



**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/Maine CDC/TB Control	
Department Contract Administrator or Grant Coordinator:		Melanie Boucher	
(If applicable) Department Reference #:		CD0-24-51TB2	
Amount: (Contract/Amendment/Grant)	\$ 9,588.41	Advantage CT / RQS #:	RQS 10A 20231127000000000781
CONTRACT	Proposed Start Date:	10/8/2023	Proposed End Date: 10/17/2023
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:		Central Maine Medical Center Lewiston ME	
Brief Description of Goods/Services/Grant:		Hospital stay for TB patient	

PART II: JUSTIFICATION FOR VENDOR SELECTION			
Check the box below for 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.

These funds cover the cost of a multi-day hospital stay at Central Maine Medical Center for a patient with complicated active Tuberculosis who was in the hospital from 10/8/2023 – 10/17/2023. Under the rules of Notifiable Conditions <http://www.maine.gov/sos/cec/rules/10/144/144c258.doc> Tuberculosis is an immediately reportable disease. These costs are associated with diagnosing and preventing the spread of treatment-resistant Tuberculosis. The patient went to the closest medical facility equipped to treat this disease.

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

The client went to a hospital where they could be treated for this condition. We had no part in the selection.

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

The TB Control Program will pay at the MaineCare reimbursement rates for services rendered. These rates are pre-approved by the Department.

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

The Department does not intend to competitively bid this service.

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

Does this request utilize ARPA/MJRP funds?

Yes, MJRP funds (023) – If Yes, please attach the approved Business Case(s).

Yes, ARPA funds (025) – If Yes, please be aware of the requirements from awarding federal agencies.

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:

Ben Moran

Date:

1/22/23

Signature of DAFS Procurement Official:

DocuSigned by:  
William J.E. Allen  
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Typed Name:

William J.E. Allen

Date:

1/9/2024

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