



**Commonwealth of Massachusetts  
Department of Public Health, Bureau of Health Professions Licensure  
Drug Control Program  
250 Washington Street, Boston, MA 02108  
Telephone 617-973-0949**

**Application for a New or Renewal of Massachusetts Controlled Substances Registration (MCSR)  
for a Community Program (MAP)**

[MAP.MCSR@mass.gov](mailto:MAP.MCSR@mass.gov)

**Please be sure to:**

- Complete the application form.
- Sign (not initial) and date the application form.
- Email a scanned copy of the original application to: [MAP.MCSR@mass.gov](mailto:MAP.MCSR@mass.gov) along with copies of the current support documents to the Drug Control Program (DCP) Medication Administration Program (MAP).

**Required Support Documents:**

A **DMH youth site** must submit both a copy of its current site license(s) and a copy of its **current Intensive Clinical Services Contract** with DMH along with this application form. A **DCF youth site** must submit both a copy of its current site license(s) and a copy of its **current Congregate Care Network Contract** with DCF along with this application form. If MCSR Application is for a potential new site also email the completed and signed Attestation Document along with this application.

An **adult site** must submit a copy of its **current DDS/DMH/MRC license** and/or its **current contract** with **DDS/DMH/MRC** along with this application form. If the license and/or contract do not indicate the site address requesting registration, an additional secondary document indicating **DDS/DMH/MRC** support for the **site address** is required. If the MAP MCSR Application is for a potential new site also email the completed and signed Attestation Document along with this application.

Incomplete application forms will be returned and will cause a delay in issuing the site's MCSR. Copies of documents must be submitted along with the original application form.

For further information visit our Web site at <http://www.mass.gov/dph/dcp> or call the Drug Control Program at 617-973-0949.

**Application Type:** (Select one)  New  Renewal  
**MCSR #:** MAP \_\_\_\_\_

In the boxes below enter the requested information.

1. <b>Classification:</b> (Select one)				
<input type="checkbox"/> DMH	<input type="checkbox"/> DDS	<input type="checkbox"/> MRC	<input type="checkbox"/> Youth Programs <input type="checkbox"/> DMH: <input type="checkbox"/> DCF	<input type="checkbox"/> Other Specify: _____
2. <b>State Operated:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
3. <b>Service Provider Business Name:</b>				
4. <b>Mail Recipient (if not Operational Manager – Box12):</b>				
5. <b>Service Provider Business Address:</b> (A P.O. Box number without a street address cannot be processed.)				
Street:				
City:		State:	ZIP:	
Telephone:		Fax:	Email:	
6. <b>Program Director (Manager) Name:</b>				
Street:				
City:		State:	ZIP:	
Telephone:		Fax:	Email:	

**7. Site Address:** (A P.O. Box number without a street address cannot be processed.)

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

---

**8. Site Supervisor (House Manager) Name:**

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

---

**9. Type Of Site:** (Check all that apply.)

<input type="checkbox"/> Individual Apartment	<input type="checkbox"/> Employment & Training	<input type="checkbox"/> Day Program
<input type="checkbox"/> Shared Apartment	<input type="checkbox"/> Short-Term Respite	<input type="checkbox"/> Work Program
<input type="checkbox"/> Staffed Apartment	<input type="checkbox"/> Supportive Housing	<input type="checkbox"/> ACCS Program
<input type="checkbox"/> Group Home/Residence	<input type="checkbox"/> ACT Program	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Group Living Environment (GLE)	<input type="checkbox"/> Centralized Program Storage Center for off-site housing	

---

**10. Population(s):** (Check all that apply.)

Adults ( 18 years of age or older)     Youth (under 18 years of age)

---

**11. Capacity:**

Site current occupancy: \_\_\_\_\_ Site total capacity: \_\_\_\_\_

**Service Provider Authorized Individual Information**

**12. Service Provider Operational Manager** (e.g. CEO, Executive Director, President, etc.)

**Contact Information:**

Print name: \_\_\_\_\_ Print title: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

I hereby certify that the information on this application is true to the best of my knowledge, and that the applicant will comply with the laws of the Commonwealth of Massachusetts and all applicable rules and regulations promulgated by the Department of Public Health.

I also certify, in accordance with M.G.L. c. 62C, s. 49A, that the applicant has to the best of my knowledge and belief filed all state tax returns and paid all state taxes required under law.

Signed under the pains and penalties of perjury.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Authorized Individual** --Service Provider Operational Manager (e.g. CEO, Executive Director, President, etc.)

**Check list for required information and documents**

For a **Youth Site** have you?

- ✓ Completed items 1 through 12?
- ✓ Attached copy of current license?
- ✓ Attached copy of current Contract?
- ✓ Signed and dated application (Box 12)?
- ✓ Attached copy of Attestation Document (if applicable)?

For an **Adult Site** have you?

- ✓ Completed items 1 through 12?
- ✓ Attached copy of current license or contract?
- ✓ Attached supporting site address documentation?
- ✓ Signed and dated application (Box 12)?
- ✓ Attached copy of Attestation Document (if applicable)?

For office use only		
Received by Drug Control Program	Comments	Staff initials