Corporation for Supportive Housing Social Innovation Fund

Request for Proposals for

Supportive Housing Linked to Coordinated Primary and Behavioral Health Services for High Utilizers of Crisis Health Services

November 28, 2011

Notice Regarding Public Disclosure: Please note that all information submitted in this procurement process may be made public if directed by the Corporation for National and Community Service (CNCS) or required by law. This may include the names of organizations that submitted proposals, contact information, summaries of proposals and budgets, reviewer ratings and comments, and other information.

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Section I: Timetable

A. Release Date of this RFP: November 28, 2011

B. Web Address of Online Pre-Recorded Instructional Webinar: http://www.csh.org/sif

C. Live Bidders' Webinar/Teleconference

Date: December 8, 2011
Time: 2:00 – 3:30pm Eastern Standard Time (EST)
Register online at: http://www.csh.org/sif

D. Instructions for Submitting Written Questions:

Submit to: sif@csh.org
Written questions may also be submitted through the online registration form for Live Bidders' Webinar/Teleconference.

E. Due Date/Time and Instructions for Submission of Optional Letters of Intent:

Interested applicants are strongly encouraged to submit Letters of Intent indicating the intention to submit full proposals. Letters of Intent may be submitted by mail or by email.

Due Date/Time: December 19, 2011
5:00pm Eastern Standard Time

Submit by mail to: Corporation for Supportive Housing
Attention: CSH SIF
50 Broadway, 17th Floor
New York, NY 10004

Submit by email to: sif@csh.org

F. Due Date/Time and Instructions for Submission of Full Proposal

Applicants must submit two (2) hard copies of the application including one (1) original signed document and one (1) complete duplicate, and one (1) electronic version of the entire application (e.g. Microsoft Word or PDF) including all attachments either by email, USB flash drive, or CD/DVD. Both hard and electronic copies of the application must be received by the due date and time below. Late submissions will be not be accepted, with no exceptions.

Due Date/Time: January 13, 2012
5:00pm Eastern Standard Time

Submit hard copies to: Corporation for Supportive Housing
Attention: CSH SIF

50 Broadway, 17th Floor
New York, NY 10004

Submit email copies to: sif@csh.org

G. Anticipated Announcement Date of Subgrant Awards: February 29, 2012

H. Anticipated Start Date of Subgrants: March 12, 2012

Section II: Program Overview

A. Purpose of this RFP

The Corporation for Supportive Housing (CSH) is seeking eligible and qualified non-profit organizations or teams of non-profit organizations to implement models of supportive housing linked to coordinated primary and behavioral health services targeted towards low-income men and women experiencing homelessness and who are high-utilizers of publicly-funded emergency health services. Selected recipients of CSH's Social Innovation Fund (SIF) grant funds (hereafter referred to as 'subgrantees') and their implemented models will be part of a national effort to demonstrate that models of integrated housing, care management, and health services are effective in improving health care and health outcomes while reducing avoidable hospitalizations, emergency room visits, and emergency/crisis health services (and attendant public costs) among homeless, high-cost frequent users of health services.

This new national demonstration program and funding opportunity is made possible through a Social Innovation Fund grant CSH received from the Corporation for National and Community Service, along with additional grant support CSH is receiving from its foundation partners. With these combined grant funds, CSH will award a total of $2.8 million in subgrants over two years to between four and twelve subgrantees located within four states or local jurisdictions. Subgrants will range in size from $100,000 to $500,000 per year for two years, with eligibility to renew the grant annually for three additional years based on performance and availability of funding. Larger grants will be awarded to larger-scale programs (i.e. those that can serve and house a larger number of individuals than the minimum required target goal of 100 individuals), and those that hold greater potential for scaling beyond the grant period. Subgrantees will be required to match their subgrant awards on a dollar-for-dollar basis in cash with eligible non-federal matching funds. Subgrantees will be required to participate in a national evaluation commissioned and paid for by CSH to measure the success of these models in improving care, health outcomes, and reducing costly emergency health services use among targeted clients. CSH will provide subgrantees with technical assistance through a national learning network around the implementation of their models, around raising and obtaining matching funds, and around sustaining and expanding their programs through engagement of mainstream housing and health systems.

B. About CSH, SIF, and CNCS

About Corporation for Supportive Housing

For 20 years, CSH has been a catalyst for housing connected with services to prevent and end homelessness. CSH develops innovative program models, provides research-backed tools and training, offers development expertise, makes loans and grants, and collaborates on public policy and systems reform to make it easier to create and operate high-quality supportive housing. To date, CSH has provided almost $300 million in financial support to communities across the country. CSH is on track to meet its goal of helping communities create 150,000 units of supportive housing nationwide by 2012. Visit us at www.csh.org.

About the Social Innovation Fund

The Social Innovation Fund is an initiative of the Corporation for National and Community Service that improves the lives of people in low-income U.S. communities. Through an innovative public-private partnership, the Social Innovation Fund and selected local and national grantmakers co-invest in programs that increase the scale of community-based solutions that have evidence of real impact in the areas of

youth development, economic opportunity or healthy futures. Every federal dollar invested is matched with private funds, and all programs are rigorously evaluated. As a result, the most effective approaches can be expanded to reach more people in need and key lessons can be captured and broadly shared. To learn more visit www.NationalService.gov/Innovation

About the Corporation for National and Community Service

The Corporation for National and Community Service is a federal agency that engages more than five million Americans in service through its Senior Corps, AmeriCorps, and Learn and Serve America programs, and leads President Obama's national call to service initiative, United We Serve. For more information, visit **NationalService.gov**.

C. Eligible Subgrantee Applicants

Eligible applicants for subgrants are non-profit organizations with 501(c) 3 status from the Internal Revenue Service who are in Good Standing with their states.

CSH will accept applications from individual organizations, but encourages organizations to partner and apply as a team of organizations to propose stronger program models with greater scale and potential impacts. For example, an applicant team may consist of a provider of supportive housing, and one or more community-based providers of primary and behavioral health services (e.g. a community health center, hospital, etc.). Applicants applying as an individual organization must show that they have experience with and capacity to deliver and implement all program elements as described in Section III.D. Applicant teams consisting of multiple non-profit organizations should identify an eligible non-profit to serve as the lead applicant, and who will serve as the primary contact for the application as well as for the project. The lead applicant may be either a provider of supportive housing, a provider of community health services to vulnerable and low-income populations, or an organization that has the capacity to coordinate and oversee the delivery of all program elements. Government and public sector agencies can be included as members of teams, but may not serve as lead applicants. Subgrantees are not permitted to re-grant any portion of CSH's SIF grant. Therefore, lead organizations for subgrantee teams must subcontract with other members of the subgrantee team.

Selected subgrantees will be required to match 100% of their subgrant awards with eligible matching funds in cash. Applicants must have 25% of this cash match at the time of their applicant submission. More information regarding eligible sources of matching funds may be found in Section III.G.

D. Program Overview

This Request for Proposals focuses on one of the most pressing policy problems currently facing states and communities and the nation as a whole: **rising public spending on health care (Medicaid) with poor health outcomes**. In nearly every state, a tragic "revolving door" of emergency room visits, inpatient hospitalizations, detox stays, and involvement in other costly crisis health services among a small subset of individuals contributes to rising Medicaid costs. Often referred to as the '5:50 population' (the 5% of beneficiaries that represent 50% of costs), these men and women have complex and co-occurring physical

and behavioral health challenges, limited support networks, and more often than not, experience homelessness or unstable housing situations.[1]

For these individuals, homelessness exacerbates chronic illnesses by increasing exposure to trauma and high-risk behaviors, which in turn, results in social isolation and difficulties accessing coordinated primary and behavioral health services needed to manage and expedite recovery. Homelessness functions as a virtual tri-morbidity, imposing additional ill-effects on health status as well as on public costs. Studies examining emergency health services use among high-need, high-cost individuals experiencing homelessness have found expenditures exceeding $60,000 per individual per year with little improvements in health—costs that could be avoided through a combination of high-touch services engagement, care coordination, and stable housing.[2]

CSH's Social Innovation: Supportive Housing with Coordinated Health Services

In recent years, select communities have, with impressive results, piloted enhanced models of supportive housing that feature direct and more deliberate links to primary and behavioral health services to reach and effectively serve these high-need, high-cost clients. These enhanced supportive housing models have shown impressive results in their ability to improve care while reducing costs, including:

- Improved physical and mental health, decreased mortality rates, and reduced substance use;
- A significant reduction in emergency room utilization;
- A significant decrease in hospital inpatient admissions and hospital days;
- Reductions in detox utilization and psychiatric inpatient admissions; and
- A significant reduction in Medicaid costs.[3]

Despite these promising findings, integrated supportive housing and health models have not yet been systematically adopted as a solution to high-need, high-cost clients. This failure-to-adopt stems in part from three challenges: a) the lack of awareness of supportive housing's potential as a solution for high-need, high-cost individuals; b) limited technical knowledge around how to pair supportive housing with integrated community health services; and c) the fragmented way that public systems serve vulnerable people (i.e. health systems repeatedly offering stand-alone medical services without addressing behavioral health and homelessness/housing needs).

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[1] Linkins, K.W., Brya, J.J., and Chandler, D.W. (2008). "Frequent Users of Health Services Initiative: Final Evaluation Report." Falls Church, VA: The Lewin Group.; Raven, M.C., Billings, J.C., Goldfrank L.R., Manheimer, E.D., Gourevitch, M.N. (2009). "Medicaid Patients at High Risk for Frequent Hospital Admission: Real Time Identification and Remediable Risks," *Journal of Urban Health* 86(2): 230-241.

[2] Raven et. al. (2009).; Flaming, D., Burns, P., Matsunaga, M. (2009). "Where We Sleep: Costs when Homeless and Housed in Los Angeles." Los Angeles: Economic Roundtable.

[3] Perlman, J., and Parvensky, J. (2006). "Denver Housing First Collaborative: Cost Benefit Analysis and Program Outcomes Report." Denver: Denver's Road Home.; Larimer et. al., (2009).; Sadowski, L.S., Kee, R.A., VanderWeele, T.J., Buchanan, D. (2009). "Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Homeless Individuals," *Journal of the American Medical Association* 301(17): 1771-1778.; Mondello, M., Gass, A.B., McLaughlin, T., Shore, N. (2007). "Cost of Homelessness: Cost Analysis of Permanent Supportive Housing State of Maine – Greater Portland." Report submitted to Corporation for Supportive Housing, MaineHousing, and Maine Department of Health and Human Services.; Massachusetts Housing and Shelter Alliance. (2007). "Home and Healthy for Good: A Statewide Pilot Housing First Program." Boston.

CSH's Social Innovation Fund aims to address these three challenges, and to set in motion the national scaled adoption and replication of integrated housing and health services as a viable alternative to the tragic and costly "revolving door" for vulnerable and homeless men and women. This effort seeks to build credible evidence regarding the cost-effectiveness of the model, raise public awareness of this approach, and create a blueprint for scaled replication through collaborative multi-sector policymaking and resource integration.

E. Initiative Goals and Objectives

CSH is seeking creative, high-capacity non-profit partners to implement models of supportive housing linked to patient-centered coordinated health and behavioral health services that can help stop the revolving door for vulnerable, high utilizers of crisis health services. Working with selected subgrantees, CSH will achieve the following goals and objectives:

- Expand or Replicate an Innovative and Effective Model – Through grantmaking and implementation technical assistance, CSH will work with selected subgrantees in four locations to develop and refine a highly effective model of housing linked to intensive care management and coordinated primary and behavioral health care through community health partnerships;
- Build A Solid Base of Evidence – A rigorous evaluation will provide credible evidence regarding supportive housing's effectiveness as a health care intervention and solution for reaching Medicaid's high-need, high-cost individuals;
- Creating A Blueprint for Scaled Replication – CSH and its subgrantees will work collaboratively to design and develop a viable policy and comprehensive approach to scaled national replication, namely through a multi-agency collaborative model in which Medicaid-funded intensive care management services are paired with federal, state, and local affordable housing resources.

Most notably, this effort will allow CSH, philanthropic partners, and subgrantees to establish supportive housing connected to health services as a cost-effective solution for addressing the needs and reducing costs among the high-need, high-cost subset of current and future Medicaid beneficiaries, and a worthwhile investment to which Medicaid and mainstream housing resources should be directed.

F. Target Population

The target population for this program is men and women who meet all of the following criteria:

- Are very low-income;
- Have a chronic behavioral health condition and/or one or more chronic physical health conditions;
- Are homeless or in persistent housing crisis; and
- Are high utilizers of crisis health services.

For purposes of this RFP, the following definitions apply:

- 'Very low-income' is defined as people who are at or below 50% of Area Median Income.
- 'Chronic behavioral health conditions' are defined as a diagnosed mental health condition or a substance use disorder.

- 'Chronic physical health conditions' include any persistent illness or disease which requires more than usual access to healthcare services for support. Eligible conditions include but are not limited to HIV/AIDS, Hepatitis C, asthma, diabetes, heart conditions/cardiovascular disease, cancer, kidney problems, or liver problems.
- 'Homeless' is defined as currently residing in a shelter, on the street, or another setting not meant for human habitation.
- 'Persistent housing crisis' is defined as a) not having a regular or fixed home, b) having experienced two or more moves, or c) having experienced a stay in one or more institutional settings (e.g. jail, prison, hospital, psychiatric center, etc.) all within the last six months.
- 'High utilizer of crisis health services' is defined as having had a higher than typical level use (as verified through one of the methods described in Section III.D) of any of the following emergency services: hospital emergency departments, inpatient hospitalizations, psychiatric hospitalizations, substance use treatment, or detoxification programs or sobering centers. Other services not listed here may be considered crisis health services pending approval from staff at CSH.

G. CSH's Technical Assistance

Organizations selected as subgrantees by CSH will join a national replication and model refinement effort. As such, subgrantees will participate in a national learning network, through which subgrantees will receive technical assistance from CSH as well as from their subgrantee peers. Technical assistance areas will include, but are not limited to: strengthening partnerships between housing and health providers, improving the coordination of services, client identification and recruitment, general implementation assistance, raising matching funds, and engaging with policymakers and mainstream health and health agencies. It is an expectation of subgrantees that they will actively participate in this learning network and engage in technical assistance.

H. Evaluation/Research Participation Requirements

Subgrantees will be required to participate in a process and impact evaluation conducted by a research partner to be selected and paid for by CSH. The evaluation will involve a rigorous methodological design that will likely have either a randomized control or matched comparison group. More information about the evaluation can be found in Section III.K.

Section III: Scope of Services

A. Program Goal and Objectives

1. Goal

The goal of the SIF Supportive Housing program is to improve housing stability and health status while reducing the use of costly emergency health services among very low-income, vulnerable people with chronic conditions who are homeless or unstably housed. Programs receiving support from this RFP will achieve these outcomes by proactively recruiting eligible members of the target population and providing them with supportive housing along with coordinated, client-centered primary and behavioral health services.

A secondary, but no less important goal of this program is to contribute to the development and synthesis of a blueprint for the scaled, national replication of models that link affordable housing, supportive services, and health care to reach very low-income high-need, high-cost individuals with chronic health challenges who experience housing crises, as well as for aligning and integrating mainstream housing with mainstream health resources (e.g. Medicaid) to finance these models. Participation in CSH's national learning network and engagement in CSH's technical assistance will be required as a condition for receiving SIF grant funds.

2. Objectives

To achieve the goals described above, each SIF Supportive Housing programs receiving support from this RFP will be expected to meet the following objectives and targets:

- At least 100 new individuals who meet the target population definition will be placed into supportive housing within eighteen (18) months of receiving a SIF grant award from CSH;
- At least 67% of eligible individuals approached to participate in the program through outreach will be offered a chance to participate in the program;
- 85% of individuals placed into supportive housing will remain in housing six (6) months following placement;
- 100% of individuals placed into supportive housing who are Medicaid eligible and who remain in housing at the six-month mark will be successfully enrolled in Medicaid within nine (9) months following placement;
- 100% of individuals placed into supportive housing and who remain in housing at the six-month mark will be assertively engaged by a health professional around receiving health or behavioral health services;
- 75% of individuals placed into supportive housing and who remain in housing at the six-month mark will have had at least one primary care visit with the subgrantee's health care partner within six (6) months following placement;
- 50% of individuals placed into supportive housing and who remain in housing at the six-month mark will have documented routine and regular visits with the subgrantee's health care partner for either primary care and/or treatment of a chronic condition within one year following placement.

B. Target Population

The target population for this program is men and women who meet all of the following criteria:

- Are very low-income;
- Have a chronic behavioral health condition and/or one or more chronic physical health conditions;
- Are homeless or in persistent housing crisis; and
- Are high utilizers of crisis health services.

For purposes of this RFP, the following definitions apply:

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- 'Homeless' is defined as currently residing in a shelter, on the street, or another setting not meant for human habitation.
- 'Persistent housing crisis' is defined as a) not having a regular or fixed home, b) having experienced two or more moves, or c) having experienced a stay in one or more institutional settings (e.g. jail, prison, hospital, psychiatric center, etc.) within the last six months.
- 'High utilizer of crisis health services' is defined as having had a higher than typical level use (as verified through one of the methods described in Section III, Part D) of any of the following emergency services: hospital emergency departments, inpatient hospitalizations, psychiatric hospitalizations, substance use treatment, or detoxification programs or sobering centers. Other services not listed here may be considered crisis health services pending approval from staff at CSH.

C. Guiding Principles

The integrated models of supportive housing and health services, which have been proven effective in improving housing and health outcomes for vulnerable high-utilizers of emergency health services, share a common set of guiding principles that CSH views as essential to their success. SIF Supportive Housing programs that will receive grant support through this RFP are expected to propose programs that incorporate these guiding principles in their approaches and practice. These include:

- Housing First
  Housing First is a philosophy and an approach to supportive housing in which people are moved out of homelessness and into permanent affordable housing rapidly and directly. Central to the Housing First philosophy is the belief that safe, affordable housing is a basic human right, as well as a platform and prerequisite for improved health and behavioral health. The Housing First approach emerged in reaction to approaches that assumed that people experiencing homelessness needed to be "housing ready," that is, where individuals must first achieve sobriety, complete a course of treatment, or demonstrate other behavioral modifications as a precondition to obtaining permanent housing.

Whereas a "housing readiness" approach considers permanent housing to be the endpoint of a linear continuum of programs, the Housing First approach entails moving people out of homelessness and into permanent housing immediately, and then providing services as needed to prevent the reoccurrence of homelessness. These services are focused on supporting housing retention, emphasize assertive engagement and relationship-building, and may include crisis intervention, eviction prevention, training around activities of daily living, re-housing as quickly as possible if the initial placement does not work, and other supportive services.

Supportive housing models that use a Housing First philosophy feature tenant screening processes and eligibility criteria to facilitate easy entry into housing, and are therefore often referred to as "low-demand" or "low-barrier" housing. Generally, such supportive housing models avoid the use of complex application processes, and have no or few requirements for tenants beyond the normal conditions of tenancy (which typically include expectations regarding paying the rent, not destroying property, and refraining from behavior that would harm other tenants or staff.) Moreover, these models adopt a stance and policy towards substance use that does not *require* sobriety or participation in substance use treatment as a condition for staying in housing, but rather engages tenants around substance so as to reduce the harm associated with use, and encourages and motivates tenants to maximize healthier behaviors (including seeking substance use treatment.)

- Housing as a Platform for Healthy Futures
  A guiding principle and core assumption underlying this effort is the belief that homelessness and unstable housing situations contribute to poor health and exacerbate chronic health conditions. By contrast, safe and stable housing can be a positive social determinant of health. Moreover, when affordable and coupled with meaningful supports and connection to health services, housing can actually be a platform and vehicle for improving health outcomes and status. Consistent and stable tenancy in affordable housing provides a platform for the improved delivery and coordination of health care to these individuals, management of chronic conditions, and health status overall.

- Reduce Risky Behaviors through Harm Reduction
  A major contributing factor to the high utilization of emergency health services among individuals experiencing homelessness is the engagement in risky behaviors (e.g. high-risk drug use, unprotected sex, sex work, etc.) that exacerbate chronic conditions and poor health. Successful models (of supportive housing integrated with coordinated health services for high-utilizers) engage and encourage individuals to reduce and avoid high-risk behaviors, and pursue lower-risk, healthier choices. Practices are informed by the set of strategies known as harm reduction, which seeks to directly confront and mitigate the harms and negative consequences associated with drug and alcohol use and other behaviors. Harm reduction entails directly engaging and communicating with clients around substance use and risk behaviors; adopting a non-judgmental attitude towards substance use and other risky behaviors; emphasizing positive reinforcement through practices like Motivational Interviewing to encourage behavior change; and providing education around safe drug use, safe sex, and other healthy choices. Clients are offered substance use treatment when they express desire and interest, but are not compelled or coerced to seek treatment.

- Patient-Centered Health Home
  A key approach to improving health care, health outcomes, and reducing avoidable hospitalizations among high-need, high-cost individuals with chronic conditions is the patient-centered medical home.

The patient-centered health home is a philosophy and approach to health care that coordinates care for individuals who have complex and co-occurring health conditions and/or who have barriers to accessing regular care. In contrast to approaches in which patients must navigate health services on their own and seek care from multiple providers for different conditions and needs, the patient-centered health home provides a system of coordinated care wherein a team of primary care, behavioral health, and other social services providers coordinate and deliver care for all aspects of the person's health. Through this approach, barriers to health care access are removed, information is shared to maximize the management and treatment of illnesses, and patients' are empowered to direct their own care.

D. Program Elements

Subgrantees receiving a grant award from CSH's SIF will use their SIF grant and matching funds to implement models of supportive housing linked to coordinated health services for very low-income individuals with chronic health conditions who are homeless or unstably housed and who are high-utilizers of emergency health services. These programs are based on and informed by existing models that have shown tremendous promise in ending homelessness, improving health outcomes, and reducing the use of costly emergency health services for this target population. As such, these programs should incorporate the guiding principles described in Section III.C. In addition, programs will encompass the following four elements found to be essential to the achievement of the initiative goals:

- Data-driven identification of target population
  Programs will use and analyze administrative data to identify the high-utilizers of crisis health services to be targeted by their supportive housing and health programs. For example, programs may review Medicaid claims data or hospital/health services admissions records to identify individuals with frequent and repeat hospitalizations, emergency room visits, or detox visits. Programs may also use predictive algorithms or tools that identify individuals with high-risk scores for high utilization of crisis health services. Other data-driven methods that identify individuals may also be used, so long as they are able to verify the individuals' patterns of high utilization of crisis health services.

- Assertive outreach, recruitment, and engagement of targeted individuals
  Programs conduct assertive outreach into crisis service and institutional settings (e.g. hospitals, clinics, detox programs, treatment programs, etc.) and homeless service settings (e.g. shelters, streets, single-room occupancy hotels, etc.) to recruit members of the target population. Programs will engage target population members and offer them the opportunity to obtain affordable housing along with health and social services. Consistent with the Housing First approach, permanent affordable housing will be offered without requiring participation in treatment or services. Recognizing that individuals may initially refuse participation and assistance, programs will be persistent in offering participation, including engaging individuals multiple times and in multiple settings to overcome reluctance.

- Supportive housing
  At the core of the programs supported through this RFP is supportive housing—a combined package of affordable housing coupled with intensive care management services that are designed to help vulnerable, formerly homeless individuals remain in housing, live with maximum independence, connect to needed clinical and mainstream services, and facilitate the attainment of their goals and aspirations. Supportive housing has several subcomponents:

- Quality permanent and affordable housing – Supportive housing is affordable rental housing with no artificial time limits on residency. Tenants in supportive housing have leases and rights and responsibilities of tenancy. Rent is adequately subsidized such that extremely low-income tenants can pay no more than 30% of their gross monthly income for rent. The design, construction, appearance, physical integrity, and maintenance of the housing units provide an environment that is attractive, safe, sustainable, functional, appropriate for the surrounding community, and conducive to tenants' stability and community integration.

- Housing stability services – Tenants are assertively engaged and offered services to maximize their tenure in housing; increase their ability to maintain their household and finances, independently perform activities of daily living, and uphold the terms of their lease; prevent lease violations and intervene and mitigate crisis situations; maximize tenant safety and security; build community among tenants; and prevent avoidable evictions.

- Informed property or landlord management – In the case of developed apartment buildings operated as supportive or affordable housing, property management effectively maintains a balance between ensuring the effective operation and management of the physical facility and asset (including the maintenance and safety of the building) and fostering tenants' housing stability and independence. Property management policies and procedures will reflect this dual orientation, including emphasizing tenant education around rights and responsibilities, rent payment contingency arrangements, and procedures for ensuring clear communications with tenants around due process. In the case of scattered-site supportive housing models where apartments are leased on the private rental market and subsidized using a rental assistance voucher, programs actively communicate, engage, advocate on behalf of tenants, and mediate conflicts with landlords.

- Care management and service coordination – In addition to services focused on helping tenants maximize housing stability, services in supportive housing also assist tenants to connect to, navigate, and coordinate needed health and social services. Services engage tenants to identify and define their own service goals and needs, and then assist with obtaining and coordinating health, behavioral health, vocational/educational, transportation, medication management, nutrition education, assistance with activities of daily living, and other services. Services may also include assistance with enrollment in entitlements, benefits, and health insurance; assistance with navigating public systems; advocating on behalf of tenants with service providers; and coordination of services.

- Comprehensive and coordinated primary and behavioral health care
  Through a clinical partner, the programs will provide participants with comprehensive primary and behavioral health services. Program participants will be assertively and creatively encouraged to engage with the clinical partner to obtain primary and behavioral health care, as well as access to other clinical and social services. Participant engagement should take place in a manner that facilitates and maximizes ease of access, and may include engagement within the participants' building or home. Participants will be assisted in enrolling in Medicaid or other health insurance, and will be encouraged to engage in regular and routine primary care visits that can serve as the point of coordination of other health services, consistent with the principles of the patient-centered health home.

CSH recognizes that programs and approaches should be tailored to local contexts, and that some degree of variation is therefore appropriate. However, it is anticipated that all programs will include these core program elements, though the specific approaches used to deliver them may vary. Applicants will be scored on their applications around the degree to which they propose sound and feasible approaches to implementing each of these program elements.

E. Engagement with State or Local Health and Housing Systems

As described in Section III.A, one of the goals of this initiative is to pilot and develop avenues for accessing and integrating mainstream health and housing resources—namely, Medicaid, Section 8 and other rental subsidy programs, and various capital funding streams—as the most viable means of bringing to scale the supportive housing and health models developed through CSH's Social Innovation Fund.

Therefore, subgrantees receiving SIF grant awards are expected to engage and communicate with their relevant state or local health and housing systems, agencies, and policymakers regarding their programs, target populations, and impacts on health and housing outcomes and public costs throughout the terms of their grants. With technical assistance from CSH, subgrantees will be expected to enlist policymakers and agencies to enact policy changes to direct mainstream housing and health resources (Medicaid, rental subsidies, and/or capital) to sustain, expand, and replicate their program models.

An assumption of this RFP is that the ability of the subgrantees to influence their health and housing systems depends upon the degree to which programs are able to capture and hold the attention and interest of local or state decision-makers. Programs are better positioned to capture and hold this attention to the degree that they are perceived as either having a large-scale impact or being scalable to achieve this large-scale impact. Therefore, applications will be scored more favorably to the degree that programs are able to serve a larger number of individuals. Applications will be scored more favorably that entail multiple organizations advancing the same program model but in multiple sites within a particular community.

F. Assumptions Regarding Organizational Experience and Capacity

Applicants eligible to apply for this RFP should meet the eligibility requirements described in Section II.C. As described in that section, applicants may be either individual non-profit organizations or teams of non-profit organizations. Applicants comprised of a team of eligible non-profits must have a lead applicant who will be responsible for the implementation of the model, reporting to and communicating with CSH, and all performance and financial management.

CSH anticipates that the lead applicant will have the following qualifications:

- Provider of supportive housing, a provider of community health services to vulnerable and low-income populations, or an organization that has the capacity to coordinate and oversee the delivery of all program elements
- Fiscally sound and capable of managing the proposed program
- Experience managing government grants or contracts is preferred
- Capability to successfully perform the administrative responsibilities related to the delivery of the proposed services in accordance with the applicable federal statutes and regulations, including fiscal management, reporting, and records management in an efficient, accurate, and timely manner

- Availability of executives at the organization to play an effective role in developing, implementing, and overseeing the program
- Requisite financial strength and resources to handle administrative and fiscal implications of a federal award

Applicant teams – including the lead applicants and all partners – must have the following qualifications:

- Experience providing both supportive housing and behavioral health services to vulnerable and low-income populations
- Coordination with the relevant public agencies and hospitals to target frequent users and link to and provide appropriate housing and health care services
- Ability to access the administrative data necessary to target frequent users of crisis health care services and/or a well-articulated plan for engaging and enrolling the target population
- Having a data system in place to track participant outcomes, and continuously improve operations
- Support from key public agency administrators, contracted administrative agencies for health payment systems (i.e. Managed Care Organizations, Accountable Care Organizations, etc.) and/or elected officials is preferred
- Effective decision-making mechanism to govern the project and key decisions
- History of effective collaboration preferred

For each partner listed in the application, the following information should be included in the proposal:

- Strong commitment from each partner indicated by providing a letter signed by the participating entity
- Clear delineation of roles and responsibilities of each partner to carry out the program successfully
- Each partner has strong experience and capacity to perform the roles and responsibilities assigned to it

G. Matching Fund Requirements

Subgrantees will be required to match the full amount of their grant received from CSH in cash with non-federal funding. Matching funds may come from state, local, or private sources, which may include State or local agencies, businesses, private philanthropic organizations, or individuals. Federal Funds, including Federal block grants being distributed by state or local governments, may not be used toward the match requirement, except under very specific circumstances. More information about allowable funding sources under match requirements can be found in OMB Circular A-122 (see http://www.whitehouse.gov/omb/circulars/index.html).

At the time of application, applicants must demonstrate that they can match a minimum of 25% of the requested subgrant award in cash. Applicants will be awarded additional points in the scoring of their proposal if they can show an available cash match above 25% as well as on their ability to secure the remaining match.

H. Program Sustainability Beyond Grant Period

Consistent with the Goals described in Part A of this Section, CSH intends for the programs supported through this RFP to continue and expand beyond the grant period. CSH believes that this program sustainability will be achieved by leveraging mainstream public housing and health resources, namely,

federal, state and local capital funds and rental subsidies administered by Housing Finance Agencies and Public Housing Authorities; Medicaid; mental health and substance abuse treatment block grants; and to some degree, philanthropy. CSH will provide subgrantees with technical assistance around how to access these resources.

Once selected to receive an award, subgrantees will be required to develop and submit a written plan to CSH for sustaining and expanding their programs beyond the grant term, including how mainstream housing and health resources will be leveraged and obtained, and discussing what technical assistance from CSH is needed to secure these resources. This due date for the submission of this written sustainability plan will be provided to subgrantees following execution of their grant award agreements.

I. Budget and Eligible Uses of Subgrant Funds

CSH plans to award grants between $100,000 and $500,000 for each year of the two-year grant period with eligibility to renew the grant annually for three additional years based on performance and availability of funding. Larger grants would support programs that have capacity to serve a greater number of participants, beyond the minimum required target of 100. Funds received from this partnership will be invested to support the expansion or replication of the program model to develop greater levels of evidence and to reach the target population as defined above.

Using the budget form included in the Attachments and described in Section IV.C, applicants must complete and submit with the full proposal: a proposed program budget for the full two-year grant term that includes the requested grant amount plus the matched funding and with a breakdown for years 1 and 2 of the project. The budgets should describe how grant funds will be used to effectively support activities described in the proposal narrative. Applicants must also submit a budget narrative to accompany the proposal budget.

Costs that may be supported by CSH Social Innovation Fund dollars include, but are not limited to:

- Project operating costs to support expansion or replication of supportive housing linked with health services
- Staff time dedicated to research efforts (see Section III.I)
- Federally approved indirect cost rates

Applicants should understand that costs associated with the grant need to meet federal standards for allowable costs, which do not necessarily include all costs that the organization will incur in order to perform their awards. For example, the costs of raising funds in order to meet the non-federal share of the budget ("matching funds") are not allowable costs under OMB cost principles. Refer to the Federal cost principles at http://www.whitehouse.gov/omb/circulars/index.html.

As described in the OMB cost principles, applicant budgets will include a combination of direct or indirect costs. Applicants with approved indirect cost rates for federal grants must use those rates for any indirect costs they include in their budgets. CSH will work with applicants selected for award who do not have approved federal indirect cost rates to help them develop and obtain approval for their rates.
Applicants must show the amounts, sources, and uses of required in-cash match equivalent to at least 25% of the requested CSH SIF subgrant amount (using eligible non-Federal grant sources). Additional amounts, sources, and uses of in-cash match should be displayed as described in applicant proposals.

J. Required Participation in CSH's Technical Assistance and National Learning Network

As described in Section II.G, selected subgrantees will be required to receive technical assistance from CSH and participate alongside other subgrantees in CSH's national learning network. Upon executing a grant award agreement, subgrantees will participate in a site visit with CSH staff to identify the subgrantee's technical assistance needs and develop a technical assistance plan. Subgrantees must regularly and actively participate in meetings, teleconferences, webinars, and site visits. Failure to participate in this learning network or technical assistance may be affect subgrantees' ability to draw down grant funds or subgrant renewal.

K. Reporting and Evaluation Requirements

Subgrantees will be required to participate in a process and impact evaluation conducted by a research partner to be selected and paid for by CSH. The evaluation will involve a rigorous methodological design that will likely have either a randomized control group or a matched comparison group.

The evaluation will track process- and impact-related outcomes including, but not limited to:

- Number of tenants recruited and enrolled each month
- Number of tenants housed
- Length of time between enrollment and being housed
- Number of tenants that left housing and reasons for leaving
- Proportion of tenants enrolled in Medicaid
- Number of case management and service contacts per month
- Number of contacts with primary and preventative health care services per month
- Overall rates of housing retention
- Changes/reductions in the use of crisis health care services/costs
- Changes/reductions in the use of other public services such as homeless shelters and jails
- Improvements in health/mental health

As part of this evaluation, subgrantees will be responsible for working with CSH and the research partner on the following research-related tasks:

- Obtaining research consent forms and explaining the research study to all participants (for both the program and comparison groups if necessary)
- Providing performance-related data including, but not limited to, number of tenants recruited, enrolled, and housed; participation in services; enrollment in Medicaid; housing retention; and reasons for program/housing exit
- Facilitating access to the administrative data needed for the evaluation (i.e. HMIS and Medicaid data)
- Coordinating with CSH and the research partner on the implementation of any tenant surveys associated with the evaluation

Finally, CSH will be monitoring subgrantee implementation in order to assure the quality of the housing and services being delivered to eligible participants. CSH staff will conduct site visits to each subgrantee to

determine whether the supportive housing being delivered meets CSH quality standards, as described above and in CSH's Dimensions of Quality in Supportive Housing. CSH will provide technical assistance and facilitate peer-to-peer learning between subgrantees to support this effort. More detail about the CSH Dimensions of Quality can be found at www.csh.org.

L. Demonstrated Levels of Evidence

Eligible applicants must demonstrate at least preliminary evidence of the effectiveness of their proposed model. Proposals must include documentation of the research studies undertaken for the proposed program model (or models that are very similar to the proposed model). Below are definitions of impact and evidence (these definitions are consistent with those used in the 2011 Social Innovation Fund NOFO), followed by examples:

- *Strong evidence* means evidence from previous studies whose designs can support causal conclusions, and studies that in total include enough of the range of participants and setting to support scaling up to the state, regional, or national level. The following examples are strong evidence: (1) more than one well-designed and well-implemented experimental or quasi-experimental study or (2) one large, well-designed and well-implemented randomized controlled, multisite trial that supports the effectiveness of the program model.

- *Moderate evidence* means evidence from previous studies whose designs can support causal conclusions but have limited generalizability, or studies with high external validity but moderate internal validity. The following would constitute moderate evidence: (1) at least one well-designed and well-implemented experimental or quasi-experimental study supporting the effectiveness of the program model with small sample sizes or other conditions of implementation or analysis that limit generalizability, (2) at least one well-designed and well-implemented experimental or quasi-experimental study that does not demonstrate equivalence between the intervention and comparison groups at program entry but that has no other major flaws related to internal validity; or (3) correlational research with strong statistical controls for selection bias and for discerning the influence of internal factors.

- *Preliminary evidence* means evidence that is based on a reasonable hypothesis supported by research findings. Thus, research that has yielded promising results for either the program, or a similar program, will constitute preliminary evidence and will meet the criteria for the CSH Social Innovation Fund. Examples of research that meet the standard include: (1) outcome studies that track program participants through a service 'pipeline' and measure participants' outcomes at the end of the program; and (2) pre- and post-test research that determines whether participants have improved on an outcome of interest.

Section IV: Format and Content of the Proposal

A. Letters of Intent

Applicants are strongly encouraged, though not required to submit a Letter of Intent to submit a full proposal. Letters of Intent will be non-binding and are intended to help CSH to determine how to deploy personnel and expertise to review applications and issue awards. Letters of Intent must have a page-limit of three (3) single-spaced pages, and are due by 5:00 pm Eastern Standard Time on December 19, 2011. Submissions will not be accepted after this due date.

Letters of Intent should include the following information:

- Name of lead applicant organization
- Name(s) of other organizations on applicant/program team
- Name of lead applicant point of contact including:
  - Mailing address
  - Phone number
  - E-mail address
- Proposed target geographic location of program
- Proposed scale of size and type of target population impacted
- Brief summary of the proposal
- Non-binding program budget estimate, requested CSH SIF grant amount, and source of required 25% in-cash match (if possible)

Letters of Intent may be submitted in hard copy by mail or by email per the instructions provided in Section I.E.

B. Proposal Instructions and Format

1. Instructions

Please submit one original signed document, one hard duplicate copy, and an electronic version of your entire application including all attachments. (See Section I. for submission instructions.)

Applicants should provide all information required in the format below. The proposal should be typed on both sides of 8 ½" X 11″ paper with 1″ margins and standard 12-point fonts. The Program Proposal Narrative (excluding the proposal checklist, proposal summary, exhibits, attachments, forms, resumes, and budget spreadsheets and narrative) **should not exceed 25 single-spaced numbered pages in length.** Pages should be numbered.

The proposal will be evaluated on the basis of its content, not length. Applicants should use the structure and order provided below, and include the topics/subtopics as the section headers in their responses. Applicants should include all requested attachments in the order presented in the Proposal Checklist (Attachment 1). Please clearly separate each attachment (for example using paper clips, colored paper dividers, etc.).

2. Proposal Format

- Proposal Summary
  The Proposal Cover Page (Attachment 2) should be completed, signed, and dated by an authorized representative of the applicant.

- Program Proposal
  The Program Proposal should be a clear, concise narrative that addresses each of the items detailed in Section III, and answers the questions in Section IV.C, below. Provide all required attachments. Note that Section IV.C.3 includes the proposed budget and budget narrative. The attachments and budget narrative do not count towards the 25-page proposal narrative limit.

C. Proposal Components and Scoring

The criteria for grantee selection will broadly include: the applicant's organizational capacity, the proposed model and approach, and budget and funding match capacity. CSH anticipates selecting applicants that are both expanding existing programs and those that are replicating the programs. Applicants will be considered expanding an existing program if they are already serving frequent users of health services in supportive housing and providing a combined intervention of supportive housing integrated with primary and behavioral health services. Applicants will be considered replicating a program if they are operating supportive housing (with or without integration with health services), but not specifically for frequent users. The content of the proposal narrative should be structured as follows.

1. Organizational Background and Capacity – 40 points

Describe in detail the composition, roles, responsibilities, background, and capacity of the partner organizations on the applicant team. Demonstrate that the lead applicant and applicant team meets the qualifications as outlined in Section III.F. The proposal must specifically address:

- *Composition of the Applicant Team.* List the partner organizations involved, which organization will serve as the lead, and the specific roles and responsibilities of each group (i.e. housing, property management, supportive services, case management, coordinated health and behavioral health care). Each applicant should also list the specific personnel who will serve as the applicant's leadership team. Include an organizational chart that shows the relationships between the organizational members of the applicant team.

- *Experience with Target Population.* Applicants must demonstrate an understanding of and prior experience working with members of the target population. Applicants must:
  - Demonstrate their understanding of the characteristics, housing needs, and health and other service challenges of members of the target population, citing local data from any preliminary local research or data analysis.
  - Demonstrate prior experience successfully providing housing, services, and/or health care to members of the target population, providing specific examples of programs and services that serve this target population.

- *Programmatic Capacity.* Applicants must demonstrate how they are able to provide the three core components of the program model: deeply subsidized affordable housing, housing-based

supportive services (i.e. care management), and coordinated primary and behavioral health services. Applicants must:
  - o Demonstrate how the applicant team has the capacity to effectively provide each of these components in a highly coordinated fashion.
  - o Demonstrate how the team can effectively coordinate around services delivery between members.
  - o Describe and identify programs that are either currently or recently operated by the applicant (or team) related to the below elements. At least one of these programs needs to be operated by the lead applicant. For each specific program cited, provide a brief description of the services offered, dates of operation, and program goals.

- *Management Capacity of Lead Applicant.* Describe the lead applicant's successful experience managing programs of a similar scale and scope as described in Section III. If relevant, describe the lead applicant's successful experience working in a leadership role to establish and lead effective partnerships. Applicants must:
  - o Describe and demonstrate the effectiveness of how the applicant currently uses data to support decision-making in existing programs.
  - o Demonstrate how the applicant has effectively used data to make significant programmatic changes in operations.
  - o Describe the applicant's use of Information Technology Systems to support a data-driven decision making process.
  - o Describe and demonstrate how executives at the lead applicant's organization will be able to and have the availability to play an effective role in developing, implementing, and overseeing the program.
  - o Describe experience managing collaborations (if applying in a partnership).

- *Financial Capacity of Lead Applicant.* Applicants must demonstrate their financial stability and infrastructure necessary to meet federal requirements. Applicants must:
  - o Demonstrate the applicant team's financial stability by describing each organization's financial and management infrastructure, including accounting practices, budgeting processes, and associated staff/qualifications.
  - o Demonstrate the applicant's capability to successfully perform the administrative responsibilities related to the delivery of the proposed services, including fiscal management, reporting and records management in an efficient, accurate and timely manner.
  - o Describe the lead applicant's experience managing and reporting on government grants or contracts.
  - o Demonstrate the applicant team's ability to match CSH's SIF grant through partnerships with private, philanthropic, and government funders.

- *Systems Policy Engagement/Coordination Capability.* Demonstrate applicant's relationships with local or state public agencies and systems (especially Medicaid or other relevant health payment systems and mainstream housing agencies) and potential for enlisting these systems to adopt the model and bring it to scale based on evidence of success. Ensure that the following points are addressed:

    - The type and level of involvement of local or state public agencies and systems in the proposed model such as participation in the identification of frequent users through administrative data analysis, participation in working or oversight committees, and/or direct funding support to the models.
    - The extent to which these groups have partnered before.
    - The logic of the proposed day-to-day partnership and coordination with these agencies.

- *Required Attachments*. For each partner organization on applicant team, please attach the following to the Proposal Narrative (not included in the 25-page limit):

  - *References.* Provide three references who are familiar with the organization's work in connection with programs of the type for which you are seeking SIF funding. For each person, include: his or her name and organizational affiliation, contact information (mailing address, telephone number, and email address), and the basis for the person's knowledge of your organization's work.
  - *Work samples/evaluations*. Please attach up to three work samples or summaries of key findings from independent evaluations that demonstrate the quality and relevance of the lead applicant's recent work to the program for which you are applying.
  - *Resumes.* Attach resumes for all key staff that would be involved in the project.
  - *Any existing MOUs between partner agencies (if applicant includes multiple organizational team members) and the applicant/program team organizational chart.*
  - *Financial statements*. Lead applicants will provide financial statements for the past two years.
  - *Signed Letters of Support.* Applicants will have signed letters of support from appropriate government agencies, indicating agency interest in the proposed work and commitment to actively participate in the subgrant.
  - *Other organizational documents including:*
    - Lead applicant's organizational chart.
    - Lead applicant's most recent Annual Report.
    - Lead applicant's Certificate of Incorporation.
    - Lead applicant's chart of accounts.
    - List of officers and Board of Directors

2. Proposed Program Model and Approach – 40 points

Describe in detail how applicant will provide the scope of services described in Section III and demonstrate that the proposed approach will fulfill CSH's goals and objectives. Applicants must specifically address:

- *Target Population and Client Identification.* Demonstrate how the proposed program will reach the target population as defined in Section III.B. Clearly articulate the characteristics, service needs, challenges/barriers, and estimated size of the population in target community. Applicants should include data from any preliminary local research or data analysis. Provide a step-by-step description of how administrative data and/or data-driven targeting tools or strategies will be used to identify high cost users of crisis health care services, and the process that eligible individuals will be located in the community for outreach and enrollment.

- *Program Elements.* Describe how the applicant team will implement and deliver the housing and services as described in Section III.D, including:
  - o Strategies for outreach, engagement, and recruitment, including where and how this will happen and how anticipated challenges will be overcome.
  - o Demonstration of ability to secure access to housing and services for frequent users within the required timeframe. Proposed supportive housing facility (if applicable) or demonstration of ability to acquire units for supportive housing, including descriptions of relationships with local landlords or other housing networks. Describe physical housing configurations, approach to ensuring affordability, and approach to property management.
  - o For applicants looking to expand an existing program, demonstration of ability to expand the program to serve additional people through the expansion of housing and services capacity and in new sites and communities.
  - o Types of care management and supportive services models to be utilized and how these services will be coordinated with housing.
  - o Approach for providing integrated and coordinated primary and behavioral health care.
  - o How proposed program will follow the guiding principles as outlined in Section III.C, including Housing First, harm reduction, and the patient-centered medical home
  - o How proposed supportive housing program will meet quality standards as defined in CSH's Seven Dimensions of Quality and in Section III.D.

- *Outcomes, Performance Measurement, and Evaluation.*
  - o Articulate the specific goals, objectives, and outcomes (at both the client and systems level) of the proposed program and how the planned activities and program elements will lead to these outcomes. In addition to describing in narrative form, provide a graphical representation of the Theory of Change as an attachment.
  - o Describe how these outcomes will be measured, including outputs and outcomes currently being tracked, the systems and procedures to track them, and the frequency with which they are tracked. Using the most recent quantitative measures of success whenever possible, demonstrate that current programs are effective in each of the following areas:
    - Achievement of tenant move in or other numbers that met or exceeded funder/program expectations (target levels vs. actual enrollments).
    - Achievement of outcomes that met or exceeded funder/program expectations (projections vs. actual outcomes).
  - o Describe the evidence of the effectiveness of current programs and services. Applicants should have at least preliminary or moderate evidence of program effectiveness as described in Section III.J. For applicants expanding an existing program, evidence about current programs should be provided. For applicants newly replicating the model, provide evidence and evaluations regarding housing and health outcomes of their existing supportive housing program, and how the similar the populations served by these programs are to frequent users in terms of their characteristics and service needs.
  - o Demonstrate the staff and systems capacity to provide the data necessary for the evaluation, as described in Section III.K.

- *Work and Staffing Plan.*
  - o Include a work plan for the first two years of the project, including details on start-up activities, implementation, and client placement with dates.\

- Include a timeline of program activities, including (but not limited to) the following program milestones: target population identification, participant recruitment, participant housing placement, participant health services engagement, and participant health insurance enrollment.
- Demonstrate and describe the adequacy and appropriateness of the staffing plan that the applicant will use to launch and maintain program operations. The plan should include the following:
  - A description of all proposed staff positions for each partner organization, including their responsibilities and the FTE (full-time equivalency, or percentage of time devoted to the program) for each position
  - A description of the expertise in the program area that existing staff already have or that staff to be hired will have
  - A resume and/or description of the qualifications that will be required for each managerial staff person who will be involved in developing, implementing, and/or executing the program.

3. Funding Match and Budget Narrative – 15 points

- *Funding Match.* Demonstrate how, as described above in Section III.F, the applicant organization is able to match a minimum of 25% of the requested subgrant award at the time of application in available cash. (If applicants consist of multiple organizational team members, matching funds may provided by any and all organizations of the applicant team.) Additional points will be awarded to applicants that can show greater percentage matches above the 25% minimum, as well as on their ability to secure the remaining match, including identified funding partners.

- *Sustainability Plan.* Describe applicant's plan for using grant funds to achieve program sustainability, favoring one-time investments to seed programs (planning costs, infrastructure improvements, and engaging consultants for additional expertise) rather than ongoing operational costs. Applicants should specifically describe the degree to which mainstream health (i.e. Medicaid) and mainstream housing resources will be used or leveraged to sustain these programs, and what steps will be taken to achieve this leverage.

- *Budget and Budget Narrative.* This section is not included in the 25-page limit program proposal and should include:
  - Complete Attachment 3 (SIF Budget Template Form – MS Excel spreadsheet) to present a line-item budget for each year of program operations.
  - Present a budget narrative to accompany Attachment 3 demonstrating cost-effectiveness and the relationship between the cost and the program components; provide sufficient justification of costs to indicate how the costs are reasonable relative to the SIF high-cost users program approach.

4. Geographic considerations – 5 points

Applicants will receive 5 additional points on the scoring of their application if they are from one of CSH's eleven priority sites. These eleven sites include: New York, NY; State of Connecticut; Detroit, MI; Franklin

County, Ohio; State of Minnesota; Denver, CO; State of New Jersey; Seattle, WA; Salt Lake City, UT; San Francisco/Bay Area, CA; and Los Angeles, CA.

CSH identified these sites as priorities because they share some or all of the following characteristics:

- Large chronically homeless populations
- Existing, small-scale frequent user or supportive housing/health pilots
- Agency data shared across agencies or routinely matched across systems
- Mature practitioner capacity
- Opportunities for health system integration
- Potential for public partnership and collaboration
- Potential local funding opportunities

Section V: Proposal Evaluation and Subgrant Award Procedures

A. Proposal Review Procedures

All proposals accepted by CSH will be reviewed to determine whether they meet eligibility criteria, which include:

- Nonprofit organizations with 501(c)3 status from the Internal Revenue Service and be in Good Standing with their states
- A lead applicant that is either a provider of supportive housing or a provider of community health services to vulnerable and low-income populations
- A team with demonstrated experience providing *both* supportive housing and behavioral health services to vulnerable and low-income populations
- A demonstrated 25% cash match at time of application

Proposals that do not meet these criteria will be rejected. A review committee will evaluate and rate all remaining proposals based on the evaluation criteria described below. The review committee will include key CSH staff as well as a number of external experts with community health, criminal justice, homelessness, housing, Medicaid, and/or evaluation experience.

The review committee reserves the right to conduct site visits and/or phone interviews as the Committee deems applicable and appropriate. Although discussions may be conducted with applicants submitting acceptable proposals, CSH reserves the right to award subgrants on the basis of the initial proposals received, without discussion, therefore, the applicant's initial proposal should contain its best programmatic, technical, and price terms.

B. Proposal Scoring Criteria

As described in Section IV, CSH will use the following criteria to score the proposals:

- Proposed Program Model and Approach (40 points)
- Organizational Background and Capacity (40 points)
- Funding Match and Budget Narrative (15 Points)
- Geographic Considerations (5 Points)

C. Basis for Subgrant Award

Award selection will be based on the best technically rated proposals whose budget does not exceed the maximum funding set forth in the RFP and that demonstrate satisfaction of all organization capacity qualifications. CSH reserves the right to award subgrants to the responsible applicants whose proposals are determined to be the most advantageous taking into consideration factors or criteria which are set forth in the RFP, geographic considerations, program diversity, and target population.

The subgrant award shall be subject to:

- Demonstration that the applicant has, or will have by the conclusion of negotiations, site control of the appropriate facilities at which to provide services and the available housing necessary to serve the number of people set forth in the proposal.

- Demonstration that the applicant will perform the proposed activities in accordance with the applicable federal statues and regulations, including but not limited to all administrative and financial records management, documentation, and reporting requirements.

- Timely completion of subgrant negotiations between CSH and the selected applicant.

Attachments

1. Proposal Checklist
2. Proposal Summary
3. Proposal Budget Form
4. Proposal Budget Instructions

CSH SOCIAL INNOVATION FUND
PROPOSAL CHECKLIST

Applicants should include all requested attachments in the order presented in the checklist. Please clearly separate each attachment (for example using paper clips, colored paper dividers, etc.).

- ☐ *Proposal Summary* (Attachment 2.)
- ☐ *Proposal Narrative* (Response to Section IV.)
- ☐ *Proposal Budget Form* (Attachment 3.) along with budget narrative
- ☐ *References.* Provide three references who are familiar with the organization's work in connection with programs of the type for which you are seeking SIF funding. For each person, include: his or her name and organizational affiliation, contact information (mailing address, telephone number, and email address), and the basis for the person's knowledge of your organization's work.
- ☐ *Work samples/evaluations.* Please attach up to three work samples or summaries of key findings from independent evaluations that demonstrate the quality and relevance of the lead applicant's recent work to the program for which you are applying.
- ☐ *Resumes.* Attach resumes for all key staff that would be involved in the project.
- ☐ *Any existing MOUs between partner agencies and the applicant/program team organizational chart.*
- ☐ *Financial statements.* Provide lead applicant's financial statements for the past two years.
- ☐ *Signed Letters of Support.* Provide signed letters of support from appropriate government agencies, indicating agency interest in the proposed work and commitment to actively participate in the subgrant.

Other organizational documents including:

- ☐ Lead applicant's organizational chart.
- ☐ Lead applicant's most recent Annual Report.
- ☐ Lead applicant's Certificate of Incorporation.
- ☐ Lead applicant's chart of accounts.
- ☐ List of officers and Board of Directors

CSH SOCIAL INNOVATION FUND
PROPOSAL SUMMARY

Complete, sign, and attach this page as the cover to the full proposal due on January 13, 2012 at 5:00pm Eastern Standard Time.

Applicant/Lead Applicant:

Organization Name:			
EIN or Tax ID Number:			
Street Address:			
City, State ZIP:			
Year Established:		*Number of Staff (FT/PT):*	
Organization Budget:			

Other Members of Applicant Team:

Other Organizations on Applicant Team (if applicable):	

President/CEO/Executive Director Contact Information

Name:	
Telephone:	
Email:	
Street Address, if different from above:	

Program/Application Lead Contact Information:

Name:	
Telephone:	
Email:	
Street Address, if different from above:	

Grant Request

Amount Requested:	
Amount (%) of Cash Match on Hand:	
Sources of Cash Match on Hand:	
Brief Bulleted Description of Uses of CSH SIF Grant funds (no more than 50 words):	

Summary of Program (no more than 250 words):

[Please describe the proposed program, geographic location, target population, number of individuals to be served, how the program satisfies the required program elements, and incorporates the guiding principles.]

Summary of Organizational Experience (no more than 250 words):

[Briefly list members of the applicant team and roles, and summarize the applicant/team's organizational experience and capacity to implement the program model.]

To the best of my knowledge and belief, all data in this proposal are true and correct, the document has been duly authorized by the governing body of the applicant, and the applicant will carry out the activities and authorized uses of the funds if the assistance is awarded.		
Typed Name of Authorized Representative:	Title:	Telephone Number:
Signature of Authorized Representative:		Date Signed:

Program Budget Instructions

Applicants are required to complete and submit the Program Budget form using the attached Excel file for their proposed subgrants, as well as an accompanying budget narrative.

The Program Budget form contains multiple worksheet tabs. All applicants are required to complete the 'Summary' and 'LeadOrgSalaries' tabs. Applicants comprised of a team of multiple organizations must also complete the 'Partner' and 'PartnerSalaries' tabs. (Applicants may create more 'Partner' or 'PartnerSalaries' tabs as necessary by right-clicking on one of the existing 'Partner' or 'PartnerSalaries' tabs, selecting 'Move or Copy…' and clicking the 'Create a Copy' checkbox, and renaming the tab.)

<u>'Summary' Worksheet</u>
The 'Summary' worksheet provides the overall budget for the program, including the amount and uses of the requested grant funds and the amount, uses, and sources of matching funds. Applicants must list program expenses using the following Budget Categories:

- 'Salaries/Wages' - Salaries and wages for full- and part-time program personnel. Provide total amount on 'Summary' tab. Further detail provided on the 'SalariesDetail' worksheet. The personnel listed here should match the staff listed in Section IV of the submitted proposal.
- 'Fringe' - Fringe benefits for program personnel, including FICA, unemployment insurance, workers compensation, disability, retirement/pension, life insurance, and medical/dental benefits. A breakdown of fringe costs should be provided in the budget narrative. The total Fringe rate should not exceed 30% of salaries.
- 'Partner Organizations' – Partner organizations are organizational members of the applicant team, and who will be subcontractors of the lead organization. The 'Summary' worksheet should indicate the total amount that is being provided to partner organizations through subcontracts. (NOTE: The amount indicated in this category should match the sum of the total of the 'Partner' worksheets.)
- 'Consultants' – Consultants are individuals or organizations retained by the lead applicant as subcontractors, but who are not considered a partner organization (i.e. do not play a core role in program operations) and who are typically playing a temporary and/or advisory role in the program. Applicants must explain the role, activities, hours, and total costs of the consultant in the budget narrative.
- 'Staff Travel' – Applicants should indicate the total amount requested for staff travel related to the program operations. Travel expenses should be explained in detail in the budget narrative. Applicants should include flight and lodging expenses for key program staff to attend three two-day in-person CSH meetings in each grant year.
- 'Supplies' – Applicants should enter the total amount requested for supplies. An explanation and description of supplies should be provided in the budget narrative.
- 'Equipment' – Equipment is defined as an item of property that has an acquisition value of $5,000 or more and an expected useful life of one year or more. Describe each item, its cost and justification in the budget narrative. General purpose equipment such as staff personal computers are not eligible for support unless primarily or exclusively for use for the program.

- 'Other Costs' – Applicants may name and request grant funds for other direct costs related to program operations. Examples of allowable other direct costs include tenant rental assistance, client temporary financial assistance, client stipends or financial incentives, tenant home furnishings and lease-up expenses, and others.
- 'Indirect Costs' – Indirect costs are expenses not easily allocable to a specific program, but which are necessary to the operation of the program. These costs are shared among programs. Examples of indirect costs may include portions of the Executive Director's and other managerial staff salaries, costs related to organizational administrative functions, and other general expenses not specific to any program. Applicants with a federal negotiated indirect cost agreement (NICRA) should indicate the most recent Indirect Cost rate and the base (total direct costs, salaries and wages, other – provide explanation) and submit a copy of the NICRA along with their budget narrative. Applicants that do not have a federally negotiated indirect cost rate should indicate the rate, base, and provide a detailed explanation of how the indirect cost rate was derived.

'LeadOrgSalaries' and 'PartnerSalaries' Worksheets

For the lead applicant organization (and any partner organizations, as applicable), applicants should complete the 'LeadOrgSalaries' worksheet, listing all staff working on the proposed program, including name, position, annual salary or hourly wage, the full-time equivalency (FTE) on the program, the total salary/wage amount for Years 1 and 2, and for the full grant term.

For applicants with multiple organizations, the total salaries listed under the 'PartnerSalaries' tabs should equal the amount listed under the 'Partner Organizations' budget category on the 'Summary' tab.