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
☐ **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

MARYLAND DEPARTMENT OF HEALTH
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**