

**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/Office of MaineCare Services		
Department Contract Administrator or Grant Coordinator:		Shawn Belanger/ Stacy Martin		
(If applicable) Department Reference #:		OMS-22-121		
Amount: (Contract/Amendment/Grant)		\$9,995	Advantage CT / RQS #:	CT 10A 20211217000000001536
CONTRACT	Proposed Start Date:	12/1/2021	Proposed End Date:	12/31/2022
AMENDMENT	Original Start Date:		Effective Date:	
	Previous End Date:		New End Date:	
GRANT	Project Start Date:		Grant Start Date:	
	Project End Date:		Grant End Date:	
Vendor/Provider/Grantee Name, City, State:		Medical Care Development Augusta, Maine		
Brief Description of Goods/Services/Grant:		Community Health Worker Consultation for Program Development		

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 checked="" type="checkbox"/>	C. Single Source/Unique Vendor	<input type="checkbox"/>	I. Federal Agency Directed
<input type="checkbox"/>	D. Proprietary/Copyright/Patents	<input 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 type="checkbox"/>	L. Other Authorization

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 Department is designing care models and payments models to address health related social needs, including through incentives for partnerships with Community Health Worker services. To effectively design and implement these models, the Department needs to work directly with Community Health Workers around shared goals, program design, capacity issues, data collection, etc. This Provider will engage, convene, and pay for community health worker consultation to aid the incorporation of Community Health Worker services with MaineCare services and care models.

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

The Provider has a unique capability to effectively engage Community Health Workers in consultation efforts. The Provider has done this work previously, leveraging their role as an organizational host for many Community Health Worker related efforts in Maine for many years, such as hosting the online Community Health Worker Trainings. The Provider has the appropriate relationships and competencies to allow this work to move forward in a timely manner and to reach the intended consultants.

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

The Provider will be using hourly that are aligned with hourly rates paid for comparable position in other Department contracts for similar services.

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

This work is time limited; the Department does not have plans to continue this particular scope of work beyond this agreement.

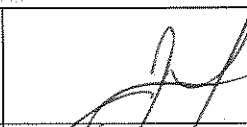

PART IV: AMERICAN RESCUE PLAN ACT (ARPA) / MAINE JOBS & RECOVERY PLAN (MJRP)

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:	12-1-22
Signature of DAFS Procurement Official:			
Typed Name:	Kathy Paquette	Date:	1/26/2022