

- 1. For a newly established organization, will DCFS consider the relevant professional experience, education, qualifications, and demonstrated capabilities of the organization's founder and proposed key personnel when evaluating organizational experience and capacity?**

The current RFI is being issued for information and planning purposes only and does not establish evaluation criteria for future procurement. Respondents are encouraged to provide information regarding the relevant experience, education, qualifications, and demonstrated capabilities of proposed key personnel, including such information for newly established organizations. Specific minimum qualifications and evaluation criteria, if applicable, would be established in any future solicitation, if issued.

- 2. Will the future procurement allow newly established organizations to participate when they demonstrate the required capacity through qualified employees, consultants, subcontractors, and established community partnerships?**

Eligibility requirements for any future procurement have not yet been established. Information received through this RFI will assist DCFS in evaluating potential service delivery models and provider capacity. Any minimum organizational qualifications, staffing requirements, or other eligibility criteria would be specified in a future solicitation, if issued.

- 3. Will the future procurement permit contractors to utilize specialized consultants, subcontractors, or formal community partnerships for areas requiring specialized expertise, including human trafficking, victim advocacy, behavioral health, medical services, legal services, and other related disciplines?**

The RFI recognizes the importance of a multidisciplinary approach and collaboration with community partners and specialized service providers. Specific requirements regarding subcontractors, consultants, and other formal partnerships have not yet been established and would be addressed in future solicitation, if issued. Respondents are encouraged to describe proposed partnership or subcontracting models that could support effective implementation of the care coordination model.

- 4. Will contractors be permitted to propose service coverage for one or more specific DCFS regions rather than being required to provide statewide coverage?**

DCFS is exploring a regional service delivery model and is seeking information regarding provider capacity to serve one or more DCFS regions. Respondents may provide information regarding the specific region(s) they are able to serve and their proposed approach to providing coverage in those areas.

The final service delivery structure, including geographic coverage requirements, regional assignments, and whether services would be provided by one or more contractors, has not yet been determined and would be established through any future solicitation, if issued.

- 5. Will DCFS establish specific minimum education, licensure, certification, and experience requirements for Care Coordinators, supervisors, and other key personnel in the future solicitation?**

Specific minimum education, licensure, certification, and experience requirements have not yet been finalized. Information received through this RFI will assist DCFS in determining appropriate staffing qualifications and requirements. Any required minimum qualifications for Care Coordinators, supervisors, or other key personnel would be specified in a future solicitation, if issued.

- 6. Will DCFS provide additional specifications regarding the required case management and data systems, including whether contractors will be expected to integrate with an existing DCFS system of record?**

Specific technology, case management, data reporting, and system integration requirements have not yet been finalized. DCFS anticipates establishing requirements necessary to support secure case tracking, data collection, reporting, performance monitoring, and confidentiality. Any required system specifications or integration requirements would be provided in a future solicitation, if issued.

- 7. Will startup and implementation costs associated with establishing required staffing, secure technology systems, training, background clearances, community partnerships, and other necessary infrastructure be considered allowable costs under the future procurement?**

Allowable costs and the payment methodology for any future procurement have not yet been finalized. Respondents are encouraged to identify anticipated startup and implementation costs, including costs associated with staffing, technology, training, background clearances, partnership development, and other infrastructure necessary to implement the proposed care coordination model. Information provided through the RFI will assist DCFS in evaluating potential funding and payment structures. Any final requirements regarding allowable costs and reimbursement would be established in a future solicitation, if issued.

- 8. 3.8.1.6 The RFI states that a vacancy in staff shall be filled within 30 days. If the agency has made a good faith effort to fill the position, but a qualified candidate has not applied, will the agency be penalized? Or may the 30 days be extended? If the agency has identified a qualified candidate, but the required background screenings and/or professional notice to a prior employer has not been completed, will the agency be penalized? Or may the 30 days be extended?**

DCFS recognizes that circumstances outside of a contractor's control may impact its ability to fill a vacancy within 30 days, including the availability of qualified applicants and completion of required background screenings or other pre-employment requirements. The intent of the 30-day requirement is to promote timely filling of vacancies and minimize disruption to service delivery.

Regardless of staffing vacancy, continuity of Care Coordination services should be maintained. The Contractor would be expected to have a plan for ensuring appropriate coverage during a vacancy so that referrals continue to be received and addressed, existing cases continue to be coordinated and monitored, required meetings and follow-up activities continue, and children, families, and multidisciplinary partners do not experience an interruption in Care Coordination services. Coverage may require temporary reassignment of responsibilities or other appropriate staffing arrangements until the vacancy is filled.

Any future solicitation or resulting contract would specify the process for addressing circumstances in which a contractor is unable to meet the established timeframe despite documented, good-faith recruitment and hiring efforts. Any extension related to filling a vacant position would not eliminate the Contractor's responsibility to maintain continuity of required Care Coordination services.

- 9. 3.9.11 The RFI states that DCFS reserves the right to require secure API access to case-level data of state monitoring and recordation in the State's system of record. Would you please clarify with an example of what this means in practice?**

DCFS has not yet finalized the technology or system-integration requirements for future procurement. This provision is intended to preserve the Department's ability to securely access or exchange certain Care Coordination data electronically if needed for program monitoring and reporting.

For example, a Contractor may maintain Care Coordination information within its own case-management system, including referrals, case status, Care Coordination activities, service linkages, and outcomes. Rather than requiring the Contractor to manually enter the same information into multiple systems or submit separate reports, DCFS may require a secure electronic method for specified data elements to be transmitted to or accessed by an authorized State system.

This does not mean that DCFS is currently requiring unrestricted access to a Contractor's entire case-management system. Any required electronic exchange or API access would be limited to authorized data necessary for approved programmatic, monitoring, reporting, or recordation purposes.

Specific requirements regarding the data elements to be exchanged, systems involved, method and frequency of exchange, authorized users, security standards, confidentiality protections, and technical specifications would be clearly defined in any future solicitation or resulting contract.

10. 3.11.1 The RFI states that the contractor shall develop real-time dashboards to monitor deliverables and service level requirements, and Contractor shall provide DCFS access to the dashboards. Would you please clarify with an example of what this means in practice?

The intent of this requirement is to provide DCFS with timely visibility into program operations and performance without relying solely on periodic reports.

For example, a dashboard could display current information such as the number of referrals received, referral status, timeliness of initial contact or meetings, active cases, service linkages, MDT participation, case closures, and other established performance measures. The dashboard should allow DCFS to monitor applicable contractual deliverables and performance indicators using current data maintained by the contractor. Specific dashboard elements, update frequency, access requirements, and reporting specifications would be established in any future solicitation or resulting contract.

11. 3.12.3 The RFI states that the Contractor shall maintain, at a minimum, eight hours of regular business operations each day, but also that the Contractor may establish regular business hours based on needs provided that sufficient availability is maintained during customary business hours. Does this mean that an RCC must document at least 40 hours of time each week, or that the RCC must be available to receive intakes and respond to partners as appropriate throughout the work week?

The requirement in Section 3.12.3 applies to the Contractor's required hours of operation and service availability. It is intended to ensure sufficient coverage to receive referrals, respond to partners, conduct care coordination activities, and meet contractual requirements throughout the customary work week.

This provision is not intended, by itself, to establish a requirement that an individual care coordinator document a specific number of billable or case-specific service hours each week. Contractors would be responsible for establishing staffing and scheduling practices sufficient to maintain required coverage and ensure timely

performance of all care coordination responsibilities. Any specific personnel timekeeping or staffing requirements would be identified in a future solicitation or resulting contract.

12. 3.13.12 The RFI provides a chart of penalties regarding performance indicators. For the service linkage and MDT participation & partner engagement items being greater than 90%, please explain how this will be calculated since each case has its own set of relevant participants and recommended services.

DCFS recognizes that appropriate services and multidisciplinary participants will vary based on the individual needs and circumstances of each child or youth. The intent of these measures is not to require identical service linkages or MDT participation across all cases.

Performance would be measured based on the services and multidisciplinary partners identified as applicable to the individual case. For service linkage, the measure would evaluate whether identified or recommended service needs were appropriately addressed through referral, linkage, coordination, or documented follow up, as applicable. For MDT participation and partner engagement, the measure would evaluate documented efforts to engage the relevant multidisciplinary partners identified for the case.

Specific calculation methodologies, documentation standards, and circumstances outside of the Contractor's control, would be further defined in any future solicitation or resulting contract.

13. 3.19.3 The RFI provides a chart for damages owed to DCFS in the event of failure to perform. Regarding the item of 95% of referred children having a first scheduled meeting within seven days of referral, does this mean if one meeting is scheduled outside of the seven days you are penalized? Does this mean if you are out of compliance with the 95% rule you are penalized per case? Also, the requirement states scheduled within the 7 days of referral, but the damage states not served within the timeframe. Will all referrals have 7 days? Please clarify.

The 95% performance standard is intended to be measured as an aggregate performance indicator over the applicable reporting period rather than as an automatic penalty for a single case that falls outside of the required timeframe. A single case outside of the established timeframe would not, by itself, constitute failure to meet the 95% performance standard if overall performance remains at or above the required threshold.

DCFS also recognizes the distinction between a meeting being scheduled within the required timeframe and a child or youth actually being served within that timeframe. The intent of this provision is to measure the Contractor's timely action following referral. Any future contract would clearly define how this performance measure is calculated, including applicable time frames, exceptions, and how any damages would be assessed.

Applicable response timeframes may also vary based on the level of need or risk identified for the referral, consistent with the response requirements established by DCFS (Appendix A). Any future solicitation or resulting contract would clearly identify the applicable timeframe for each referral category.

14. Existing model: What information or identified needs informed DCFS's consideration of a different structure for Care Coordination, and are there specific areas of the current model DCFS hopes to improve?

DCFS is evaluating the structure of Human Trafficking Care Coordination to identify opportunities to strengthen statewide consistency, accountability, multidisciplinary engagement, service coordination, performance monitoring, and responsiveness to regional needs. The RFI is intended to gather information from interested organizations regarding provider capacity, regional service delivery, staffing, implementation, data collection, performance measurement, and other considerations that may inform future program planning.

15. Existing CAC/MDT services: As DCFS considers the future model, how does it envision Care Coordination integrating with existing CAC and MDT services to minimize duplication and maintain continuity for children and families?

DCFS anticipates that Care Coordination will continue to operate within a multidisciplinary framework and in collaboration with CACs, MDTs, DCFS, law enforcement, medical and behavioral health providers, victim service organizations, and other relevant partners.

Care Coordination is intended to complement and strengthen, rather than duplicate existing CAC/MDT and partner functions. The Care Coordinator's role is to help ensure that the multidisciplinary response remains connected and coordinated over time. This includes identifying and engaging the appropriate partners; facilitating multidisciplinary communication and collaborative planning; identifying needs, gaps, and barriers; coordinating and tracking service linkages; documenting and following up on agreed-upon action items; re-engaging partners when necessary; and helping ensure continuity as the child's needs or circumstances change.

Respondents are encouraged to identify strategies for integrating Care Coordination with existing regional infrastructure while minimizing duplication and maintaining continuity for children and families.

16. 2025 service data: Of the 1,091 children who received Care Coordination in 2025, is information available regarding how many were also served through a CAC/MDT and what additional services were provided specifically through Care Coordination?

DCFS does not currently have data available that identifies how many of the 1,091 children were also served through a CAC/MDT. Care Coordination is not intended to duplicate services already provided by CAC's, MDT partners, or other providers. Its role is to coordinate the multidisciplinary response, connect children and families to appropriate services, identify barriers, support communication and follow up among partners, and track identified needs and next steps.

17. Roles and responsibilities: How does DCFS distinguish the functions of Care Coordination, victim advocacy/navigation, and DCFS case management within the proposed model?

Care Coordination is a multidisciplinary coordination function focused on bringing relevant partners together; facilitating communication and collaborative planning; identifying needs, gaps, and barriers; coordinating and tracking service linkages; facilitating follow up on agreed upon actions; and supporting continuity of the multidisciplinary response.

Victim advocacy/navigation generally focuses on direct support to the child or youth and family, including assistance in understanding and accessing available services and resources and providing direct victim-centered support.

DCFS case management is performed pursuant to the Department's statutory responsibilities and applicable child welfare policy and includes assessment of child safety, case planning, service planning and monitoring, family engagement, permanency, court related responsibilities, and other day-to-day responsibilities associated with the Department's involvement with the child and family.

Care Coordination does not replace the responsibilities of DCFS, victim advocates, or other service providers. Rather, it supports coordination across those systems.

18. Performance measures: For performance measures that depend on participation or response from multiple agencies, how does DCFS anticipate distinguishing contractor performance from delays or barriers involving other MDT partners?

DCFS recognizes that a Care Coordinator cannot control whether an independent MDT partner ultimately participates, responds to outreach, or completes an action within an established timeframe. Performance measures should therefore distinguish between circumstances outside of the Contractor's control and the actions the Contractor is responsible for taking to actively develop and maintain a multidisciplinary response.

While the Contractor cannot guarantee partner participation, the Contractor is responsible for making meaningful and documented efforts to identify and engage the partners relevant to each case. Care Coordination should include outreach to appropriate disciplines based on the needs and circumstances of the child or youth. This may include law enforcement, CAC/MDT representatives, medical and behavioral health providers, prosecutors, schools, placement providers, legal representatives, specialized service providers, and other community partners, as applicable to the individual case.

Contractor performance may therefore consider whether the Care Coordinator timely identified appropriate partners; initiated and documented outreach; invited relevant partners to participate in multidisciplinary discussions; followed up when partners did not respond or participate; facilitated meaningful communication and collaborative planning among involved partners; identified and addressed barriers to participation; and escalated persistent barriers when appropriate.

Specific methodologies, documentation requirements, exclusions, and circumstances outside of the Contractor's control would be defined in any future solicitation or resulting contract.

19. Data ownership and systems: Who will own the Care Coordination data? What systems will contractors be required to use? Who will have API/dashboard access, and how will confidentiality requirements governing CAC/MDT information be protected?

Final requirements regarding data ownership, required information systems, API or other system integration, dashboard access, and data-sharing protocols have not yet been established. These requirements would be clearly defined in any future solicitation or resulting contract.

As described in question #9, DCFS is preserving the ability to require secure electronic access to or exchange of specified Care Coordination data when necessary for State monitoring, reporting, or recordation. This should not be interpreted as requiring unrestricted DCFS access to all information maintained within a Contractor's system.

Contractors would be expected to maintain sufficient Care Coordination data to document activities, monitor performance, track required outcomes, and meet applicable reporting requirements. Access to that information would be limited to authorized individuals and to information necessary for approved purposes.

Specific requirements regarding data ownership, system use, authorized access, data-sharing responsibilities, and confidentiality protections would be established prior to implementation through any future solicitation or resulting contract.