

**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:		Jennifer Levesque/ Melinda Farrell	
(If applicable) Department Reference #:		OMS-24-7006A	
Amount: (Contract/Amendment/Grant)	Original: \$60,000.00 Amend: \$45,740.00 Revised: \$105,740.00	Advantage CT / RQS #:	CT 10A 2023091300000000728
CONTRACT	Proposed Start Date:		Proposed End Date:
AMENDMENT	Original Start Date:	10/1/2023	Effective Date:
	Previous End Date:	3/30/2024	New End Date:
GRANT	Project Start Date:		Grant Start Date:
	Project End Date:		Grant End Date:
Vendor/Provider/Grantee Name, City, State:		Tri-County Mental Health Services Lewiston, ME	
Brief Description of Goods/Services/Grant:		Certified Community Behavioral Health Clinic Evaluation	

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 checked="" type="checkbox"/>	G. Grant
<input checked="" 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 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

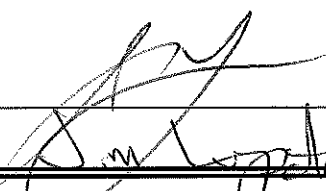
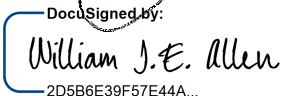
Please respond to ALL of the questions in the following sections.

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.	<p>Section 223 of the PAMA helps states establish Certified Community Behavioral Health Clinics (CCBHCs). Section 223 creates and evaluates a demonstration program, overseen by SAMHSA, for states to certify community behavioral health clinics. Certified clinics must meet specific criteria emphasizing high-quality care.</p> <p>A revision to the original scope of work and funding is required to align with supporting CCBHC development in providing adequate behavioral health response due to a mass-violence event in Lewiston.</p>
2. Provide a brief justification for the selected vendor to supplement the response in Part II. Reference the RFP number, if applicable.	<p>This work is funded by the SAMHSA CCBHC Demonstration Grant, and the and funding for selected CCBHCs is included in the grant application. Tri-County Mental Health Services is a prospective CCBHC eligible to receive contractor funding to pilot population specific interventions as identified in the SAMHSA CCBHC Planning Grant. Tri-County Mental Health Services provides care in Androscoggin County, in Juvenile Community Corrections Region 2 which had the 2nd highest rate of all referrals to the Department of Corrections (147 referrals, 32% of all referrals in 2023 YTD) and 13% of all referrals by offense type involved Drugs and Alcohol.</p>
3. Explain how the negotiated costs or rates are fair and reasonable; or how the funding was allocated to grantee.	<p>The scope of work and budget have been reviewed and approved by SAMHSA.</p>
4. Describe the plan for future competition for the goods or services.	<p>This work is supported by a Federal grant award and is not expected to continue beyond the grant period.</p>

PART IV: AMERICAN RESCUE PLAN ACT (ARPA) / MAINE JOBS & RECOVERY PLAN (MJRP)	
Does this request utilize ARPA/MJRP funds?	
<input type="checkbox"/> Yes, MJRP funds (023) – If Yes, please attach the approved Business Case(s).	
<input type="checkbox"/> Yes, ARPA funds (025) – If Yes, please be aware of the requirements from awarding federal agencies.	
<input checked="" type="checkbox"/> 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:	6 - Feb - 24
Signature of DAFS Procurement Official:			
Typed Name:	William J.E. Allen	Date:	2/12/2024

NOI 0220240166 02/12/2024 - 02/18/2024