



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.*

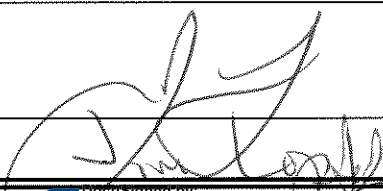
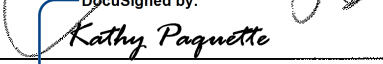
PART I: OVERVIEW				
Department Office/Division/Program:		DHHS/OADS/Consultation / Ingrid Diamond		
Department Contract Administrator or Grant Coordinator:		Althea Harris/ Lora Blackwell		
(If applicable) Department Reference #:		ADS-22-9812A		
Amount: (Contract/Amendment/Grant)	Orig: \$10,000.00 Amd A: \$10,000.00 Total: \$20,000.00	Advantage CT / RQS #:	10A 20220103000000001610	
<b>CONTRACT</b>	Proposed Start Date:		Proposed End Date:	
<b>AMENDMENT</b>	Original Start Date:	01/01/2022	Effective Date:	01/01/2023
	Previous End Date:	12/31/2022	New End Date:	12/31/2023
<b>GRANT</b>	Project Start Date:		Grant Start Date:	
	Project End Date:		Grant End Date:	
Vendor/Provider/Grantee Name, City, State:		Elizabeth B. Simpson, M.D. Pawtucket, RI		
Brief Description of Goods/Services/Grant:		Specialized psychiatric services		

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 checked="" 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.
<p>The purpose of this Agreement is to provide specialized psychiatric services for individuals who have a diagnosis of ID or Autism and a diagnosed or suspected co-occurring mental illness. Services may include but not be limited to the following:</p> <ul style="list-style-type: none"> <li>- Psychiatric evaluation and diagnosis of clients referred to the Provider by the Department;</li> <li>- Consultation with the Department to identify and implement appropriate treatment options for the client; and</li> <li>- Consultation with the Department to identify and implement appropriate services and supports that facilitate successful transition of clients from medical facilities to long-term residential placements.</li> </ul> <p>This amendment is to extend for another year and add funding.</p>	
2.	Provide a brief justification for the selected vendor to supplement the response in Part II. Reference the RFP number, if applicable.
<p>Sufficient staffing or expertise is not available within the Department to perform the services outlined above. This work must be performed by a licensed psychiatric practitioner who has training and experience in diagnosis and evaluation of individuals having ID or Autism and a co-occurring mental illness.</p> <p>Dr. Simpson possesses the following qualifications needed to provide these services:</p> <ol style="list-style-type: none"> <li>1. An active license to practice medicine;</li> <li>2. Board certification in Psychiatry; and</li> <li>3. Training and experience in diagnosis and evaluation of individuals having ID or Autism with co-occurring mental illness.</li> </ol>	
3.	Explain how the negotiated costs or rates are fair and reasonable; or how the funding was allocated to grantee.
<p>The rate charged by the Provider is considered fair and reasonable based on comparison with the rates commonly charged by qualified Providers for similar services. The rates are based on region and compared to other psychiatric practitioners in the area.</p>	
4.	Describe the plan for future competition for the goods or services.
The Department does not intend to issue an RFP for these services.	

PART IV: AMERICAN RESCUE PLAN ACT (ARPA) / MAINE JOBS & RECOVERY PLAN (MJRP)	
Does this request utilize ARPA/MJRP funds?	
<input type="checkbox"/> Yes – If Yes, please attach the approved Business Case(s).	
<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:	23-Mar-22
Signature of DAFS Procurement Official:			
Typed Name:	41C2BA36FAF44CD... Kathy Paquette	Date:	5/2/2022