

# AGENCY PROVIDER APPLICATION

Commonwealth of Massachusetts  
Autism Division of the Department of Mental Retardation  
APPLICATION TO QUALIFY AS A PROVIDER OF AUTISM SUPPORT SERVICES

Name:  
Address:  
E-Mail:           @  
  
FEIN : #

Date:  
  
Phone:

Service: Expanded Habilitation, Education  
Please indicate your experience level (check all that apply):

**SENIOR LEVEL THERAPIST** (Expanded Habilitation only): Role is to oversee the development and implementation of the Expanded Habilitation, Education Intervention Plan ("HIP"). This includes the creation of the HIP as well as Quarterly Progress Reports.

Requirements

- Doctoral Degree
- Applicable License
- 1500 hours of Training, including course work in principles of child development theory and behavior analysis
- 2 years of experience in a lead role in designing and implementing behaviorally based therapies for children with ASD

Agencies must attest that copies of the following information are on file and available to the Autism Division if necessary:

**(Do not send with application)**

- Copy of Current Professional License
- Copy of Resume
- Any other relevant certification documents
- Copy of MA License or ID Card

**OR**

Requirements:

- Master's Degree
- 2000 hours of Training
- 2 years of experience
- 10 hours Professional Development

Agencies must attest that copies of the following information are on file and available to the Autism Division if necessary:

**(Do not send with application)**

- Copy of Current Professional License
- Copy of Resume
- Copy of Transcript (to confer training hours)
- Any other relevant certification documents
- Copy of MA License or ID Card

**THERAPIST** (Expanded Habilitation only): Families may choose to use a therapist to provide one-to-one staff support for the implementation of the Habilitation Plan (HIP) and related tasks as assigned by the Senior Therapist. However this is the choice of the family to hire either a therapist or a direct staff person for the implementation of the plan for the individual receiving Expanded Habilitation, Education.

Requirements

- Master's Degree
- 800 hours of Course Work including course work in relevant principles of behavior analysis
- Experience in Development and Implementation of Therapies
- One year Supervised Post Degree Experience
- 10 hours of Professional Development

Agencies must attest that copies of the following information are on file and available to the Autism Division if necessary:

**(Do not send with application)**

- Copy of Current Professional License
- Copy of Resume
- Copy of Transcript (to confer training hours)
- Any other relevant certification documents
- Copy of MA License or ID Card

# AGENCY PROVIDER APPLICATION

**OR**

Requirements

- Bachelor's Degree in psychology, education or related field
- 800 hours of Course Work/Training including course

Agencies must attest that copies of the following information are on file and available to the Autism Division if necessary: (Do not send with application)

Copy of Current Professional License (If Applicable)

**OR**

Requirements

- Bachelor's Degree in non-related field
- 800 hours of Training Experience in the Development

Agencies must attest that copies of the following information are on file and available to the Autism Division if necessary: (Do not send with application)

**DIRECT SUPPORT STAFF** (Expanded Habilitation only): Role is to implement the Habilitation, Intervention Plan as designated by the Senior Therapist including one-to-one behavioral interventions and skills training and community integration activities for individuals receiving Expanded Habilitation, Education Services.

Waiver Program Services:

- Habilitation/ADL/Independent Living Skills
- Habilitation/Community Integration
- Family Training



# AGENCY PROVIDER APPLICATION

---

## CERTIFICATION

I certify that the statements made on this application are true and complete to the best of my knowledge. Any misstatement of fact, may lead to disqualification and dismissal and to such other penalties as may be prescribed by law or regulations. All statements made on this application, including employment information or conviction records are subject to verification as a condition of qualification as a provider. By signing this statement, I hereby give permission for the release of any and all information necessary to verify staff qualifications.

\_\_\_\_\_  
Signature of Authorized Agency  
Representative

\_\_\_\_\_  
Date

MAIL TO:  
**AUTISM DIVISION AT DMR**  
**Attention: PROVIDER APPLICATIONS**  
**500 Harrison Ave, Boston, MA 02118**