

**New Jersey Department of Human Services (DHS)  
Division of Mental Health and Addiction Services (DMHAS)  
Mental Health Fee-For-Service (MH FFS) contract  
Hospital Based Provider Agency Administrative Information Form**

**CONTRACT TERM: 7/1/2026 to 6/30/2028**

*Please type or print all information clearly, preferably in block style.*

**ADMINISTRATIVE INFORMATION**

MENTAL HEALTH FEE FOR SERVICE (MH FFS) CONTRACT NUMBER: \_\_\_\_\_

AGENCY NAME: \_\_\_\_\_

ADMINISTRATIVE ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ - \_\_\_\_\_

COUNTY: \_\_\_\_\_ WEB PAGE: \_\_\_\_\_

MAIN AGENCY TELEPHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

FAX NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ FEDERAL TAX ID #: \_\_\_\_\_

HOSPITAL EXECUTIVE DIRECTOR / CEO\*:

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

TELEPHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

MH FFS DIRECTOR / MH FFS LEAD CONTACT FOR CONTRACTED PROGRAMS\*:

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

TELEPHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

LEAD FISCAL CONTACT FOR MH FFS CONTRACTED PROGRAMS\*:

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

TELEPHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

MH FFS BILLING SUPERVISOR CONTACT\*:

NAME: \_\_\_\_\_

TITLE: \_\_\_\_\_

TELEPHONE NUMBER: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

**\*NOTE: All four (4) contacts must be different and distinct personnel from the agency.**

