MassHealth

THE COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health and Human Services
www.mass.gov/masshealth

Massachusetts Rehabilitation Commission Home and Community Services Waiver Provider Application

Provider Type 35

1. Provider name (please print)

2. Provider doing business address (for self-employed provider please enter address of self-employment)

3. City	4. State	5. Zip code (5+4 digits, if known) –
6. Legal entity name	7. Legal entity street address	
8. City	9. State	10. Zip code (5+4 digits, if known) –
11. Telephone number (daytime)	12. Cell phone number (optional)	
13. Fax number (if available)	14. E-mail address (please print)	
15. Tax ID # or Social Security #		
16. Contact person	17. Telephone number of contact person	

18. Do you currently have any Medicaid provider numbers (in addition to the one you are applying for) with this application? ☐ Yes ☐ No
If Yes, please explain on a separate signed, dated piece of paper stapled to this application.

20. Have you ever been excluded from participation in the Medicaid or Medicare program? ☐ Yes ☐ No

21. Type of ownership (check one)

- ☐ 01–individual applicant (sole owner)
- ☐ 02–partnership
- ☐ 03–nonprofit organization
- ☐ 04–government entity
- ☐ 05–corporation
- ☐ 06–trust
- ☐ 07–other (please specify): _____