



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/DDS/Dental Services		
Department Contract Administrator or Grant Coordinator:		Nancy Tan / Melanie Boucher		
(If applicable) Department Reference #:		ADS-23-5842		
Amount: (Contract/Amendment/Grant)	\$962,400.00	Advantage CT / RQS #:	CT 10A 20220608000000003261	
CONTRACT	Proposed Start Date:	07/01/2022	Proposed End Date:	06/30/2023
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:		Praveen Pavuluru, DMD, LLC Bangor, Maine		
Brief Description of Goods/Services/Grant:		General and IV Deep Sedation Dental Services (Specialized 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.

This agreement is needed to assure provision of comprehensive General and IV Sedation dental services for individuals with intellectual disabilities or autism served by OADS. Due to the personal and clinical behavioral characteristics of individuals with intellectual disabilities or autism, IV Sedation may be needed to perform dental procedures. These dental procedures are necessary to maintain the overall health of individuals with intellectual disabilities or autism. The consumers cannot afford dental services and have no alternative means of getting dental care.

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

DHHS, the Office of Aging and Disability Services, has determined that this Provider is uniquely qualified to provide these services. The Provider has demonstrated an exceptional level of expertise and ability to serve the unique needs of individuals with intellectual disabilities or autism, who often have significant communication and/or behavioral challenges which compromise their ability to maintain good oral health and make delivery of needed dental services in a clinical office setting particularly difficult. The Provider has also demonstrated the organizational skills needed to coordinate and work as part of an interdisciplinary team to provide dental services under IV Sedation to effectively serve these patients. This Provider has a consistent and excellent patient safety and satisfaction record serving this clinically difficult and challenging population. Further, maintaining continuity of care by the same dental team is crucial to encouraging ongoing patient compliance with good oral health practices and maintaining the overall health and well-being of the population served.

Historically, no other Provider has been able or willing to provide the level of services required. During a previous RFP process in 2008 this Provider was the only dentist who responded.

The provider must have an active license to practice dentistry in the State of Maine from the Maine Board of Dental Practice, a valid unrestricted Drug Enforcement Administration registration, and valid Basic Life Support and Advanced Cardiac Life Support certifications.

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

The total agreement cost for these services is based on analysis of the prevailing rates of compensation for the contracted dentist, dental assistant, dental hygienist, Registered N (RN) Practice Manager, and Certified Nurse Anesthetist (CRNA), as well as the cost of supplies required to provide the services.

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

The Department does not intend to issue an RFP for these services.

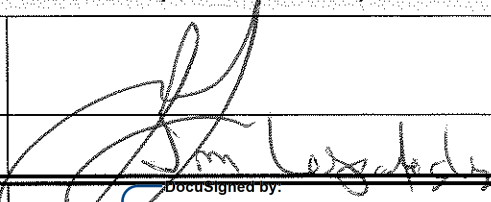

PART IV: AMERICAN RESCUE PLAN ACT (ARPA) / MAINE JOBS & RECOVERY PLAN (MJRP)

Does this request utilize ARPA/MJRP funds?

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:	Jim Longobardi	Date:	14-Jun-22
Signature of DAFS Procurement Official:			
Typed Name:	kathy Paquette	Date:	6/22/2022