

State of Maine Procurement Justification Form

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 website (Forms page) for additional instructions.

PART I: OVERVIEW

| | | | | |
|---|----------------------|---|--------------------|------------------|
| Department Office/Division/Program: | | MCDCP/Infectious Disease Surveillance/HIV Prevention | | |
| Department Contract Administrator or Grant Coordinator: | | Chris Moiles / Patti Wall | | |
| (If applicable) Department Reference #: | | Multiple (See Attached Table) | | |
| Amount: (Contract/Amendment/Grant) | See Attached Table | Advantage CT / RQS #: | See Attached Table | |
| CONTRACT | Proposed Start Date: | 9/01/2020 | Proposed End Date: | 6/30/2021 |
| 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: | | See Attached Table | | |
| Brief Description of Goods/Services/Grant: | | HIV & Viral Hepatitis Prevention Syringe Services Program | | |

PART II: JUSTIFICATION FOR VENDOR SELECTION

Mark an "X" before the justification(s) that applies to this request. (Check all that apply.)

| | | | |
|--|-----------------------------------|----------|----------------------------------|
| | A. Competitive Process | | G. Grant |
| | B. Amendment | | H. State Statute/Agency Directed |
| | C. Single Source/Unique Vendor | | I. Federal Agency Directed |
| | D. Proprietary/Copyright/Patents | X | J. Willing and Qualified |
| | E. Emergency | | K. Client Choice |
| | F. University Cooperative Project | | L. Other Authorization |

PART III: SUPPLEMENTAL INFORMATION

Please respond to ALL of the following:

1. Provide a more detailed description and explain the need for the goods, services or grant to supplement the response in Part I.

The purpose of this Agreement is to expand and increase certified syringe service programs (SSP) in Maine. These services would expand staffing, referral services, distribution of naloxone, and fund the purchase of physical program supplies (such as syringes, cotton balls, prep pads, filters, and HIV and Hepatitis C point of care rapid testing kits) for Certified Hypodermic Apparatus Exchange Programs in Maine, as directed in LD1707 and LD1552 and in accordance with Title 22, §1341, Hypodermic Apparatus Exchange Programs

State of Maine Procurement Justification Form

PART III: SUPPLEMENTAL INFORMATION

(<http://legislature.maine.gov/statutes/22/title22sec1341.html>) and any applicable rules, see:
<https://www.maine.gov/sos/cec/rules/10/chaps10.htm>

2. Provide a brief justification for the selected vendor to supplement the response in Part II.

DHHS Maine CDC has determined that these providers are uniquely qualified to provide these services because they offer Certified Hypodermic Apparatus Exchange Programs in Maine and are therefore one of the only agencies that can legally do this work. Certified Hypodermic Apparatus Exchange Programs in Maine, as directed in LD1707 and LD1552 and in accordance with Title 22, §1341, Hypodermic Apparatus Exchange Programs (<http://legislature.maine.gov/statutes/22/title22sec1341.html>) and any applicable rules, see:
<https://www.maine.gov/sos/cec/rules/10/chaps10.htm>

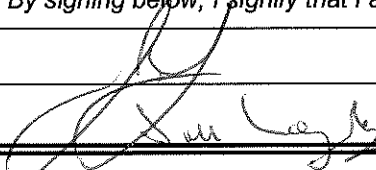
3. Explain how the negotiated costs or rates are fair and reasonable; or how the funding was allocated to grantee.

As directed by statute/22/title22sec1341 the funding each Exchange Program is “based on rates of intravenous drug use and negative health outcomes related to drug use in the geographic area surrounding a program; if applicable, the amount of services historically provided by the certified program; and other relevant factors”. The rate for this service is comparable amongst the different willing and qualified providers.

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

The Department Does not intend to RFP these services as they are offered to Providers who are willing and qualified to provide these services.

PART IV: APPROVALS

| | | | |
|---|---|--------------|-----------|
| Signature of requesting Department's Commissioner (or designee): | <i>By signing below, I signify that I approve of this procurement request.</i> | | |
| Printed Name: |  | Date: | 12-May-21 |
| Signature of DAFS Procurement Official: | <i>Kathy Paquette</i> | | |
| Printed Name: | Kathy Paquette | Date: | 6/14/2021 |

**State of Maine
Procurement Justification Form**

Office: Maine CDC
Service Group: HIV Prevention
Start: 9/1/2020
End: 6/30/2021

| Vendor | Agreement Number | CT 10A | Agreement Amount |
|------------------------------|-------------------------|----------------------|-------------------------|
| Amistad | CD1-21-5102 | 20201217000000001900 | \$100,000 |
| Wabanaki Health and Wellness | CD9-21-5124 | 20210308000000002416 | \$60,000 |
| Total: | | | \$ 160,000 |