

**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/On Site Vaccinations	
Department Contract Administrator or Grant Coordinator:		Jennifer Levesque/Melinda Farrell	
(If applicable) Department Reference #:		Multiple, See Addendum	
Amount: (Contract/Amendment/Grant)		Multiple, See Addendum	Advantage CT / RQS #: Multiple, See Addendum
CONTRACT	Proposed Start Date:	7/1/2024	Proposed End Date: 6/30/2025
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:		Multiple, See Addendum	
Brief Description of Goods/Services/Grant:		On Site Vaccinations	

**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 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 Agreement is to provide knowledge of reliable and available resources, and to support related to COVID-19 and Influenza vaccinations to the LTSS population of older adults and those with disabilities.

The Provider shall focus on increasing the number of members who are fully educated on the risks of both COVID-19 and Influenza, and the probable negative health effects on the members. Additionally, the provider will work to increase the percentage of vaccinated members in both the categories of COVID-19 and Influenza.

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

The Office of Aging and Disability has determined that these providers have the requisite training and experience to deliver this service. These providers have been assisting with in home vaccinations efforts, in clinics and in facilities, throughout the pandemic. These community providers have staff qualified to administer vaccinations and can help ensure wide reach to their already established client population.

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

The cost is considered fair and reasonable based on analysis of the scope of work that needs to be accomplished and the concern for completing the work as expeditiously as possible.

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

The Department does not plan to RFP for this service.

### 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.

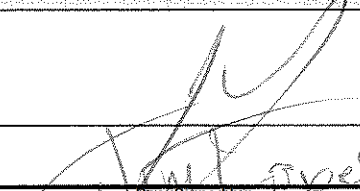
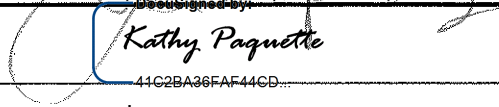
### PART V: CONFLICTS OF INTEREST (COI); CONTRACT WITH THE STATE

*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 signatures below indicate approval of this procurement request.

Signature of requesting Department's Commissioner (or designee):			
Typed Name:	<i>[Handwritten Name]</i>	Date:	<i>6-Aug-24</i>
Signature of DAFS Procurement Official:	 <small>Designated by: Kathy Paquette</small> <small>41C2BA36FAF44CD...</small>		
Typed Name:	Kathy Paquette	Date:	8/9/2024

DHHS Office: OADS

Service: ON SITE VACCINATIONS-SFY25

CTMV 10A 20240530000000000023

Vendor Name	Agreement Number	Start Date	End Date	Projected Spend
VNA Home Health & Hospice dba Northern Light Home Care & Hospice	ADS-25-9916	7/1/2024	6/30/2025	\$42,840.00
Penobscot Community Health Center	ADS-25-9919	7/1/2024	6/30/2025	\$67,160.00
Total Items	2		Total Projected	\$110,000.00