



## 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/OBH/ Cindy McPherson & Sara Wade		
Department Contract Administrator or Grant Coordinator:		Jennifer Levesque/Matt Galletta		
(If applicable) Department Reference #:		Multiple- See attached list		
Amount: (Contract/Amendment/Grant)		\$ 725,255.00	Advantage CT / RQS #:	Multiple- See attached list
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:		Multiple- See attached list		
Brief Description of Goods/Services/Grant:		WRAP 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 type="checkbox"/>	C. Single Source/Unique Vendor	<input type="checkbox"/>	I. Federal Agency Directed
<input type="checkbox"/>	D. Proprietary/Copyright/Patents	<input checked="" 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.

OBH is responsible for services and unmet needs for persons with serious and persistent mental health disorders. These individuals are often low income, and at times because of their poverty or in part because of their disorder have individual emergent/ unmet needs that cannot be met by other resources. WRAP funds assist in meeting basic emergent/unmet needs and the organization that manages those funds. The Providers are required to assemble Wrap committee that includes a peer with lived experience to meet on a weekly basis to review applications, to ensure that Wrap applicants must be Section 17 eligible in order to qualify for Wrap funding, to ensure the Wrap applications are complete and accurate, and provide a 5 day turnaround from application submission to approval /denial of Wrap funding with written notice to the applicant.

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

DHHS, Office of Behavioral Health services has determined that this provider is willing and qualified to provide these WRAP services. Willing and qualified Providers are licensed with the Division of Licensing and Regulatory Services and have a contract with the Department to provide these services.

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

The allocation for each agency is based on regional need, the historical allotment and resulting utilization for the area plus an administrative fee which is calculated as 30% of the total program expense for all Providers of the service.

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

The Department does not intend to competitively procure this service. Any willing and qualified provider can submit a proposal for consideration by OBH to provide this service.

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

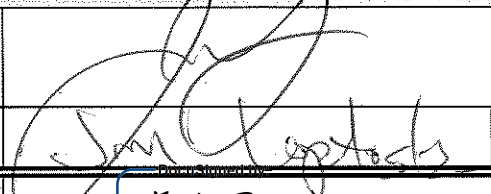
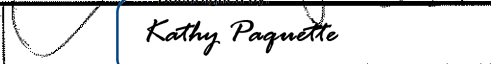
Does this request utilize ARPA/MJRP funds?

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):			Date:	23 - May - 23
Signature of DAFS Procurement Official:			Date:	6/9/2023
Typed Name:	Kathy Paquette	41C2BA36FAF44CD...	Date:	6/9/2023

**DHHS Office:** OBH  
**Service:** WRAP

Vendor Name	Agreement Number	Amd	CT 10A	Start Date	End Date	Contract Amount
THE OPPORTUNITY ALLIANCE	MH1-24-4005		20230502000000003010	7/1/2023	6/30/2024	\$240,000.00
MAINEHEALTH	MH2-24-4003		20230502000000003011	7/1/2023	6/30/2024	\$60,000.00
SWEETSER	MH2-24-4004		20230502000000003012	7/1/2023	6/30/2024	\$37,350.00
ANGLEZ BEHAVIORAL HEALTH SERVICES	MH2-24-4012		20230502000000003013	7/1/2023	6/30/2024	\$72,240.00
AROOSTOOK MENTAL HLTH SERV INC	MH3-24-4001		20230502000000003014	7/1/2023	6/30/2024	\$98,989.00
COMMUNITY HEALTH & COUNSELING SERVICES	MH3-24-4002		20230502000000003015	7/1/2023	6/30/2024	\$216,676.00
<b>Total Items</b>	6				<b>Totals</b>	\$725,255.00