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/CDC/TB Control | | | | |
| Department Contract Administrator or Grant Coordinator: | Melanie Boucher | | | | |
| (If applicable) Department Reference #: | CD0-24-54TB1 | | | | |
| Amount: (Contract/Amendment/Grant) | $ 9,009.35 | Advantage CT / RQS #: | RQS 10A 20230719000000000145 | | |
| CONTRACT | Proposed Start Date: | **7/1/2023** | Proposed End Date: | 8/31/2023 | |
| 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: | MaineHealth dba MMP Adult Infectious Disease Pittsburgh, PA | | | | |
| Brief Description of Goods/Services/Grant: | Hospital stay for TB patient | | | | |

| PART II: JUSTIFICATION FOR VENDOR SELECTION | | | |
|---|---|---|---|
| Mark an "**X**" before the justification(s) that applies to this request. (Check all that apply.) | | | |
| ☐ | A. Competitive Process | ☐ | G. Grant |
| ☐ | B. Amendment | ☐ | H. State Statute/Agency Directed |
| ☒ | C. Single Source/Unique Vendor | ☐ | I. Federal Agency Directed |
| ☐ | D. Proprietary/Copyright/Patents | ☐ | J. Willing and Qualified |
| ☐ | E. Emergency | ☐ | K. Client Choice |
| ☐ | F. University Cooperative Project | ☐ | 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.

These funds cover the cost of a multi-day hospital stay at Maine Medical Center for a patient with complicated active tuberculosis who was in the hospital from 03/29/2023 to 04/04/2023.

Under the rules for Notifiable Conditions http://www.maine.gov/sos/cec/rules/10/144/144c258.doc , tuberculosis is an immediately reportable infectious disease. These costs are associated with diagnosing and preventing the spread of treatment-resistant tuberculosis. The patient went to the closest medical facility equipped to treat this disease.

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

The client went to a hospital where he could be treated for his condition. We had no part in this selection.

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

The TB Control Program will pay at the MaineCare reimbursement rates for services rendered. These rates are pre-approved by the Department.

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

The Department does not intend to competitively bid this 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): | | | |
| Typed Name: | | Date: | 9/7/23 |
| Signature of DAFS Procurement Official: | DocuSigned by: Michelle Fournier | | |
| Typed Name: | Michelle Fournier 066BBD96EE5347F... | Date: | 10/4/2023 |