



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/MCH Anna Cyr / Darren Bean		
Department Contract Administrator or Grant Coordinator:		Chris Moiles / Patricia Wall		
(If applicable) Department Reference #:		CD0-24-4256		
Amount: (Contract/Amendment/Grant)		\$ 697,136.00	Advantage CT / RQS #:	CT 10A 20230501000000002998
CONTRACT	Proposed Start Date:	07/01/2023	Proposed End Date:	06/30/2025
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 Maine Medical Center Portland Maine		
Brief Description of Goods/Services/Grant:		Clinical Services for Cleft Lip and or Palate		

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.

The purpose of this Agreement is to provide Comprehensive Interdisciplinary Clinical Services for children with Cleft Lip and/or Cleft Palate.

The Provider shall be responsible for providing integrated case management through a Cleft Team who shall provide optimal evaluations of newborns with Craniofacial Anomalies, and subsequent evaluations and recommendations through age twenty-one (21). The Cleft Team shall monitor short and long-term outcomes as well as develop and implement treatment plans for individual patients. The goal of the Cleft Lip and/or Palate clinic is to ensure that patient care is provided in a coordinated, consistent manner with proper sequencing of evaluations and treatment within the framework of the patient's overall developmental, medical, and psychological needs as recommended by the American Cleft Palate-Craniofacial Association Parameters of Evaluation and Treatment. Refer to: <http://journals.sagepub.com/doi/pdf/10.1177/1055665617739564>.

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

The medical providers who specialize in these services are employees of Maine Health, therefore Maine Health is the only provider who currently provides these services Statewide.

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

The costs and rates of this vendor were considered fair and reasonable and the best value for the Department.

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

If another hospital in Maine develops a specialized medical team who can provide cleft lip and palate services, the Department would deem these services as willing and qualified.

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

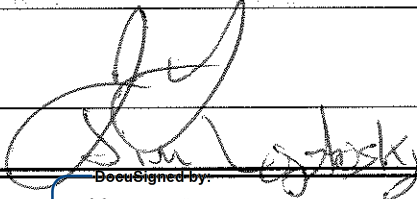
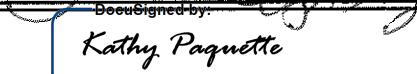
Does this request utilize ARPA/MJRP funds?

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:	6-16-23
Signature of DAFS Procurement Official:	DocuSigned by: 		
Typed Name:	41C2BA36FAF44CD... Kathy Paquette	Date:	10/16/2023