

**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: 7/1/2027 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.**

