



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:		Maine CDC/Disease Prevention and Control/Oral Health		
Department Contract Administrator or Grant Coordinator:		Chris Moiles / Melanie Boucher		
(If applicable) Department Reference #:		CD2-23-4512		
Amount: (Contract/Amendment/Grant)	\$ 12,000.00	Advantage CT / RQS #:	CT 10A 20230227000000002175	
CONTRACT	Proposed Start Date:	7/1/2023	Proposed End Date:	6/30/2024
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:		Portland Community Health Center, Portland, ME		
Brief Description of Goods/Services/Grant:		Clinical Dental 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 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.

Access to clinical dental services for MaineCare eligible and low-income persons is a challenge in many parts of the state, including the service area of Portland Community Health Center. The Dental Services Subsidy Program, for which this contract provides funding, was designed to assist qualified community agencies in providing these services. This funding program is mandated by 22 MRSA § 2127, which makes certain funds available to eligible and qualified community oral health programs, with the intent to subsidize the provision of oral health care for persons whose gross income is below 200% of the federal poverty level, and who are without insurance for that care. The intent of the legislature in allocating the funds was to assist these programs by supporting their sliding fee scales, thus enabling the agencies to keep those fees at levels affordable and accessible to the individuals they intend to serve. In other words, the intent of the Subsidy Program is to assist qualified community programs in maintaining fee structures that will keep their services financially accessible to potential patients.

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

This funding program is mandated by 22 MRSA § 2127, which makes certain funds available to eligible and qualified community oral health programs, with the intent to subsidize the provision of oral health care for persons whose gross income is below 200% of the federal poverty level, and who are without insurance for that care. As noted above, vendor name is the primary source of dental services for the intended population within its particular service area. The organization is able to provide those services with appropriate licensed professionals, maintains a sliding fee scale that is acceptable to the Department, and has certified to the Department that it meets the Department's and other legislative requirements for eligibility to participate in the Dental Services Subsidy Program.

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

The basis on which contractors in the Dental Services Subsidy Program are paid is a formula that calculates payment based on what patients pay for services provided on the contractor's sliding fee scale. Fee scales are in turn based on the Federal Poverty Level or fees may be discounted in increments from the fee the organization charges for insured patients. The Department requires that each contractor provide its current sliding fee scale when providing the necessary documentation to demonstrate eligibility for this program. Portland Community Health Center has satisfactorily provided that information which is not part of the contract but is kept in the program file.

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

The Department does not intend to RFP these services.

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



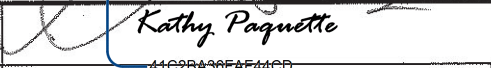
Does this request utilize ARPA/MJRP funds?

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:	13 Apr 23
Signature of DAFS Procurement Official:			
Typed Name:	Kathy Paquette	Date:	5/8/2023