



### PROCUREMENT JUSTIFICATION FORM (PJF)

This form must accompany all contract requests and sole source requisitions (RQS) over \$10,000 submitted to the Office of State 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 Procurement Services intranet site (Forms page) for additional instructions.*

PART I: OVERVIEW			
Department Office/Division/Program:		DHHS/CDC/Maternal and Child Health/ Children and Youth with Special Health Care Needs	
Department Contract Administrator or Grant Coordinator:		Chris Moiles / Nicole Mitchell	
(If applicable) Department Reference #:		CD0-26-4256	
Agency Department Code:	10A	Advantage CT / RQS # :	20250624000CD0264256
Amount: (Contract/Amendment/Grant)		\$ 678,518.96	
CONTRACT	Proposed/Original Start Date:	7/1/2025	Proposed/Most Recent End Date: 6/30/2027
AMENDMENT	New Effective Date:		New End Date (if Applicable):
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			
Check the box below for 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. Higher Education 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 solicitation (RFP/RFA/RFQ) number and the date of award notification, if applicable.

MMC is the only Provider with these services available who has the required providers with the appropriate licensure/certification to provide clinical services for Cleft Lip and/or Palate patients.

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

These rates were set in the 2018 RFP process, and MMC adjusts their budget each year/contract period. The budget is fair and reasonable because it accounts for the cost of provider salaries and subcontracts accurately to staff the clinic for each year.

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, MJRP funds (023) – If Yes, please attach the approved Business Case(s).

Yes, ARPA funds (025) – If Yes, please be aware of the requirements from awarding federal agencies.

No – If No, proceed to Part V.

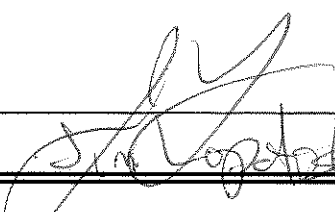
### PART V: CONFLICTS OF INTEREST (COI); CONTRACT WITH THE STATE

Maine law contains Conflict of Interest statutes directed to State Departments, State Officers, and Employees Generally under MRS [Title 5, §18](#) and [§18-A](#), in harmony with MRS [Title 17, §3104](#).

The requesting department signatory understands and acknowledges Maine's Conflict of Interest statutes.

**PART VI: APPROVALS**


The signature below indicates approval of this procurement request.

Signature of requesting Department's Commissioner (or designee):			
Typed Name:	<i>J. Paquette</i>	Date:	17-Sep-25

**PART VII: EMERGENCY – Required only if selecting E. Emergency Justification**

The signature below indicates approval by the Commissioner or designee of this procurement request.

Signature of requesting Department's Commissioner (or designee):			
Typed Name:		Date:	

Signature of DAFS Procurement Official:	DocuSigned by:  41C2BA36FAF44CD...		
Typed Name:	Kathy Paquette	Date:	11/20/2025