



MEMBERSHIP APPLICATION FORM

Agency Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone/800 Number: _____ FAX: _____

TDD: _____ Website URL: _____

Hours of Operation: _____

Tell us about your organization:

Please attach a brochure, or provide description(s) of the service(s) provided by your agency.

What type(s) of services do you provide?

Do you provide Information and Referral (I&R) services to people who call your agency? YES NO

Name of person(s) who will respond to I&R calls or other information requests? _____

What telephone number can they be reached at? _____

Email address: _____

The above Information (including the name of the I&R Specialist and their phone number) will be placed on our website.

Please provide us with an Administrative Contact

Administrative Contact Name: _____
Phone Number: _____
Email: _____

If you have any questions about this form or the MNIP, please call Angie Aguirre at 781-642-0289

_____ acknowledges its intent to participate in the
Massachusetts Network of Information Providers for People with Disabilities (MNIP)

Executive Director

Signature

Date