



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.)			
<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. 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.

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)


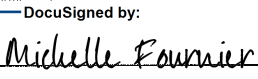
Does this request utilize ARPA/MJRP funds?

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:	Ben Murray	Date:	9/7/23
Signature of DAFS Procurement Official:	DocuSigned by: 		
Typed Name:	Michelle Fournier	Date:	10/4/2023