# ATTACHMENT A

### PROPOSAL DOCUMENT CHECKLIST

**Please reference Section 7.0 for the appropriate format and quantities for each proposal submission.**

|  |  |  |  |
| --- | --- | --- | --- |
| **RFP 20024– Independent Evaluation of the New York State (NYS) Health and Recovery Plans (HARP) Program and Self-Directed Care (SDC) Pilot Program** | | | |
| **FOR THE ADMINISTRATIVE PROPOSAL** | | | |
| **RFP §** | **SUBMISSION** | | **INCLUDED** |
| **§ 6.1.A** | **Attachment 1 – Bidder’s Disclosure of Prior Non-Responsibility Determinations, completed and signed.** | |  |
| **§ 6.1.B** | **Freedom of Information Law – Proposal Redactions (If Applicable)** | |  |
| **§ 6.1.C** | **Attachment 3- Vendor Responsibility Attestation** | |  |
| **§ 6.1.D** | **Attachment 4 - Vendor Assurance of No Conflict of Interest or Detrimental Effect** | |  |
| **§ 6.1.E** | **M/WBE Participation Requirements:** | |  |
| **Attachment 5 Form 1** | |  |
| **Attachment 5 Form 2 (If Applicable)** | |  |
| **Attachment 5 Form 4** | |  |
| **Attachment 5 Form 5** | |  |
| **§ 6.1.E** | **Attachment 6- Encouraging Use of New York Businesses** | |  |
| **§ 6.1.G** | **Attachment 7 - Bidder’s Certified Statements, completed & signed.** | |  |
| **§ 6.1.H** | **Attachment 9 – References** | |  |
| **§ 6.1.J** | **Attachment 10 - Diversity Practices Questionnaire** | |  |
| **§ 6.1.I** | **Attachment 11 - Executive Order 177 Prohibiting Contracts with Entities that Support Discrimination** | |  |
| **FOR THE TECHNICAL PROPOSAL** | | | |
| **RFP §** | **SUBMISSION** | **INCLUDED** | |
| **§ 6.2.A** | **Title Page** | |  |
| **§ 6.2.B** | **Table of Contents** | |  |
| **§ 6.2.C** | **Documentation of Bidder’s Eligibility (Requirement)** | |  |
| **§ 6.2.D** | **Technical Proposal Narrative** | |  |
| **FOR THE COST PROPOSAL REQUIREMENT** | | | |
| **RFP §** | **REQUIREMENT** | | **INCLUDED** |
| **§ 6.3** | **Attachment B- Cost Proposal** | |  |

# 

# ATTACHMENT B

### COST PROPOSAL

***RFP #20024***

**For the deliverables and milestones identified in the form below, Bidders should complete the column furthest to the right titled “Cost.” Bidders must not change the column titled “Deliverables,” nor can they change the existing milestones listed in the column titled “Milestones” below, but they can add additional milestones and associated cost, as applicable, to the form below to align with the proposed milestones in their Technical Proposal.**

**For each Deliverable Milestone listed below, place the “Quantity” (number of times you will complete this milestone) and the “Price Per” (the price you are bidding for each time you complete the milestone) in the column titled Cost, then complete the row titled “Milestone Total” (total cost for that Milestone) by multiplying the rows labeled “Quantity” by the “Price Per” for each Deliverable Milestone.**

**For each Deliverable a Grand Total should be completed, add each Milestone Total within each Deliverable.**

|  |  |  |
| --- | --- | --- |
| **Deliverable** | **Cost** | |
| 1 – Expanded Evaluation Plan - HARP | | |
| Milestone 1 –  Draft Plan | Number |  |
| Price Per |  |
| Total |  |
| Milestone 2 –  DOH-approved Revised Plan | Number |  |
| Price Per |  |
| Total |  |
| Milestone 3 –  CMS-approved Final Plan | Number |  |
| Price Per |  |
| Total |  |
| Deliverable 1 Total |  |  |
| 2 – Expanded Evaluation Plan – SDC Pilot | | |
| Milestone 1 –  Draft Plan | Number |  |
| Price Per |  |
| Total |  |
| Milestone 2 –  DOH-approved Revised Plan | Number |  |
| Price Per |  |
| Total |  |
| Milestone 3 –  CMS-approved Final Plan | Number |  |
| Price Per |  |
| Total |  |
| Deliverable 2 Total |  |  |
| 3 – Evaluation Report - HARP | | |
| Milestone 1 –  Draft Report | Number |  |
| Price Per |  |
| Total |  |
| Milestone 2 –  DOH-approved Revised Report | Number |  |
| Price Per |  |
| Total |  |
| Milestone 3 –  CMS-approved Final Report | Number |  |
| Price Per |  |
| Total |  |
| Milestone 4 –  Monthly Progress Reports | Number |  |
| Price Per |  |
| Total |  |
| Deliverable 3 Total |  |  |
| 4 – Evaluation Report – SDC Pilot | | |
| Milestone 1 –  Draft Report | Number |  |
| Price Per |  |
| Total |  |
| Milestone 2 –  DOH-approved Revised Report | Number |  |
| Price Per |  |
| Total |  |
| Milestone 3 –  CMS-approved Final Report | Number |  |
| Price Per |  |
| Total |  |
| Milestone 4 –  Monthly Progress Reports | Number |  |
| Price Per |  |
| Total |  |
| Deliverable 4 Total |  |  |
| 5 - HARP, Goal 1 | | |
| Milestone 1 –  Preliminary Analyses | Number |  |
| Price Per |  |
| Total |  |
| Milestone 2 –  Final Analyses | Number |  |
| Price Per |  |
| Total |  |
| Milestone 3 –  Interpretation of Findings | Number |  |
| Price Per |  |
| Total |  |
| Deliverable 5 Total |  |  |
| 6 - HARP, Goal 2 | | |
| Milestone 1 –  Preliminary Analyses | Number |  |
| Price Per |  |
| Total |  |
| Milestone 2 –  Final Analyses | Number |  |
| Price Per |  |
| Total |  |
| Milestone 3 –  Interpretation of Findings | Number |  |
| Price Per |  |
| Total |  |
| Deliverable 6 Total |  |  |
| 7 – HARP, Goal 3 | | |
| Milestone 1 –  Preliminary Analyses | Number |  |
| Price Per |  |
| Total |  |
| Milestone 2 –  Final Analyses | Number |  |
| Price Per |  |
| Total |  |
| Milestone 3 –  Interpretation of Findings | Number |  |
| Price Per |  |
| Total |  |
| Deliverable 7 Total |  |  |
| 8 – SDC Pilot, Goal 1 | | |
| Milestone 1 –  Preliminary Analyses | Number |  |
| Price Per |  |
| Total |  |
| Milestone 2 –  Final Analyses | Number |  |
| Price Per |  |
| Total |  |
| Milestone 3 –  Interpretation of Findings | Number |  |
| Price Per |  |
| Total |  |
| Deliverable 8 Total |  |  |
| 9 – SDC Pilot, Goal 2 | | |
| Milestone 1 –  Preliminary Analyses | Number |  |
| Price Per |  |
| Total |  |
| Milestone 2 –  Final Analyses | Number |  |
| Price Per |  |
| Total |  |
| Milestone 3 –  Interpretation of Findings | Number |  |
| Price Per |  |
| Total |  |
| Deliverable 9 Total |  |  |
| 10 – SDC Pilot, Goal 3 | | |
| Milestone 1 –  Preliminary Analyses | Number |  |
| Price Per |  |
| Total |  |
| Milestone 2 –  Final Analyses | Number |  |
| Price Per |  |
| Total |  |
| Milestone 3 –  Interpretation of Findings | Number |  |
| Price Per |  |
| Total |  |
| Deliverable 10 Total |  |  |

|  |  |
| --- | --- |
| By signing this Cost Proposal Bid Sheet, bidder agrees that the prices above are binding for 365 days from the proposal due date. | |
| Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Print Name and Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

# ATTACHMENT C

### HARP Targeting Criteria and Risk Factors[[1]](#footnote-1)

1. **HARPs:** Adult Medicaid beneficiaries 21 and over who are eligible for mainstream Managed Care Organizations (MCOs) are eligible for enrollment in the HARP if they meet either:
2. Target criteria and risk factors as defined below (individuals meeting these criteria will be identified through quarterly Medicaid data reviews by Plans and/or New York State [NYS]); or
3. Service system or service provider identification of individuals presenting with serious functional deficits as determined by:
   1. A case review of individual's usage history to determine if Target Criteria and Risk Factors are met; or
   2. Completion of HARP eligibility screen.
4. ***HARP Target Criteria:*** NYS has chosen to define HARPtargeting criteria as:
5. Medicaid enrolled individuals age 21 and over;
6. Serious Mental Illness (SMI)/Substance Use Disorder (SUD) diagnoses;
7. Eligible to be enrolled in Mainstream MCOs;
8. Not Medicaid/Medicare enrolled ("duals");
9. Not participating or enrolled in a program with the NYS Office for People with Developmental Disabilities (OPWDD) (i.e., participating in an OPWDD program).
10. ***HARP*** ***Risk Factors***: For individuals meeting the targeting criteria, the HARP Risk Factor criteria include any of the following:
11. Supplemental Security Income (SSI) individuals who received an "organized" mental health service in the year prior to enrollment.
12. Non‑SSI individuals with three (3) or more months of Assertive Community Treatment (ACT) or Targeted Case Management (TCM), Personalized Recovery Oriented Services (PROS) or prepaid mental health plan (PMHP) services in the year prior to enrollment.
13. SSI and non‑SSI individuals with more than 30 days of psychiatric inpatient services in the three (3) years prior to enrollment.
14. SSI and non‑SSI individuals with three (3) or more psychiatric inpatient admissions in the three (3) years prior to enrollment.
15. SSI and non‑SSI individuals discharged from a NYS Office of Mental Health (OMH) Psychiatric Center after an inpatient stay greater than 60 days in the year prior to enrollment.
16. SSI and non‑SSI individuals with a current or expired Assisted Outpatient Treatment (AOT) order in the five (5) years prior to enrollment.
17. SSI and non‑SSI individuals discharged from correctional facilities with a history of inpatient or outpatient behavioral health (BH) treatment in the four (4) years prior to enrollment.
18. Residents in OMH-funded housing for persons with SMI in any of the three (3) years prior to enrollment.
19. Members with two (2) or more services in an inpatient/outpatient chemical dependence detoxification program within the year prior to enrollment.
20. Members with one (1) inpatient stay with a SUD primary diagnosis within the year prior to enrollment.
21. Members with two (2) or more inpatient hospital admissions with SUD primary diagnosis or members with an inpatient hospital admission for an SUD-related medical diagnosis‑related group and a secondary diagnosis of SUD within the year prior to enrollment.
22. Members with two (2) or more emergency department (ED) visits with primary substance use diagnosis or primary medical non-substance use that is related to a secondary substance use diagnosis within the year prior to enrollment.
23. Individuals transitioning with a history of involvement in children’s services (e.g., RTF, HCBS, B2H waiver, RSSY).
24. **Behavioral Health Home and Community Based Services (BH HCBS) Service Eligibility and Assessment Process:** HARP members who meet Targeting Criteria and Risk Factors as well as Need-Based Criteria (below), will have access to an enhanced benefit package of BH HCBS.
25. **Need-based Criteria**: Individuals meeting one (1) of the Needs-Based Criteria identified below will be eligible for BH HCBS:
26. An individual with at least “moderate” levels of need as indicated by a State-designated score on a tool derived from the interRAI Assessment Suite.
27. An individual with need for BH HCBS services as indicated by a face to face assessment with the interRAI Assessment Suite and a risk factor of a newly-emerged psychotic disorder suggestive of Schizophrenia herein called individuals with First Episode Psychosis (FEP). Individuals with FEP may have minimal service history.
28. A HARP-enrolled individual who either previously met the needs-based criteria above or has one of the needs based historical risk factors identified above; AND who is assessed and found that, but for the provision of BH HCBS for stabilization and maintenance purposes, would decline to prior levels of need (i.e., subsequent medically necessary services and coordination of care for stabilization and maintenance is needed to prevent decline to previous needs-based functioning).
29. All individuals in the HARP will be evaluated for eligibility for BH HCBS.
30. Once an individual is enrolled in the HARP, a Health Home (or other State-designated entity) will initiate an independent, person-centered planning process to determine a plan of care.
31. This will include the completion of an evaluation for BH HCBS eligibility.
32. This process will comply with federal conflict-free case management requirements.
33. Individuals determined eligible for the BH HCBS services based on the brief evaluation using the BH HCBS Eligibility Brief Assessment will receive a conflict-free functional assessment from an appropriately qualified individual.
34. The assessment determines eligibility for BH HCBS and is used to establish a written, person-centered, individualized plan of care.
35. Assessments are conducted using a BH HCBS Eligibility Assessment, a tool derived from the interRAI, a standardized clinical and functional assessment tool consistent with the State’s approved Balancing Incentive Payment Program.
36. The results of the functional assessment will be incorporated into the individual’s person-centered plan of care.
37. These plans must be approved by the HARP or their designee.
38. Reassessment of the plan of care (including need for BH HCBS) must be done at least annually; when the individual’s circumstances or needs change significantly; or at the request of theindividual. Plans may require more frequent reviews of plans of care to evaluate progress towards goals, determine if goals have been achieved or whether the plan of care requires revision.

# ATTACHMENT D

**Perception of Care Survey for Medicaid Managed Care Members**

Please tell us about your experience with your Medicaid Managed Care plan, the care you receive(d) from providers, and your perception of your own health and well-being.

**We’re asking about** **the behavioral health services covered in your plan. Behavioral health means mental health and/or substance use disorder.**

* We want to know about your experience with behavioral health services like counseling, rehabilitation, inpatient treatment, emergency/crisis services, or medicine for mental health or substance use conditions.

1. Our records show that you are now in [HEALTH PLAN NAME]. Is that right?

🞏 Yes 🡪 Go to Question 3

🞏 No 🡪 Go to Question 2

1. What is the name of your health plan? (please print)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PART I: YOUR BEHAVIORAL HEALTH SERVICES**

3. Did you receive behavioral health services in the last 12 months? 🞏 Yes 🞏 No

4. In the last 12 months, did you receive any treatment, counseling, or medicine for:

a.Emotional or mental illness? 🞏 Yes 🞏 No

b. Alcohol use? 🞏 Yes 🞏 No

c. Drug use? 🞏 Yes 🞏 No

d. Tobacco use? 🞏 Yes 🞏 No

5. Are you currently receiving behavioral health services? 🞏 No 🞏 Yes

🡪 **If Yes, Go To Question7**

6. Please select the ONE main reason why you are no longer receiving behavioral health services.

|  |
| --- |
| 🞏 a. I no longer needed treatment because the problem that led to treatment was addressed. |
| 🞏 b. Treatment was not working as well as expected, so I stopped treatment. |
| 🞏 c. Treatment was no longer possible due to problems with transportation. |
| 🞏 d. Treatment was no longer possible due to problems paying for treatment. |
| 🞏 e. Treatment was no longer possible due to problems with finding time for treatment. |
| 🞏 f. Other reason(s) (please explain): |

**If you have not received behavioral health services in the past 12 months, skip to Part 3.**

**PART 2: ACCESS and QUALITY OF CARE**

**The next questions are about all the behavioral health services you got in the last 12 months that were covered by your Medicaid Managed Care plan.**

* **Please consider those services when answering the questions below.**
* **Please do NOT comment here about services that are NOT covered by your healthcare plan (e.g., self-help groups).**
* **If you have not received behavioral health services in the past 12 months, skip to Part 3.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **In the last 12 months…** | **Never** | **Sometimes** | **Usually** | **Always** | **Not Applicable** |
| 7. How often did the people you went to for counseling or treatment explain things in a way you could understand? | **○** | **○** | **○** | **○** | **○** |
| 8. How often did the people you went to for treatment treat you with respect and kindness? | **○** | **○** | **○** | **○** | **○** |
| 9. How often did you get services at days/times that were convenient to you? | **○** | **○** | **○** | **○** | **○** |
| 1. How often did you get services where you needed them? | **○** | **○** | **○** | **○** | **○** |
| 1. How often did you get the services you needed as soon as you wanted? | **○** | **○** | **○** | **○** | **○** |
| 12. How often did the people you went to for counseling or treatment spend enough time with you? | **○** | **○** | **○** | **○** | **○** |
| 13. How often did you feel safe when you were with the people you went to for counseling or treatment? | **○** | **○** | **○** | **○** | **○** |
| 14. How often did the people you went to for treatment listen carefully to you? | **○** | **○** | **○** | **○** | **○** |
| 15. How often were you involved as much as you wanted in your treatment? | **○** | **○** | **○** | **○** | **○** |
| 16. How often were the people you went to for treatment sensitive to your cultural background (race, religion, language, etc.) | **○** | **○** | **○** | **○** | **○** |
| 17. How often did the people you went to for treatment tell you what medication side effects to watch for? | **○** | **○** | **○** | **○** | **○** |
| 18. How often were the accommodations (for example wheelchair accessibility) you need to obtain services available? | **○** | **○** | **○** | **○** | **○** |

1. In the last 12 months, how much were you helped by the counseling or treatment you got?

🞏 Not at all 🞏 Somewhat 🞏 Very Much

**The following questions are about services that you might receive through your healthcare plan. For each of the services listed below that you received in the past 12 months, please tell us how helpful the services were.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Services you might receive** | **If you received this service in the past 12 months, how helpful was the service?** | | |  |
| **Very Helpful** | **Somewhat Helpful** | **Not at All Helpful** | **I did not receive this service** |
| 1. A Health Home care manager who coordinates your medical, behavioral health, and social service needs | **○** | **○** | **○** | **○** |
| 1. Peer support services (support and help provided by people who have experienced mental illness and/or substance use disorder) | **○** | **○** | **○** | **○** |
| 1. Assistance with returning to school or a training program | **○** | **○** | **○** | **○** |
| 1. Assistance with finding or maintaining a job | **○** | **○** | **○** | **○** |
| 1. Assistance with transportation other than medical transportation | **○** | **○** | **○** | **○** |
| 1. Help with finding housing or better housing | **○** | **○** | **○** | **○** |
| 1. Help in pursuing friendships and personal interests | **○** | **○** | **○** | **○** |
| 1. Help in figuring out my finances, including getting any benefits I may be entitled to | **○** | **○** | **○** | **○** |
| 1. Family support and training | **○** | **○** | **○** | **○** |
| 1. Crisis respite services; i.e., residential care for 7 days or less, during a behavioral health crisis | **○** | **○** | **○** | **○** |
| 1. Help with developing a crisis or relapse prevention plan | **○** | **○** | **○** | **○** |

**PART 3: HEALTH, WELLNESS, AND QUALITY OF LIFE**

**The next questions are about your health.**

1. During the **past 4 weeks**, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health? *(Please select one)*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| None at all  🞏 | Very little  🞏 | Somewhat  🞏 | Quite a lot  🞏 | Could not do physical activities  🞏 |

1. Have you used tobacco (e.g., cigarettes, e-cigarettes, pipes, cigars, smokeless or chewed tobacco) in the past 12 months?

🞏 Yes 🞏 No 🞏 Prefer not to answer

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  | **Yes** | **No** | **Not Applicable** |
| 33. Have you experienced any difficulties as a result of your tobacco use in the last 12 months (e.g., health, social, legal, or financial problems)? | | **○** | **○** | **○** |
| 34. Have you experienced any difficulties as a result of your alcohol use in the last 12 months (e.g., personal/family conflict, job instability, legal problems, and/or injuries)? | | **○** | **○** | **○** |
| 35. Have you experienced any difficulties as a result of your drug use in the last 12 months (e.g., personal/family conflict, job instability, legal problems, and/or injuries)? | | **○** | **○** | **○** |

**The next group of questions ask about how satisfied you feel, using a zero to 10 scale. Zero means you feel no satisfaction at all. 10 means you feel completely satisfied. The middle of the scale is 5, which means you are neither happy nor sad.**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **How satisfied are you with…… ?** | **0** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | **8** | **9** | **10** |
| 36. the things you have? Like the money you have and the things you own? | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** |
| 37. your health? | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** |
| 38. what you are achieving in life? | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** |
| 39. your personal relationships? | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** |
| 40. how safe you feel? | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** |
| 41. feeling part of your community? | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** |
| 42. how things will be later on in your life? | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** | **○** |

**Please tell us if you Strongly Agree, Agree, are Neutral, Disagree, or Strongly Disagree with each statement below.**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Strongly Agree** | **Agree** | **Neutral** | **Disagree** | **Strongly Disagree** |
| 1. I am aware of community supports available to me. | **○** | **○** | **○** | **○** | **○** |
| 1. My living situation feels like home to me. | **○** | **○** | **○** | **○** | **○** |
| 1. I have access to reliable transportation. | **○** | **○** | **○** | **○** | **○** |
| 1. I have trusted people I can turn to for help. | **○** | **○** | **○** | **○** | **○** |
| 1. I have at least one close relationship. | **○** | **○** | **○** | **○** | **○** |
| 1. I am involved in meaningful productive activities. | **○** | **○** | **○** | **○** | **○** |

**PART 4: BACKGROUND INFORMATION**

**The following information is collected to help ensure that services meet the needs of all individuals. Please do not share your name. Please check the boxes and fill in the blanks as applicable.**

1. What is your age? \_\_\_\_\_\_\_\_\_
2. What was sex were you assigned at birth, on your original birth certificate? 🞏 Female 🞏 Male 🞏 Unknown
3. Current gender identity – How do you describe yourself? (check one) 🞏 Female 🞏 Male 🞏 Transgender

🞏 Do not identify as female, male, or transgender 🞏 Prefer not to answer

1. How would you describe your sexual orientation?  Heterosexual or Straight  Homosexual, gay or lesbian

 Bisexual  Other

 Not sure  Prefer not to answer

1. In what language do you prefer to communicate with your health care providers?

🞏 English 🞏 Spanish 🞏Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. In what language do you prefer to read things about your health care?

🞏 English 🞏 Spanish 🞏Other (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

55. Are you of Hispanic/Latino Origin? 🞏 Yes, Hispanic or Latino 🞏 No, not Hispanic or Latino

56. What is your race? (Select all that apply)

🞏 White 🞏 American Indian/Alaska Native 🞏 Asian

🞏 Black/African American 🞏 Native Hawaiian/Other Pacific Islander 🞏 Other

57. What is your highest level of education completed?

🞏 Less than High School 🞏 High School diploma or GED 🞏 Business or technical school

🞏 Some college, no degree 🞏 College degree or higher

58. Are you currently enrolled in school? 🞏 Yes 🞏 No

59. Are you currently enrolled in a job training program? 🞏 Yes 🞏 No

60. Have you been employed in the past 12 months? 🞏 Yes, I am currently employed

🞏 Yes, but I am not currently employed 🞏 No

61. Please indicate whether the following things affect your ability to work or your decisions about working. Select all that apply to you.

|  |  |
| --- | --- |
| a. Lack of good jobs | ○ |
| b. Concern about losing benefits (e.g., Medicaid, etc.) | ○ |
| c. Lack of transportation | ○ |
| d. Physical health condition | ○ |
| e. Mental health condition | ○ |
| f. Arrest history | ○ |
| g. Lack of job training / education | ○ |
| h. Medication side effects | ○ |
| i. Workplace attitudes about mental illness and/or substance use problems | ○ |
| j. Retired and no longer looking for work | ○ |

62. Have you been arrested in the past 12 months? 🞏 Yes 🞏 No

63. Have you experienced any difficulties with your housing over the past 12 months (e.g., 3 or more moves, having no permanent address, being homeless, living in a shelter)? 🞏 Yes 🞏 No

**THANK YOU FOR COMPLETING THE SURVEY**

1. New York Request for Qualifications for Behavioral Health Benefit Administration: Managed Care Organizations and Health and Recovery Plans. March 21, 2014. <https://www.omh.ny.gov/omhweb/bho/final-rfq.pdf> [↑](#footnote-ref-1)