



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 / OADS / Long Term Care Services and Supports (LTSS) / Home-Based Supports and Services (HBSS) Programs		
Department Contract Administrator or Grant Coordinator:		Jennifer Levesque / Melinda Farrell		
(If applicable) Department Reference #:		Multiple, See Addendum		
Agency Department Code:	10A	Advantage CT / RQS #:	CTMV 20250416HOMEBASEDCAR	
Amount: (Contract/Amendment/Grant)		Amendment: \$836,119.97 Revised: \$29,029,318.97		
CONTRACT	Proposed/Original Start Date:	7/1/2025	Proposed/Most Recent End Date:	6/30/2026
AMENDMENT	New Effective Date:	10/1/2025	New End Date (if Applicable):	No change
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:		Statewide Service Coordination by a Service Coordination Agency (SCA) to support the Department's Home-Based Supports and Services (HBSS) Programs		

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 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. 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.

This amendment adds overall funding to the CTMV to accommodate MaineCare rate increases for each Provider.

The Department provides supportive, preventive, protective, and public health and intervention services to preserve public health and assist Maine residents in meeting their needs. The Department strives to provide these programs and services while respecting the rights and preferences of individuals and families. The Department provides services that promote the highest level of independence, health, and safety of older citizens, vulnerable adults, and adults with disabilities.

This contract provides for Statewide Service Coordination as well as other administrative services related to State-funded in-home long-term services and supports provided to older adults and adults with disabilities. The services provided under this contract support the state-funded Home-Based Supports and Services (HBSS) [10-149 CMR Ch. 5 Section 63](#).

The Department provides services in support of approximately 1,200 participants per month. Services under the HBSS, including but not limited to: Service Coordination; Personal Care; Nursing; Therapies; Respite; Adult Day Services; Environmental Modifications; Emergency Response System; and limited transportation to activities covered in the Authorized Plan of Care. Personal Care and In-home Respite Services may be Participant-directed and include Skills Training and Fiscal Intermediary (FI) services required under State statute. All these in-home services are intended to assist eligible individuals to remain as independent as possible in their homes and communities, delaying or preventing more expensive institutional care.

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.

DHHS, OADS determined that these providers are willing and qualified providers who are licensed with the Division of Licensing and Regulatory Services and have a contract with OADS. OADS allocates State General Funds and Federal Block Grant dollars on a Fee for Service basis at the MaineCare rate for clinically eligible consumers who do not have MaineCare.

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

Rates are standardized, consistent with the MaineCare rate, and established by rate setting.

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

The Department does not intend to issue an RFP for these willing and qualified services.

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.

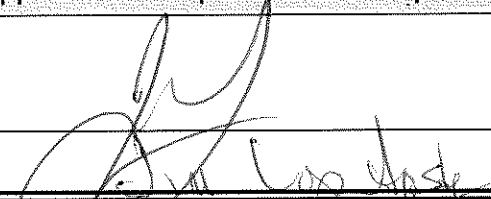
PART V: CONFLICTS OF INTEREST (COI); CONTRACT WITH THE STATE

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:		Date:	10-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:	10/21/2025

DHHS Office: OADS

Service: HOME BASED CARE-SFY26 Amend 1

CTMV: 10A 20250416HOMEBASEDCAR

Vendor Name	Agreement Number	Amend Number	CTP 10A	Start Date	End Date	Projected Spend
SENIORSPLUS	ADS-26-3351	A	20250416000ADS263351	7/1/2025	6/30/2026	\$14,416,698.01
ALPHA ONE INC	ADS-26-9702	A	20250416000ADS269335	7/1/2025	6/30/2026	\$13,526,500.99
CARE LYNC GEORGIA LLC	ADS-26-9335	A	20250416000ADS269702	7/1/2025	6/30/2026	\$250,000.00
Total Items	3				Total Projected	\$28,193,199.00