New Jersey Department of Health
Division of Mental Health and Addiction Services
Mental Health Fee-For-Service (MH FFS) contract
Agency Administrative Information Form
FY 2019

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: _____

MH FFS ADMINISTRATIVE CONTACT:

NAME: _____

TITLE: _____

TELEPHONE NUMBER: (_____) _____ - _____ ext _____

EMAIL ADDRESS: _____

MH FFS BILLING CONTACT:

NAME: _____

TITLE: _____

TELEPHONE NUMBER: (_____) _____ - _____ ext _____

EMAIL ADDRESS: _____

Please provide for each contracted site. Please attach additional sheet if necessary. Instructions:

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)* _____

I understand and agree to deliver services according to the MH FFS contract and the MH FFS Annex A requirements. I have reviewed these contract requirements with agency staff and affirm that our agency policies and procedures support adherence to these requirements. I understand that our agency will be monitored by DMHAS for adherence to these contract requirements.

SIGNATURE OF PERSON COMPLETING THIS DOCUMENT: _____

PRINT NAME: _____ TITLE: _____ DATE: _____