**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**   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **FY 2018 Contract Number:** |  | **Contract Award Amount: $** |  | **Contract Period:**  July 01, 2017 – June 30, 2018 |  |  |  | | --- | --- | | **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   |  |  | | --- | --- | | **FISCAL REPORTING**: Monthly  Quarterly  Semi-Annual  Annual  Bi**-** Monthly |  | |  |   **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: | |