



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

Table with fields: Department Office/Division/Program, Department Contract Administrator or Grant Coordinator, (If applicable) Department Reference #, Amount, Advantage CT / RQS #, Proposed Start Date, Proposed End Date, Original Start Date, Effective Date, Previous End Date, New End Date, Project Start Date, Grant Start Date, Project End Date, Grant End Date, Vendor/Provider/Grantee Name, City, State, Brief Description of Goods/Services/Grant.

PART II: JUSTIFICATION FOR VENDOR SELECTION

Mark an "X" before the justification(s) that applies to this request. (Check all that apply.)

Table with justification options A through L, each with a checkbox. Option C is checked.

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 one specific client needing out of State specialized in-patient treatment services. This contract period will cover 30-36 days of treatment at the facility, the admission date has yet to be determined.

Client requested a single-case agreement from OMS that was denied. Client appealed decision and it was denied based on IMD exclusion. 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 RFP 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.

Walden Inpatient Level of Care is \$3,125 per day but the Office was able to negotiate a per diem rate of \$1,625.00. The average length of stay is 30 days with some individuals completing treatment in less than 30 days while others take longer. This contract represents a maximum length of stay of 36 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)

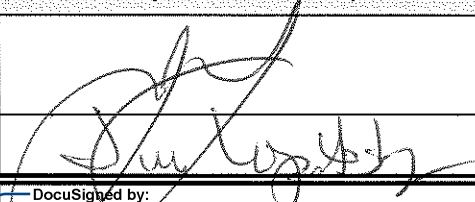

Does this request utilize ARPA/MJRP funds?

Yes – 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:	29-Oct-23
Signature of DAFS Procurement Official:	DocuSigned by: 		
Typed Name:	891CE7A1493D45B... Martha Verhille	Date:	10/27/2023