

**New Jersey Department of Human Services (DHS)
 Division of Mental Health and Addiction Services (DMHAS)
 Mental Health Fee-For-Service (MH FFS) contract
 Non-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 #: _____

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: All 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 #, if applicable	MH FFS SITE ADDRESS	MH FFS PROGRAM TYPE	MH FFS Residential Levels Of Care, if applicable	MEDICAID #

