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

Autism Waiver Program
Individual Homemaker
Application

Name:	TIN/SSN:	Date:	
Address:	City:	State:	Zip:
Phone number:	Email:		

☐ **Homemaker**

☐ Requirements

- Tax Identification Number/Copy of W-9
- 18 years of age or older
- 2 Personal or professional references
- Licensed and bonded (preferred)
- Must demonstrate compliance with state and national criminal history background checks

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

☐ Tax Identification Number

☐ 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.

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.

40 Broad Street, 4th Floor
Boston, MA 02109
(617) 624-7778 | AutismDivision@Mass.gov

Certification/Attestation

I certify that the statements made by me on this application are true and complete to the best of my knowledge. I understand that if I knowingly make any misstatement of fact, I am subject to disqualification and dismissal and to such other penalties as may be prescribed by law or personnel regulations. All statements made on this application, including employment information or conviction records, are subject to verification as a condition of employment. I also understand that a Criminal Offender Record Information ("CORI") Check and DDS fingerprint-based National Criminal Background Check will be completed prior to my qualification as an Autism Waiver Program – Individual Provider. By signing this statement, I hereby give permission for the release of any and all information for the sole purpose of conducting an employment check.

Click or tap here to enter text. Click or tap to enter a date.

Applicant Signature **Date**

Submit Application

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

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.