



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 – OADS Ingrid Diamond		
Department Contract Administrator or Grant Coordinator:		Nancy Tan Lisa Munster		
(If applicable) Department Reference #:		ADS-22-9912		
Amount: (Contract/Amendment/Grant)	\$25,000.00	Advantage CT / RQS #:	10A 20211027000000001077	
CONTRACT	Proposed Start Date:	10/1/2021	Proposed End Date:	9/30/2022
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:		Occupational Health Centers of SW PA dba Concentra Medical Ctrs Cranston RI		
Brief Description of Goods/Services/Grant:		Medical Assistance Services		

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 State of Maine Office of Aging and Disability Services (OADS), within the Department of Health and Human Services, is deploying N95 respirators for use by certain staff members during the COVID-19 pandemic. In order to deploy and use these masks safely, staff members must first be evaluated by a medical professional to ensure that the staff member is medically eligible to wear an N95 respirator and physically able to perform required tasks while wearing a respirator. The need for evaluation services is statewide and expected to be ongoing.

This Provider will provide the required respiratory evaluation and related services for OADS staff statewide. Evaluation services to be provided include evaluation of individual staff responses on a completed OSHA Respirator Medical Evaluation Questionnaire, a medical exam, and delivery of an OSHA Written Medical Opinion Letter to document fitness to wear a respirator.

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

This provide has a unique infrastructure across the State which allows OADS caseworker, at any DHHS location, to go into a local Concentra office and get fit tested for using an N95 mask before interacting with a COVID-19 positive individual.

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

The rates charged by the Provider are the standard posted rates for the services provided.

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

The Department does not anticipate future competitive procurement of these services.

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

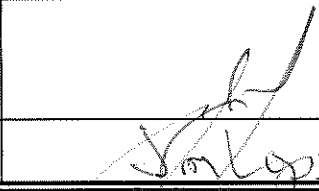

Does this request utilize ARPA/MJRP funds?

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:	8-Dec-21
Signature of DAFS Procurement Official:			
Typed Name:	41C2BA36FAF44CD... Kathy Paquette	Date:	12/27/2021