



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/Occupational Therapy (OT) Jennifer Keaten / Lori Harding		
Department Contract Administrator or Grant Coordinator:		Jennifer Levesque / Patricia Wall		
(If applicable) Department Reference #:		ADS-24-9216		
Amount: (Contract/Amendment/Grant)	\$96,400.00	Advantage CT / RQS #:	CT 10A 20230420**2774	
CONTRACT	Proposed Start Date:	07/01/2023	Proposed End Date:	06/30/2025
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:		Gallant Therapy Services Augusta, Maine		
Brief Description of Goods/Services/Grant:		Occupational Therapy Evaluation 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.

Pursuant to 34-B M.R.S.A. § 5462, to ensure that persons with intellectual disability or autism receive needed services, an Occupational Therapy assessment of the person's needs must be completed, to the extent possible, for persons found by the Department to have an intellectual disability or autism and in need of services.

Adult Protective Services also serves persons who receive services, and an Occupational Therapy assessment of the person's needs, to the extent possible, may need to be completed.

In some instances, a functional assessment performed by a licensed occupational therapy practitioner is needed to assess cognitive and sensory motor abilities, development of self-care activities and capacity for independence, physical capacity for prevocational and work tasks, play and leisure performance, and appraisal of living areas for the individual. After conducting a functional assessment, the occupational therapy practitioner, relying on his or her training, education, and experience, can make written recommendations designed to enhance the assessed person's capacity for independence and overall quality of life.

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 Aging and Disability Services, has determined that this provider is willing and qualified to provide these services because they require specific licensure and registration as an occupational therapy practitioner and experience making recommendations to enhance the capacity and independence for adults served by the Office of Aging and Disability Services.

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

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 occupational therapists in the area.

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)

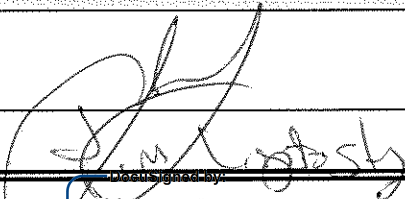

Does this request utilize ARPA/MJRP funds?

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:		Date: 5-June-23
Signature of DAFS Procurement Official:		
Typed Name:	Kathy Paquette	Date: 6/21/2023