



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/DS Dental		
Department Contract Administrator or Grant Coordinator:		Jennifer Levesque/ Melinda Farrell		
(If applicable) Department Reference #:		Multiple, see attached		
Amount: (Contract/Amendment/Grant)	Multiple, see attached	Advantage CT / RQS #:	Multiple, see attached	
<b>CONTRACT</b>	Proposed Start Date:	<b>07/01/2023</b>	Proposed End Date:	<b>06/30/2025</b>
<b>AMENDMENT</b>	Original Start Date:		Effective Date:	
	Previous End Date:		New End Date:	
<b>GRANT</b>	Project Start Date:		Grant Start Date:	
	Project End Date:		Grant End Date:	
Vendor/Provider/Grantee Name, City, State:		Multiple, see attached		
Brief Description of Goods/Services/Grant:		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 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.

One of the largest unmet needs within the developmental services populations served by OADS is dental services. The consumers served often cannot afford dental services and have no alternative means of getting them.

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

Historically, individuals served by OADS have not been able to identify dentists who are able and willing to accept new patients. The Provider is willing to accept new patients for dental hygiene and restorative dental services and provide these services under the terms of this contract.

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

The Provider delivers services in accordance with rate tables submitted to the Department. The costs for services are consistent with the rates charged to all patients who receive services from the Provider.

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

The Department does not intend to RFP this willing & qualified service.

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

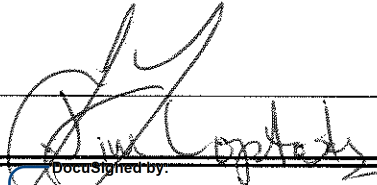
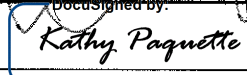
Does this request utilize ARPA/MJRP funds?

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:	21-Jul-23
Typed Name:				
Signature of DAFS Procurement Official:			Date:	8/28/2023
Typed Name:	Kathy Paquette			

Office of Aging and Disability Services  
Dental Services SFY-24

Agreement Number	Amendment Number	Contract Start Date	Contract End Date	Agreement Amount	Vendor Name
ADS-24-5836		7/1/2023	6/30/2025	\$40,000.00	JOSEPH WHITE DMD
ADS-24-5844		7/1/2023	6/30/2025	\$50,000.00	STEINKE & CARUSO DENTAL CARE dba CENTRAL MAINE SMILES