

**A. TAP Resident Engagement Program FY 2026-2027 Submission Checklist Form**  
**\*This form is required for Current and New applicants**

Organization or applicant's name \_\_\_\_\_

**TAP Resident Engagement Program FY 2026 -2027 Forms:**

Cover Page *Form B* (Current and New Applicants)

Presenter/Facilitator Information *Form C* (Current and New Applicants)

Program Summary *Form D.1-D.2* (Current Vendor Applicants Only)

How many programs/trainings/workshops submitted

Program Summary *Form E* (New Vendor Applicants Only)

Program/Training/Workshop *Forms F.1-F.5* (New Vendor Applicants Only)

How many programs/trainings/workshops submitted

References *Form G* (New Vendor Applicants Only)

**B. Cover Page Form**

**\*This form is required for Current and New applicants**

Applicant name: \_\_\_\_\_

Organization (if applicable): \_\_\_\_\_

Title of contact person: \_\_\_\_\_

Address: \_\_\_\_\_

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

Email: \_\_\_\_\_ Website: \_\_\_\_\_

Certified Minority Business Enterprise (MBE) Vendor: yes no Process

Certified Women Business Enterprise (WBE) Vendor: yes no Process

Certified Minority Women Business Enterprise (M/WBE) Vendor: yes no Process

Certified Disadvantaged Business Enterprise (DBE) Vendor: yes no Process

Certified Disability Owned Business Enterprise (DOBE) Vendor: yes no Process

Certified Service Disabled Veteran Owned Business Enterprise (SDVOBE): yes no Process

Certified Veteran Business Enterprise (VBE) Vendor: yes no Process

Certified Lesbian, Gay, Bi-Sexual, Transgender, Business Enterprise (LGBTBTE): yes no Process

**Waiver:**

I shall be entirely and solely responsible for my actions and the actions of my employees and by submitting this application to be a vendor in the TAP program, I agree to indemnify and hold harmless MassHousing against all claims, demands, suits, awards, and judgments, made or recovered by any persons or agencies due to the negligent actions of myself or my employees.

**Signature**

**Electronic Signatures:** This application may be executed by electronic signature, which shall be considered as an original signature for all purposes, shall be binding on the parties and shall have the same force and effect, for all purposes, as an original signature. Without limitation, in addition to electronically produced signatures, "electronic signature" shall include faxed versions of an original signature or electronically scanned and transmitted versions (e.g., via pdf) of an original signature.

**C. Presenter/Facilitator Information**

**\*This form is required for Current and New applicants**

Organization or applicant name: \_\_\_\_\_

First Name

Last Name

Email Address

Check this box if you have additional individuals that will participate in TAP programs, if selected to proceed.

**Background Check (required):** If selected as a vendor, all individuals for FY26-27 TAP Resident Programming presenting, facilitating and/or providing services as part of the TAP Resident Program are required, with no exception, to undergo a background check related to his/her past activities, to supply any and all information concerning to his/her background, and release the same from any liability resulting in providing such information. The information will be limited to a public record history of my name(s), address(es), criminal convictions and pending cases, and state sex offender data. This will be done by DISA Global Solutions. The name and email will be provided to DISA Global Solutions and an email will be sent directly to the individual to enter information to complete the required background check.

If a participant has a positive CORI check, they will be notified via email that they are ineligible to participate as a TAP vendor.

Participants then have a right to review the criminal history report provided to us, dispute the CORI, or request reconsideration of the decision on eligibility. Participants need to submit a written request for a copy of the criminal history report within five business days of receiving the notification should they wish to review and/or appeal the report of status.

**D.1 Program Summary: CURRENT VENDOR FORM**

**\*This form is required for CURRENT vendor applicants**

**Applicant Name** \_\_\_\_\_

Do you have general liability insurance?      yes                  no

**List the proposed program/s for FY2026-2027 (up to 5 programs)**

Title	Single or series	Proposed Fee
1. _____	single      series	\$ _____
New or Existing Program in the catalogue:	New Program	Existing Program
Are there any proposed changes to this program:	Yes	No
If new program or existing program with changes, please provide description below:		

2. _____	single      series	\$ _____
New or Existing Program in the catalogue:	New Program	Existing Program
Are there any proposed changes to this program:	Yes	No
If new program or existing program with changes, please provide description below:		

3. _____	single      series	\$ _____
New or Existing Program in the catalogue:	New Program	Existing Program
Are there any proposed changes to this program:	Yes	No
If new program or existing program with changes, please provide description below:		

4. _____	single      series	\$ _____
New or Existing Program in the catalogue:	New Program	Existing Program
Are there any proposed changes to this program:	Yes	No
If new program or existing program with changes, please provide description below:		

**D.2 Program Summary**

**\*This form is required for CURRENT vendor applicants**

**Applicant Name** \_\_\_\_\_

**List the proposed program/s for FY2026-2027**

<b>Title</b>	<b>Single or series</b>		<b>Proposed Fee</b>
5. _____	single	series	\$ _____
New or Existing Program in the catalogue:	New Program	Existing Program	
Are there any proposed changes to this program:	Yes	No	
If new program or existing program with changes, please provide description below:			

If you are a current vendor requesting a fee increase for an existing program, please indicate any contributing factors:

**E. Program Summary Form**

**\*This form is required for NEW vendor applicants**

Applicant Name

Do you have the relevant credentials, license, or certifications to present/facilitate proposed program? (If selected, MassHousing will follow up)                      yes              no              n/a- credentials/license/certifications are not a part of the proposed program (s)

Do you have general liability insurance?                      yes              no

**List the proposed program/s for FY2026-2027**

Title	Single or Series	Proposed Fee
1. _____	<input type="checkbox"/> single <input type="checkbox"/> series	\$ _____
2. _____	<input type="checkbox"/> single <input type="checkbox"/> series	\$ _____
3. _____	<input type="checkbox"/> single <input type="checkbox"/> series	\$ _____
4. _____	<input type="checkbox"/> single <input type="checkbox"/> series	\$ _____
5. _____	<input type="checkbox"/> single <input type="checkbox"/> series	\$ _____

**Please list any materials you will provide for each program.**

- 1.
- 2.
- 3.
- 4.
- 5.

**F.1 Program/Training/Workshop Information Form 1**

**\*This form is required for NEW vendor applicants**

Organization or applicant name: \_\_\_\_\_

Title of the program: \_\_\_\_\_

How many presenters or facilitators for this program: \_\_\_\_\_

Name of all presenters or facilitators: \_\_\_\_\_

**Topic:**                      **Select:**                      # of session(s) \_\_\_\_ # hours per session(s) \_\_\_\_

**Program delivered in:**              English only              Other languages \_\_\_\_\_

**Geographic area covered for program:**

**Targeted audience:**

Western	Boston	Youth --ages ____	Elderly
Metro Boston	Northeast	Statewide	Adults
Central	Southeast	Families	All

**Period:**

**Group size:**

All year      If seasonal, please specify: \_\_\_\_\_      min. \_\_\_\_\_      max. \_\_\_\_\_      n/a

**Program Summary:** In 50 words or less provide a brief summary of the program/training/workshop to be included in TAP's Annual Program Catalogue if program is approved.

**Does the site need to have something in place to provide this program?**

yes  no      If yes, specify \_\_\_\_\_



**F.3 Program/Training/Workshop Information Form 3**

**\*This form is required for NEW vendor applicants**

Organization or applicant name: \_\_\_\_\_

Title of the program: \_\_\_\_\_

How many presenters or facilitators for this program: \_\_\_\_\_

Name of all presenters or facilitators: \_\_\_\_\_

**Topic:**                      **Select:**                      # of session(s) \_\_\_\_ # hours per session(s) \_\_\_\_

**Program delivered in:**              English only              Other languages \_\_\_\_\_

**Geographic area covered for program:**

**Targeted audience:**

- |              |           |           |                   |          |
|--------------|-----------|-----------|-------------------|----------|
| Western      | Boston    |           | Youth --ages ____ | Elderly  |
| Metro Boston | Northeast | Statewide | Adults            | Disabled |
| Central      | Southeast |           | Families          | All      |

**Period:**

**Group size:**

All year      If seasonal, please specify: \_\_\_\_\_ min. \_\_\_\_\_ max. \_\_\_\_\_ n/a

**Program Summary:** In 50 words or less provide a brief summary of the program/training/workshop to be included in TAP's Annual Program Catalogue if program is approved.

**Does the site need to have something in place to provide this program?**

yes  no If yes, specify \_\_\_\_\_

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**F.4 Program/Training/Workshop Information Form 4**

**\*This form is required for NEW vendor applicants**

Organization or applicant name: \_\_\_\_\_

Title of the program: \_\_\_\_\_

How many presenters or facilitators for this program: \_\_\_\_\_

Name of all presenters or facilitators: \_\_\_\_\_

**Topic:**                      **Select:**                      # of session(s) \_\_\_\_ # hours per session(s) \_\_\_\_

**Program delivered in:**              English only              Other languages \_\_\_\_\_

**Geographic area covered for program:**

**Targeted audience:**

Western	Boston	Youth --ages ____	Elderly
Metro Boston	Northeast	Statewide	Adults
Central	Southeast	Families	All

**Period:**

**Group size:**

All year      If seasonal, please specify: \_\_\_\_\_      min. \_\_\_\_\_      max. \_\_\_\_\_      n/a

**Program Summary:** In 50 words or less provide a brief summary of the program/training/workshop to be included in TAP's Annual Program Catalogue if program is approved.

**Does the site need to have something in place to provide this program?**

yes  no      If yes, specify \_\_\_\_\_

**F.5 Program/Training/Workshop Information Form 5**

**\*This form is required for NEW vendor applicants**

Organization or applicant name: \_\_\_\_\_

Title of the program: \_\_\_\_\_

How many presenters or facilitators for this program: \_\_\_\_\_

Name of all presenters or facilitators: \_\_\_\_\_

**Topic:** \_\_\_\_\_ **Select:** \_\_\_\_\_ # of session(s) \_\_\_\_ # hours per session(s) \_\_\_\_

**Program delivered in:** English only Other languages \_\_\_\_\_

**Geographic area covered for program:**

**Targeted audience:**

- |              |           |                    |         |
|--------------|-----------|--------------------|---------|
| Western      | Boston    | Youth --ages _____ | Elderly |
| Metro Boston | Northeast | Statewide          | Adults  |
| Central      | Southeast | Families           | All     |

**Period:**

**Group size:**

All year If seasonal, please specify: \_\_\_\_\_ min. \_\_\_\_\_ max. \_\_\_\_\_ n/a

**Program Summary:** In 50 words or less provide a brief summary of the program/training/workshop to be included in TAP's Annual Program Catalogue if program is approved.

**Does the site need to have something in place to provide this program?**

yes  no If yes, specify \_\_\_\_\_

## G. References Form

**\*This form is required for NEW vendor applicants**

Organization or applicant name: \_\_\_\_\_

Have you done work in housing?       yes       no

If yes, where \_\_\_\_\_

If different than above, have any of the presenters/facilitators done work in housing?      yes      no

If yes, name of presenter/facilitator and where \_\_\_\_\_

Provide three (3) professional references:

a. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

b. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

c. Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_