



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 (Form's Page) for additional instructions.

PART I: OVERVIEW				
Department Office/Division/Program:		DHHS/ MCDCP/Infectious Disease Surveillance/HIV Prevention Lauren Gauthier / Robert Chicoria		
Department Contract Administrator or Grant Coordinator:		Chris Moiles / Patricia Wall		
(If applicable) Department Reference #:		See Attached Table		
Amount: (Contract/Amendment/Grant)		\$1,026,263.00 See Attached Table	Advantage CT / RQS #:	See Attached Table
CONTRACT	Proposed Start Date:	7/1/2022	Proposed End Date:	6/30/2023
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:		See Attached Table		
Brief Description of Goods/Services/Grant:		HIV Prevention Syringe 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.

This Agreement aims 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 by 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>

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

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 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 the 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 number 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: AMERICAN RESCUE PLAN ACT (ARPA) / MAINE JOBS & RECOVERY PLAN (MJRP)

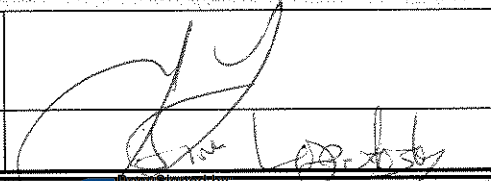
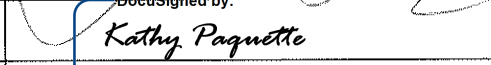
Does this request utilize ARPA/MJRP funds?

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:	29 Jun 22
Signature of DAFS Procurement Official:			
Typed Name:	kathy Paquette	Date:	7/18/2022

Office: Maine CDC
Service Group: HIV Prevention SSP
Start: 7/1/2022
End: 6/30/2023

Provider	Agreement Number	CT Number	Agreement Amount
Amistad 103 India St. Portland, ME 04101	CD1-23-5102	CT 10A 20220516**2878	\$78,317.00
Tri-County Mental Health Services PO Box 2008 Lewiston, ME 04241	CD3-23-5100	CT 10A 20220516**2879	\$32,845.00
Maine Access Points 51 Harpswell RD., Suite 500, Brunswick, ME 04011	CD4-23-5109	CT 10A 20220516**2880	\$163,236.00
Wabanaki Health & Wellness P.O. Box1356 Bangor, ME 04401	CD9-23-5124	CT 10A 20220516**2881	\$42,587.00
City of Portland DBA Portland Public Health/WCV, 39 Forest Ave. Portland, ME 04101	CDM-23-5102	CT 10A 20220516**2882	\$150,985.00
MaineGeneral Medical Center 35 Medical Center Parkway, Augusta, ME 04330	CDM-23-5103	CT 10A 20220516**2883	\$94,630.00
Down East Aids Network INC. DBA Health Equity Alliance 304 Hancock St., Suite 3B Bangor, ME 04401	CDM-23-5104	CT 10A 20220516**2884	\$350,714.00
Church of Safe Injection P.O. Box 11200 Portland, ME 04104	CDM-23-5155	CT 10A 20220516**2885	\$112,949.00
Total			\$1,026,263.00