



## PROCUREMENT JUSTIFICATION FORM (PJF)

This form must accompany all contract requests and sole source requisitions (RQS) over \$10,000 submitted to the Office of State 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 Procurement Services intranet site (Forms page) for additional instructions.

| PART I: OVERVIEW                                        |                               |                                            |                                |           |
|---------------------------------------------------------|-------------------------------|--------------------------------------------|--------------------------------|-----------|
| Department Office/Division/Program:                     |                               | DHHS/OBH/Deb Poulin & Sara Wade            |                                |           |
| Department Contract Administrator or Grant Coordinator: |                               | Jeanne Garza / Melinda Farrell             |                                |           |
| (If applicable) Department Reference #:                 |                               | MH4-27-2025                                |                                |           |
| Agency Department Code:                                 | 10A                           | Advantage CT / RQS #:                      | 20260424000MH4272025           |           |
| Amount:<br>(Contract/Amendment/Grant)                   |                               | \$240,000.00                               |                                |           |
| CONTRACT                                                | Proposed/Original Start Date: | 7/1/2026                                   | Proposed/Most Recent End Date: | 6/30/2027 |
| AMENDMENT                                               | New Effective Date:           |                                            | New End Date (if Applicable):  |           |
| GRANT                                                   | Project Start Date:           |                                            | Grant Start Date:              |           |
|                                                         | Project End Date:             |                                            | Grant End Date:                |           |
| Vendor/Provider/Grantee Name, City, State:              |                               | Walden Behavioral Care, LLC<br>Waltham, MA |                                |           |
| Brief Description of Goods/Services/Grant:              |                               | Complex Care                               |                                |           |

| PART II: JUSTIFICATION FOR VENDOR SELECTION                                                        |                                         |                          |                                  |
|----------------------------------------------------------------------------------------------------|-----------------------------------------|--------------------------|----------------------------------|
| Check the box below for 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 checked="" type="checkbox"/>                                                                | C. Single Source/Unique Vendor          | <input type="checkbox"/> | I. Federal Agency Directed       |
| <input type="checkbox"/>                                                                           | D. Proprietary/Copyright/Patents        | <input type="checkbox"/> | J. Willing and Qualified         |
| <input type="checkbox"/>                                                                           | E. Emergency                            | <input type="checkbox"/> | K. Client Choice                 |
| <input type="checkbox"/>                                                                           | F. Higher Education 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.

The purpose of this contract is to meet the care needs of clients needing out of State specialized in-patient treatment services. This contract period will cover 30-36 days of treatment at the facility.

Chief Hearing Officer cited 14-193 CMR ch 40 which obliges the Office of Behavioral Health to conduct a prior authorization process to determine eligibility for out-of-state funding.

2. Provide a brief justification for the selected vendor to supplement the response in Part II. Reference the solicitation (RFP/RFA/RFQ) number if applicable.

This out of State provider operates a specialized PNMI type facility that specializes in treatment of eating disorders. Due to this client's acuity, there is no other provider alternatives within the State of Maine that provide this in-patient level of specialized services.

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

The Department was able to negotiate a per diem rate of \$1,600.00. The average length of stay is 30 days with some individuals completing treatment in less than 30 days while others take longer. This contract covers 150 inpatient days.

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

The Department does not intend to RFP this service.

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

Does this request utilize ARPA/MJRP funds?

☐ Yes, MJRP funds (023) – If Yes, please attach the approved Business Case(s).

☐ Yes, ARPA funds (025) or (026) – If Yes, please be aware of the requirements from awarding federal agencies.

☒ No – If No, proceed to Part V.

### PART V: CONFLICTS OF INTEREST (COI); CONTRACT WITH THE STATE

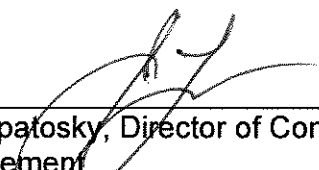
Maine law contains Conflict of Interest statutes directed to State Departments, State Officers, and Employees Generally under MRS [Title 5, §18](#) and [§18-A](#), in harmony with MRS [Title 17, §3104](#).

☒ The requesting department's signatory affirms, understands, and acknowledges Maine's Conflict of Interest statutes and, in accordance with those statutes and to the best of their knowledge, has determined that no conflict of interest exists at the time of this contract, renewal, or amendment.

**PART VI: APPROVALS**

Governor/Department Commissioner or Designee

1. The signature below indicates approval of this procurement request.

|                                                                        |                                                                                   |       |          |
|------------------------------------------------------------------------|-----------------------------------------------------------------------------------|-------|----------|
| Signature of requesting<br>Department's Commissioner<br>(or designee): |  |       |          |
| Typed Name:                                                            | Jim Lopatosky, Director of Contract<br>Management                                 | Date: | 4-May-26 |

2. Additional signature required **ONLY** if box E (Emergency) is selected in PART II. The signature below indicates approval by the Department's Commissioner, or the designee specifically authorized to approve emergency procurement requests.

|                                                                        |  |       |  |
|------------------------------------------------------------------------|--|-------|--|
| Signature of requesting<br>Department's Commissioner<br>(or designee): |  |       |  |
| Typed Name:                                                            |  | Date: |  |

**\*\*OSPS Section Only\*\***

|                                            |                                                                                                 |       |           |
|--------------------------------------------|-------------------------------------------------------------------------------------------------|-------|-----------|
| Signature of DAFS<br>Procurement Official: | Signed by:<br> |       |           |
| Typed Name:                                | <small>41C2BA36FAF44CD...</small><br>Kathy Blais                                                | Date: | 8/11/2026 |