

**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/OBH/Robert Porter/Kristen King		
Department Contract Administrator or Grant Coordinator:	Althea Harris / Brianne Carrero		
(If applicable) Department Reference #:	Multiple: See Attached Listing		
Amount: (Contract/Amendment/Grant)	Amend A: \$43,633.00 Revised: \$1,522,408.00	Advantage CT / RQS #:	Multiple: See Attached Listing
CONTRACT	Proposed Start Date:		Proposed End Date:
AMENDMENT	Original Start Date:	9/30/2022	Effective Date:
	Previous End Date:	9/29/2023	New End Date:
GRANT	Project Start Date:		Grant Start Date:
	Project End Date:		Grant End Date:
Vendor/Provider/Grantee Name, City, State:	Multiple: See Attached Listing		
Brief Description of Goods/Services/Grant:	Co-Responder: Post Overdose Response Team		

**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 checked="" type="checkbox"/>	B. Amendment	<input type="checkbox"/>	H. State Statute/Agency Directed
<input type="checkbox"/>	C. Single Source/Unique Vendor	<input type="checkbox"/>	I. Federal Agency Directed
<input type="checkbox"/>	D. Proprietary/Copyright/Patents	<input checked="" 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 Amendment is to add funds for Co-responders being added to Androscoggin and York counties.**

The purpose of this Agreement is to create and deploy Co-responder(s) in 16 counties that are Substance Use Disorder (SUD)/Dual Diagnosis capable Licensed or Certified SUD clinicians. These Co-responder(s) will be assigned to each county. The clinical staff members will be embedded within a law enforcement agency in each of those counties. The services rendered through this agreement are to provide OUD/SUD overdose response, assessment, behavioral health crisis de-escalation, referral to community treatment modules, system navigation, short-term counseling interventions, increase recovery capital, and aid in completion of the State's Medicaid program application for uninsured population. The clinicians may also accept proactive referrals from first responders and other community SUD service providers for engagement of an individual prior to an overdose.

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

These vendors have agreed to continue the embedded SUD clinician model, and due to their well-developed connections with law enforcement through their Crisis Intervention service work, and their clinical oversight structures, they are uniquely positioned to provide this service.

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

The negotiated costs are based on Bureau of Labor statistics for salary and fringe for licensed or certified clinicians, equivalent IT-associated costs, and aligned travel reimbursement.

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

This service is willing and qualified. The Department does not intend to RFP in the future.

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

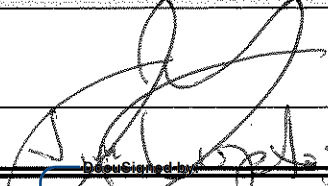

Does this request utilize ARPA/MJRP funds?

☐ 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:	11-Oct-23
Signature of DAFS Procurement Official:	 41C2BA30FAF44CD...		
Typed Name:	Kathy Paquette	Date:	12/13/2023

DHHS Office:  
OBH  
Service:  
CO\_RESPONDER  
: POST  
OVERDOSE  
RESPONSE  
TEAM-SFY23

Vendor Name	Agreement Number	Amd	CT 10A	Start Date	End Date	Amendmen t Amount	Revised Amount
TRI-CTY MENTAL HLTH SERV	OSA-23-6001	A	20221014000000001102	9/30/2022	9/29/2023	\$15,000.00	\$115,000.00
SWEETSER	OSA-23-6002	A	20221014000000001103	9/30/2022	9/29/2023	\$28,633.00	\$995,633.00
Total Items	2				Totals	\$43,633.00	\$1,110,633.00