualified licensed practitioners, such as Licensed Clinical Social Workers (LCSWs), Licensed Marital & Family Therapists (LMFTs), and Licensed Alcohol & Drug Counselors (LADCs).

95. **Additionally, what has been successfully billed by current providers, if applicable?**

Answer: **Refer to question17**

adult co-occurring clinical services (treatment for both mental health and substance use disorders) are billable and covered under Medicaid in Connecticut (HUSKY Health). Services must be deemed medically necessary and provided by qualified licensed practitioners, such as Licensed Clinical Social Workers (LCSWs), Licensed Marital & Family Therapists (LMFTs), and Licensed Alcohol & Drug Counselors (LADCs).

96. **Bilingual On-Call Coverage Expectations**

What are the expectations for bilingual on-call coverage? Are staff expected to be on call at all times, or would use of a language line when staff are not on call be sufficient for support?

Answer: Please refer to question 15. The Department looks forward to hearing your plan to address crisis for this population within the guidelines of the contract.

97. **Clinical / Program Clarification – Billing Context**

At the bidder's conference, questions were raised regarding billing practices and what services are considered billable under the program. Can DCF provide clarification on what has historically been successfully billed by current providers?

Answer: **Refer to question 17**

adult co-occurring clinical services (treatment for both mental health and substance use disorders) are billable and covered under Medicaid in Connecticut (HUSKY Health). Services must be deemed medically necessary and provided by qualified licensed practitioners, such as Licensed Clinical

Social Workers (LCSWs), Licensed Marital & Family Therapists (LMFTs), and Licensed Alcohol & Drug Counselors (LADCs).

98. Team Meeting Frequency Clarification

The RFP states on page 15 that there are "regularly scheduled monthly team meetings," however it also states later on the same page that "team meetings occur every 60 days." Are these referring to the same meetings? If so, should they occur monthly or every 60 days?

Answer: The monthly meetings are **Case Collaboration (HUB)Meetings** The Intimate Partner Violence Specialist (IPVS) will facilitate a monthly meeting with providers and the CPS worker assigned to the case to review each family being serviced. The IPVS will email the schedule of families to be discussed with CPS workers and the awarded provider. The CPS team will ensure the written documentation is entered into the CPS CT Kind record.

Team meetings After every 60 days the provider will be the primary leader in the coordination of team meetings. The provider along with DCF (and/or Community Partner Agencies) will coordinate child and family team meetings with the family to discuss progress, challenges and barriers to reaching the goals developed by and with each family. These meetings shall be integrated into already existing structures for families, which may vary in each Region. Discharge planning will also be determined through a team process. These meetings shall include the gatekeeper, CPS social worker (and/or Community Partner Agency worker), and/or supervisor along with the agency staff providing a direct service to the family and other relevant persons as identified by the family. Should additional stakeholders be involved due to providing services to the family, they may also be invited to participate in the team meeting.

99. Training Requirements

Are the required trainings listed on pages 18–19 provided at no cost by DCF, or should costs be included in the budget request? If they must be budgeted, can DCF provide the cost for each required training?

Answer: Refer to question 12.

100. Staffing Structure Clarification

Page 17 of the RFP lists 3.0 FTE Family Support Navigators, while pages 24–25 list 2.0 Family Navigators. Which staffing structure is correct?

Answer: Refer to question 4.

101. Page 23 requests a Workforce Analysis as Attachment #7. Please provide a direct web address or link to the required form.

Answer: Attachment #7 has been omitted.

102. Can clarification be provided on the type of MAT treatment the Psychiatrist is required to do?

Answer: Please refer to question #22.

103. How many hours of Psych time should agencies budget for "Part time" Psychiatry?

Answer: Please refer to question #22.

104. Change in the team composition? Considering the scope of practice, fidelity, and the increased significance of case management, can you please explain the operational plan for integrating two navigators across three clinicians' dyadic caseloads?

Answer: Navigators are not required to attend every session with clinician. Family Navigators will meet with each caregiver at least once weekly during this period. This intensive phase supports completion of assessments and development of treatment plans using Motivational Interviewing approach to build engagement and trust. Clinician will meet with caregivers 2X during initial engagement (first 6 weeks).

105. Please confirm Annual contract dollar amount for the IPV-Fair program?

Answer: The total annual funding amount for this program is $615,038.33.

106. Please define the expectation of "weekend hours"?

Answer: Refer to question 6.

107. Is the length of service 6 months with possible extensions?

Answer: Yes, in consultation with model developer in accordance to clinical necessity.

108. We are seeking clarification on allowable service delivery and billing parameters under this RFP. Specifically, given the need to supplement the awarded budget through third-party billing for budget projections and feasibility:

Answer: Refer to question 17.

109. Are there defined requirements regarding the proportion of home-based versus office-based sessions?

Answer: Refer to question 11.

110. If the IPV FAIR model requires a minimum of two sessions per week, is it permissible for one session to be conducted in the home (non-billable) and one in the office (billable)?

Answer: Refer to question 17.

111. Substance screens are required at intake and discharge. Are these urine screens expected to be observed or unobserved?

Answer: https://ncsacw.acf.gov/files/drug-testing-brief-1-508.pdf
A trauma-informed approach to drug testing in child welfare prioritizes safety, transparency, and collaboration to reduce re-traumatization for parents. It involves using non-punitive, supportive procedures, such as informing parents of testing expectations, providing privacy, and using less invasive methods. The trauma-informed approach is guided four assumptions, known as the "Four R's": Realization about trauma and how it can affect people and groups, recognizing the signs of trauma, having a system which can respond to trauma, and resisting re-traumatization.

112. Can a list be provided with all screeners, assessments and model specific tools required to be completed and the timeline expected for them to be completed during the intervention?

Answer: See page 13 for assessment and screenings.

113. On page 15 – please clarify the difference between the two monthly meetings noted for discussion/planning of each case - Case Collaboration and Team meetings and their frequency.

Answer: See page 15-16 of **Case Collaboration (HUB)Meetings:** The Intimate Partner Violence Specialist (IPVS) will facilitate a monthly meeting with providers and the CPS worker assigned to the case to review each family being serviced. The IPVS will email the schedule of families to be discussed with CPS workers and the awarded provider. The CPS team will ensure the written documentation is entered into the CPS CT Kind record.

Team meetings: After every 60 days the provider will be the primary leader in the coordination of team meetings. The provider along with DCF (and/or Community Partner Agencies) will coordinate child and family team meetings with the family to discuss progress, challenges and barriers to reaching the goals developed by and with each family. These meetings shall be integrated into already existing structures for families, which may vary in each Region. Discharge planning will also be determined through a team process. These meetings shall include the gatekeeper, CPS social worker (and/or Community Partner Agency worker), and/or supervisor along with the agency staff providing a direct service to the family and other relevant persons as identified by the family. Should additional stakeholders be involved due to providing services to the family, they may also be invited to participate in the team meeting.

114. Page 17 – the staffing under Intensive Family Violence Services lists 3 FTE Navigators? Is this accurate as other place in RFP has Navigators listed at 2 FTE (pg. 18).

Answer: This has been amended to reflect that there will be 2 FTE Family Support Navigators.

115. Please clarify the expectations of consultation with the model developer – page 20: 1st bullet says bi-weekly; 4th bullet says as determined and then in next section under team clinical consultation it states monthly. Can a full grid of what is expected of the provider related to consultation, all agency meetings with developer etc. be provided with frequency of these meetings?

Answer: Please refer to Charts in Question 12.

116. Over the past four years, this program has been consistently underfunded, resulting in an average annual deficit for our agency of approximately $104,000. In prior discussions with DCF, we jointly reviewed these deficits and were advised that the funding gap would be addressed in the 2026 reprocurement. Based on those discussions and the criticality of this service, we made the strategic decision to absorb the loss given the alignment with our mission. However, under the current IPV-FAIR RFP, overall funding has been reduced, and we project an even larger budget shortfall which is causing us to evaluate the feasibility of our agency maintaining this service. We are recommending that a break-even funding model be considered.

- **While this gap could theoretically be offset through increased billable revenue, the billable components of this service—specifically clinical services for adults—are currently limited to services delivered in-office or via telehealth. In-home service delivery, which is integral to the model and client needs, is not billable under existing parameters.**

Given this context, does DCF plan to increase flexibility around in-home service delivery to allow for expanded billable service provision? Alternatively, are there other planned strategies to increase funding or otherwise address the projected funding gap for this service under the 2026 reprocurement?

Answer: Billable questions: **Refer to question 17**

adult co-occurring clinical services (treatment for both mental health and substance use disorders) are billable and covered under Medicaid in Connecticut (HUSKY Health). Services must be deemed medically necessary and provided by qualified licensed practitioners, such as Licensed Clinical Social Workers (LCSWs), Licensed Marital & Family Therapists (LMFTs), and Licensed Alcohol & Drug Counselors (LADCs).

117. Start Date of 1/1/2027 – what is the plan for 7/1/2026 through 12/31/2026 for service provision and staffing?

Answer: All existing contracts will remain in place and effective through start date of newly awarded contracts. Funding will be pro-rated/adjusted as necessary for the end/start dates.

118. Program Outcome Goals

a. VIGOR and Safety Plan: RFP states that VIGOR must be completed by 100% of participants, however it is currently not completed with offending parents. Will this be adjusted to 100% of non-offending parents or will the percentage be reduced?

b. Substance use goal – As IPV-FAIR is not primarily a substance use program, how will the programmatic outcome of "80% of participants who identify substance abuse "will show improvement" be measured?

Answer: The outcome measure of an 80% reduction in substance use will be measured at the client population level based on identified treatment goals. So that, among clients who identify a reduction in substance use as a treatment goal, 80% will meet that treatment goal.

119. Service provision component

a. "Will accept all referrals" seems in contrast to "only accept a referral as utilization allows". Also, "accept all referrals made by the DCF gatekeeper" is a potential concern – what if a family does not meet criteria once more information is discovered?

Answer: Provider will work with Intimate partner Violence Specialist and CPS to discuss best fit.

120. Family engagement

a. Is there a timeframe or limit for assertive engagement without response from the family (or can this be specified)?

Answer: regarding referral process in attempting to engage families into treatment 14 days. After intake this is not a time frame but more of a

collaborative approach with DCF and provider to work in partnership in engaging family into services. Provider to document all efforts as well does DCF in CT KIND.

121. Safety planning

a. What is the Behavior Action Plan and its implications for use and what is the rationale for completing a VIGOR following the Behavior Action Plan? (Currently, the program uses the Family Development Plan with an offending parent.)

Answer: A behavior action plan is for addressing the individual using violence to prevent any further use of violence. The rationale for completing the Vigor with the person using violence after the Behavior Action plan is to prevent the person using violence from having access to the questions used with their partner/ex partner in the early stages of treatment. Please refer to Page 14 of the RFP.

122. Case management

a. RFP states service provision frequency of 2-3 visits per week for both Case Management and Clinical Sessions. Does this mean that the IPV-FAIR team will be meeting with a family for a total frequency of 4-6 visits per week or is the 2-3 visits per week the team total?

Answer: 2-3 visits per week the team total.

123. Team meetings:

a. What is the rationale for the change in leadership of the CFTM meeting from current state (DCF leads) to the provider assuming the leadership role?

b. Please provide clarification regarding the different objectives and purposes of the monthly CFTM and monthly HUB meetings.

Answer: **A.** The shift in leadership of Child and Family Team Meetings (CFTMs) from Department of Children and Families (DCF) staff to community-based providers is intended to drive a more family-centered, collaborative, and strengths-based process. This change supports a transformation in child welfare from a purely investigative model to one focused on prevention and long-term well-being. **Empowering Families and Enhancing Voice:** Provider-led meetings are intended to create a less intimidating environment, fostering

higher engagement from families and enabling them to be central decision-makers in their own care plans
B. Monthly Hub meetings- see page 15-16 of RFP this is a point in time clinical update on the treatment of identified clients. This also gives DCF an opportunity to share information on the CPS side as well. (similar to a clinical rounds on treatment).

124. Complexity/demands of their daily lives, have initial engagement difficulties, or have an occasional canceled session.

Answer: The four months that was written has been amended. The Length of Service is Six months.

125. Staffing Requirements: Is program manager equivalent to supervisor?

i. Yes - licensing requirements remain the same.

126. Caseload

- **RFP states the length of service is six months under caseload whereas it states 4 months in other sections. Please clarify.**
- **8 caregiver pairs/16 individuals x 3 clinicians x 3 cycles per year= annual capacity of 72 caregiver pairs or 144 individuals, but the RFP indicates annual capacity of 48/55 caregiver pairs. Please clarify.**
- **Given the requirement that clinicians meet with each client 2-3 times per week and are expected to maintain a caseload of 8 caregiver pairs or 16 individuals:**
  - **Meeting 2x/week= 32 session hours. Remaining 8 hours per week would need to accommodate drive time, documentation, PIE entry, lunch/break time, mandatory monthly HUBs (1.5 hrs per month, consults (2 hours/month), statewide meetings (1 hours per month), provider meetings (at least 1 hour per month)**
  - **Meeting 3x/week = 48 session hours. Staff will be 8 hours over their work week without accounting for drive time, documentation, PIE entry, lunch/break time, mandatory monthly HUBs (1.5 hrs per month, consults (2 hours/month), statewide meetings (1 hours per month), provider meetings (at least 1 hour per month).**

- **Please clarify workload expectations for clinical staff**
- **Please advise on whether the intent is for Family Navigators to be responsible for some of the required meetings, taking into account that with the reduction to 2 Navigators, each Navigator will be responsible for supporting 12 caregiver pairs or 24 individuals at any point in time, and that the expanded expectation around coordinating psychiatric and substance abuse treatment will increase their responsibilities significantly.**
  - **Recommendation: To accommodate the increased session density, reduce caseload to 6 -7 families or approximately 10-12 individuals at the stated 2-3 visit/week frequency.**

Answer: RFP has been updated and amended with correct calculations. Please refer to page 17 Length of services.

Family Navigator responsibilities- see page 15 case management on the RFP.

Clinician workload expectations please see page 17 and 18 and training chart in question 12.

127. **Psychiatry- Funding in this RFP does not allow the addition of program-specific psychiatry or psych APRN time. Given the current shortage of adult psychiatric resources, is the psychiatry expectation that referral to a psychiatry provider occur within 24-48 hours of assessing need, which would be feasible, or for a first appointment within 24-48 hours, which would rarely be possible?**

Answer: Refer to question #22 for answer.