



## 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/OBH/ Outpatient Services/Corinna O'Leary & Kristen King		
Department Contract Administrator or Grant Coordinator:		Nancy Tan / Jeanne Garza		
(If applicable) Department Reference #:		Multiple: see attachment		
Amount: (Contract/Amendment/Grant)	Multiple: see Attachment	Advantage CT / RQS #:	Multiple: see Attachment	
<b>CONTRACT</b>	Proposed Start Date:	7/1/2022	Proposed End Date:	6/30/2024
<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 Attachment		
Brief Description of Goods/Services/Grant:		Outpatient Services		

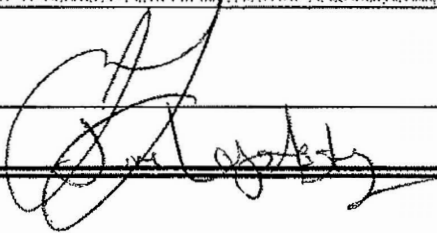
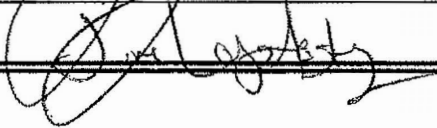
### PART II: JUSTIFICATION FOR VENDOR SELECTION

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.	<p>Maine is in the midst of a substance use epidemic. Treatment services and interventions are needed to combat Opioid Use Disorder (OUD), Substance Use Disorder (SUD) and alcohol dependence. Outpatient services are lower levels of care and aid in the prevention of an individual needing a higher more costly level of care such as Residential treatment. These services include individual, group and family counseling and are widely available across the State.</p> <p>Outpatient Services: represent a point of entry initiating treatment and recovery. It is a community-based service on the care continuum.</p>
2. Provide a brief justification for the selected vendor to supplement the response in Part II. Reference the RFP number, if applicable.	<p>DHHS, Office of Behavioral Health has determined that these providers are willing and qualified to provide these services because they are licensed to provide these services, they employ qualified licensed practitioners, and they are the providers of these services under MaineCare with a contract with SAMHS/DHHS.</p>
3. Explain how the negotiated costs or rates are fair and reasonable, or how the funding was allocated to grantee.	<p>The rates are standardized and consistent with the MaineCare rate as set by MaineCare as stated in the MaineCare Benefits Manual, Chapter III Section 65.</p>
4. Describe the plan for future competition for the goods or services.	<p>These services will continue as any willing &amp; qualified provider and will not be RFP'd.</p>

PART IV: AMERICAN RESCUE PLAN ACT (ARPA) / MAINE JOBS & RECOVERY PLAN (MJRP)	
Does this request utilize ARPA/MJRP funds?	
<input type="checkbox"/> Yes – If Yes, please attach the approved Business Case(s).	
<input checked="" type="checkbox"/> 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:
Typed Name:			5 July 22
Signature of DAFS Procurement Official:			Date:
Typed Name:			

DHHS Office: Behavioral Health Services  
Service Group: Outpatient (SA) – SFY23

Agreement Number	Vendor Name	CT Number	Agreement Amount
OSA-23-219	MAINEHEALTH	CT 10A 20220614000000003344	\$463,032.00
OSA-23-3001	TRI-CTY MENTAL HLTH SERV	CT 10A 20220614000000003345	\$644,715.00
OSA-23-311	CRISIS & COUNSELING CTR INC	CT 10A 20220614000000003346	\$650,102.00
OSA-23-312	CROSSROADS FOR WOMEN INC	CT 10A 20220614000000003347	\$664,402.00
OSA-23-317	MAINEGENERAL COMMUNITY CARE	CT 10A 20220614000000003348	\$752,000.00
OSA-23-323	KENNEBEC BEHAVIORAL HEALTH	CT 10A 20220614000000003349	\$262,701.00
OSA-23-326	DAY ONE	CT 10A 20220614000000003350	\$1,920,494.00
OSA-23-369	CATHOLIC CHARITIES MAINE	CT 10A 20220614000000003351	\$635,968.00
OSA-23-382	REGIONAL MEDICAL CTR AT LUBEC	CT 10A 20220614000000003353	\$183,694.00
OSA-23-389	AROOSTOOK MENTAL HLTH SERV INC	CT 10A 20220614000000003354	\$732,000.00
OSA-23-390	A TIME TO RISE- C & W	CT 10A 20220614000000003356	\$50,400.00
OSA-23-4073	MAINEHEALTH	CT 10A 20220614000000003357	\$100,000.00
			\$7,059,508.00