Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Developmental Services

Autism Waiver Program
Agency Homemaker Application

Name of Agency:	FEIN:		Date:
Executive Director/Owner:	Agency Contact:		
Address:	City:	State:	Zip:
Phone number:	Email:		
Registered to do business in MA: ☐ Yes ☐ No			

☐ Requirements

- Tax Identification Number/Copy of W-9
- 18 years of age or older
- 2 Personal or professional references
- Licensed and bonded (preferred)

Please attest that copies of the following information are on file and available to the Autism Division if requested:

☐ Copy of Business Certificate: registration to do business in the state of Massachusetts.

☐ Copy of W9

☐ Name and contact information of two references

☐ Copy of MA License or ID Card

Service Area: Please indicate the geographic region (s) where you are able to provide services (check all that apply)

☐ West ☐ Southeast ☐ Central ☐ Metro ☐ Northeast

If applicable, please list the town (s) that you do not provide service to within a region.

Language: Please indicate if you speak a language in addition to English.

1000 Washington Street
Boston, MA 02118
(617) 624-7778 AutismDivision@Mass.gov

Provider Directory:

☐ I am applying to qualify to provide services/support to (name of individual) only.

☐ I am willing to be placed on a Master list of qualified providers to be considered by individuals/families.

Agency Certification

I certify that the statements made by me as a representative of _____ agency on this application are true and complete to the best of my knowledge. I understand that if I knowingly make any misstatements of fact our agency is subject to disqualification and dismissal and to such other penalties as may be prescribed by law or personnel regulations.

I certify that it is the policy of our agency to run a mandatory criminal history background check (CORI) on each individual employee working with families and that our agency keeps these up-to-date.

Our agency understands that all statements made on this application, including employee credentials, and CORI reviews are subject to verification as a condition of employment. By signing this statement, I hereby give permission for the staff of the Autism Division to request and review materials as necessary for the services provided to individuals enrolled in the Autism Waiver Program.

Agency Designee Signature **Date**

Submit Application

Please submit this application to the Autism Division or to your Autism Support Broker or to your Autism Clinical Manager

Or mail to: Department of Developmental Services
40 Broad Street, 4th Floor
Boston, MA 02109
Attention: Children's Autism Waiver Program

Or Email to: AutismDivision@Mass.gov. Include "Children's AWP Provider Application" in the subject line.