MARYLAND DEPARTMENT OF HEALTH
OFFICE OF PROCUREMENT AND SUPPORT SERVICES
CONTRACT MANAGEMENT TOOL

GENERAL INFORMATION	
Project Title:	**Project Number:**
Contract Term: year(s) month(s)	**Contract Amount:**
Contract File Location Paper:	**Electronic:**

CONTRACT MONITOR
Name: **Phone:**   **Email:**

CONTRACTOR CONTACT
Name: **Phone:**   **Email:**

KEY PERSONNEL
Contractor:
Name:
Title:
Phone: **Email:**

KICK-OFF MEETING
☐ **Kick-Off Meeting**   **Where:**   **When:**
Summary:
☐ **Review Contract and Scope of Work**

MINIMUM REQUIREMENTS, CERTIFICATIONS, ETC.				
Requirement	Expiration Date	Within Contract Term	Contacted for Renewal	Renewal Complete
		☐	☐	☐
		☐	☐	☐
		☐	☐	☐

INSURANCE

☐ **Insurance** (If yes, please check all applicable Types and indicate corresponding Amounts in the table below.)

Type	Amount	Insurance Certificate Expiration
☐ **Commercial General Liability**		
☐ **Bodily Injury**		
☐ **Property Damage**		
☐ **Personal and Advertising Injury Liability**		
☐ **Errors and Omissions**		
☐ **Professional Liability**		
☐ **Automobile**		
☐ **Commercial Truck**		
☐ **Employee Theft**		
☐ **Workers' Compensation**		

INVOICES				
Date Due	**Amount**	**Accurate & Complete** (Yes/No)	**If No, Was Contractor Notified?** (Yes/No)	**Resubmission Required** (Yes/No)

DELIVERABLES

Deliverable Item	Contract Section	Date Due	Received On Time?	If No, Was Vendor Notified?	Accurate & Complete?	Resubmission Required?	If Yes, When?	If No, Was Payment Withheld?

MBE GOALS

☐ **MBE**

If yes, what is the goal? _____ %   ☐ **Subgoals** (If yes, please identify subgoals below.)

African American: %	Asian American: %	Hispanic American: %	Women: %

CONTRACTORS

Vendor Name	Address	Contact Name	Phone	Email

VENDOR INVOICES

Month	Vendor Name	MBE Invoice Received	If No, Vendor Contacted?	Prime Contractor Invoice Received	If No, Vendor Contacted?	Match	If No, Both Vendors Contacted?

VSBE GOALS

☐ **VSBE**

If yes, please enter the goal: _____ %

CONTRACTORS

Vendor Name	Address	Contact Name	Phone	Email

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF PROCUREMENT AND SUPPORT SERVICES
PROGRAM/CONTRACTOR MEETING

Date: _____

Contractor Name: _____

Contact Name: _____ **Title:** _____ **Phone:** _____ **Email:** _____

Reason for meeting:

Was issue resolved? ☐

        If no, list next steps:

REPORTING REQUIREMENTS

Report Name	Frequency	Received On Time	FY	January-December	If No, Contractor Notified?	If Yes, Result

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