School Year 2017-18
Application for New Applicants (under age 18)

Thank you for your interest in MGH Aspire. There are 2 ways to complete the application: you may download the application form as a pdf file and enter your responses electronically or you may print this form and enter handwritten responses. If you wish to email your application, you'll need to save the document or scan it into electronic file format (pdf).

A complete application includes:

- **School Year 2017-18 Application for New Applicants (under age 18)**
- **Applicant Photo** (may be electronic)
- $75 non-refundable **application fee**
- Most recent **Neuropsychological** or **Psychological Evaluation**
- Other helpful documents (Speech Pathology Evaluation, Behavioral Plan, Occupational Therapy Evaluation)
- Most recent **IEP** or **504**
- **Medical Record Number (MRN):** Please see instructions below on how to get your MRN:
  *To apply to an Aspire program, each applicant **must register** with the Massachusetts General Hospital Registration and Referral Center. Please call the MGH Patient Referral and Registration Department at 781-960-1203 and register (a parent must register the applicant if applicant is under age 18) to obtain a Medical Record Number (MRN).*

Please Submit Your Application Via:

Email	**Fax**	**Mail**
mghaspire@partners.org	781-860-1920	MGH Aspire 1 Maguire Road Lexington, Massachusetts 02421

You will receive a confirmation email within 5 business days of Aspire receiving your application. Applications are accepted on a rolling basis. Candidates will be scheduled for an intake session at our main office in Lexington upon receipt of the complete application packet.
Please contact us at 781-860-1900 or email us at mghaspire@partners.org if you have any questions.

A $200 non-refundable program deposit is due upon program acceptance.
Program tuition must be paid in full prior to the start of group. Aspire does not offer refunds.

Financial assistance is awarded based on financial need and fund availability.
The financial aid application can be downloaded from our website.

Thank you for applying to Aspire!
Please carefully review this form for required attachments and submittal information.

Please select which **Fall 2017** program(s) you are interested in applying for. See our website for more detailed information about our programs.

NAME: _____

☑	Age	Program	Location	Start Time	End Time	Day	Length
	Teen Adult	Games*	Lexington	4:15 PM	5:30 PM	Monday	75
	Child	Social Group	Newton	4:30 PM	5:45 PM	Monday	75
	Child	Creative Arts/Improv	Lexington	4:30 PM	5:45 PM	Monday	75
	Teen Adult	Gender and Identity*	Lexington	6:00 PM	7:15 PM	Monday	75
	Child	Group Projects	Lexington	4:30 PM	5:45 PM	Tuesday	75
	Child	Creative Arts/Improv	Lexington	4:30 PM	5:45 PM	Wednesday	75
	Teen	Guild Chronicles	Newton	4:30 PM	5:45 PM	Wednesday	75
	Teen	Guild Chronicles	Newton	6:15 PM	7:30 PM	Wednesday	75
	Child	Social Group	Newton	4:15 PM	5:30 PM	Thursday	75
	Teen	Social Group	Lexington	4:15 PM	5:30 PM	Thursday	75
	Child	Games Group	Lexington	4:30 PM	5:45 PM	Thursday	75
	Teen Adult	Neurodiversity*	Lexington	4:45 PM	6:00 PM	Thursday	75
	Child	Mindful Me	Lexington	10:00 AM	11:00 AM	Saturday	60
	Teen	Guild Chronicles	Lexington	10:15 AM	11:30 AM	Saturday	75
	Child	Active Play	Newton	11:00 AM	12:15 PM	Saturday	75
	Child	Cooking	Lexington	11:45 AM	1:15 PM	Saturday	90
	Teen	Guild Chronicles	Lexington	12:00 PM	1:15 PM	Saturday	75
	Teen	Explorations	Newton	12:00 PM	4:30 PM	Saturday	4.5 hours
	Teen	Explorations	Lexington	12:00 PM	4:30 PM	Saturday	4.5 hours
	Teen	Explorations	Charlestown	12:00 PM	4:30 PM	Saturday	4.5 hours
	Child	Team Sports	Newton	1:30 PM	3:00 PM	Saturday	90
	Child	LEGO	Lexington	2:00 PM	3:15 PM	Saturday	75

**These groups will be run as either Adult or Teen groups, depending upon interest*.

If you are applying for a special event or program, please list the name here: _____

Applicant Information		
First Name:	Last Name:	
Home Address:		
City:	State:	Zip Code:
DOB:	MGH Medical Record No.:	
Home Phone:	Cell Phone:	
Email:	Primary Language:	
Parent/Guardian 1 Information		
First Name:	Last Name:	
Home Address (if different than applicant):		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Email:	Relationship to applicant:	
Employer:	Job Title:	
Parent/Guardian 2 Information		
First Name:	Last Name:	
Home Address (if different than applicant):		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	
Email:	Relationship to applicant:	
Employer:	Job Title:	
Participant lives with: ☐ P/G1	☐ P/G2 ☐ Both	☐ Self
Marital status of parents/guardians:	☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Other (please explain):	
How did you hear about us?	☐ Internet ☐ School ☐ Agency (AANE, etc.) ☐ Conference:	☐ Other provider:

Please list all siblings or other immediate family members besides parents/guardians:

Name	Relationship to Applicant	Age	Lives in Household
			☐
			☐
			☐
			☐

Medical Information	
Applicant's Physician:	
Physician Town:	Physician Phone:
Please provide the diagnoses received, for example, Asperger's Syndrome, ASD, PDD-NOS, NLD, ADHD, or other:	
Does the applicant know his/her diagnostic label? ☐ Yes ☐ No	
What diagnostic words or language have your shared with the applicant about him/herself?:	
Is the applicant currently taking any prescription and/or non-prescription medication? If yes, please list:	
Does the applicant have any of the following (if yes, please explain): ☐ Allergies ☐ Special Diet ☐ Chronic Health Conditions (e.g., asthma, diabetes, seizures)	
Has the applicant ever been hospitalized (medical or psychological)? If yes, please describe reason and date:	
Please describe the applicant's endurance for physical activities (walking/running/hiking/swimming):	

Community Provider Information				
What type of professional support is the applicant currently receiving OUTSIDE OF SCHOOL?				
Provider Type	**Provider Name and Location**	**Purpose / Treatment Goals**	**For how long? / How often?**	**Helpful?** 1 = No 2 = Little 3 = Somewhat 4 = Very
Therapist ☐ Psychologist ☐ Social Worker				☐ 1 ☐ 2 ☐ 3 ☐ 4
Psychiatrist				☐ 1 ☐ 2 ☐ 3 ☐ 4
Speech Therapy				☐ 1 ☐ 2 ☐ 3 ☐ 4
Occupational Therapy / Sensory Integration (SI)				☐ 1 ☐ 2 ☐ 3 ☐ 4
Social Skills Group				☐ 1 ☐ 2 ☐ 3 ☐ 4
Applied Behavioral Analysis (ABA)				☐ 1 ☐ 2 ☐ 3 ☐ 4
Other				☐ 1 ☐ 2 ☐ 3 ☐ 4
Other				☐ 1 ☐ 2 ☐ 3 ☐ 4

School Information			
School Type:	☐ Public ☐ N/A	☐ Private	☐ Home School
School Name:		Grade:	
Classroom Setting:	☐ Mainstream ☐ Self-contained	☐ Learning Center ☐ Other:	☐ Resource Room

Extracurricular Interests	
Please list any group or individual extracurricular activities that the applicant has participated in over the last **2** years (e.g. sports, music, youth clubs, camps, afterschool programs)	
Group Activity	Did the applicant enjoy the activity and was his/her participation successful?

Social/Behavioral Information			
Does applicant follow directions and accept limits from:	**Demonstrates this skill when expected**		
	1 = Rarely	2 = Sometimes	3 = Always
Family members	☐ 1	☐ 2	☐ 3
Professionals who interact with applicant on a daily basis (e.g. classroom teacher, supervisor, etc.)	☐ 1	☐ 2	☐ 3
Professionals who interact with applicant in a group setting (e.g. Inclusion Teacher, SLP, OT)	☐ 1	☐ 2	☐ 3
Therapists who support applicant outside of school or work	☐ 1	☐ 2	☐ 3
What are the applicant's strengths and interests?			
Does the applicant have a history of aggressive (verbal or physical) behavior at home, in school, or in the community?	☐ Yes	☐ No	
If yes, when? Please describe:			
Does the applicant bolt or run away from others?	☐ Yes	☐ No	
If yes, when? Please describe:			
Please describe the specific factors or events that trigger frustration or nervousness for the applicant:			

Goals
What are your social goals for the applicant?:
What are your Daily Living Skills and/or Life Skills goals?:
Is there anything else that you would like us to know about the applicant?

Application Signatures	
I hereby make an application for the applicant to attend Aspire Programs. I have filled out all of the information to the best of my knowledge.	
Parent/Guardian Signature	Date:
Parent/Guardian Signature	Date:
Applicant Signature (optional)	Date:

☐ **Person responsible for payment and billing:**

Name/Relationship: _____

A note on insurance: Please be aware that Aspire offers multidisciplinary interventions that do not fit standard medical procedure codes; therefore, our services are not reimbursable by medical insurers.

☐ Yes - I plan to submit a financial aid application

☐ Yes - add me to the Aspire Wire (electronic newsletter) at the following address:

☐ Yes - add me to the Lurie Center Research electronic newsletter at the following address: