

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:		DHHS/OBH/Jessica Gerrish		
Department Contract Administrator or Grant Coordinator:		Shawn Belanger Patti Wall		
(If applicable) Department Reference #:		Multiple		
Amount: (Contract/Amendment/Grant)	\$982,990	Advantage CT / RQS #:	Multiple	
CONTRACT	Proposed Start Date:	7/1/2020	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:		Multiple		
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

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 Department's Office of Behavioral Health is responsible for services and unmet needs for persons with serious and persistent mental health disorders. These individuals are often poor 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 a Wrap committee that includes a peer with lived experience to meet on a weekly

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PART III: SUPPLEMENTAL INFORMATION

basis to review applications, to ensure that Wrap applicants must be Section 17 eligible in order to qualify for Wrap funding, to insure the Wrap applications are complete and accurate, and provide quick 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.

The Department's Office of Behavioral Health has determined that these Providers are willing and qualified to provide these WRAP services. The Providers are also licensed with the Department's Division of Licensing and Certification and have a contract with the Department's Office of Behavioral Health. These Providers have the expertise and knowledge to ensure that the Wrap services are met.


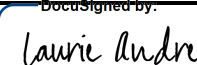
3. Explain how the negotiated costs or rates are fair and reasonable; or how the funding was allocated to grantee.

The amount of allocation for each region was based upon the historical allotment and resulting utilization for the area plus an administrative fee (20% of monthly activity that is reported). The Department considers these costs to be fair and reasonable.

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

The Department does not intend to RFP this service as this is a willing and qualified service.

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>		
	<small>DocuSigned by:</small>		
			
Printed Name:	Laurie Andre	Date:	6/29/2020
Signature of DAFS Procurement Official:	<small>DocuSigned by:</small>		
			
Printed Name:	Laurie Andre	Date:	7/7/2020

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WRAP SERVICES

7/1/2020 – 6/30/2021

PROVIDER	AGR #	CT NUMBER	DOLLAR AMT
The Opportunity Alliance	MH1-21-4005	20200522*3440	\$240,836.00
Maine Behavioral Healthcare	MH2-21-4003	20200522*3441	\$93,075.00
Sweetser	MH2-21-4004	20200522*3443	\$66,696.00
JMPB, Inc.	MH2-21-4011	20200522*3444	\$208,847.00
Aroostook MH Services	MH3-21-4001	20200522*3445	\$154,671.00
Community Health & Counseling	MH3-21-4002	20200522*3446	\$218,865.00
		TOTAL	\$982,990.00