STATE OF NEW JERSEY

DEPARTMENT OF HUMAN SERVICES

DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES

Request for Proposals (RFP)

STATEWIDE SERVICES AND SPECIAL PROJECTS FOR SUBSTANCE ABUSE PREVENTION

Part 1 Funding Opportunity – Community-Based Services

Part 2 Funding Opportunity – Special Projects

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Proposals Due: October 30, 2014

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Table of Contents

Purpose and Intent 3
Background 3
Who Can Apply? 6
Community-Based Services Contract Scope of Work 7
Community-Based Services Proposal Criteria 15
Special Projects Contract Scope of Work 19
Special Projects Proposal Criteria 26
General Contracting Information 31
Mandatory Bidders Conference 32
Submission of Proposals 32
Review of Proposals 35
Appeal of Award Decisions 35
Post Award Requirements 36
Attachments 37
Attachment A - County Funding Amounts 38
Attachment B - Prevention Classification Definitions 41
Attachment C - Definition of Indicated Prevention Strategies 42
Attachment D – Standards for Agencies Providing Substance Abuse Prevention Services for DHS/DMHAS 43
Attachment E – Directions to Mandatory Bidders Conference 52
Attachment F – Cover Page 53
Attachment G – Addendum to RFP for Social Service and Training Contracts 54
Attachment H – Statement of Assurances 56
Attachment I - Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions 58
Attachment J – Disclosure of Investment Activities in Iran 61

Purpose and Intent

The Department of Human Services (DHS) Division of Mental Health and Addiction Services (DMHAS) is issuing this Request for Proposals (RFP) for Statewide Services and Special Projects for Substance Abuse Prevention. The guidelines and requirements specified in this document were developed by DMHAS in accordance with and support of the DMHAS Substance Abuse Prevention Strategic Plan. The RFP contains funding opportunities divided into two (2) parts: Part 1 - Community-Based Services and Part 2 - Special Projects. Funding for all services will be provided by the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant and administered by DMHAS. Total funding availability, subject to appropriations, is $5,750,000. Part 1 provides approximately $5,200,000 for community-based service contracts and Part 2 offers approximately $550,000 for special projects service contracts.

Bidders are encouraged to carefully review the RFP to determine which set of goals can best be achieved and which services can best be delivered. Bidders should pay special attention to the *"Standards for Agencies Providing Substance Abuse Prevention Services for the Department of Human Services/Division of Mental Health and Addiction Services (DHS/DMHAS),"* attached to this RFP. Only those bidders that have the capacity to uphold these operational and programmatic standards should consider applying for funds.

Cost sharing is not required. Actual funding levels will depend on the availability of funds. This RFP will provide funding for substance abuse prevention services for a five (5) year period, 2015-2019. Annual continuation and renewal are subject to availability of funds, satisfactory performance, as well as compliance and completion of all required/requested data collection and reporting.

The following summarizes the application schedule:

September 26, 2014	Notice of Funding Availability
October 10, 2014	Mandatory Bidders Conference
October 30, 2014	Deadline for receipt of proposals - no later than 5:00 p.m.
December 1, 2014	Preliminary award announcement
December 8, 2014	Appeal deadline
December 15, 2014	Final award announcement
January 1, 2015	Award start date

Background

In late 2010, DMHAS began a strategic prevention planning process to guide the development and implementation of new programming, and to evaluate its prevention goals as a means of guiding the organization's actions and decision-making with respect to prevention activities. There are numerous and often competing issues of concern to the community. In order to reflect its commitment to inclusiveness and

collaboration in statewide planning, the Division sought the counsel of stakeholders to determine priority areas.

Through a competitive application process 15 community members were selected to serve on the Planning Committee. Thirty applications were received, and applications were scored based on criteria such as the bidder's experience in/familiarity with prevention and experience participating in planning workgroups. In addition, DMHAS reached out to all state departments and divisions that provide prevention programming to their service population and requested they provide a representative to serve on the Planning Committee.

Beginning in October 2010, the Planning Committee met monthly to complete the first three (3) of five (5) sections of the plan. Workgroups met more frequently based upon a schedule determined by workgroup members. The group reconvened in the Fall of 2012 to complete the final two (2) sections of the plan.

DMHAS PREVENTION GOALS

DMHAS has identified four (4) goals to achieve in meeting its mission related to substance abuse prevention, which are:

1. New Jersey's citizens have access to the prevention services they need, which are identified by means of an intensive data-driven needs assessment process;
2. Substance abuse and its harmful consequences are prevented;
3. Services and programs are cost-effective and resources are maximized; and
4. Partnerships with communities are created and sustained to assess, develop, implement, and advocate for prevention policies, programs, and services.

PURPOSES OF THE PLAN

Acting upon its commitment to prevent substance abuse and its harmful consequences, and as specified in DMHAS' Strategic Planning Project Charter, DMHAS sought to:

1. Develop a data-driven five-year Addiction Prevention Strategic Plan that will become a roadmap for DMHAS-funded statewide prevention activities and funding decisions;
2. Address the Center for Substance Abuse Prevention's (CSAP) recommendation that New Jersey develop a unified strategic plan for prevention services;
3. Align primary stakeholder groups' prevention efforts and resources with the identified priority areas;
4. Use the Addiction Prevention Strategic Plan to guide prevention decision making and policy development at the State, County, and provider levels; and
5. Create an infrastructure plan to guide the continued development of DMHAS' Prevention Outcomes Management System (POMS) to collect environmental, outcome, and performance indicator data.

Further, DMHAS determined that the Addiction Prevention Strategic Plan would:

1. Be developed jointly by DMHAS staff and stakeholders who participated in the Planning Committee and/or its work groups;
2. Utilize data to determine the substance abuse prevention needs in New Jersey;
3. Indicate the types of prevention services to be offered in New Jersey;
4. Estimate New Jersey's capacity to provide these services and specify capacity gaps, where identified;
5. Identify planning principles that will be used in this planning process;
6. Offer an implementation strategy to realize the recommendations in the Plan; and
7. Include the intention to evaluate the effectiveness of DMHAS in meeting its goals, objectives, activities, key products, and outcomes.

DMHAS PREVENTION FRAMEWORK

DMHAS seeks to institutionalize a systematic approach to prevention that synthesizes and strengthens knowledge from multiple disciplines and addresses substance abuse and its related societal concerns based upon the following tenets:

- Health is more than healthcare or the absence of injury or disease;
- The environment in which we live profoundly shapes our health and well-being;
- Prevention requires commitment and dedication; and
- Prevention offers hope by saving lives and money.

Additionally, DMHAS seeks to fund programs and strategies that:

- Apply a comprehensive strategy across diverse disciplines, populations, and issues;
- Respond to and address national priorities and directives as identified by Federal funders;
- Advance changes in social norms and systems;
- Advocate for solutions that concurrently impact multiple problems;
- Research, synthesize, and disseminate information that builds upon successes;
- Inspire a broad vision and fresh approach that incorporates a variety of strategies;
- Are responsive to, and reflective of, community needs including culturally diverse communities and individuals with special needs;
- Acknowledge the importance of a comprehensive approach to prevention that includes both individual and family-focused evidence based curricula as well as environmental approaches;
- Integrate a community and policy orientation into prevention practice that utilizes a multi-dimensional approach to risk and protective factors in order to impact multiple problems and communities; and
- Expand the field by encouraging new participants, dialogue, and explorations.

UTILIZING A PUBLIC HEALTH APPROACH TO PREVENTION

Both DMHAS and the Planning Committee acknowledge the importance and utility of a public health approach to substance abuse prevention that is based on the following six (6) key principles:

1. Prevention is an ordered set of steps along a continuum to promote individual, family, and community health, prevent behavioral disorders, support resilience and recovery, and prevent relapse;
2. "Prevention is prevention is prevention." That is, the common components of effective prevention for the individual, family or community within a public health model are the same;
3. Common risk and protective factors exist for many substance abuse and mental health problems. Good prevention focuses on these common risk factors that can be altered. Risk and protective factors exist in the individual, the family, the community and the broader environment;
4. Resilience is built by developing assets in individuals, families, and communities through evidence-based health promotion and prevention strategies;
5. Systems of prevention services work better than service silos. Implementing these strategies within a broader system of services increases the likelihood of successful, sustained prevention activities. Collaborative partnerships enable communities to leverage scarce resources and make prevention everyone's business; and
6. Baseline data, common assessment tools, and outcomes shared across service systems can promote accountability and effectiveness of prevention efforts.

This framework represents a foundation that, if integrated into the structure and function of the community system, can potentially impact and prevent alcohol and substance abuse, while reducing violence, teenage pregnancy, crime, absenteeism, school drop-out, delinquency and other social problems throughout the lifespan. As such, DMHAS seeks to ensure that all funded programs and strategies offer the potential to effectuate lasting change by ultimately improving the capacity of the prevention system to work with many sectors to improve the health status of all people in a community.

Terms used in this RFP that have specific meanings related to substance abuse prevention programs are defined in the Attachment "Standards for Agencies Providing Substance Abuse Prevention Services for the DHS/DMHAS."

Who Can Apply?

To be eligible for consideration for this RFP, bidders must meet or agree to the following requirements:

1. The bidder must have a New Jersey address and be able to conduct business from a facility located in New Jersey;
2. The bidder must be a fiscally viable non-profit organization;
3. The bidder must have all outstanding Plans of Correction (PoC) for deficiencies submitted to DMHAS for approval prior to submission;
4. The bidder must not appear on the State of New Jersey Consolidated Debarment Report at http://www.state.nj.us/treasury/debarred/debarsearch.htm or be suspended or debarred by any other State or Federal entity from receiving funds.

5. The bidder must have a governing body that provides oversight as is legally permitted. No member of the Board of Directors may be employed as a consultant for the successful bidder;
6. The bidder must comply with all rules and regulations for any DMHAS program element of service proposed by the bidder;
7. A non-public bidder must demonstrate that it is incorporated through the New Jersey Department of State and provide documentation of its current non-profit status;
8. The bidder must comply with the terms and conditions of the Department of Human Services' contracting rules and regulations as set forth in the Standard Language Document, the Contract Reimbursement Manual (CRM) and the Contract Policy and Information Manual (CPIM). A copy of this manual can be accessed from the web at: http://www.state.nj.us/humanservices/ocpm/home/resources/manuals/; and
9. The bidder must attend the Mandatory Bidders Conference on October 10, 2014 from 1:00 p.m. – 4:00 p.m. at the New Jersey Forensic Science Technology Center in Hamilton, NJ. Directions are provided as an Attachment to the RFP.

Community-Based Services Contract Scope of Work

DMHAS defines prevention as a proactive, evidence-based process that focuses on increasing protective factors and decreasing risk factors that are associated with alcohol and drug abuse in individuals, families, and communities. DMHAS' approach to alcohol and substance abuse prevention and the conceptual framework that supports it has continuously evolved over time. It is based on emerging national research findings and the State's experience in program development, implementation and evaluation. Current research regarding prevention continues to prove that effective substance abuse prevention must include evidence-based strategies for addressing risk and protective factors across multiple domains. In addition, these strategies must be implemented at appropriate levels of intensity and in appropriate settings such as schools, workplaces, homes and community venues. Community Anti-Drug Coalitions of America (CADCA) has developed the following effective strategies that are essential components of lasting community change (the first three (3) are of particular relevance to the types of programs this part of the RFP will fund):

1. Providing Information - Educational presentations, workshops or seminars or other presentations of data (e.g., public announcements, brochures, dissemination, billboards, community meetings, forums, web-based communication);
2. Enhancing Skills - Workshops, seminars or other activities designed to increase the skills of participants, members and staff needed to achieve population level outcomes (e.g., training, technical assistance, distance learning, strategic planning retreats, curricula development);
3. Providing Support - Creating opportunities to support people to participate in activities that reduce risk or enhance protection (e.g., providing alternative activities, mentoring, referrals, support groups or clubs);

4. Enhancing Access/Reducing Barriers - Improving systems and processes to increase the ease, ability and opportunity to utilize those systems and services (e.g., ensuring healthcare, childcare, transportation, housing, justice, education, safety, special needs, cultural and language sensitivity);
5. Changing Consequences (Incentives/Disincentives) - Increasing or decreasing the probability of a specific behavior that reduces risk or enhances protection by altering the consequences for performing that behavior (e.g., increasing public recognition for deserved behavior, individual and business rewards, taxes, citations, fines, revocations/loss of privileges);
6. Physical Design - Changing the physical design or structure of the environment to reduce risk or enhance protection (e.g., parks, landscapes, signage, lighting, outlet density); and
7. Modifying/Changing Policies - Formal change in written procedures, by-laws, proclamations, rules or laws with written documentation and/or voting procedures (e.g., workplace initiatives, law enforcement procedures and practices, public policy actions, systems change within government, communities and organizations).

The risk and protection-focused prevention framework that DMHAS has historically endorsed is based on the work of Hawkins and Catalano and recognizes specific research-based risk and protective factors that are present in four (4) domains or broad areas of life: Individual/Peer Relationships; Family Relationships; School Environment; and Community Environment. The most effective prevention programs incorporate strategies that address risk factors across more than one (1) of these domains.

DMHAS defines prevention as a process that not only addresses the reduction of risk factors, but also seeks to enhance or increase protective factors. Risk factors tell us what to focus on to reduce unhealthy behaviors such as substance abuse. Protective factors are those characteristics and processes that have been shown by research to mediate the negative effects of exposure to risk factors by young people. Information regarding risk and protective factors can be found online at: http://www.state.nj.us/humanservices/das/prevention/factors/.

When using this framework, it is important to remember that:

- Individuals face alcohol and substance abuse risk factors in several domains;
- Different risk factors are related to different periods of development;
- The more risk factors that are present, the greater the risk for alcohol and substance abuse;
- When many risk factors are present, multiple protective factors have a buffering effect on risk, reducing the likelihood of substance abuse;
- Risk and protective factors show consistency over time and across different races, cultures and classes;
- While focusing on the multiple risks that individuals face, it is equally important to increase protective factors; and

- Prevention programs that strengthen the individual's protective factors by providing opportunities, skills and rewards and by developing consistent norms and standards for behavior across families, school, communities and peer groups are more likely to be effective.

This framework represents a foundation that, if integrated into the structure and function of the community system, can potentially impact and prevent not only alcohol and substance abuse, but assist in preventing violence, teenage pregnancy, crime, absenteeism, school drop-out, delinquency and other social problems throughout the lifespan. As such, DMHAS seeks to not merely fund the delivery of prevention programs, but to ensure that funded programs offer the potential to effectuate lasting change by ultimately improving the capacity of the prevention system to work with many sectors to improve the health status of all people in a community.

Each county in the State has been assigned a funding allocation from the total funds available based on its relative need. The funding allocation is determined based on the presence and intensity of social indictors, past 30-day use rates, treatment admission rates, as well as need and risk factors within each county. Each county's funding allocation can be found in the Attachment 2014 County Grants for Community Based Prevention Services. Unless otherwise noted, funding requests must be submitted for a minimum of $50,000.

Bidders are required to utilize evidence-based programs developed for use with individuals and families. Environmental-type programs such as Community Trials Intervention and Communities Mobilizing for Change will not be funded.

DMHAS highly recommends, though does not require, that bidders serve communities in the county in which the bidder has an office or administrative presence. Bidders that propose to serve communities in their county will receive priority.

Bidders will be required to address the risk and protective factors specific to the prevention priority as well as the population (e.g. families, middle or high school students, older adults, workplaces, etc.) they propose to serve. Bidders must provide quantitative data to substantiate the need for the substance abuse prevention services within the community and population they intend to target. Many of these data are available at http://www.state.nj.us/humanservices/das/news/reports/.

Additionally, helpful information provided by the Robert Wood Johnson Foundation and the University of Wisconsin is available online at http://www.countyhealthrankings.org/app/new-jersey/2014/overview.

In identifying the most significant prevention priorities that will be addressed by your program, it would be very worthwhile to consider the prevention priorities identified by the Municipal Alliances that are funded by the Governor's Council on Alcoholism and Drug Abuse (GCADA) and coordinate the bidder's efforts with those of the Municipal

Alliance(s) in the community. A list of Municipal Alliance priorities can be found here: http://www.state.nj.us/humanservices/das/prevention/resources/.

The goals of this project are meant to address the prevention priorities identified by DMHAS' Prevention Strategic Planning Committee and to complement and reflect the first of the Substance Abuse and Mental Health Services Administration's (SAMHSA) Eight Strategic Initiatives.

The DMHAS Strategic Planning committee formed needs assessment, capacity, and planning sub-committees to analyze existing data on addictions in the state population and current prevention resources. These data provided the foundation for identifying and selecting the following prevention priorities:

1. Reduce underage drinking;
2. Reduce the use of illegal substances; and
3. Reduce prescription medication misuse across the lifespan.

Underage Drinking: Underage drinking cost the citizens of New Jersey $1.5 billion in 2010. These costs include medical care, work loss, and pain and suffering associated with the multiple problems resulting from the use of alcohol by youth. This translates to a cost of $1,825 per year for each youth in the State or $2.42 per drink consumed by underage drinkers. Excluding pain and suffering from these costs, the direct costs of underage drinking incurred through medical care and loss of work cost New Jersey $600 million each year or $0.99 per drink. In contrast, a drink in New Jersey retails for $1.48.

Costs of Underage Drinking by Problem, New Jersey, 2010 **Problem**	**Total Costs** **(in millions)**
Youth Violence	$710.6
Youth Traffic Crashes	$330.7
High-Risk Sex, Ages 14-20	$142.0
Youth Property Crime	$104.5
Youth Injury	$64.2
Poisonings and Psychoses	$25.5
FAS Among Mothers Age 15-20	$28.5
Youth Alcohol Treatment	$60.4
Total	**$1,466.5**

Youth violence (homicide, suicide, aggravated assault) and traffic crashes attributable to alcohol use by underage youth in New Jersey represent the largest costs for the State. However, a host of other problems contribute substantially to the overall cost. Among teen mothers, Fetal Alcohol Spectrum Disorder (FASD) alone costs New Jersey $29 million. Young people who begin drinking before age 15 are four (4) times more likely to develop alcohol dependence and are two and a half times more likely to become abusers of alcohol than those who begin drinking at age 21. In 2009, 1,484 youth 12- 20

years old were admitted for alcohol treatment in New Jersey, accounting for 7% of all treatment admissions for alcohol abuse in the state.

In New Jersey according to the SAMHSA Report to Congress on the Prevention and Reduction of Underage Drinking, May 2011, 316,000 persons aged 12 to 20 (30% of the population in that age group) reported alcohol use in the past month while 199,000 persons aged 12 to 20 (19% of the population in that age group) reported binge alcohol use in the past month. Note: Binge alcohol use is defined as drinking five (5) or more drinks on the same occasion (i.e., at the same time or within a couple hours of each other) on at least one (1) day in the past 30 days.

Opioids and Medication Misuse: Mortality data associated with prescription drug/opioid use have demonstrated a steady increase in deaths for all but one age group (35-44 years of age). From 2004 to 2011, there was a 41% increase in deaths associated with prescription drug/opioid involvement (325 to 458). The percentage of deaths for persons 24 years of age and under increased from 9.8% of the total deaths in 2004 to 14% of the total deaths in 2011. The total deaths for persons 24 years of age and under increased by 100% during this eight year period (32 to 64).

New Jersey State Prescription Opioid-Involved Deaths by Age*

Age	2007	2008	2009	2010	2011	2012	2013
Under 18	8	4	3	4	10	11	14
19-24	43	55	53	52	54	68	78
25-34	115	87	105	111	102	166	207
35-44	168	102	116	125	104	112	142
45-54	116	113	123	115	128	140	151
55-64	32	31	26	35	56	55	67
65 +	1	6	8	7	4	7	8
Total	483	398	434	449	458	559	667

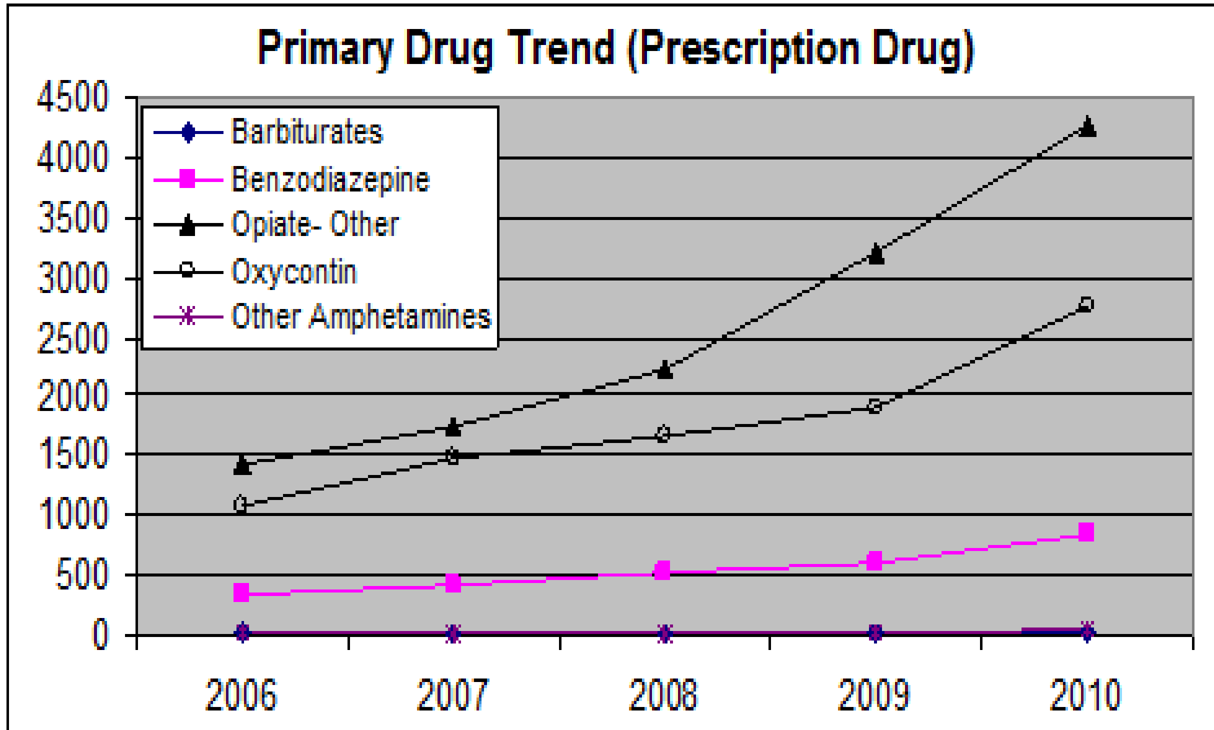
*New York/New Jersey High Intensity Drug Trafficking Area 2012 Drug Abuse Assessment Report (via the New Jersey State Medical Examiner's Office)

NJ SAMS Treatment Admissions 2009-2012

Year	Age	Alcohol	Heroin	Other Opiates*
2009	<18	565	138	71
	18-25	3480	5875	2016
	60+	758	239	42
2010	<18	422	112	79
	18-25	3861	5566	3133
	60+	950	220	49
2011	<18	389	76	92
	18-25	4160	6370	3571
	60+	826	223	85
2012	<18	411	118	99
	18-25	3933	7337	2993

	60+	891	346	88
Change 2009-2012	<18	-27%	-15%	39%
	18-25	13%	25%	49%
	60+	18%	45%	110%

*Other opiates: Methadone (non-prescription use), Oxycontin, and Opiate Other

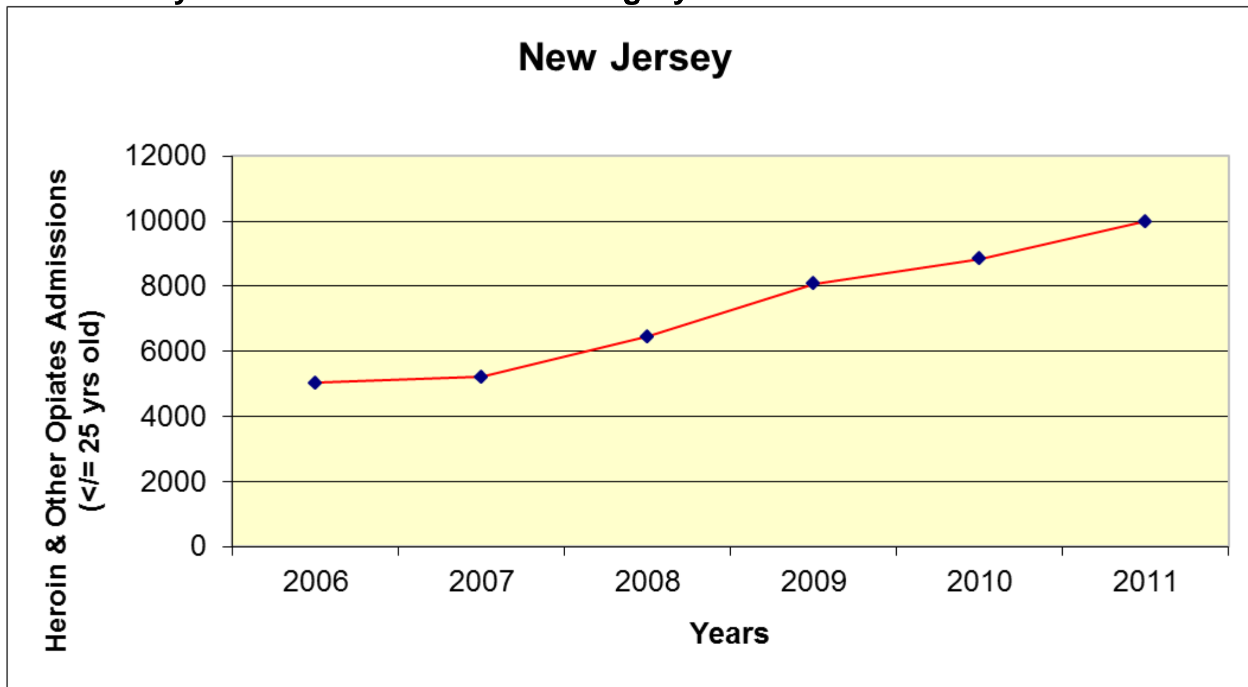


High School Risk & Protective Factor Survey -
Prevalence of Prescription Drug Use by Subgroups

	Lifetime %	Past Year %
NJ High School Students	15	12
Grade		
9th/10th	13	10
11th/12th	17	14
Gender/Sex		
Male	13	10
Female	17	14
Race/Ethnicity		
White	17	15
African-American	8	5

Hispanic	14	10
Other	12	8.7

New Jersey Substance Abuse Monitoring System Data on Treatment Admissions



- Statewide annual increase between 2006-2011 = 99%
- Annual admissions for heroin & other opiates have nearly doubled from 2006 to 2011 (99.01%)
- Counties annual admissions increases split around state increase: 10 counties > 99%; 11 counties < 99%
- There was an increase of nearly 5,000 total annual admissions from '06-'11 (4976): 35% attributable to persons from Ocean and Monmouth Counties seeking treatment (1754)
- For most years, admissions for Ocean and Monmouth Counties combined have exceeded 25% of total state admissions
- One regional pattern: three (3) counties with highest increases are shore counties (Cape May, Ocean, Monmouth)

SAMHSA has identified eight (8) strategic initiatives to focus its resources on areas of urgency and opportunity. The initiatives also will enable SAMHSA to respond to national, state, territorial, tribal, and local trends and support implementation of the Affordable Care Act and the Mental Health Parity and Addictions Equity Act.

SAMHSA's Strategic Initiative #1: Prevention of Substance Abuse and Mental Illness

This entails creating communities where individuals, families, schools, faith-based organizations, and workplaces take action to promote emotional health and reduce the

likelihood of mental illness, substance abuse including tobacco, and suicide. This Initiative will include a focus on the Nation's high-risk youth, youth in Tribal communities, and military families.

The promotion of positive mental health and the prevention of substance abuse and mental illness have been key components of SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. The evidence base in this area continues to grow and was summarized by the 2009 Institute of Medicine (IOM) report, *Preventing Mental, Emotional, and Behavioral Disorders among Young People.* The Affordable Care Act places emphasis on prevention and promotion activities at the community, State, Territorial, and Tribal levels. By means of this Federal Initiative, SAMHSA is working to take advantage of the opportunities presented by the Affordable Care Act and the growing evidence base behind prevention to achieve the following goals:

Goal 1.1: With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.
Goal 1.2: Prevent or reduce consequences of underage drinking and adult problem drinking.
Goal 1.3: Prevent suicides and attempted suicides among populations at high risk, especially military families, LGBTQ youth, and American Indians and Alaska Natives.
Goal 1.4: Reduce prescription drug misuse and abuse.

Additionally, the "National Prevention and Health Promotion Strategy", which was introduced on June 16, 2011, includes actions that public and private partners can take to help Americans stay healthy and fit. It helps move the nation away from a health care system focused on sickness and disease to one focused on wellness and prevention. Two (2) of the seven (7) priority areas identified in the National Prevention and Health Promotion Strategy are of particular relevance to the goals this RFP seeks to achieve: 1) preventing drug abuse and excessive alcohol use and 2) mental and emotional well-being.

Effective January 1, 2015, all DHMAS-funded prevention providers will be required to employ a staff member who has earned the Certified Prevention Specialist (CPS) credential. Providers who do not meet this requirement on January 1, 2015 will have until December 31, 2016 to hire a staff person or provide CPS training for an existing staff member. Credentials or degrees that will be accepted in lieu of the CPS are the Certified Health Education Specialist (CHES), Masters in Public Health (MPH), or a Doctoral degree in the medical, health, or behavioral sciences. This requirement is described in the "Standards for Agencies Providing Substance Abuse Prevention Services for the DHS/DMHAS."

Community-Based Services Proposal Criteria

The narrative portion of the proposal should be single-spaced with one (1) inch margins, no smaller than 12 point Arial, Times New Roman or Courier font, and not exceed 20 pages in length, excluding budget detail and appendices. Appendices should be limited to no more than 200 pages. The narrative section of the proposal must address the following topics, and be submitted according to the following sections.

Bidder Organization
Describe the bidder's history and record of accomplishment in providing substance abuse prevention services within the specific domains identified by the county in the County Priorities Appendix. Include any information on how the agency has achieved desired outcomes in the past (i.e., an increase in protective factors and a reduction in risk factors within the domain). Include data to support these results. Attach an organizational chart and identify where the program will fit into the existing structure.

Needs and Resource Assessment
Bidders should identify data sources when responding to the questions below.

1. Which risk factors in the community are related to the prevention priority the bidder has chosen to address? Include social indicator data to demonstrate how prevalent these risk factors are.
2. How prevalent are these problems/issues among the population proposed to serve?
3. How important are these problems/issues to different sectors of the community (e.g., parents, youth, service providers, the faith community, policymakers, etc.)?
4. What factors in the community, families, or individuals protect people from these problems/issues?
5. Which resources already exist in the community to address the targeted problem, either through reducing risk factors or strengthening protective factors?

Bidders are directed to use the following processes in conducting their needs assessment related to the identified prevention priorities.

a. Consider the priorities according to:
    - Consequences and social costs in the bidder's county;
    - Consumption levels and prevalence of use; and
    - Causal factors (i.e., risk and protective factors) that predict population prevalence.

b. Also use the following criteria to further refine the selection of prevention priorities:
    - Substances most commonly used/abused that impact the greatest numbers residents in the bidder's county; and
    - Substances that lead to the most severe consequences for the greatest numbers of residents in the bidder's county.

Goals
Prepare and present a five (5) year goal statement that the program will adopt based on the Needs and Resource Assessment.

Goals should be identified for all services that the program participants will receive from the beginning until the end of the program. Goals are broad statements that describe the desired long-term impact of what the agency wants to accomplish. The organization's goal statement should be the driving force behind the prevention programming the agency intends to implement. It should be the touchstone against which everything done on the project is measured. A good project goal statement is SMART (Specific, Measurable, Agreed-upon, Realistic and Time-framed).

- *Specific* - The goal should state exactly what the organization plans to accomplish. It should be phrased using action words (such as "design," "build," "implement," etc.). It should be limited to those essential elements of the project that communicate the purpose of the project and the outcome expected.

- *Measurable* - If you can't measure it, you can't manage it. In the broadest sense, the whole goal statement is a measure for your project; if the goal is accomplished, the project is a success. However, there are usually several short-term or small measurements that can be built into the goal. Caution: Watch for words that can be misinterpreted such as improve, increase, and reduce (by how much?). If you must include them, be sure to include how they will be measured.

- *Agreed-upon* - Those individuals in the organization who control the resources necessary to complete the project need to agree that it is important. In addition, those who will be impacted by the project should agree that it needs to be done (and this is a key aspect of your needs assessment).

- *Realistic* - This is not a synonym for "easy." Realistic, in this case, means "doable." It means that the learning curve is not a vertical slope; that the skills needed to do the work are available; that the project fits with the overall strategy and goals of the organization. A realistic project may push the skills and knowledge of the people working on it but it shouldn't break them. This consideration related to the "capacity" of the bidder to undertake the project.

- *Time-framed* - Probably one of the easiest parts of the goal to establish the deadline. Very little is ever accomplished without a deadline. Building the deadline into the project goal keeps it in front of the team and lets the organization know when they can expect to see the results. The deadline can specify when the project or program will begin, when it will achieve certain milestones, and when it will end.

Objectives (Outcome Statements)
Describe the specific changes in attitude, knowledge and behavior of the program's participants or changes in the environment that will occur as a result of the program.

Objectives should be identified for all services that the program participants will receive from the beginning until the end of the program.

Objectives (Outcome Statements) are changes that occur as a result of specific programs. Typically, objectives are related to changes in the following.

- *Knowledge* - What people learn or know about a topic (e.g., warning signs of marijuana use, effective ways for setting limits with adolescents).

- *Attitudes* - How people feel toward a topic (e.g., attitudes toward substance abuse, merchants' attitudes toward selling alcohol to minors).

- *Behaviors* - Changes in behavior (e.g., reduced use of alcohol among middle school youth, increased frequency in "carding" underage youth attempting to buy cigarettes).

- *Skills* - The development of skills to prevent substance abuse (e.g., peer refusal skills, parental supervision skills).

In order to be quantified and measurable, objectives must include the following information:

- Who or what is to change?
- In what direction will the changes occur (increase/decrease)?
- How much change (percentage) is anticipated?
- What is the projected time frame for change to occur?

Methods

Methods describe the services to be conducted to achieve the desired objectives. Bidders are required to use multiple strategies in multiple settings to work toward a common goal.

Bidders must choose evidence-based programs from one (1) of the registries listed below. Identify reasons the selected curriculum is appropriate to the risk and protective factors that have been selected and the goals and objectives of the proposed program.

Describe how the bidder will incorporate all curriculum components in order to ensure program fidelity.

Provide a narrative depicting the services that individuals and/or families will receive when they participate in the program. The narrative should describe how participants will be identified and the frequency with which services will be provided. A description of ancillary services that will support education services (i.e., mentoring, recreational and cultural activities, and community service) should be also be provided.

Describe the setting(s) or location(s) used for program implementation (i.e., school, church, or housing site). Note: the same settings may be used for more than one (1) program/strategy.

Describe how the proposed program/strategy fits with other community prevention activities that address the needs of the population to be served.

Describe when each proposed prevention activity will begin and end, and the expected program achievements for each.

Describe how the organization will collaborate with and coordinate its efforts with those of the local DMHAS-funded Regional Coalition.

Awardees must utilize evidence-based programming. Bidders should select programs that target the risk and protective factors related to the priority they will be addressing. Programs must be listed on one (1) of the following registries:

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3. SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) – does not provide information regarding the risk and protective factors targeted by the program, so bidders will need to find that information elsewhere http://nrepp.samhsa.gov/.
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5. Effective Interventions (focused on HIV prevention, but includes numerous programs that concurrently focus on substance abuse prevention): http://www.effectiveinterventions.org/en/Home.aspx.

Staff and Administrative Support

Describe the staffing structure and enclose an organizational chart for the proposed program. Provide resumes of current staff and job descriptions, including credential requirements of future staff, and consultant agreements, where applicable. Please provide copies of staff CPS certificates or evidence of advanced degree and experience.

Describe other staff or consultants involved with the program and list their qualifications.

Budget Note: According to Budget criteria, staff working on this contract must spend a minimum of 60% of their time providing direct services.

Community Linkages
Describe how the bidder will provide or create access to services and resources that support the proposed program. Include copies of signed Memoranda of Agreement (MOAs) and contracts detailing how parties will work together to offer more comprehensive services. These should be included as an appendix to the proposal(s). (Signed MOAs **must** be included if the bidder is proposing to do a program with a particular school district or agency.)

Budget
Complete the DMHAS Application for Contract Funds in its entirety. This application should be included in Section A of the proposal(s). It will be distributed at the Mandatory Bidders Conference and can be located on the DMHAS website at http://www.state.nj.us/humanservices/das/information/contracts/DAS%20ContractApp.Jan10.doc.

Special Projects Contract Scope of Work

These funds are for special prevention projects or innovative programming delivered to underserved populations in New Jersey. These statewide contracts are intended to serve indicated individuals and groups in the State who are at an increased risk for substance abuse addiction relative to the general population, but who, because of the unique nature of their situation or circumstances, may not be identified through the county planning process described in Part 1- Community-Based Services.

For this reason, DMHAS has identified two (2) special projects through which these special populations may be better served through various other initiatives. A total of approximately $550,000 will be available to fund the Special Projects as identified. The minimum award will be $75,000. Contracts may be renewed on an annual basis for a maximum of five (5) years, contingent upon program performance and the availability of funds. All awards will be given on a competitive basis.

Effective January 1, 2015, all DHMAS-funded prevention providers will be required to employ a staff member who has earned the Certified Prevention Specialist (CPS) credential. Providers who do not meet this requirement on January 1, 2015 will have until December 31, 2016 to hire a staff person or provide CPS training for an existing staff member. Credentials or degrees that will be accepted in lieu of the CPS are the Certified Health Education Specialist (CHES), Masters in Public Health (MPH), or a Doctoral degree in the medical, health, or behavioral sciences. This requirement is described in the “Standards for Agencies Providing Substance Abuse Prevention Services for the DHS/DMHAS.”

DMHAS seeks proposals for services that are comprehensive and that employ prevention strategies that are evidence-based or that have been empirically demonstrated as effective in working with these specific groups. Background and rationale for offering these services is provided below.

1. Prevention Services for families of military personnel who are living or stationed in New Jersey (approximately $325,000)

The New Jersey Army National Guard is made up of over 9,000 Guardsmen and Guardswomen. In recent years, Americans have witnessed the greatest number of females being deployed both to combat zones and /or various military bases across the country. With some of the most active military bases (Joint Base McGuire – Dix-Lakehurst, Fort Monmouth, Naval Weapons Station Earle and Picatinny Arsenal) in the country, and a significant number of military Reserve and National Guard units, New Jersey continues to play a vital role in the country's military mission.

MILITARY LIFESTYLE

Stress can be more severe for both military personnel and their families when certain risk factors exist. Families with a history of problems, young families experiencing their first military separation or families who recently moved to a new duty station are more vulnerable to the stresses of deployment. Additionally, families with foreign-born spouses, service members without a unit affiliation or those serving in the National Guard or Reserves are more likely to experience higher stress levels.

Overall, 44% of Department of Defense military personnel have children in 2011, compared to 40% in 2000. Of the 1,985,471 total military children in 2011, the largest percentage are between birth and 5 years of age (37%), followed by 6 to 11 years of age (30%), and 12 to 18 years of age (25%). Fewer children are between 19 and 22 years of age (7%).

Moving frequently as service members are transferred is a common feature of military life. A survey of military teens showed they had moved five times on average. Moving also may be prompted by a military member's deployment. Military operations in recent years have increased the numbers of deployments, relocations, and family separations. Mobilization and deployment of National Guard and Reserve members have increased the number of affected families.

Moving means that families experience disruption and may not be able to establish deeply rooted support systems. Families of National Guard members and Reservists often live in communities without base-connected services and support systems. Support systems for military families also may be weakened by living far from extended families.

For children, the stress of moving includes leaving friends, schools, and activities and readjusting at the new location. Especially for adolescents, such transitions intensify the normal pressures of youth such as physical changes, search for identity and independence, and evolving peer and parental relationships.

The multiple moves that children in many military families go through can bring about an adjustment disorder—a severe emotional reaction to a difficult event in one's life.

Moving also may lead to academic problems due to loss of continuity of education as well as family and social disruption. Children who attend schools that serve military families also may experience academic and social problems even when their families do not move.

Moving to new communities also is likely to interrupt children's connection to their schools as ties to teachers, activities, and school culture are cut. Because the degree of school bonding makes youth more or less likely to engage in substance abuse, youth in military families who become less connected to school as a result of moving are at increased risk for substance abuse.

A CULTURE OF ALCOHOL USE

Norms, or group standards, that condone substance abuse and other problem behaviors make it more likely that people will engage in them. Young people who live on or near military bases may be at increased risk of underage drinking in view of a military culture that is favorable to alcohol use. Rates of both heavy drinking and binge drinking among young adults in the military are higher than among civilian young adults, including full-time college students aged 18 to 22, the group with the highest rates in the general population. Military personnel often use alcohol to cope with stress, boredom, loneliness, and the lack of other recreational activities.

The alcohol culture in military life is supported by ease of access that includes low prices in base stores, frequent barracks parties, drink promotions in bars near bases, and multiple opportunities for underage drinking with friends both in and outside the armed services.

While youth in military families may not participate in the same social activities as service members or gain access to alcohol through the same channels, these young people are exposed to a climate accepting of alcohol use. Youth whose parents use alcohol and view drinking favorably tend to drink more.

DEPLOYMENT

A parent's deployment often brings heightened stress for military families. This stress begins when a service member is notified of a pending deployment and extends through a lengthy period after he or she returns. In the pre-deployment phase, children experience stress in anticipation of the parent's absence, with young children prone to confusion about why the parent is leaving and what will happen as a result. Children's stress tends to increase as they sense the strain their parents go through in preparing for separation.

In addition to new routines and responsibilities for both children and parents, deployment may involve relocation. A study of military members and service providers found that remaining parents often moved to be near extended family. While moving isolated military members' spouses from many forms of assistance, the spouses faced

reduced resources during deployment if they stayed. Limited availability and accessibility of programs for children complicated their supervision during deployment.

Youth may cope with emotional distress by engaging in high-risk behaviors. Youth who become emotionally distressed as a result of a parent's military deployment are at increased risk for substance abuse. Adolescents also may react to emotional distress with misdirected anger such as acting out and intentionally hurting or cutting themselves; school problems, especially sudden or unusual changes; signs of apathy such as loss of interest, non-communication, and denial of feelings; significant weight loss; regressive behavior; and friends becoming more important.

In addition, children fare better when a parent provides a consistent environment. The importance of consistency was illustrated in research with adolescents who said the "worst thing about deployment" was the disruption in routine, everyday life. Such disruption may lead to family management problems that are risk factors for substance abuse and other adolescent problem behaviors.

AFTER DEPLOYMENT

The reunification phase can be stressful for children, as returning parents may be ready to pick up family life where they left off. However, these expectations may not be realistic in view of the changes that children have undergone in the parents' absence. Adolescents may be defiant and disappointed if the returning parent does not acknowledge their contributions during the deployment. Old conflicts with the returning parent may resurface. Family management issues also may present new problems as parents and children renegotiate their roles.

Reunion is likely to be harder for children when a parent returns with physical or psychological problems. One (1) out of every ten (10) veterans alive today was seriously injured at some point while serving in the military, and three-quarters of those injuries occurred in combat. For many of these 2.2 million wounded warriors, the physical and emotional consequences of their wounds have endured long after they left the military, according to a Pew Research Center survey of a nationally representative sample of 1,853 veterans conducted from July 18 to Sept. 4, 2011.

Veterans who suffered major service-related injuries are more than twice as likely as their more fortunate comrades to say they had difficulties readjusting to civilian life. They are almost three (3) times as likely as other veterans to report they have suffered from post-traumatic stress disorder (PTSD). They are also less likely in later life to be in overall good health or to hold full-time jobs. Stress-related mental health problems and the challenges they bring to family life often emerge during the months after a service member returns home. In fact, a study by the RAND Corporation, a private, non-partisan research institute, concluded that as many as 300,000 service members - or nearly one-fifth of the 1.6 million troops who have served in Iraq and Afghanistan - suffer from depression or PTSD, and 50 percent of those with PTSD do not seek treatment.

Children whose parents have mental health problems may have an increased risk of social, emotional, or behavior problems. Children who have a parent with a mental illness also may be at risk for substance abuse. In addition, the post deployment phase may not be final, since units are being deployed repeatedly into combat situations. Since the U.S. went to war in Afghanistan in 2001 and Iraq in 2003, about 2.5 million members of the Army, Navy, Marines, Air Force, Coast Guard and related Reserve and National Guard units have been deployed in the Afghanistan and Iraq wars, according to Department of Defense data. Of those, more than one-third were deployed more than once. In fact, as of 2013 nearly 37,000 Americans had been deployed more than five (5) times, among them 10,000 members of National Guard or Reserve units. Records also show that 400,000 service members have done three (3) or more deployments.

Youth may have severe reactions if deployment results in a parent's death or trauma. The post deployment phase raises the possibility of an increased risk of child abuse. Research indicates that families with service members who experience combat-related stress after their return may be at risk for increased violence against children. In addition to deployment-related issues, common features of military life—such as occupational stress, frequent separations, geographic isolation, and young families living apart from social supports—are risk factors for child abuse. To the extent that child abuse occurs in military families, these children are at increased risk for substance abuse and other risky behaviors, health problems, and negative social consequences.

SUMMARY

Children in military families often are subject to stressful conditions stemming from difficult transitions. The frequent moving characteristic of military life disrupts children's school and social lives while a parent's deployment disrupts family life. In addition to the direct effects of these events, children are affected by their parents' circumstances and ability to cope. The various stressors that arise from these transitions increase children's risk for emotional distress, substance abuse, and other risky behavior. In addition, a culture favorable to alcohol use and abuse puts children in military families and communities at increased risk for underage drinking. While children of service members are resilient, the stressors they face call for a variety of supports for them, their parents, and their communities.

DMHAS is committed to serving military families with prevention education, addressing military community risk levels, striving to mitigate the risk factors, and enhancing the protective factors to support military members and their families in making responsible parenting and individual choices in regards to drug and alcohol use.

2. Prevention Services for Minority Gay/Lesbian/Bisexual/Transgendered or Questioning (GLBTQ) Youth (aged 12-24) in New Jersey (approximately $225,000)

The odds of substance use for gay, lesbian bisexual, transgendered or questioning (GLBTQ) youth are on average 190% higher than for heterosexual youth, according to a

study by University of Pittsburgh researchers published in the March 2008 issue of *Addiction.* What's more, for some sub-populations of GLBTQ youth, the odds were substantially higher.

As members of more than one minority group, GLBTQ youth of color face special challenges in a society which often presents heterosexuality as the only acceptable sexual orientation and in which nonwhites have disproportionately higher rates of negative sexual outcomes. Economic and cultural disparities, as well as sexual risk taking and other risk-taking behavior, make these youth vulnerable to HIV, pregnancy, and sexual violence.

GLBTQ youth of color often face challenges in a homophobic society. After coming out to their family or being discovered, many GLBTQ youth are thrown out of their home, mistreated, or made the focus of their family's dysfunction. Youth of color are significantly less likely to have told their parents they are GLBTQ. One study (Consolacion, 2004) found that while about 80 percent of GLBTQ whites were out to parents, only 71% of Latinos, 61 percent of African Americans, and 51% of Asians and Pacific Islanders (APIs) were out to parents. One study found that African American same-sex attracted youth were more likely to have low self-esteem and experience suicidal thoughts than their counterparts of other ethnicities. African American same-sex attracted young men were also more likely to be depressed. In a large survey of attendees of Black Pride events, over half reported that their church or religion viewed homosexuality as “wrong and sinful.” In many Latino communities, machismo and religion contribute to homophobic attitudes that hamper efforts to reach Latino gay and bisexual youth with HIV prevention information. Asian American and Pacific Islander GLBTQ youth often feel that they have shamed their families when they diverge from cultural expectations to marry and have children. GLBTQ youth of color report feeling pressure to choose between their ethnic and their sexual identities; these youth are less likely to be involved in gay social and cultural activities than their white counterparts.

There is a paucity of medical literature on minority transsexuals, including transsexuals from other countries. Most of the literature deals with Anglo, white, and European-American transsexuals (Winter, 2002). The scant literature that does exist regarding transsexual minorities generally comes from the social sciences (e.g., Green, 1999; Prieur, 1998). There is emerging new literature dealing specifically with male-to-female adolescents, mainly from San Francisco. This population is generally urban, very poor, with high rates of substance abuse and psychiatric disorders, frequent histories of physical and sexual abuse, and at high risk for HIV infection. In popular culture, and in the sex trade industry, they would be identified as “she-males,” although this is not a term the youths use among themselves.

In San Francisco, Garofalo et al. (2006) reported on a population of 51 male-to-female transgender teenagers and transitional-age youth (ages 16–25), a high percentage of them African-American (AA). They found high rates of incarceration, homelessness, unemployment, and poor access to health care. African-American transgender youth had the highest HIV infection rates of all the ethnic groups. Many of these transgender

youth engage in sex work, as is suggested by all of the she-male pornography and "escort" service sites found on the Internet. These youth often encounter situations of forced sex, unsafe sex, and substance abuse. There is also a lot of self-injection of hormones that are purchased on the street, as well as self-injection of silicone for breast, hip, and buttock enlargement. In a meta-analysis of HIV prevalence and risk behaviors of transgender people, Herbst et al. (2008) confirmed the particularly high rates of HIV infection among African-American transgendered youth. This study also looked at contextual factors for the high risk sex behaviors, unprotected sex, and sex work and found high rates of depression, anxiety, histories of physical and sexual abuse, and poverty in this population. Many of these individuals need to engage in unsafe sex work to make money. In a qualitative study of minority transgender girls in San Francisco, Nemoto et al. (2004) found that these subjects reported engaging in unprotected sex in order to feel closer to their partners, to not distance them, to feel more female, or simply because they needed the money. Nemoto et al. also found high rates of drug use in these transgender girls, which helped them cope with their difficult lives on the streets engaging in sex work.

New Jersey participated in the recent National Youth Advocacy Coalition's "Lesbian, Gay, Bisexual Transgender and Questioning Youth National Health Survey" for individuals between 13 and 24 years of age. Results of the survey indicate that the majority of survey respondents have used alcohol (53%) and a large percentage of participants have used tobacco (42%) and marijuana (43%). Nine (9) percent of the youth have used crystal meth in the past 12 months and nine (9) percent have used cocaine/crack in the same time period. Seven percent indicated having used Ecstasy. Two (2) percent report having used heroin/morphine and two percent report having used PCP. Three (3) percent indicated using other drugs including soma, mushrooms, special K and speed during this time period. Participants reported that in the six (6) months prior to completing the survey they had sex with someone under the influence of drugs/alcohol (21%); with someone who injects drugs (1%); and/or while under the influence of drugs/alcohol (30%). Seven (7) percent of respondents have been hospitalized or received treatment because of alcohol or drug use and one percent report being denied substance abuse treatment because of their identity.

In a meta-analysis of 18 previous studies from 1994 to 2006, which tested the association between sexual orientation and teen substance use, the University of Pittsburgh researchers found that gay youth reported higher rates of cigarette, alcohol and marijuana use, as well as other illicit drugs, including cocaine, methamphetamines and injection drugs. The authors conducted a systematic review of the prevention and intervention guidelines published by the American Medical Association, the National Institute on Drug Abuse, the National Institute on Alcohol and Alcoholism and the Institute of Medicine. They found that none of the institutions mentioned sexual orientation as a potential risk factor for substance use in teens, and did not provide information for researchers and health care professionals on how to prevent such problems. DMHAS seeks to address this oversight.

- There is an estimated 2.7 million school age GLBT youth in the U.S.

- GLBTQ youth are more likely than their heterosexual peers to experience depression, attempt suicide, be harassed at school and in the community, experience verbal and physical violence, abuse substances, drop out of school and become homeless.
- 31% of LBGTQ youth report skipping school each month because of fear of their own safety. This rate is 4.5 times higher than peers.
- 28% of LGBTQ youth drop out of school because of peer harassment. This percentage is three times the national average.
- 84% of GLBTQ youth report being verbally harassed at school.
- Over 39% of all gay, lesbian and bisexual youth report being punched kicked or injured with a weapon at school because of their sexual orientation.
- Between 20-40% of homeless youth are GLBTQ.
- 26% of GLBT youth who “come out” to their families are thrown out of their homes because of conflicts with moral and religious values.
- 78% of GLBTQ youth in foster care are removed or run away from their foster placements as a result of hostility toward their sexual orientation.
- 33% of GLBTQ high school students attempted suicide in the previous year, compared to 8% of their heterosexual peers.
- GLBTQ youth of color often do not identify as ‘gay,’ which may mean they will not seek services or hear message designed for the White GLBTQ community.

Bidders are encouraged to use multiple strategies in multiple settings to work toward a common goal. Bidders may refer to the end of this document for the “Standards for Agencies Providing Substance Abuse Prevention Services for DHS/DMHAS” for complete definitions of the Center for Substance Abuse Prevention (CSAP) strategies.

Special Projects Proposal Criteria

The narrative portion of the proposal should be single-spaced with one (1) inch margins, no smaller than 12 point Arial, Times New Roman or Courier font, and not exceed 20 pages in length, excluding budget detail and appendices. Appendices should be limited to no more than 200 pages. The narrative section of the proposal must address the following topics, and be submitted according to the following sections:

Bidder Organization

Describe the bidder’s history and record of accomplishment in providing substance abuse prevention services to the special population (s) identified for this project. Include any information on how the agency has achieved desired outcomes in the past (i.e., an increase in protective factors and a reduction in risk factors within the target population). Attach an organizational chart and identify where the program will fit into the existing structure.

Needs and Resources Assessment

Bidders should identify data sources when responding to the questions below.

1. Which risk factors in the community are related to the prevention priority the bidder has chosen to address? Include social indicator data to demonstrate how prevalent these risk factors are.
2. How prevalent are these problems/issues among the population proposed to serve?
3. How important are these problems/issues to different sectors of the community (e.g., parents, youth, service providers, the faith community, policymakers, etc.)?
4. What factors in the community, families, or individuals protect people from these problems/issues?
5. Which resources already exist in the community to address the targeted problem, either through reducing risk factors or strengthening protective factors?

Bidders are directed to use the following processes in conducting their needs assessment related to the identified prevention priorities.

Consider the priorities according to:

- Consequences and social costs specific to the special population you will serve;
- Consumption levels and prevalence of use within this population; and
- Causal factors (i.e., risk and protective factors) that predict population prevalence.

Also use the following criteria to further refine the selection of prevention priorities:

- Substances most commonly used/abused that impact the greatest numbers in the population to be served; and
- Substances that lead to the most severe consequences for the greatest numbers in the population to be served.

Goals

Prepare and present a five (5) year goal statement that the program will adopt based on the Needs and Resource Assessment.

Goals should be identified for all services that the program participants will receive from the beginning until the end of the program. Goals are broad statements that describe the desired long-term impact of what the agency wants to accomplish. The organization's goal statement should be the driving force behind the prevention programming the agency intends to implement. It should be the touchstone against which everything done on the project is measured. A good project goal statement is SMART (Specific, Measurable, Agreed-upon, Realistic and Time-framed).

- *Specific* - The goal should state exactly what the organization plans to accomplish. It should be phrased using action words (such as "design," "build," "implement," etc.). It should be limited to those essential elements of the project that communicate the purpose of the project and the outcome expected.

- *Measurable* - If you can't measure it, you can't manage it. In the broadest sense, the whole goal statement is a measure for your project; if the goal is accomplished, the project is a success. However, there are usually several short-term or small measurements that can be built into the goal. Caution: Watch for words that can be misinterpreted such as improve, increase, and reduce (by how much?). If you must include them, be sure to include how they will be measured.

- *Agreed-upon* - Those individuals in the organization who control the resources necessary to complete the project need to agree that it is important. In addition, those who will be impacted by the project should agree that it needs to be done (and this is a key aspect of your needs assessment).

- *Realistic* - This is not a synonym for "easy." Realistic, in this case, means “doable.” It means that the learning curve is not a vertical slope; that the skills needed to do the work are available; that the project fits with the overall strategy and goals of the organization. A realistic project may push the skills and knowledge of the people working on it but it shouldn't break them. This consideration related to the “capacity” of the bidder to undertake the project.

- *Time-framed* - Probably one of the easiest parts of the goal to establish the deadline. Very little is ever accomplished without a deadline. Building the deadline into the project goal keeps it in front of the team and lets the organization know when they can expect to see the results. The deadline can specify when the project or program will begin, when it will achieve certain milestones, and when it will end.

Objectives (Outcome Statements)
Describe the specific changes in attitude, knowledge and behavior of the program’s participants or changes in the environment that will occur as a result of the program. Objectives should be identified for all services that the program participants will receive from the beginning until the end of the program.

Objectives (Outcome Statements) are changes that occur as a result of specific programs. Typically, objectives are related to changes in the following.

- *Knowledge* - What people learn or know about a topic (e.g., warning signs of marijuana use, effective ways for setting limits with adolescents).

- *Attitudes* - How people feel toward a topic (e.g., attitudes toward substance abuse, merchants’ attitudes toward selling alcohol to minors).

- *Behaviors* - Changes in behavior (e.g., reduced use of alcohol among middle school youth, increased frequency in “carding” underage youth attempting to buy cigarettes).

- *Skills* - The development of skills to prevent substance abuse (e.g., peer refusal skills, parental supervision skills).

In order to be quantified and measurable, objectives must include the following information:

- Who or what is to change?
- In what direction will the changes occur (increase/decrease)?
- How much change (percentage) is anticipated?
- What is the projected time frame for change to occur?

Methods
Methods describe the services to be conducted to achieve the desired objectives. Bidders are required to use multiple strategies in multiple settings to work toward a common goal.

Bidders must choose evidence-based programs from one (1) of the registries listed below. Identify reasons the selected curriculum is appropriate to the risk and protective factors that have been selected and the goals and objectives of the proposed program.

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Provide a narrative depicting the services that individuals and/or families will receive when they participate in the program. The narrative should describe how participants will be identified and the frequency with which services will be provided. A description of ancillary services that will support education services (i.e., mentoring, recreational and cultural activities, and community service) should be also be provided.

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Describe how the proposed program/strategy fits with other community prevention activities that address the needs of the population to be served.

Describe when each proposed prevention activity will begin and end, and the expected program achievements for each.

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Staff and Administrative Support

Describe the staffing structure and enclose an organizational chart for the proposed program. Provide resumes of current staff and job descriptions, including credential requirements of future staff, and consultant agreements, where applicable. Please provide copies of staff CPS certificates or evidence of advanced degree and experience.

Describe other staff or consultants involved with the program and list their qualifications.

If the bidder will provide early intervention services, provide documentation to demonstrate that staff has appropriate training.

Budget Note: According to Budget criteria, staff working on this contract must spend a minimum of 60% of their time providing direct services.

Community Linkages

Describe how the bidder will provide or create access to services and resources that support the proposed program. Include copies of signed Memoranda of Agreement (MOAs) and contracts detailing how parties will work together to offer more comprehensive services. These should be included as an appendix to the proposal(s). (Signed MOAs **must** be included if the bidder is proposing to do a program with a particular school district or agency.)

Budget

Complete the DMHAS Application for Contract Funds in its entirety. This application should be included in Section A of your proposal(s). It will be distributed at the Mandatory Bidders Conference and can be located on the DMHAS website at http://www.state.nj.us/humanservices/das/information/contracts/DAS%20ContractApp.Jan10.doc.

General Contracting Information

All bidders will be notified in writing of the State's intent to award a contract. All proposals are considered public information and as such will be made available upon request after the completion of the RFP process.

Preliminary awards will be announced on December 1, 2014 with a scheduled contract start date of January 1, 2015. Expenses incurred by successful bidders during the transition period after selection, but prior to the effective date of the contract, will not be reimbursed.

A contract awarded as a result of this RFP may be annually renewable at DMHAS' sole discretion with the agreement of the awardee. Funds may only be used to support services that are specific to this award; hence, this funding may not be used to supplant or duplicate existing funding streams. Actual funding levels will depend on the availability of funds, satisfactory performance, as well as compliance and completion of all required/requested reports.

Contract commitment will be negotiated based upon representations made in response to the RFP. Failure to deliver commitments may result in termination of the contract.

Operating expenses for services will be awarded with sufficient time to implement service provision. Should service provision be delayed, through no fault of the provider, funding continuation will be considered on a case-by-case basis based upon the circumstances creating the delay. In no case shall the Division be required to continue funding when service commencement commitments are not met and in no case shall funding be provided for a period of non-service provision in excess of three (3) months. Should services not be rendered, funds provided pursuant to this agreement shall be returned to the Division.

Awardees are expected to adhere to all applicable state and federal cost principles. Budgets should be reasonable and reflect the scope of responsibilities in order to accomplish the goals of this project.

Awardees must uphold all programmatic standards outlined in the "Standards for Agencies Providing Substance Abuse Prevention Services for DHS/DMHAS," attached to the RFP. These standards are intended to ensure that prevention programs funded by DMHAS achieve their desired outcomes. A site visit may be conducted to bidders before a contract is awarded. The site visit will determine the applicant's capacity to maintain these standards.

Projects awarded pursuant to this RFP will be separately clustered until the DMHAS determines, in its sole discretion, that the program is stable in terms of service provision, expenditures, and applicable revenue generation. All proposal and expenditure data pertaining to these contract funds must be independent of any other DMHAS or non-DMHAS funded program of the bidder/awardee.

Mandatory Bidders Conference

A bidder intending to submit a proposal in response to this RFP must attend a Mandatory Bidders Conference. A proposal submitted by a bidder not in attendance will not be considered. The Mandatory Bidders Conference will be held as follows:

Date:	October 10, 2014
Time:	1:00 – 4:00 pm
Location:	Hamilton Technology Center 1200 Negron Drive Hamilton, NJ 08691

The Mandatory Bidders Conference will provide the bidder with an opportunity to ask questions about the RFP requirements or the award process, as well as clarify any changes that may be made to this RFP. This ensures that all potential bidders have equal access to information. Questions regarding intent or allowable responses to the RFP, outside the Mandatory Bidders Conference, are not permitted. Any necessary response to questions posed by a potential bidder during the Mandatory Bidders Conference that cannot be answered at that time will be furnished via electronic mail to all potential bidders registered as being in attendance. Specific individual guidance will not be provided to individual bidders at any time.

The meeting room and facility is accessible to individuals with physical disabilities. Anyone who requires special accommodations should notify Helen.Staton@dhs.state.nj.us or call 609-633-8781. For sign language interpretation, please notify Helen Staton as soon as possible. Once reserved, a minimum of 48 hours is necessary to cancel this service, or else the cost will be billed to the requestor.

Potential bidders to this RFP are requested to register for the Mandatory Bidders Conference by registering online at https://njsams.rutgers.edu/training/sssp/register.aspx.

Due to space limitations, only one person from each agency may register to attend the Mandatory Bidders Conference. You may contact Helen Staton at Helen.Staton@dhs.state.nj.us or 609-633-8781 if you have difficulties accessing the web-based registration. Directions to the venue can be found in an Attachment to the RFP.

Submission of Proposals

DMHAS assumes no responsibility and bears no liability for costs incurred by the bidder in the preparation and submittal of a proposal in response to this RFP.

Bidders may apply for one (1) or both funding opportunities outlined in this two (2) part RFP. However, separate proposals are required for each contract opportunity. If the

bidder proposes to provide community-based services in more than one (1) county, a separate proposal for each county must be submitted.

Proposals must be received by 5:00 p.m. on October 30, 2014 and include one signed original and five (5) copies. Faxed or electronic proposals, as well as those received after the deadline, will not be reviewed. Send the signed original and five (5) copies of your proposal(s) to:

For United States Postal Service, please address to:
Helen Staton
Division of Mental Health and Addiction Services
New Jersey Department of Human Services
PO Box 700
Trenton, NJ 08625
609-633-8781

For FedEx, UPS, other courier service or hand delivery, please address to:
Helen Staton
Division of Mental Health and Addiction Services
New Jersey Department of Human Services
222 South Warren Street, 4th floor
Trenton, NJ 08608
609-633-8781

Please note that if you send your proposal package through United States Postal Service two-day priority mail delivery to the P.O. Box, your package may not arrive in two (2) days. In order to meet the deadline, please send your package earlier than two (2) days before the deadline or use a private carrier's overnight delivery to the street address.

You will NOT be notified that your package has been received. If you require a phone number for delivery, you may use 609-633-8781.

Bidders shall submit their proposal(s) organized in the following manner and include all components as listed:

Section A

a) Funding Proposal Cover Sheet (See Attachment)
b) Abstract that provides a one page summary of the program described in the proposal including the overall funding request
c) Narrative in response to the Proposal Criteria applicable to the specific funding opportunity (community-based services versus special projects)
d) Project budget utilizing the Application for Contract Funds found online at http://www.state.nj.us/humanservices/das/information/contracts/DAS%20ContractApp.Jan10.doc.

Section B - Appendices (should be limited to no more than 200 pages)
Organization Information

a) Mission statement;
b) Organizational chart;
c) Job descriptions of key personnel, limited to 2 pages each;
d) Resumes of key personnel if on staff, limited to 2 pages each;
e) Current salary ranges, if not included in the job descriptions;
f) Letters of Support;
g) List of agencies for referral and affiliation agreements;
h) Affirmative Action Certificate of Employee Information Report and /or newly completed AA 302 form;
i) Department of Human Services Statement of Assurances (See Attachment)
j) Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions (See Attachment); and
k) Documentation of organization's prior disciplinary action, if any.

Organization Policies

a) Organization code of ethics and/or conflict of interest policy;
b) Co-occurring policies and procedures;
c) Policies regarding the use of medications; and
d) Policies regarding Recovery Support, specifically peer support services.

Fiscal Documentation

a) List all current contracts and grants as well as those for which the college/university has applied for from any Federal, State, local government or a private agency during the proposed contract term, including awarding agency name, amount, period of performance, and purpose of the contract/grant, as well as a contact name for each award and the phone number;
b) List of the names and addresses of those entities providing support and/or money to help fund the program for which the proposal is being made, including the funding amount;
c) Source Disclosure Certification Form;
d) Disclosure of Investment in Iran (see attachment); and
e) If there are any audits pending or in progress, list the firm completing this audit(s), contact name and telephone number.

The documents listed below are required to be included with the proposal(s), **unless the bidder has a current contract with DMHAS and these documents are already on file with DMHAS.**

a) Copy of a certificate of incorporation;
b) Copy of business registration;
c) Evidence of the bidder's nonprofit status under federal IRS regulations;
d) Copy of the Annual Report-Charitable Organization (for information visit: http://www.state.nj.us/treasury/revenue/dcr/programs/ann_rpt.shtml);
e) Most recent single audit report (A133) or certified statements (submit only two copies);

f) Any other audits performed in the last two years (submit only two (2) copies);and
g) Most recent IRS Form 990/IRS Form 1120, and Pension Form 5500 (if applicable) (submit only two (2) copies)

Review of Proposals

Proposals received after the due date and time will not be accepted by DMHAS and will not be evaluated. There will be a review process for all timely submitted proposals which meet all the requirements outlined in this RFP.

DMHAS will convene a review committee consisting of state employees who will conduct a review of each proposal accepted for review. All potential reviewers will complete conflict of interest forms. Those with conflicts or the appearance of conflicts will be disqualified from participating in the review.

Award decisions will be based on such factors as the scope and quality of the proposal and appropriateness and reasonableness of the budget. The review committee will look for evidence of cultural competence in each section of the narrative. The review committee may choose to visit any bidders' existing program(s) and/or review any programmatic or fiscal documents in the possession of DMHAS. Any disciplinary action in the past must be revealed and fully explained. Bidders are advised that awards may be made conditional upon changes suggested by the review committee and/or DMHAS staff. The requested changes, along with their requested implementation dates, will be communicated to the prospective awardees prior to final award.

The Division reserves the right to reject all proposals when circumstances indicate that it is in its best interest to do so. The Division's best interests in this context include, but are not limited to, loss of funding, inability of the bidder(s) to provide adequate services, and indication of misrepresentation of information and/or non-compliance with State and federal laws and regulations, existing Department Contracts, and procedures set forth in DHS CPIM Policy Circular P1.04.

DMHAS will notify all bidders of awards, contingent upon the satisfactory final negotiation of a contract, by December 1, 2014.

Appeal of Award Decisions

An appeal of any determination may be made only by the respondents of this proposal. Appeals must be made in in writing and must be received by DMHAS at the address below no later than 5:00 p.m. on December 8, 2014. The written request must clearly set forth the basis for the appeal. Appeal correspondence should be addressed to:

Lynn Kovich, Assistant Commissioner
Division of Mental Health and Addiction Services
222 South Warren Street, PO Box 700

Trenton, New Jersey 08625-0700

Please note that all costs incurred in connection with any appeals of DMHAS decisions are considered unallowable costs for purposes of DMHAS contract funding. The DMHAS will review any appeals and render final funding decisions by December 15, 2014. Awards will not be considered final until all timely appeals have been reviewed and final decisions rendered.

Post Award Requirements

DOCUMENTATION

Upon award announcement, the successful bidder must submit one (1) copy of the following documentation (if not already submitted with the application) in order to process the contract in a timely manner:

1. Proof of insurance naming the State of New Jersey, Department of Human Services, Division of Mental Health and Addiction Services, PO Box 700, Trenton, NJ 08625-0700 as an additional insured;
2. Board Resolution authorizing who is approved for entering into a contract and signing related contract documents;
3. Department of Human Services Standard Language Document;
4. Current Agency By-laws;
5. Current Personnel Manual or Employee Handbook;
6. Copy of Lease or Mortgage;
7. Certificate of Incorporation;
8. Conflict of Interest Policy;
9. Affirmative Action Policy;
10. Affirmative Action Certificate of Employee Information Report and/or newly completed AA 302 form (AA Certificate must be submitted within 60 days of submitting completed AA302 form to Office of Contract Compliance);
11. A copy of all applicable licenses;
12. Local Certificates of Occupancy;
13. Most recent State of New Jersey Business Registration;
14. Procurement Policy;
15. Current Equipment inventory of items purchased with DHS funds (Note: the inventory shall include: a description of the item, a State identifying number or code, original date of purchase, date of receipt, location at the Provider Agency, person(s) assigned to the equipment, etc..);
16. All Subcontracts or Consultant Agreements, related to the DHS Contracts, signed and dated by both parties;
17. Business Associate Agreement (BAA) for Health Insurance Portability Accountability Act of 1996 compliance, if applicable, signed and dated;
18. Updated single audit report (A133) or certified statements, if differs from one submitted with application;
19. Updated IRS Form 990, if differs from one submitted with application;
20. Updated Pension Form 5500, if applicable, if differs from one submitted with

application;
21. Copy of Annual Report;
22. N.J.S.A. 52:34-13-2 Source Disclosure Certification (replaces Executive Order 129); and
23. Disclosure of Investment in Iran.

AWARD REQUIREMENTS
Awardees must adhere to the following:

1. Enter into a contract with DMHAS and comply with applicable DHS and DMHAS contracting rules and regulations;
2. Comply with all applicable State and Federal assurances, certifications and regulations regarding the use of these funds;
3. Inform the Program Management Officer of any publications/publicity based on the award;
4. Comply with all appropriate State licensure regulations; and
5. Comply with the Americans with Disabilities Act requirements.

OTHER INFORMATION
1. DMHAS may provide post contract support to awardee through technical assistance; and
2. DMHAS Program Management Officers will conduct site visits to monitor the progress in accomplishing responsibilities and corresponding strategy for overcoming these problems. An awardee's failure to comply with reporting requirements may result in loss of the contract. The awardee will receive a written report of the site visit findings and will be expected to submit a plan of correction if necessary.

Attachments

Attachment A - County Funding Amounts

1. Reduce underage drinking
2. Reduce the use of illegal substances
3. Reduce prescription medication misuse across the lifespan

COUNTY	PRIORITY	FUNDING AMOUNT
Atlantic		
	Underage Drinking	$122,200
	Illegal Substances	$122.200
	TOTAL	**$244,400**
Bergen		
	Underage Drinking	$137,000
	Prescription Drugs	$112,000
	Illegal Substances	$104,600
	TOTAL	**$353,600**
Burlington		
	Underage Drinking	$116,000
	Illegal Substances	$128,000
	TOTAL	**$244,400**
Camden		
	Underage Drinking	$153,000
	Illegal Substances	$119,000
	Prescription Drugs	$92,000
	TOTAL	**$364,000**
Cape May		
	Underage Drinking	$106,000
	Prescription Drugs	$126,740
	TOTAL	**$232,740**
Cumberland		
	Underage Drinking	$100,000
	Illegal Substances	$118,400
	TOTAL	**$218,400**
Essex		
	Underage Drinking	$86,000
	Prescription Drugs	$159,000
	Illegal Substances	$145,000
	TOTAL	**$390,000**
Gloucester		
	Underage Drinking	$78,000
	Illegal Substances	$130,000
	TOTAL	**$208,000**
Hudson		
	Underage Drinking	$93,000

	Prescription Drugs	$101,000
	Illegal Substances	$81,600
	TOTAL	**$275,600**
Hunterdon		
	Underage Drinking	$65,000
	Prescription Drugs	$49,400
	TOTAL	**$114,400**
Mercer		
	Underage Drinking	$93,000
	Illegal Substances	$111,700
	Prescription Drugs	$102,100
	TOTAL	**$306,800**
Middlesex		
	Underage Drinking	$91,500
	Illegal Substances	$112,900
	Prescription Drugs	$101,880
	TOTAL	**$306,280**
Monmouth		
	Underage Drinking	$91,500
	Illegal Substances	$101,880
	Prescription Drugs	$112,900
	TOTAL	**$306,280**
Morris		
	Underage Drinking	$87,000
	Prescription Drugs	$121,000
	TOTAL	**$208,000**
Ocean		
	Underage Drinking	$82,000
	Illegal Substances	$135,000
	Prescription Drugs	$119,600
	TOTAL	**$336,600**
Passaic		
	Underage Drinking	$100,000
	Illegal Substances	$101,000
	Prescription Drugs	$100,300
	TOTAL	**$301,300**
Salem		
	Underage Drinking	$57,000
	Illegal Substances	$59,000
	TOTAL	**$116,000**
Somerset		
	Underage Drinking	$85,000
	Illegal Substances	$83,300
	TOTAL	**$168,300**
Sussex		

	Underage Drinking	$52,000
	Prescription Drugs	$73,700
	TOTAL	**$125,700**
Union		
	Underage Drinking	$121,000
	Illegal Substances	$115,500
	TOTAL	**$236,500**
Warren		
	Underage Drinking	$60,000
	Prescription Drugs	$82,700
	TOTAL	**$142,700**
	GRAND TOTAL	**$5,200,000**

Attachment B - Prevention Classification Definitions

Universal prevention: The mission of universal prevention is to deter the onset of drug abuse by providing all individuals in a population with the information and skills necessary to prevent the problem. All members of the population share the same general risk for drug abuse, although the risk may vary greatly among individuals. Universal prevention programs are delivered to large groups without any prior screening for drug abuse risk status of the individual program recipients. The entire population is assumed at-risk for substance abuse. *Examples: Substance abuse education in schools, media and public awareness (i.e., Red Ribbon Week, Alcohol Awareness Month).*

Selective prevention strategies: Selective prevention targets specific subgroups of the population that are believed to be at greater risk than others. Age, gender, family history, place of residence (i.e., high drug use, or low-income neighborhoods) and victimization, or physical and/or sexual abuse may define the targeted subgroups. ***Selective prevention targets the entire subgroup regardless of the degree of risk of any individual within the group.*** One individual in the subgroup may not be at personal risk for substance abuse, whereas another individual in the same subgroup may be abusing substances. The selective prevention program is presented to the entire subgroup because the subgroup as a whole is at higher risk for substance abuse than the general population. An individual's personal risk is not specifically assessed or identified and is based solely on a presumption given in his or her membership in the at-risk subgroup. *Examples: Skills training for groups affected by environmental influences like high crime rate, unemployment and community disorganization.*

Indicated prevention strategies: Indicated prevention approaches are used for individuals who may or may not exhibit early signs of substance abuse but exhibit risk factors. Examples of risk factors include school failure, interpersonal social problems, delinquency, and other anti-social behaviors and psychological problems such as depression and suicidal behavior that increase their chances of developing a substance abuse problem***. Indicated prevention programs typically address risk factors associated with the individual***, such as conduct disorders and alienation from parents, schools, and positive peer groups. The aim of indicated prevention programs is not just the reduction in first time substance abuse but also reduction in the length of time the signs continue, delay of onset of substance abuse, and/or reduction in the severity of substance abuse. Individuals can be referred to indicated prevention programs by parents, teachers, school counselors, school nurses, youth workers, friends or the courts. *Examples: Youth already engaged in substance abuse and/or negative behaviors, such as truancy, early anti-social behavior, Children of Substance Abusers.*

Reference: *Drug Abuse Prevention: What Works,* National Institute of Drug Abuse, NIH Publication *No. 97-45110*

Attachment C - Definition of Indicated Prevention Strategies

<u>Indicated Prevention Strategies</u>

- Indicated prevention strategies identify individuals who are experiencing early signs of substance abuse and other related problem behaviors associated with substance abuse and target them with special programs.

- The individuals identified at this stage, though showing signs of early substance abuse, have not reached the point where a clinical diagnosis of substance abuse can be made.

- Indicated prevention strategies are used for individuals who may or may not be abusing substances, but exhibit risk factors such as:

    - school failure;
    - interpersonal social problems;
    - delinquency and other antisocial behaviors;
    - psychological problems such as depression; and
    - suicidal behavior that increases their chances of developing a drug abuse problem

- Indicated prevention strategies require a precise assessment of an individual's personal risk and level of related problem behaviors, rather than relying on the person's membership in an at-risk group as in the selected approach.

- Programs are frequently extensive and highly intensive; they typically operate for longer periods of time, at a greater frequency of contact and require greater effort on the part of participants than do selective or universal programs.

- Programs require highly skilled staff who have clinical training, counseling and other skills. In the field of substance abuse, an indicated prevention intervention would be a substance abuse program for high school students who are experiencing a number of problem behaviors, including truancy, failing academic grades, juvenile depression, suicidal ideation, and early signs of substance abuse.

Source: *"Reducing Risks for Mental Health Disorders: Frontiers for Preventive Intervention Research." National Institute of Medicine*

Attachment D – Standards for Agencies Providing Substance Abuse Prevention Services for DHS/DMHAS

STANDARDS FOR AGENCIES PROVIDING SUBSTANCE ABUSE PREVENTION SERVICES
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MENTAL HEALTH AND ADDICTION SERVICES (DHS/DMHAS)

Revised September 2014

FORWARD

This document outlines program requirements for agencies providing substance abuse prevention services for the Department of Human Services (DHS), Division of Mental Health and Addiction Services (DMHAS), Office of Prevention and Early Intervention. This document supplements requirements specified in each contractees "State of New Jersey Department of Human Services Standard Language Document for Social Service and Training Contracts".

The Office of Prevention and Early Intervention is a unit of DMHAS within DHS. It is responsible for the administration of the prevention set-aside portion of the Substance Abuse Prevention and Treatment (SAPT) Federal Block Grant. This office maintains a staff of Program Managers who interact with and monitor all contractees to ensure their compliance with all program requirements.

Questions regarding the content of this document may be directed to:

Dr. Donald Hallcom
Director of Prevention and Early Intervention Services
Division of Mental Health and Addiction Services
New Jersey State Department of Human Services
P.O. Box 362
Trenton, New Jersey 08625-0362
(609) 984-4049
FAX (609) 341-2315

SECTION I - PURPOSE

The purpose of this document is to outline the operational requirements for all agencies that receive DMHAS Provider Service Contracts for substance abuse prevention. These formal statements are the minimum standards to which the providers must adhere in order to provide quality prevention services to their clients and to meet their contract requirements.

Prevention contracts are intended to promote efforts which increase protective and resiliency factors to prevent the illegal use or abuse of alcohol, tobacco, and other substances by New Jersey's citizens of all ages.

NOTE: For purposes of this document, the words "guidelines" and "standards" are interchangeable.

SECTION II - FACILITY and OPERATIONAL REQUIREMENTS

A. Location

Every prevention program must have an identifiable physical location/facility, evidenced by a street address, from which client and/or administrative services are provided. This is required regardless of whether it is a free-standing program or a program within a multi-purpose organization. The name of the agency must be on a sign or directory visible to the public from outside the building or within a public access reception area.

B. Legal Status

The agency must be county or other local government, a hospital, free standing clinic, or a public or incorporated non-profit organization which meets the Internal Revenue Service Code Section 501(c) 3.

C. Hours of Operation/Telephone

Each prevention agency must establish and post in a visible public place, and in the agency, the agency's regular hours of operation as well as communicate this availability to the community in its promotional literature. The agency must be available by phone during these hours. All contracts are to operate throughout the year. Closure of the operation for "breaks" is not permitted.

D. Accessibility

Each program should be accessible to persons with disabilities and must comply with the requirements of The Americans with Disabilities Act (ADA).

E. Adherence to Codes

Each program must adhere to local and state health and safety codes. If the facility is not a licensed health care facility, it must meet or exceed all fire, building and safety codes of the municipality in which it is situated. Current and valid certificates from the local government shall be on file and available for inspection.

F. Supplies

Appropriate and adequate supplies and equipment should be available to the staff to carry out the mission of the agency.

SECTION III - STAFFING AND RELATED PERSONNEL POLICIES

A. Office of the Director

Every prevention program must have one (1) person identified as the Director who has at least a Bachelor's degree from an approved institution, in a health, education, psychology, science, or human service field, and two (2) years of experience in program administration.

B. Prevention Specialist Qualifications

Effective January 1, 2015, all DHMAS-funded prevention providers will be required to employ a staff member who has earned the Certified Prevention Specialist (CPS) credential. Providers who do not meet this requirement on January 1, 2015 will have until December 31, 2016 to hire a staff person or provide CPS training for an existing staff member. Credentials or degrees that will be accepted in lieu of the CPS are the Certified Health Education Specialist (CHES), Masters in Public Health (MPH), or a Doctoral degree in the medical, health, or behavioral sciences. This requirement is described in the "Standards for Agencies Providing Substance Abuse Prevention Services for the DHS/DMHAS." Please provide copies of staff certificates or evidence of advanced degree and experience.

C. Administrative Support

A prevention program must have a staff which devotes adequate time to ensure full competency in all administrative requirements of the program. At a minimum, the administrative staffing pattern should include a Program Director and an Accountant/ Bookkeeper.

A Bookkeeper must have a High School Diploma and formal training in bookkeeping and accounting principles and/or successful experience as a bookkeeper. Successful experience will be determined by DMHAS.

D. Table of Organization/Job Descriptions

Each prevention agency must have on file a table of organization which reflects how the agency is structured to deliver its services and lines of authority among its staff members. Written descriptions of duties, responsibilities and credentials are required for all jobs.

According to budget criteria, staff working on substance abuse prevention contracts must spend a minimum of 60% of their time providing direct services.

E. Staff Development Plan and Continuing Education

Every prevention program must have in place a staff development plan to ensure that each staff member has knowledge and skills in the prevention field. The agency shall have written policies regarding a plan for continuing education of its staff. Such policies shall include support for attendance at conferences and symposia and similar activities which foster obtaining or maintaining prevention credentials.

F. Personnel Policies and Procedures

Each agency shall have on file a policy and procedure manual that includes but is not limited to the following items:

- staff hiring procedures
- orientation protocols
- sick and vacation time policies
- staff evaluation procedures
- determination procedures
- fiscal controls
- conflict of interest policies
- hiring of consultants
- confidentiality of records assurance (see Attachment 3: Confidentiality of Drug and Alcohol Patient Information 42 U.S.C. 290dd-2, 42 C.F.R. Part 2)

SECTION IV - ADMINISTRATIVE REQUIREMENTS

A. Administration

The administration of the agency shall provide the staff with facilities, equipment and supplies needed to implement the prevention program in an efficient, economical and effective manner.

B. Administrative Policies and Procedures

Every program shall have written policies and procedures on file for the use of vehicles, which documents mileage, purpose and driver; purchase of equipment; leasing of

equipment and facilities; rentals; inventory controls; fees for services; and medical emergencies. Policies and procedures are required to address justification of expenditures and the personnel authorized to approve both programmatic and fiscal needs.

C. Criteria for Board of Directors

The facility shall have a Board of Directors which shall assume legal responsibility for the management, operation, and financial viability of the agency. The Board of Directors shall be responsible for, but not limited to, the following:

1. Services provided and the quality of care rendered to participants.
2. Provision of a safe physical plant, equipped and staffed to maintain the agency and services.
3. Adoption and documented review of written by-laws, or their equivalent, in accordance with a schedule established by the Board of Directors.
4. Ensuring development and review of all policies and procedures in accordance with a schedule established by the Board of Directors.
5. Determination of the frequency of meetings of the Board of Directors and its committees, or equivalent; conducting such meetings, and documenting them through minutes.
6. Delineation of the duties of the officers of any committees, or equivalent, of the Board of Directors. When the governing authority establishes committees, their purpose, structure, responsibilities, and authority, and the relationship of the committee to other entities within the facility, shall be documented.
7. Establishment of the qualifications of members and officers of the Board of Directors, the procedures for electing and appointing officers, and the terms of service for members, officers, and committee chairpersons or equivalent.

D. Administrative Records

Each program shall maintain files that include but are not limited to: service grants and/or contracts for services from any source; insurance policies; certificates of need where applicable; rental agreements; and personnel records.

E. Property

Accurate property records, inventory control and maintenance for equipment and for all other non-expendable (non-consumable) personal property acquired under the contract must be maintained. Property records must provide a description of the property, identification number, date of acquisition, cost, present location and/or disposition of property. A physical inventory of non-expendable personal property must be taken and the results reconciled with the property records at least once every two (2) years to verify the existence, current utilization and continued need for the property. A control system must be in effect to ensure adequate safeguards to prevent loss. Damage or theft must be investigated and fully documented.

F. Client and Programmatic Records

Each program shall maintain records that document the delivery of services including the place, date, number of participants, the risk factors being addressed that pertain to the population being served, the prevention strategies and activities that were utilized, and outcome related comments. When appropriate, (i.e., in events that employ strategies other than pure information in large events such as assemblies), the program shall also maintain records indicating the names of the participants, their ages, attendance records and other pertinent information.

G. Confidentiality

The program must have and enforce procedures protecting the confidentiality of participant information.

H. Smoke-Free Environment

1. In accordance with the Synar Amendment (P.L.102, Section 321), programs shall:
   - ensure that all prevention activities will be conducted in a smoke-free environment; and
   - ensure that individuals under 18 years of age are not permitted to smoke in any part of the agency or its premises.
2. In accordance with the Pro-Children's Act of 1994 (P.L. 103-227), no smoking will be permitted in any portion of any indoor facility owned, leased, or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services for children under eighteen (18) years of age.

I. Lavatory Facilities

Lavatory facilities with sinks shall be available on premises.

J. Insurance

The agency is required to have sufficient fire and theft insurance to cover the fair market value of the equipment and building occupied by the agency.

K. Affirmative Action

The agency is required to have a formal non-discrimination policy and to have and enforce an affirmative action plan.

L. Fiscal Control

The agency has adequate internal controls, management and administrative procedures and qualified personnel to assure the appropriate use and accounting for all the resources of the agency. Further, the agency must have not less than one (1) annual audit by an approved public accountant, as required in the DHS Contract Manual, Terms and Conditions, and Federal Office of Management and Budget, Cost Principals.

M. Other General State Requirements

1. Political Activity - Federal funds cannot be used for partisan political activity of any kind by any person or organization involved in the administration of federally- assisted programs. Hatch Act (5 U.S.C. 1501-1508) and Intergovernmental Personnel Act of 1970 as amended by Title VI of Civil Service Reform Act (P.L. 95-454 Section 4728).
2. Davis-Bacon Act - When required by the Federal grant program legislation, all laborers and mechanics employed by contractors or subcontractors to work on construction projects financed by Federal assistance must be paid wages not less than those established for the locality of the project by the Secretary of Labor (40 Stat. 1494, Mar. 3, 1921, Chap. 411, 40 U.S.C. 276 A-5).
3. Civil Rights - No person shall, on the ground of sex, race, color, national origin, age, or disability, be excluded from participation in or be subjected to discrimination in any program or activity funded, in whole or in art, by Federal funds. Discrimination on the basis of sex or religion is also prohibited in some Federal programs. (Age-42 U.S.C. 6101, et. seal; Race-42 U.S.C. 2000d; Handicap-29 U.S.C. 794).

SECTION V- PROGRAMMATIC REQUIREMENTS

A. Mission Statement

Each agency that provides substance abuse prevention services must have a written mission statement on file, as well as a summary of its overall goals and services to fulfill this mission.

B. Cultural and Linguistic Competence

Culture and language have considerable impact on how clients access and respond to prevention services. All prevention contractees will be required to adhere to the standards and procedures listed below:

1. Promote and support the attitudes, behaviors, knowledge, and skills necessary for staff to work respectfully and effectively with clients and each other in a culturally competent work environment.
2. Have a comprehensive management strategy to address culturally and linguistically appropriate prevention services, including strategic goals, plans, policies, procedures, and designated staff responsible for implementation.
3. Develop and implement a strategy to recruit, retain and promote qualified,

diverse and culturally competent prevention staff that are trained and qualified to address the needs of the racial, ethnic, and other minority communities being served.

4. Require and arrange for ongoing education and training for prevention staff in culturally and linguistically competent service delivery.
5. Provide all clients with limited English proficiency (LEP) access to bilingual prevention staff or interpretation services.
6. Provide oral and written notices, including translated signage at key points of contact, to clients in their primary language informing them of their right to receive no-cost interpreter services.
7. Translate and make available signage and commonly-used written client educational material and other materials for members of the predominant language groups in service areas.
8. Use a variety of methods to collect and utilize accurate demographic, cultural, epidemiological and clinical outcome data for racial and ethnic groups in the service area, and become informed about the ethnic/cultural needs, resources, and assets of the surrounding community.

Attachment E – Directions to Mandatory Bidders Conference

HAMILTON TECHNOLOGY CENTER AUDITORIUM
1200 Negron Drive, Hamilton, NJ 08691, (609) 584-5051

FROM THE NEW JERSEY TURNPIKE:

- Take Exit 7A, and proceed west on I-195.
- Take Exit 5A (RT 130 south) to the Horizon Blvd. exit on the right @ first traffic light.
- Turn right on Horizon Blvd. and proceed to stop sign. The Technology Center will be in front of you.
- Make a left turn and the first right turn in front of the complex, which will be on your right on Negron Drive.
- For Auditorium parking, once you have made the right turn onto Negron Drive, proceed straight to the north side of the Center, passing the Center and making a right between the Center and the NJSP Communications Center, entering the Auditorium parking area.

FROM THE PARKWAY:

- Take the Parkway to Exit 98 and proceed west on I-195.
- Take Exit 5A (RT 130 south) to the Horizon Blvd. exit on the right @ first traffic light.
- Turn right on Horizon Blvd. and proceed to stop sign. The Technology Center will be in front of you.
- Make a left turn and the first right turn in front of the complex, which will be on your right on Negron Drive.
- For Auditorium parking, see above

FROM TRENTON:

- Take Rt. 29 South to I-195 East.
- Take Exit 5A (RT 130 south) to the Horizon Blvd. exit on the right @ first traffic light.
- Turn right on Horizon Blvd. and proceed to stop sign. The Technology Center will be in front of you.
- Make a left turn and the first right turn in front of the complex, which will be on your right on Negron Drive.
- For Auditorium parking, see above

FROM ROUTE 1:

- Take Rt. 1 to I-295 South.
- Take I-195 East (Shore Points)
- Take Exit 5A (RT 130 south) to the Horizon Blvd. exit on the right @ traffic light. Turn right on Horizon Blvd. and proceed to stop sign. The Technology Center will be in front of you.
- Make a left turn at the stop sign and then the first right turn in front of the complex (Negron Drive). The main entrance is in the center of the building.
- Take Exit 5A (RT 130 south) to the Horizon Blvd. exit on the right @ first traffic light.
- Turn right on Horizon Blvd. and proceed to stop sign. The Technology Center will be in front of you.
- Make a left turn and the first right turn in front of the complex, which will be on your right on Negron Drive.
- For Auditorium parking, see above

Attachment F – Cover Page

____
Date Received

STATE OF NEW JERSEY
DEPARTMENT OF HUMAN SERVICES
Division of Mental Health and Addiction Services
Statewide Services and Special Projects for Substance Abuse Prevention

Incorporated Name of Bidder: ____

Type: Public _______ Profit _______ Non-Profit____ Hospital-Based _____

Federal ID Number: ______________ Charities Reg. Number (if applicable) ________________

Address of Bidder: ____

____

Chief Executive Officer Name and Title: _______________________________________

Chief Executive Officer Phone No. & Email Address: ______________________________

Contact Person Name and Title: ____

Contact Person Phone No. & Email Address: ___________________________________

Contract in which bidder is applying for (check one):

- ☐ Part 1 – Community-Based Services: Underage Drinking
- ☐ Part 1 – Community-Based Services: Illegal Substances
- ☐ Part 1 – Community-Based Services: Prescription Drugs
- ☐ Part 2- Special Projects: Military
- ☐ Part 2- Special Projects: Minority Gay/Lesbian/Bisexual/Transgender or Questioning Youth

County in which services are to be provided:____________________________________

Total dollar amount requested: _________________ Fiscal Year End: _____________________

Funding Period: From ________________________ to _____________________________

Total number of unduplicated consumers to be served: _________________________________

Authorization: Chief Executive Officer (printed name):___________________________________

Signature:___________________________________ Date: __________________________

Attachment G – Addendum to RFP for Social Service and Training Contracts

STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES

ADDENDUM TO REQUEST FOR PROPOSAL FOR SOCIAL SERVICE AND TRAINING CONTRACTS

Executive Order No. 189 establishes the expected standard of responsibility for all parties that enter into a contract with the State of New Jersey. All such parties must meet a standard of responsibility that assures the State and its citizens that such parties will compete and perform honestly in their dealings with the State and avoid conflicts of interest.

As used in this document, "provider agency" or "provider" means any person, firm, corporation, or other entity or representative or employee thereof that offers or proposes to provide goods or services to or performs any contract for the Department of Human Services.

In compliance with Paragraph 3 of Executive Order No. 189, no provider agency shall pay, offer to pay, or agree to pay, either directly or indirectly, any fee, commission, compensation, gift, gratuity, or other thing of value of any kind to any State officer or employee or special State officer or employee, as defined by N.J.S.A. 52:13D-13b and e, in the Department of the Treasury or any other agency with which such provider agency transacts or offers or proposes to transact business, or to any member of the immediate family, as defined by N.J.S.A. 52:13D-13i, of any such officer or employee, or any partnership, firm, or corporation with which they are employed or associated, or in which such officer or employee has an interest within the meaning of N.J.S.A. 52:13D-13g.

The solicitation of any fee, commission, compensation, gift, gratuity or other thing of value by any State officer or employee or special State officer or employee from any provider agency shall be reported in writing forthwith by the provider agency to the Attorney General and the Executive Commission on Ethical Standards.

No provider agency may, directly or indirectly, undertake any private business, commercial or entrepreneurial relationship with, whether or not pursuant to employment, contract or other agreement, express or implied, or sell any interest in such provider agency to, any State officer or employee or special State officer or employee having any duties or responsibilities in connection with the purchase, acquisition or sale of any property or services by or to any State agency or any instrumentality thereof, or with any person, firm or entity with which he is employed or associated or in which he has an interest within the meaning of N.J.S.A. 52:13D-13g. Any relationships subject to this provision shall be reported in writing forthwith to the Executive Commission on Ethical Standards, which may grant a waiver of this restriction upon application of the State officer or employee or special State officer or employee upon a finding that the present

or proposed relationship does not present the potential, actuality or appearance of a conflict of interest.

No provider agency shall influence, or attempt to influence or cause to be influenced, any State officer or employee or special State officer or employee in his official capacity in any manner which might tend to impair the objectivity or independence of judgment of said officer or employee.

No provider agency shall cause or influence, or attempt to cause or influence, any State officer or employee or special State officer or employee to use, or attempt to use, his official position to secure unwarranted privileges or advantages for the provider agency or any other person.

The provisions cited above shall not be construed to prohibit a State officer or employee or special State officer or employee from receiving gifts from or contracting with provider agencies under the same terms and conditions as are offered or made available to members of the general public subject to any guidelines the Executive Commission on Ethical Standards may promulgate.

Attachment H – Statement of Assurances

Department of Human Services
Statement of Assurances

As the duly authorized Chief Executive Officer/Administrator, I am aware that submission to the Department of Human Services of the accompanying application constitutes the creation of a public document that may be made available upon request at the completion of the RFP process. This may include the application, budget, and list of applicants (bidder's list). In addition, I certify that the applicant:

- Has legal authority to apply for the funds made available under the requirements of the RFP, and has the institutional, managerial and financial capacity (including funds sufficient to pay the non-Federal/State share of project costs, as appropriate) to ensure proper planning, management and completion of the project described in this application.

- Will give the New Jersey Department of Human Services, or its authorized representatives, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with Generally Accepted Accounting Principles (GAAP). Will give proper notice to the independent auditor that DHS will rely upon the fiscal year end audit report to demonstrate compliance with the terms of the contract.

- Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain. This means that the applicant did not have any involvement in the preparation of the RLI, including development of specifications, requirements, statement of works, or the evaluation of the RLI applications/bids.

- Will comply with all federal and State statutes and regulations relating to non-discrimination. These include but are not limited to: 1) Title VI of the Civil Rights Act of 1964 (P.L. 88-352;34 CFR Part 100) which prohibits discrimination based on race, color or national origin; 2) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794; 34 CFR Part 104), which prohibits discrimination based on handicaps and the Americans with Disabilities Act (ADA), 42 U.S.C. 12101 et seq.; 3) Age Discrimination Act of 1975, as amended (42 U.S.C. 6101 et. seq.; 45 CFR part 90), which prohibits discrimination on the basis of age; 4) P.L. 2975, Chapter 127, of the State of New Jersey (N.J.S.A. 10:5-31 et. seq.) and associated executive orders pertaining to affirmative action and non-discrimination on public contracts; 5) federal Equal Employment Opportunities Act; and 6) Affirmative Action Requirements of PL 1975 c. 127 (NJAC 17:27).

- Will comply with all applicable federal and State laws and regulations.
- Will comply with the Davis-Bacon Act, 40 U.S.C. 276a-276a-5 (29 CFR 5.5) and the New Jersey Prevailing Wage Act, N.J.S.A. 34:11-56.27 et seq. and all regulations pertaining thereto.
- Is in compliance, for all contracts in excess of $100,000, with the Byrd Anti-Lobbying amendment, incorporated at Title 31 U.S.C. 1352. This certification extends to all lower tier subcontracts as well.
- Has included a statement of explanation regarding any and all involvement in any litigation, criminal or civil.
- Has signed the certification in compliance with federal Executive Orders 12549 and 12689 and State Executive Order 34 and is not presently debarred, proposed for debarment, declared ineligible, or voluntarily excluded. The applicant will have signed certifications on file for all subcontracted funds.
- Understands that this provider agency is an independent, private employer with all the rights and obligations of such, and is not a political subdivision of the Department of Human Services.
- Understands that unresolved monies owed the Department and/or the State of New Jersey may preclude the receipt of this award.

Applicant Organization	Signature: Chief Executive Officer or Equivalent
Date	Typed Name and Title

6/97

Attachment I - Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions

READ THE ATTACHED INSTRUCTIONS BEFORE SIGNING THIS CERTIFICATION. THE INSTRUCTIONS ARE AN INTEGRAL PART OF THE CERTIFICATION.

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion Lower Tier Covered Transactions

1. The prospective lower tier participant certifies, by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by an Federal department or agency.

2. Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

____

Name and Title of Authorized Representative

____

Signature Date

This certification is required by the regulations implementing Executive order 12549, Debarment and Suspension, 29 CFR Part 98, Section 98.510

Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion
Lower Tier Covered Transactions

Instructions for Certification

1. By signing and submitting this proposal, the prospective lower tier participant is providing the certification set out below.

2. The certification in this clause is a material representation of facts upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances.

4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion--Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines

the eligibility of its principals. Each participant may, but is not required to, check the List of Parties Excluded from Federal Procurement and Non-Procurement Programs.

8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible, or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

Attachment J – Disclosure of Investment Activities in Iran

DISCLOSURE OF INVESTMENT ACTIVITIES IN IRAN

Applicant / Bidder: ______________________________

PART 1: CERTIFICATION

APPLICANT / BIDDER MUST COMPLETE PART 1 BY CHECKING EITHER BOX.

FAILURE TO CHECK ONE OF THE BOXES WILL RENDER THE PROPOSAL NON-RESPONSIVE.

Pursuant to Public Law 2012, c. 25, any person or entity that submits a bid or proposal or otherwise proposes to enter into or renew a contract must complete the certification below to attest, under penalty of perjury, that the person or entity, or one of the person or entity's parents, subsidiaries, or affiliates, is not identified on a list (on the web at http://www.state.nj.us/treasury/purchase/pdf/Chapter25List.pdf) created and maintained by the New Jersey Department of the Treasury as a person or entity engaging in investment activities in Iran. If the Director finds a person or entity to be in violation of the principles which are the subject of this law, s/he shall take action as may be appropriate and provided by law, rule or contract, including but not limited to, imposing sanctions, seeking compliance, recovering damages, declaring the party in default and seeking debarment or suspension of the person or entity.

☐ **I certify, pursuant to Public Law 2012, c. 25, that neither the bidder listed above nor any of the bidder's parents, subsidiaries, or affiliates is listed on the NJ Department of the Treasury's list of entities determined to be engaged in prohibited activities in Iran pursuant to P.L. 2012, c. 25 ("Chapter 25 List"). I further certify that I am the person listed above, or I am an officer or representative of the entity listed above and am authorized to make this certification on its behalf. I will skip Part 2 and sign and complete the Certification below.**

OR

☐ **I am unable to certify as above because the bidder and/or one or more of its parents, subsidiaries, or affiliates is listed on the Department's Chapter 25 list. I will provide a detailed, accurate and precise description of the activities in Part 2 below and sign and complete the Certification below. Failure to provide such will result in the proposal being rendered as nonresponsive and appropriate penalties, fines and/or sanctions will be assessed as provided by law.**

PART 2: PLEASE PROVIDE FURTHER INFORMATION RELATED TO INVESTMENT ACTIVITIES IN IRAN

Using attached sheets, provide a detailed, accurate and precise description of the activities of the bidding person/ entity, or one of its parents, subsidiaries or affiliates, engaging in the investment activities in Iran outlined above.

Certification: I, being duly sworn upon my oath, hereby represent and state that the foregoing information and any attachments thereto to the best of my knowledge are true and complete. I attest that I am authorized to execute this certification on behalf of the above-referenced person or entity. I acknowledge that the State of New Jersey is relying on the information contained herein and thereby acknowledge that I am under a continuing obligation from the date of this certification through the completion of any contracts with the State to notify the State in writing of any changes to the answers of information contained herein. I acknowledge that I am aware that it is a criminal offense to make a false statement or misrepresentation in this certification, and if I do so, I recognize that I am subject to criminal prosecution under the law and that it will also constitute a material breach of my agreement(s) with the State of New Jersey and that the State at its option may declare any contract(s) resulting from this certification void and unenforceable.

Full Name (print): ______________________________

Signature: ______________________________

Title: ______________________________

Date: ______________________________