



DEPARTMENT OF ADMINISTRATIVE AND FINANCIAL SERVICES  
**DIVISION OF PROCUREMENT SERVICES**  
 STATE OF MAINE

**PROCUREMENT JUSTIFICATION FORM (PJF)**

This form must accompany all contract requests and sole source requisitions (RQS) over \$5,000 submitted to the Division of Procurement Services.

*INSTRUCTIONS: Please provide the requested information in the white spaces below. All responses (except signatures) must be typed; no hand-written forms will be accepted. See the guidance document posted with this form on the Division of Procurement Services intranet site (Forms page) for additional instructions.*

**PART I: OVERVIEW**

Department Office/Division/Program:		DHHS/OADS/In-Home Vaccinations Ingrid Diamond / Gretchen Zeh-Higgins		
Department Contract Administrator or Grant Coordinator:		Nancy Tan / Patricia Wall		
(If applicable) Department Reference #:		Multiple: See Attachment		
Amount: (Contract/Amendment/Grant)		Multiple: See Attachment	Advantage CT / RQS #:	Multiple: See Attachment
<b>CONTRACT</b>	Proposed Start Date:	12/01/2021	Proposed End Date:	02/28/2023
<b>AMENDMENT</b>	Original Start Date:		Effective Date:	
	Previous End Date:		New End Date:	
<b>GRANT</b>	Project Start Date:		Grant Start Date:	
	Project End Date:		Grant End Date:	
Vendor/Provider/Grantee Name, City, State:		Multiple: See Attachment		
Brief Description of Goods/Services/Grant:		In-Home Vaccinations		

**PART II: JUSTIFICATION FOR VENDOR SELECTION**

Mark an "X" before the justification(s) that applies to this request. (Check all that apply.)

<input type="checkbox"/>	A. Competitive Process	<input type="checkbox"/>	G. Grant
<input type="checkbox"/>	B. Amendment	<input type="checkbox"/>	H. State Statute/Agency Directed
<input type="checkbox"/>	C. Single Source/Unique Vendor	<input type="checkbox"/>	I. Federal Agency Directed
<input type="checkbox"/>	D. Proprietary/Copyright/Patents	<input checked="" type="checkbox"/>	J. Willing and Qualified
<input type="checkbox"/>	E. Emergency	<input type="checkbox"/>	K. Client Choice
<input type="checkbox"/>	F. University Cooperative Project	<input checked="" type="checkbox"/>	L. Other Authorization: COVID-19

Please respond to ALL of the questions in the following sections.

**PART III: SUPPLEMENTAL INFORMATION**

1. Provide a more detailed description and explain the need for the goods, services or grant to supplement the response in Part I.

The purpose of this Agreement is to provide knowledge of reliable and available resources and also provide support related to COVID-19 and influenza vaccinations to the LTSS population of older adults and those with disabilities.

The Provider shall focus on increasing the number of members who are fully educated on the risks of both COVID 19 and influenza and the probable negative health effects on the members. Additionally, the provider will work to increase the percentage of vaccinated LTSS members in both the categories of COVID 19 and influenza.

**PART III: SUPPLEMENTAL INFORMATION**

2. Provide a brief justification for the selected vendor to supplement the response in Part II. Reference the RFP number, if applicable.

The Office of Aging and Disability has determined that these providers have the requisite training and experience to deliver this service on an emergency basis. These providers have been assisting with in-home vaccinations efforts, in clinics and in facilities throughout the pandemic. These community providers have staff qualified to administer vaccinations and can help ensure wide reach to their already established client population.

3. Explain how the negotiated costs or rates are fair and reasonable; or how the funding was allocated to grantee.

The cost is considered fair and reasonable, based on analysis of the scope of work that needs to be accomplished and the concern for completing the work as expeditiously as possible.

4. Describe the plan for future competition for the goods or services.

The Department does not intend to RFP this willing and qualified service.

**PART IV: AMERICAN RESCUE PLAN ACT (ARPA) / MAINE JOBS & RECOVERY PLAN (MJRP)**

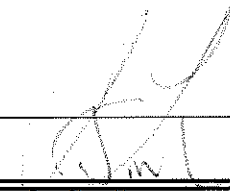
Does this request utilize ARPA/MJRP funds?

Yes – If Yes, please attach the approved Business Case(s).

No – If No, proceed to Part V

**PART V: APPROVALS**

The signatures below indicate approval of this procurement request.

Signature of requesting Department's Commissioner (or designee):			
Typed Name:		Date:	11-Jan-22
Signature of DAFS Procurement Official:	DocuSigned by: <i>Kathy Paquette</i>		
Typed Name:	41C2BA36FAF44CD... Kathy Paquette	Date:	1/14/2022

**In-Home Outreach Vaccinations****12/1/2021 – 2/28/2023**

<b>Vendor/Provider Name</b>	<b>DHHS Agreement #</b>	<b>Total Contract Amount</b>
Eastern Maine Healthcare Systems dba Northern Light Home Care and Hospice	ADS-22-9916	\$50,000.00
Penobscot Community Health Center PCHC	ADS-22-9919	\$50,000.00
Androscoggin Home Health and Hospice	ADS-22-9920	\$150,000.00
	<b>3</b>	<b>\$250,000.00</b>