



**Commonwealth of Massachusetts
Department of Public Health, Bureau of Health Professions Licensure
Drug Control Program**

**239 Causeway Street, Suite 500, Boston, MA 02114
Telephone 617-973-0949 Fax 617-753-8233**

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

Please be sure to:

- Complete the application form.
- Sign (not initial) and date the application form.
- Mail in original application along with copies of current support documents to the address listed above.

Required Support Documents:

A **youth site** must submit both a copy of its **site license(s)** and a copy of its **current Caring Together Contract** with DMH/DCF along with this application form.

An **adult site** must submit a copy of its **current DDS/DMH license** and/or its **current contract** with **DDS/DMH** 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** support for the **site address** is required.

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. **Classification:** (Select one)

- | | | | |
|--|------------------------------|--|--------------------------------|
| <input type="checkbox"/> DMH | <input type="checkbox"/> DDS | <input type="checkbox"/> Caring Together | <input type="checkbox"/> Other |
| Specify: <input type="checkbox"/> DCF <input type="checkbox"/> DMH | | Specify: _____ | |

2. **State Operated:** Yes No

3. **Service Provider Business Name:**

4. **Mail Recipient (if not Operational Manager – Box12):**

5. **Service Provider Business Address:** (A P.O. Box number without a street address cannot be processed.)

Street:			
City:	State:	ZIP:	
Telephone:	Fax:	Email:	

6. **Program Director (Manager) Name:**

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"/> Group Home/Residence	<input type="checkbox"/> Other (specify): _____
<input type="checkbox"/> Supportive Housing	<input type="checkbox"/> ACT Program	
<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 Caring Together Contract?
- ✓ Signed and dated application (Box 12)?

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)?

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