CONSOLIDATED HOUSING FUND

FY26 RFP Q&A

What is the deadline for questions in the application process?

The current deadline to submit questions is end of day Monday, 5/19/25. We may extend that deadline by a week, and any extension will be posted on the website. This deadline applies specifically to questions that will be publicly posted. However, we will continue to respond to technical questions beyond that date.

Emergency Solutions Grant (ESG) requires 100% match – is that still the case this funding cycle? Any match requirements for other funding sources?

Yes, a 100% match is still required for ESG, but otherwise there are no match requirements. We can't guarantee matches like in past years, but we'll make every effort to try. This year, approximately $1 million in ESG is available.

Do we anticipate losing beds from shelters that can't bridge the gap in funding?

We currently have around 1,400 beds. If reductions happen, we may return to the capacity levels we had in spring 2023 (an estimated loss of 300 beds). While that would be a step back, it is still better than the more drastic fallback to the 652 beds that we had in the past.

Can you talk a little more about Homelessness Prevention Services (HPS), especially legal service connection?

Fundamentally, the way to end homelessness is by stopping inflow and increasing outflow. HPS plays a central role in reducing inflow into the system. Legal services are an impactful and critical part of this work, and we are interested in funding programs that include legal support and other targeted interventions.

More broadly, beyond this RFP, we would like to collaborate more with other state agencies and departments to break down silos and tackle systemic issues together. Our goal is to intervene before people become homeless. We're also watching the Rhode Island Department of Human Services' HPS pilot (which utilizes TANF dollars) closely, along with related efforts at the federal level.

What is the range of funding that has been designated for Housing Problem Solving?

Last year we awarded about 5% of our total available CHF funding towards Housing Problem Solving. This year we anticipate awarding at least the same percentage. Of course, the actual amount will depend on total available funding and the applications we receive from providers and other vendors.

Are warming centers covered in this RFP or only in the July one?

Warming centers are only covered in the July RFP. Note, there may be 2 different RFPs in July due to municipal support (which would be avail only to those municipalities) but that is currently TBD.

Given the substantial loss of funding this cycle, will RIH implement caps for funding requests in applications?

We have not applied any funding caps (within reason). The only cap we currently have set is on emergency shelter bed costs. For 24hr shelters, that cap is $13,000 per year per bed; for night-by-night shelters, $9,000 per year per bed.

In order to encourage providers to look for cost savings, we are implementing an application scoring point bonus for projects that come in below these caps (2 bonus points awarded for every $1000 under the cap).

How should providers budget for capital expenses? Ex. if we end up needing a new roof, but hadn't anticipated that and therefore had not included it in our calculations.

For providers operating emergency shelters in State-owned facilities where they don't have rent, they may include basic maintenance and janitorial expenditures, but not capital expenses. We expect to have more discussions with providers after the RFP closes in order to review budgets in more detail.

What are the insurance requirements for the RFP?

Insurance requirements have not changed since our last RFP. Providers may refer to their existing contracts or reach out to us by email for insurance details.

The Department of Housing provided great budget and budget narrative templates for providers. Why is the budget page in eCivis much less detailed?

That's just how the eCivis system works, and we're unable to adjust it on this end. Next year there won't be SFRF or ERA2, which means all invoicing will have to go through eCivis for these new contracts. However, the budget template we redesigned for this year is the main one we will ultimately work out of. Providers will fill out the templates RI Department of Housing has provided, then we will plug in those numbers to eCivis.

Explain more about Regional Access Points (RAP), their structure, and what RI Dept. of Housing wants to see from applicants.

The conversation around RAPs began in response to concerns with how the Coordinated Entry System (CES) was working. Some providers noted that people in their communities were stuck waiting for CES referrals without access to shelter; hence,

a 25% set-aside was proposed to let providers reserve beds for these people (set-aside is 75% for new projects). This model has proven effective in reducing barriers to shelter.

Regional Access Points are meant to support more than just CES referrals—they are entry points for diversion, Homelessness Prevention Services (HPS), connections to mental health or substance use resources, etc. The goal is to offer multiple ways for people to access help, especially for those who can't or don't want to travel far. The Department is not mandating criteria or setting parameters. We hope to see creative proposals from applicants to help us fill gaps we haven't identified.

For the Regional Access Points concept, what are the scope/metrics/expectations for establishing them, if a project meets the standards to be considered an RAP?

There aren't any officially established expectations or criteria because there are so many different ways to run these models. We understand this is a big change to the system and we plan to keep the conversation going over the summer.

We want to work with providers and community partners to find ways to eliminate barriers in ways that will still meet HUD and CES requirements. HUD gives states and communities some leeway to meet those standards in whatever way works for them.

Will we continue to expect that all providers will operate from a "Housing First" position through these access points?

Our continued expectation is that all providers operate with a Housing First philosophy across all funded programs.

How do you see the transition happening with Continuum of Care (COC) / Coordinated Entry System (CES) and RAPs?

It's important to note that CES is mandated by HUD and falls under Continuum of Care guidance. While the state contributes funds to CES, we work closely with the Continuum of Care to coordinate efforts.

Once we receive proposals, we can form a better idea of how the transition will look. We also expect to continue these conversations over the summer. Currently, we've executed a street outreach contract amendment to begin piloting access points with three providers in anticipation of a larger system change. The pilots are not fully operational yet, but we now have some infrastructure in place.

Within this RFP timeline, should providers expect to no longer get referrals from CES but from RAPs instead?

Ultimately, yes -- referrals would shift from the CES call center to Regional Access Points. The Continuum of Care board decides on the Coordinated Entry System policies and procedures, and prior to the statutory establishment of the State Housing Department, COC had decided to use the coordinated entry call center for shelter

referrals. We believe that no longer serves the needs of providers and people experiencing homelessness, so we expect to eliminate the CES call center as we currently know it.

However, we don't plan to propose any major changes to the CES without taking a broad range of input from providers, the community, and especially from people experiencing homelessness.

Will RAPs have access to shelter availability and be able to directly place clients into specific shelters functioning similarly to CES?

That's the goal. How we get there depends on the tools available (ex. real-time dashboards showing shelter availability). One of our goals is for providers to know day-to-day shelter availability so that Street Outreach teams—even at encampments—can reserve beds on the spot for clients in need.

How will "region" be defined, and who will come up with that standard?

RAPs would generally be county-based but should ultimately be shaped by where the people experiencing homelessness are. Some communities may propose more specialized access points (example, domestic violence services providers might have different needs or approaches to structuring services). The goal is to work alongside providers and the community to help define what these "regions" should look like based on actual service needs and population patterns.

Will there be a single centralized RAP per region, or will there be multiple RAPs in communities with greater needs?

The number of RAPs that are launched will depend on what's feasible based on cost. Higher-density areas like Providence might have multiple RAPs, since that's where a significant portion of people experiencing homelessness in Rhode Island are physically located. We don't have a fixed number or configuration in mind.

Functionally, drop-in centers appear to work similarly to the RAPs, so do existing programs need to connect their drop-in centers or day services projects with an RAP in their application?

We do not have an official list of criteria to differentiate these, but you can think of drop-in centers as RAP-lite. The Regional Access Points idea won't disrupt any established centers, and anyone who already operates a drop-in center wouldn't need to reapply for it as a RAP (unless they wanted to).

If you're applying for drop-in centers or day services, you still apply through the Supportive Services Only section of the application form.

How can Street Outreach be redesigned to work with Regional Access Points?

One of the main reasons we released this RFP early was so we could begin reviewing creative proposals from applicants and work on applying promising ideas throughout existing systems.

If we establish Regional Access Points where people can access a range of housing-related services, and think of Street Outreach as an extension of those RAPs into the community, there will naturally be changes that happen within SO.

For application purposes, should providers submit two different applications for Street Outreach / Regional Access Points, or can these be consolidated?

While Street Outreach teams can naturally flow out of Regional Access Points (you can think of them like hubs), we don't require providers to apply for both programs. If a provider wants to do only Street Outreach without including a Regional Access Point in their application, we still welcome those proposals.

Regarding supportive services and how the Department sees that (case management, etc.), are there specific gaps we're trying to fill?

Regarding Supportive Services Only, we've seen past examples like day centers, which operate as drop-in spaces and are not focused on long-term solutions. That model is different from the RAP model. There have also been services-only projects that provide case management or support services without operating PSH, RRH, or similar housing programs. These are examples of what a Supportive Services Only project might look like. But there are not specific gaps we are looking to fill through this project type.

For organizations who don't provide shelter, do we envision extending HPS services like diversion through RAP?

Our goal is for HPS and other services to flow through Regional Access Points, allowing people to connect with these services more directly.

We see a helpful model in Connecticut's "CANs" (Coordinated Access Networks) where people experiencing housing crisis can access HPS, diversion, and related supports in one place. We envision a similar structure here, which would support a more effective and holistic system while helping us adapt to anticipated funding reductions.

Please talk a little more about the vision for integration between Street Outreach and Regional Access Points.

We'd like to see the Regional Access Points built out as home bases for Street Outreach case managers and their clients. Many Street Outreach providers and staff have expressed frustration that they have to go through call centers (often resulting in significant wait times and delays in responses) to help their clients access shelter beds and other services. We'd like to operationalize the system where street outreach workers can reserve a bed right there and then facilitate getting that person there.

Are Staff-to-Client ratios just for shelters? How about for RAP, and would that requirement be for shelter only ratios, or for all providers?

Staff-to-Client ratios do not apply to all projects, just to shelters, but we would like all providers to consider RAP. These access points are designed to be for all kinds of services, including diversion.

We intentionally provided an open framework for RAPs in the RFP to give providers the space to shape proposals based on community needs. Once all applications are in, we will begin assessing the system more holistically to shift towards diversion efforts and begin collaborating with the COC to align Coordinated Entry policies accordingly.

Can providers partner with another org to create a blended project?

Yes -- we encourage providers to collaborate if they would like to do so.