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: 7/1/2024 to 6/30/2026

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.*

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

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

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.

HOSPITAL DIRECTOR / CEO SIGNATURE: _____
Authorized Representative

PRINT NAME: _____ TITLE: _____ DATE: _____