The Commonwealth of Massachusetts

Executive Office of Health & Human Services
Department of Developmental Services

Application for DDS Eligibility

Birth to 4 Years Old

APPLICANT INFORMATION

Full Name: _____ DOB: _____/_____/_____
Last First MI

Address: _____
Street Number Street Name Apartment/Unit #

_____ _____
City/Town State Zip Code SS#

In what language would the guardian or parent prefer to:

- Speak about the applicant? _____
- Receive written materials about the applicant? _____
- Are interpreter services needed for hearing? ☐Yes ☐ No
  NOTE: Translation and interpretation are free of charge to applicants

How may we best contact you? (Please check all that apply)

☐ Primary ( ) _____ May we leave a message Yes ☐ No ☐
☐ Secondary ( ) _____ May we leave a message Yes ☐ No ☐
☐ Email _____

REQUIRED DOCUMENTATION

All applications to DDS require <u>copies</u> of the following documents:

- Birth Certificate
- Social Security Card
- Health Insurance Card(s) (MassHealth, Medicare, Private Insurance)
- Proof of MA Domicile– EX. MA Driver's License, MA ID Card, Utility Bill with Name/Address noted
- Reports documenting the diagnosis for the criteria for which you wish to be considered
- Notice of Privacy Practices Acknowledgment Form (embedded in application)

If your child received any of the below services or evaluations, please provide the documentation:

- Early Intervention/Developmental Profile
- IEP and Related Assessments and or 504 Accommodation Plan
- Adaptive Skills Reports
- Report with a diagnosis of an intellectual disability (ID) and or autism spectrum disorder (ASD)
- Report of IQ via psychological or neuropsychological evaluations
- Genetic testing results

GUARDIANSHIP

This section is to be filled out only if there is a court appointed guardian

If the applicant has a court appointed guardian the guardianship papers must be submitted with this application. In the event of a court appointed guardian this application must be signed by that guardian

Name of Legal Guardian _____ Relationship_____
Last First To applicant

Guardians Address _____
Number and Street City/Town Zip

Email _____ Phone _____

CURRENT SITUATION

Does the child live at home with their family? Yes ☐ No ☐ _____
If no, where do you live except a residential school?

Is the family homeless? Yes ☐ No ☐ _____
If yes, for how long?

Is the family involved with another state agency? Yes ☐ No ☐ _____
If yes, which agency?

TYPE OF APPLICATION

Substantial Developmental Delay (Previously known as Global Developmental Delay)
Are you applying to DDS for services due to a Substantial Developmental Delay (SDD)? Yes ☐ No ☐

If you are applying on behalf of a child with a diagnosis of Substantial Developmental Delay (SDD), you must submit a comprehensive diagnostic report from a licensed qualified practitioner such as a Ph.D, Psy.D MD etc. Your diagnosis must be verified in the document(s). This would include all IQ and cognitive testing and/or assessments.

PARENT OR IMMEDIATE CONTACT

Full Name: _____ Relationship: _____
Last First MI To applicant

_____
Street Number Street Name Apartment/Unit # City State Zip

How may we best contact them? (Please check all that apply)

☐ Primary ( ) _____ May we leave a message Yes ☐ No ☐

☐ Secondary ( ) _____ May we leave a message Yes ☐ No ☐

☐ Email _____

AUTHORIZED CONTACT(S)

If you have someone you would like to authorize as a contact for the purpose of eligibility please indicate below. This can be a social worker, teacher, therapist etc. This person cannot be the legal guardian.

Full Name: _____ Relationship: _____
Last First MI To applicant

_____
Street Number Street Name Apartment/Unit # City State Zip

How may we best contact them? (Please check all that apply)

☐Primary ( ) _____ May we leave a message Yes ☐ No ☐

☐ Secondary ( ) _____ May we leave a message Yes ☐ No ☐

☐ Email _____

I give permission to DDS to discuss my application and records with the person named above for the purposes of completing the eligibility determination process.

_____ _____
Signature of Applicant/Legal Guardian Date

AUTHORIZATION FOR DDS ELIGIBILITY DETERMINATION

I request that the Department of Developmental Services (DDS) conduct a determination of eligibility for services. This permission is valid until my application is fully processed or unless I notify DDS in writing that I revoke it.

The signature of authorization for an eligibility determination for: _____
Applicant's Name

☐ Parent ☐ Legal Guardian

_____ _____
Signature of Applicant/Legal Guardian Date

_____ _____
Print Name of Applicant/Legal Guardian Full address of legal guardian

_____-_____-_____ _____-_____-_____
Primary # Secondary #

Commonwealth of Massachusetts
Department of Developmental Services

AUTHORIZATION FOR RELEASE OF INFORMATION FORM

SECTION I. Personal Information:

Individual's Name: _____ Other Name(s): _____

Address: _____ Phone: _____

_____

_____

Social Security #: _____ Date of Birth: _____

☐ I hereby authorize the Department of Developmental Services to disclose to the provider, agency, entity, or individual named in Section II below the following information:

☐ I hereby authorize the provider, agency, entity, or individual named in Section II below to release the following information to the Department of Developmental Services:

☐ Psychological Testing ☐ Complete Record ☐ Other Service Plan
☐ Medical History ☐ Medication History ☐ Guardianship Documents
☐ Educational History ☐ ITP/ISP ☐ Hospital Reports

☐ Other (Specify) _____

_____

SECTION II. **Authorized Recipient(s).** I give my permission to the provider, agency, entity, or individual listed below to share/receive the information listed in Section I with/from the Department of Developmental Services:

_____
Name

_____
Organization

_____
Address

SECTION III. **Purpose of Disclosure**. Please state the purpose of the use or disclosure of information (e.g. medical care, legal, insurance, personal, etc. – be specific. If you do not want to list a reason, you may simply write: "at my request," if you are initiating the request)

_____

Any other use or disclosure of this information is prohibited under Massachusetts statutes and Departmental regulations and policies.

SECTION IV. Additional Disclosure(s). The Department of Developmental Services or the provider, agency, entity or individual listed in Section II may share my information with this person(s) or organization:

_____

Name

_____

Organization

_____

Address

SECTION V. Certification. I have been informed of the benefits and disadvantages of releasing the above information and I voluntarily execute release. I understand that I have a right to revoke the authorization at any time. If I revoke this authorization, I must do so in writing and present it to the person/facility/agency that was authorized to release the information. I understand that the revocation will not apply to information that has already been released in response to this authorization.

This authorization will expire _____ (date or event – must not exceed one year). I understand that once the above information is disclosed, the recipient may redisclose it and the information may not be protected by federal or state privacy laws or regulations. I understand that authorizing the use or disclosure of the information identified above is voluntary. I understand that I do not need to sign this form to continue to receive health services from DDS.

_____ _____

Signature of Individual who is the Subject of the Information or Guardian Date

_____

Print Name (and identify legal authority if signed by Guardian or other Legally/Authorized Representative)

SECTION VI. Specific Authorizations. I specially authorize release of the following information (please check all that apply):

☐ To the extent that my medical record contains information concerning HIV antibody and antigen testing that is protected by M.G.L. c.111 S.70F, an HIV/AIDS diagnosis or HIV/AIDS treatment, I specifically authorize release or disclosure of such information.

☐ To the extent that my medical record contains information concerning alcohol or drug treatment that is protected by Federal Regulation, 42 CFR, Part 2, I specifically authorize release or disclosure of such information.

_____ _____

Signature of individual who is the subject of the Information or Guardian Date

INSTRUCTIONS:

1. This form must be completed in full (excluding Specially Authorized Releases) to be considered valid.
2. Ensure that the expiration date or event listed on page 2 is practical.
3. **Distribution of copies: Original to provider; copy to individual or personal representative; copy**

to person/facility/agency making request.

FINAL INSTRUCTIONS FOR SUBMITTING AN APPLICATION TO DDS

- Assure all information in this application is completed
- Assure all required signatures are completed
- Attach all requested documentation to this application
- On the following pages read the NOTICE OF PRIVACY PRACTICES (4 pages)
  - Retain the four pages of the Notice of Privacy Practices for your own records
  - Sign and return the Notice of Privacy Practices Acknowledgment Form with the application

Forward this completed packet to your local DDS Regional Office c/o The Regional Eligibility Team identified below. If you have any questions prior to sending in your application and necessary attachments, please feel free to contact your local Regional Eligibility Team.

DDS Central/West Region
One Federal Street
Springfield, MA 01105
Intake Line: **(413)-205-0940**
Fax: (413) 205-1603

DDS Metro Region
465 Waverley Oaks Road Suite 120
Waltham, MA 02452
Intake Line: **(781) 314-7513**
FAX: 781-314-7539

DDS Southeast Region
151 Campanelli Drive Suite B
Middleboro, MA 02346
Intake Line **(508)-866-8800**
Fax Number: (508) 866-8859

DDS Northeast Region
Hogan Regional Center
PO Box A Hathorne, MA 01937
Intake Line: **(978) 774-5000 x850**
FAX 978-739-0420

The Commonwealth of Massachusetts

Executive Office of Health & Human Services
Department of Developmental Services

Notice of Privacy Practices Acknowledgment Form

Name of Applicant: _____

Facility/Region/Area/Program: _____

I have reviewed a copy of the DDS Notice of Privacy Practices

Signature: _____ Date_____
Personal Representative with legal authority to make healthcare decisions

If signed by a Personal Representative:

Print Name: _____

Role: _____ (parent/ guardian etc.)

Witness: _____ Date: _____

This form must be retained for a period of at least six years in the appropriate records in accordance with the DDS Privacy handbook

The Commonwealth of Massachusetts

Executive Office of Health & Human Services
Department of Developmental Services

KEEP THIS DOCUMENT FOR YOUR OWN RECORDS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose:
This notice is to inform you about the Department of Developmental Services's privacy practices and legal duties related to protection of the privacy of your medical or health records that we create or receive. This notice also explains your rights regarding your health information and the Department's responsibilities. As explained below, we are required by law to ensure that medical or health information that identifies you is kept private.

If you have any questions about the content of this Notice of Privacy Practices, if you need to contact someone at the Department about any of the information contained in this Notice of Privacy Practices, or if you have a complaint about the Department's Privacy Practices, you may contact the Department's Privacy Office at:

Privacy Officer
Department of Developmental Services
1000 Washington Street
Boston, MA 02118
(888) 367-4435, ext. 7717

I. What is Protected Health Information?

Protected Health Information (**PHI**) is information which the Department gathers about your past, present or future health or condition, about the provision of health care to you, or about payment for health care. Whether based upon our confidentiality policies, or applicable law, the Department has a long-standing commitment to protect your privacy and any personal health information that we hold about you. Under federal law, we are required to give you this Notice about our privacy practices that explains how, when, and why we may use or disclose your PHI.

You may request a copy of the notice from any Department of Developmental Services Office. It is also posted on our website at www.dds.state.ma.us.

II. How May the Department Use and Disclose Your PHI?

In order to provide services to you, DDS must use and disclose Protected Health Information in a variety of ways. The following are examples of the types of uses and disclosures of PHI that are permitted *without your authorization.*

Generally, the Department may use or disclose your PHI as follows:

- **For Treatment**: DDS may use PHI about you to provide you with treatment or services. For example, your treatment team members may internally discuss your PHI in order to develop and carry out a plan for your services. DDS may also disclose PHI about you to people or service providers outside the Department who may be involved in your medical care, but only the minimum necessary amount of information will be used or disclosed to carry this out.
- **To Obtain Payment**: DDS may use or disclose your PHI in order to bill and collect payment for your health care services. For example, DDS may release portions of your PHI to the Medicaid program, Social Security Office, staff at the Department, or to a private insurer.
- **For Health Care Operations**: DDS may use or disclose your PHI in the course of operating the Department's facilities, offices, developmental centers and all other Department programs. These uses and disclosures are necessary to run our programs including ensuring that all of our consumers receive quality care. For example, we may use your PHI for quality improvement to review our treatment and services and to evaluate the performance of Department and/or provider staff in caring for you. We may also disclose information to doctors, nurses, technicians, medical students and other personnel as listed above for review and learning purposes. It may also be necessary to obtain or exchange your information with other Massachusetts state agencies.

The law provides that we may use or disclose your PHI *without consent or authorization* in the following circumstances:

- **When Required By Law and For Specific Governmental Functions**: DDS may disclose PHI when a law requires that we report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. We may also disclose PHI to authorities that monitor compliance with these privacy requirements. We may also disclose PHI to government benefit programs relating to eligibility and enrollment, such as Medicaid, for workers' compensation claims, and for national security reasons, such as protection of the President.
- **For Public Health and Safety Activities**: DDS may disclose PHI when we are required to collect information about disease or injury, or to report vital statistics to a public health authority, reporting adverse medication reactions, product recalls, or preventing disease.
- **For Health Oversight Activities**: DDS may disclose PHI within the Department or to other agencies responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents, and monitoring of the Medicaid program.
- **Relating to Decedents**: DDS may disclose PHI related to a death to coroners, medical examiners, or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants. Information may also be disclosed in relation to internal or external investigations.
- **For Research, Audit or Evaluation Purposes**: In certain circumstances, and under the oversight of a research review committee, DDS may disclose PHI to approved researchers and their designees in order to assist research.

- **To Respond to Lawsuits and Legal Actions**: DDS may share health information about you in response to a court or administrative order, or in response to a subpoena to the extent authorized by state law or federal law, including but not limited to G.L. c. 123B, § 17 (DDS Records Confidentiality); G.L. c. 66A, § 2 (Fair Information Practices Act); G.L. c. 111, § 70(f) (HIV testing); G.L. c. 111B, § 11 (alcohol treatment); and G.L. c. 111E, § 18 (drug treatment).
- **To Avert Threat(s) to Health or Safety**: In order to avoid a serious threat to health or safety, DDS may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.

III. Uses and Disclosures of PHI Requiring your Authorization.

For uses and disclosures other than treatment, payment and healthcare operations purposes we are required to have your written authorization, unless the use or disclosure falls within one of the exceptions described above. Authorizations may be revoked at any time to stop future uses/disclosures except to the extent that we have already undertaken an action in reliance upon your authorization.

IV. Limited Uses and Disclosures to Families, Friends, and Others Provided You Do Not Object

We may disclose a limited amount of your PHI to families, friends, or others involved in your care if we inform you about the disclosure in advance and you do not object, as long as the law does not otherwise prohibit the disclosure.

V. Your Preference(s) for How DDS Shares Your Protected Health Information

For certain health information you can inform DDS your preferences for how/what we may share. In these cases, you have both the right and choice to inform DDS to:

- Share information with your family, close friends, or others involved in your care;
- Share information in a disaster relief situation;
- Include your information in a hospital/facility directory;
- Contact you for fundraising efforts.

If you are not able to tell us your preferences, for example if you are unconscious, DDS may share your information if we believe it is in your best interest. We may also share your information when necessary to lessen a serious and imminent threat to health or safety.

VI. Prohibited Disclosures

The Department will never use or disclose your protected health information for marketing purposes, for sale of your information, or for most sharing of your psychotherapy notes unless you have provided your written permission authorizing such. In the case of fundraising, DDS may contact you for fundraising efforts – but you may advise DDS not to contact you again.

VII. Your Rights Regarding Your Protected Health Information

You have the following rights relating to your protected health information:

- **To Obtain a Copy of this Notice of Privacy Practices**: You may ask DDS for a paper copy of this notice at any time.
- **To Inspect and Request a Copy of Your PHI:** Unless access to your records is restricted for clear and documented treatment reasons, you have a right to inspect and obtain a copy of your paper and electronic protected health information upon your written request. A request should be made to the Privacy Officer through your service coordinator or Area Office. DDS will respond to your request within 30 days. If you want copies of your PHI, a charge may be assessed.
- **To Choose Someone to Act for You**: If you have given someone medical power of attorney or if someone is your legal guardian, that person may exercise your rights and make choices about your health information to the extent authorized by law. DDS will respect the requests/choices of your legally authorized representative to the extent authorized by law.
- **To Request Restrictions on Uses/Disclosures:** You have the right to ask that DDS limit how we use or disclose your PHI or request that DDS not use or share certain health information for treatment, payment, or health care operations. The Department will consider your request, but is not legally bound to agree to the restriction if it may affect your care or service provision. If you pay for service or health care item out-of-pocket in full, you can ask that DDS not share that information for the purposes of payment or our operations with your health insurer.
- **To Choose How We May Contact You**: You have the right to ask that DDS send you information at an alternative address or by an alternative means; including request(s) that we contact you by confidential communications.
- **To Request Amendment of your PHI**: If you believe there is a mistake or missing information in our record of your PHI, you may request, in writing, that DDS correct or add to the record. DDS will respond within 60 days of receiving your request. Any denial will state the reason for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI.
- **To Request an Accounting of What Disclosures Have Been Made**: In certain circumstances, you have a right to get a list of when, to whom, for what purpose, and what content of your PHI has been released.
- **To File a Complaint**: If you think DDS may have violated your privacy rights, or you disagree with a decision the Department has made about access to your PHI, you may file a complaint with the DDS Privacy Officer. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or by visiting HHS's Website at: www.hhs.gov/ocr/privacy/hipaa/complaints/. The Department will take no retaliatory action against you if you make such a complaint.

VIII. DDS's Privacy and Security Responsibilities

The Department has the following responsibilities relating to your protected health information:

- **Protect the Privacy of Your Health Information**: DDS is required by law to maintain the privacy and security of your protected health information.
- **Notify You of Breaches**: DDS will contact you promptly if there is a breach of security that may have compromised the privacy or security of your unsecured health information.

- **Notice of Privacy Practices**: DDS must adhere to the duties and privacy practices described in this notice and make copies of such available to you.
- **Authorized Uses and Disclosures**: DDS will not use or share your information other than as described in this notice unless authorized by you in writing. You may also change your mind and revoke your authorization at any time by contacting the Department in-writing.

For additional information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Application and Effective Date:
This notice applies to the use or disclosure of protected health information at all Department Facilities, Offices, Developmental or Regional Centers, and all other Department programs; including the use or disclosure of PHI by individuals or entities engaged in an organized health care arrangement (OHCA) with the Department. Any individual or entity so engaged with DDS in an OHCA shall adhere to DDS's duties and privacy practices as described in this notice.

This notice is effective as of April 14, 2003 (as revised September 1, 2014). The Department reserves the right to make changes to its privacy practices and the terms of this Notice at any time. The new notice will be available upon request, in any DDS Office, and on the Department's website.

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF DEVELOPMENTAL SERVICES
Regional Intake and Eligibility
Regional Cities/Towns

DDS Central/West Region
Regional Eligibility Coordinator
One Federal Street
Springfield, MA 01105
Intake Line: (413)-205-0940 Fax:
(413) 205-1605

CENTRAL/ WEST Cities and Towns:

Adams, Agawam, Alford, Amherst, Ashburnham, Ashby, Ashfield, Ashley Falls, Athol, Auburn, Ayer, Baldwinville, Barre, Becket, Belchertown, Bellingham, Berlin, Bernardston, Blackstone, Blandford, Bolton, Boylston, Brimfield, Brookfield, Buckland, Charlemont, Charlton, Cherry Valley, Cheshire, Chester, Chesterfield, Chicopee, Clarksburg, Clinton, Colrain, Conway, Cummington, Dalton, Deerfield, Douglas, Dudley, East Brookfield, Easthampton, East Longmeadow, Egremont, Erving, Feeding Hills, Fitchburg, Florida, Franklin, Gardner, Gill, Goshen, Grafton, Granby, Granville, Groton, Great Barrington, Greenfield, Hadley, Hancock, Hampden, Hardwick, Harvard, Hatfield, Hawley, Heath, Hinsdale, Holden, Holland, Holyoke, Hopedale, Housatonic, Hubbardston, Huntington, Indian Orchard, Lancaster, Lanesboro, Lee, Leeds, Leicester, Lenox, Leominster, Leverett, Leyden, Longmeadow, Ludlow, Lunenburg, Medway, Mendon, Middlefield, Millers Falls, Milford, Millbury, Millville, Monroe, Monson, Montague, Monterey, Montgomery, Mt. Washington, New Ashford, New Braintree, New Marlboro, New Salem, North Adams, Northampton, Northbridge, Northfield, North Brookfield, Oakham, Orange, Otis, Oxford, Palmer, Paxton, Pelham, Pepperell, Petersham, Peru, Phillipston, Pittsfield, Plainfield, Princeton, Richmond, Rowe, Royalston, Russell, Rutland, Sandisfield, Savoy, Sheffield, Shelburne, Shirley, Shrewsbury, Shutesbury, Southbridge, South Deerfield, South Hadley, Leominster, Southampton, Southwick, Spencer, Springfield, Sterling, Sturbridge, Stockbridge, Sunderland, Sutton, Templeton, Tolland, Townsend, Turners Falls, Tyringham, Upton, Uxbridge, Wales Ware, Warren, Warwick, Washington, Webster, Wendell, West Boylston, West Brookfield, Westfield, Westhampton, Westminster, West Springfield, West Stockbridge, Whately, Whitinsville, Wilbraham, Williamsburg, Williamstown, Winchendon, Windsor, Worthington, Worcester

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF DEVELOPMENTAL SERVICES
Regional Intake and Eligibility
Regional Cities/Towns

DDS Metro Region
Regional Eligibility Coordinator
465 Waverley Oaks Road Suite 120
Waltham, MA 02452
Intake Line: (781) 314-7513
Fax Number: (781) 314-7539

Metro Region Cities and Towns:

Allston, Ashland, Beacon Hill, Belmont, Boston, Brighton, Brookline, Cambridge, Canton, Charlestown, Chelsea, Chestnut Hill, Chinatown, Dedham, Dorchester, Dover, Downtown Crossing, East Boston, Foxboro, Framingham, Holliston, Hopkinton, Hudson, Hyde Park, Jamaica Plain, Marlboro, Mattapan, Medfield, Millis, Natick, Needham, Newton, Norfolk, Northborough, North Dorchester, North End, Norwood, Plainville, Revere, Roslindale, Roxbury, Sharon, Sherborn, Somerville, Southborough, South Boston, South End, Sudbury, Walpole, Waltham, Watertown, Wayland, West Roxbury, Wellesley, Westborough, Weston, Westwood, Winthrop, Wrentham

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF DEVELOPMENTAL SERVICES
Regional Intake and Eligibility
Regional Cities/Towns

DDS Northeast Region
Regional Eligibility Coordinator
Hogan Regional Center
PO Box A
Hathorne, MA 01937
Intake Line: (978) 774-5000 x850
Fax Number: (978)739-0420

Northeast Region Cities and Towns:

Acton, Amesbury, Andover, Arlington, Bedford, Beverly, Billerica, Boxborough, Boxford, Bradford, Burlington, Carlisle, Chelmsford, Concord, Danvers, Dracut, Dunstable, Essex, Everett, Georgetown, Gloucester, Groveland, Hamilton, Haverhill, Ipswich, Lawrence, Lexington, Lincoln, Littleton, Lowell, Lynn, Lynnfield, Malden, Manchester, Marblehead, Maynard, Medford, Melrose, Merrimac, Methuen, Middleton, Nahant, Newbury, Newburyport, North Andover, North Reading, Peabody, Reading, Rockport, Rowley, Saugus, Salem, Salisbury, Stoneham, Stow, Swampscott, Tewksbury, Topsfield, Tyngsboro, Wakefield, Wenham, West Newbury, Wilmington, Winchester, Woburn, Westford

COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF DEVELOPMENTAL SERVICES
Regional Intake and Eligibility
Regional Cities/Towns

DDS Southeast Region
Regional Eligibility Coordinator
151 Campanelli Drive Suite B
Middleboro, MA 02346
Intake Line (508)-866-5000
FAX Number (508)-866-8859

Southeast Region Cities and Towns

Abington, Acushnet, Assonet, Attleboro, Avon, Barnstable, Berkley, Bourne, Braintree, Brewster, Bridgewater, Brockton, Carver, Chatham, Chilmark, Cohasset, Dartmouth, Dennis, Dighton, Duxbury, East Bridgewater, Eastham, Easton, Edgartown, Fairhaven, Fall River, Falmouth, Freetown, Gay Head, Gosnold, Halifax, Hanover, Hanson, Harwich, Hingham, Holbrook, Hull, Hyannis, Kingston, Lakeville, Mansfield, Marion, Marshfield, Mashpee, Mattapoisett, Middleboro, Milton, Nantucket, New Bedford, North Attleboro, Norton, Norwell, Oak Bluffs, Orleans, Pembroke, Plymouth, Plympton, Provincetown, Quincy, Randolph, Raynham, Rehoboth, Rochester, Rockland, Sandwich, Scituate, Seekonk, Somerset, Stoughton, Swansea, Taunton, Tisbury, Truro, Wareham, Wellfleet, West Bridgewater, Westport, West Tisbury, Weymouth, Whitman, Yarmouth