New Jersey Department of Human Services (DHS)
Division of Mental Health and Addiction Services (DMHAS)
Mental Health Fee-For-Service (MH FFS) contract
Agency Administrative Information Form
FY 2022

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

ADMINISTRATIVE INFORMATION

AGENCY NAME:____

ADMINISTRATIVE ADDRESS: ____

CITY: ____________________________ STATE: ____________________ ZIP: __________ - _____

COUNTY: __________________ WEB PAGE: __________________________________

MAIN AGENCY TELEPHONE NUMBER: (________) ______ - ________

FAX NUMBER: (_________) ______ - ________

FEDERAL TAX ID #: ______________________

AGENCY EXECUTIVE DIRECTOR / CEO*:

NAME: ____

TITLE: ____

TELEPHONE NUMBER: (________) ______ - ________ ext ________

EMAIL ADDRESS: ____

AGENCY CFO / LEAD FISCAL CONTACT*:

NAME:____

TITLE: ____

TELEPHONE NUMBER: (________) ______ - ________ ext ________

EMAIL ADDRESS: ____

MH FFS BILLING SUPERVISOR CONTACT*:

NAME: ____

TITLE: ____

TELEPHONE NUMBER: (________) ______ - ________ ext ________

EMAIL ADDRESS: ____

**NOTE: the above three (3) contacts must be different and distinct personnel from the agency.*

Please provide the following information for each contracted site. Please attach additional sheet, if necessary.

DOH LICENSE #	MH FFS SITE ADDRESS	MH FFS PROGRAM TYPE	MH FFS Residential Levels Of Care, if applicable	MEDICAID #

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

APPLICANT AGENCY

Check one:

☐ PRIVATE NON-PROFIT CORPORATION *(provide copy of 501c3 letter)*

☐ PUBLIC AGENCY

☐ FOR-PROFIT CORPORATION

☐ LLC

☐ OTHER *(Explain)* ______________________________

By submission of this Agency Administration Information Form, provider agency certifies that all of the information provided (including information contained in additional schedules attached) is true, accurate and complete.

AGENCY DIRECTOR / CEO SIGNATURE: ______________________________
Authorized Representative

PRINT NAME: ______________________ TITLE: ______________________ DATE:______________