**FY 2018 Contract Management System (CMS)**

**REGISTRATION FORM**

Please complete this form by identifying the Provider Organization staff or Consultant that will have the responsibility of submitting the Program (if applicable) and Fiscal Reports/Invoices for payment to Behavioral Health System Baltimore, Inc. Once the form has been completed, please ***email*** the form to the assigned BHSB Senior Contract Administrator of your Contract. This information can be located on the official Behavioral Health System Baltimore, Inc. **FY 2018 Letter of Award (LOA)**.

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| --- | --- |
| **Date**: / / | **Provider/Consultant Name**: **Program Name**: **Address**: **City, State Zip Code**: **Phone Number**: **Email Address**: |

**FY 2018 Contract INFORMATION**

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| --- | --- | --- | --- | --- |
| **FY 2018 Contract Number:**  |  | **Contract Award Amount: $** |  | **Contract Period:** July 01, 2017 – June 30, 2018 |

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| --- | --- |
| **Type of Contract:**Advance Basis Cost Reimbursement - SUD **[ ]**  Advance Basis Cost Reimbursement – MH **[ ]**  Actual Expenditures Cost Reimbursement **[ ]**  Fee-for-Service (FFS) **[ ]**  Consultant **[ ]**   |  |
|  |  |

**PROGRAM REPORTING**: Monthly **[ ]**  Quarterly **[ ]**  Semi-Annual **[ ]**  Annual **[ ]**

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| **FISCAL REPORTING**: Monthly **[ ]**  Quarterly **[ ]**  Semi-Annual **[ ]**  Annual **[ ]**  Bi**-** Monthly **[ ]**   |  |
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 **fy 2018 cms uSER INFORMATION****PROGRAMMATIC REPORT SUBMISSION USER INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Name:  | Title:  | Email Address:  | Phone Number:  |
|  |  |  |  |
| Name:  | Title:  |  Email Address:  | Phone Number:  |

**Fiscal report submission user information**

|  |  |  |  |
| --- | --- | --- | --- |
| Name:  | Title:  | Email Address:  | Phone Number:  |
|  |  |  |  |
| Name:  | Title:  | Email Address:  | Phone Number:  |

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