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 2020

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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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: _____