3LPLACE MEMBER APPLICATION

2025

212 HOLLAND STREET, SOMERVILLE MA

3LPLACE.ORG

Thank you for your interest in 3LPlace!

The decisions ahead of you and your family at this time are exciting, complex, and important. At 3LPlace, we want to help you make decisions that will lead to a satisfying, productive, and as independent a life as possible. We want to know and understand your needs, just as we want you to better understand 3LPlace. "FIT" matters to us both.

We begin our journey with this application, which is designed to help us figure out together if 3LPlace is right for you. When we receive it, along with an assessment fee of $500, which covers the cost of our staff's evaluation of each individual and their needs, we will review it with care. With this review process in mind, **submitting an application is not a guarantee of admission**.

If you have any questions about this process, please contact us before applying. We are happy to discuss it with you and to explain exactly what you can expect. This is a partnership between us, and we want you to feel comfortable and empowered as we work together to make this important decision about your future.

Along with the application form, please send us the documents listed in the checklist on the following page. 3LPlace is not a mental health treatment program, so if your family member has a history of psychiatric issues, please discuss that with us frankly so that we can jointly determine the appropriateness of our setting.

3LPlace has a rolling admissions process, which allows for members to be admitted throughout the year as openings arise. The application process takes two to four weeks, so please plan ahead!

Once your application is received, we'll contact you to discuss any questions that have arisen during the application review process.

At any point in the admission process, if there are questions about the appropriateness of our setting, we may request additional information.

Please send your application and materials to 3LPlace: You can forward materials by email to admissions@3lplace.org or mail them to 212 Holland Street, Somerville, MA 02144-1975. You can reach us by phone at **617-764-3280**.

We look forward to working with you!

CHECKLIST

Here's a handy guide to make sure you send along everything we need. Please include all items in the green box below with your application. We regret that we cannot process incomplete applications. If you need to reach out with questions you can email: admissions@3lplace.org

Application Checklist: _____

- ☐ Completed application (All sections)
- ☐ Most recent IEP or ISP
- ☐ Most recent therapeutic summary that is dated within the last 5 years. (i.e. psychology report or evaluation, termination report, or related documents)
- ☐ Three references: at least one clinical and one educational and one community connection
- ☐ Release Authorization Form for school and health records
- ☐ $ 500 Application fee

Other reports and evaluations: *If available, you are welcome to include the following reports with the application. These reports will be utilized in addition to those above if we need further clarification and/or if the applicant is accepted into the program as part of our onboarding process:*

- ☐ Teacher progress reports, person-centered planning or self-determination documents, or reports from current program providers (including current ISP goals)
- ☐ Any assessments/evaluations related to reading, writing, and comprehension level
- ☐ Speech and language evaluations
- ☐ Occupational therapy evaluations
- ☐ Physical therapy evaluations
- ☐ Resume, if available

Date of application: _____ Preferred enrollment date: _____

Prospective Member Information:

If other than Member, name of the parent/guardian completing application:	
Full Name of Prospective Member:	
Member's Date of Birth & Age:	Birthdate: _____ Age: _____
Gender:	☐ Male ☐ Female ☐ Non Binary
Member's Preferred Pronouns:	☐ he/him ☐ they/them ☐ she/her
Does your member reside at home?	☐ Yes ☐ No
If so, with whom does the member primarily reside?	
Members Phone Number:	
Member's Email Address:	
Address:	Primary Residence Street:_____ _____ City:_____ State: _____ ZIP: _____

Is the member their own guardian?	☐ Yes ☐ No
If No, name of parent/guardian:	
If under guardianship, conservatorship, health care proxies, or power of attorney, tell us who acts in this capacity for the member?	
Member's Primary Diagnosis	
Member's other diagnostic Information (if applicable)	
Is the Member now enrolled in a school program?	☐ Yes ☐ No
If yes, where? When do they turn 22?	
Is the member enrolled in a CBDS Program?	☐ Yes ☐ No
If yes:	Number of hours/week: _____ Provider Name: _____
Is the member enrolled in a DayHab Program?	☐ Yes ☐ No
If yes:	Number of hours/week: _____ Provider Name: _____
Does the member have in-home services?	☐ Yes ☐ No

If yes:	Number of hours/week: _____ Type of Provider: _____ Provider Name: _____
Does the member receive services through insurance?	☐ Yes ☐ No
If yes:	Number of hours/week: _____
Does the member receive any mental health counseling or related services?	☐ Yes ☐ No
If yes:	Number of hours/week: _____
Does the member receive Personal Care Attendant (PCA) Services?	☐ Yes ☐ No
If yes:	Number of hours/week: _____
Does your member have an Adult Foster Care (AFC) provider	☐ Yes ☐ No
If yes:	☐ Level I ☐ Level II

How did you learn about 3LPlace?

Insurance and Support Services Information

Private Insurance:

- ☐ Yes
- ☐ No

Name of Insurer (if applicable):

_____

Services: (check all that apply)

☐ MassHealth	☐ Personal Care Assistant
☐ Department of Developmental Services	☐ Section 8 (Housing)
☐ Department of Mental Health	☐ Waitlist
☐ Adult Family Care	☐ Current
☐ Supplemental Security Income	☐ Long Term Services and Supports
☐ Social Security Disability Insurance	☐ Other (please list and describe)

If "Other" please list and describe:

_____

_____

Therapeutic: (check all that apply)

	Previously	Currently	None
Occupational Therapy	☐	☐	☐
Speech and Language Therapy	☐	☐	☐
Behavioral Therapy/Consulting	☐	☐	☐
Other	☐	☐	

If "Other" please list and describe:

_____

_____

Relevant Skills:

Please identify on a scale of 1-5 how independent the applicant is in these key areas:

	1 (Not independent)	**2** (Needs significant help)	**3** (Needs help)	**4** (Independent with minimal help)	**5** (Completely Independent)
Eating	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐
Getting Dressed	☐	☐	☐	☐	☐
Toileting	☐	☐	☐	☐	☐
Mobility	☐	☐	☐	☐	☐
Continence	☐	☐	☐	☐	☐
Reading	☐	☐	☐	☐	☐
Technology	☐	☐	☐	☐	☐

Please describe the level of assistance currently given in any of the areas above that is rated 3 or below:

	Yes	No
Is the applicant able to read independently to themselves and/or out loud?	☐	☐
Is the applicant able to write with a pen/pencil and/or type on an iPad/keyboard?	☐	☐
Is the applicant able to walk long distances out in the community?	☐	☐
If yes, what is a comfortable distance or number of minutes walking?		

What is the applicant's preferred method of communication?

How does the applicant manage transitions and/or unexpected changes?

What is the applicant's experience and acceptance of other neurodiverse individuals?

Education or DDS Day Program Information

1. School/program (most recent):

Name:	
Projected school/program completion date (if applicable):	
School/program contact name:	
School/program contact title:	
Phone Number:	
Email Address	
Address:	Street:_____ _____ City:_____ State: _____ ZIP: _____

2. Other school/program:

Name:	
Projected school/program completion date (if applicable):	
School/program contact name:	
School/program contact title:	
Phone Number:	
Email Address	
Address:	Street:_____ _____ City:_____ State: _____ ZIP: _____

3. Has the member ever been dismissed/suspended from a program?

   ☐ Yes
   ☐ No

   If yes, please describe the circumstances and date:

_____

_____

_____

4. If under age 22, is your family member in the Turning 22 DDS class?
   ☐ Yes
   ☐ No

Medical Information- General

Describe any current or previous medical conditions:

What diagnoses have been given in regard to the member's disability?

1. Does the Member take medication?

   ☐ Yes
   ☐ No

2. Does the Member administer their own medication?

   ☐ Yes
   ☐ No
   ☐ Needs Supervision

	Medication & Reason	Dosage:	Time of day:
1	Name: _____ Reason: _____		
2	Name: _____ Reason: _____		
3	Name: _____ Reason: _____		
4	Name: _____ Reason: _____		
5	Name: _____ Reason: _____		

List of any allergies

Allergy	airborn	ingestion	mild	moderate	severe	requires EpiPen
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐

If EpiPen is required, can the member self-administer their EpiPen?	☐ Yes ☐ No
For listed allergies, should an allergic reaction arise, what should staff do? Who should staff call in a crisis?	
Is the member on a special diet?	☐ Yes ☐ No
If yes, please explain:	
Other treatment not previously discussed:	

Employment Information

Check off if your member is currently involved in… (check all that apply)

- ☐ Paid Employment
- ☐ Internship
- ☐ Volunteer work

If you checked any of the above boxes, if you are willing to share, please include… ● The job/internship/volunteer position(s) ● the setting/industry ● Length of time at the position(s)

If your member is employed/interning/volunteering, is their work setting somewhere they wish to continue, or would they rather explore other vocational opportunities?

What is the current level of support for your individual in a work/internship/volunteer environment?

Mental Health History

Here at 3LPlace we understand that people are complex. We ask the following questions to better understand and serve your member, and to be prepared to welcome them to our community.

1. Has the prospective member ever been hospitalized for mental health reasons?	☐ Yes ☐ No
If yes, please give date and explain, include the number of times, the length of stay/s, and the reason for the hospitalization	

2. Does the member have any history of behavioral or emotional difficulties in school/program or residential settings?	☐ Yes ☐ No
If yes, please describe, the behaviors or difficulties in detail, including any triggers, how long the issues lasted and how the member and the program handled it:	

3. Does the member have any history of suicidal behavior or ideation?	☐ Yes ☐ No
If yes, how would you classify said suicidal behavior/ideation (mild, moderate, or severe)? Additionally, please describe any incidents or history pertaining to your member's suicidal behavior/ideation:	

4. Does the member have any history of physical episodes with self, peers, staff, family or property?	☐ Yes ☐ No
If yes, please explain any triggers, frequency, duration, interventions and outcomes of these behaviors:	
Did anyone involved (if staff or peers) need medical attention for a physical episode or incident?	☐ Yes ☐ No

5. Does the member have any history or current difficulty with anger management or elopement?	☐ Yes ☐ No
If yes, please give date and explain:	
What helps in these situations?	

6. Have there been any past, recent, or ongoing trauma experiences that they are experiencing and or re-experiencing?	☐ Yes ☐ No
Diagnosis (if any):	

7. Is the trauma:
   - ☐ Physical
   - ☐ Sexual
   - ☐ Emotional
   - ☐ Other (please specify)

8. Circumstances and any effect on daily life or activities?

9. Is there a current outside psychiatric/therapeutic support that is working on trauma with the prospective member? (Please be sure to include contact information for this person on the health release at the end of the application).

10. Is this something they speak of:
    - ☐ Openly?
    - ☐ Selectively?

11. Are there any significant phobias that might make them safety compromised for either in house or community activities? (ex. bees, pigeons, loud trucks, fire alarms)
    - ☐ **Mild**—can manage but might act instantly anxious
    - ☐ **Moderate**—Movements or dialogue are startling around phobia, but safety isn't fully compromised
    - ☐ **Severe**—Can't manage phobia functionally and puts self and/or others at physical risk in effort to avoid phobia

12. Anything else we should know?

Thank you.

Your candor will help us keep your member and others safe!

Member's 3LPlace Schedule & Program Funding:

1. Please select the preferred number of days to attend (3LPlace has a two day minimum):

   - ☐ 2
   - ☐ 3
   - ☐ 4

2. Please identify the days of the week that the member is available to attend the program. Actual days of participation will be determined by the availability within the program and the days noted here.

   - ☐ Tuesday
   - ☐ Wednesday
   - ☐ Thursday
   - ☐ Friday

3. In which of the following 3LPlace Modules are you interested? (Check all that apply):

   - ☐ Daring to Dream
   - ☐ Community
   - ☐ Work and Career
   - ☐ Life Skills
   - ☐ Social Skills

4. Please indicate the planned method for tuition payment:
   - ☐ DDS Funding through the PDP Program, Education and Training Institute Service
   - ☐ School Funding through the LEA for transition service
   - ☐ Private Pay
   - ☐ Other/combination (please specify)

This next section should be completed by the prospective member.

YOUR NAME_____

Before you get started

We want this section to feel special, creative, and fun! Please work on this as independently as you can. If you need support, that is fine.

We are excited to know more about you

We want these ideas to be yours because we want to know the real you! Please share anything you think we should know about you as you answer the questions. If you need more space, just attach additional pages to your application.

❑ **I prefer to:** Handwrite my answers

❑ **I prefer to:** Type my answers (please attach!)

Member's Name: _____ **Signature**_____

Today's Date: _____

Tell 3LPlace more

Three things that I am passionate about…  **(Things I really love)**

1.

2.

3.

Two special talents or ways I shine…  **(Things I'm good at)**

1.

2.

My favorite thing about myself and why…  **(A part of me I'm proud of)**

Things that I find hard or difficult…  **(Things that stress me out)**

1.

2.

3.

Two ways I handle my stress when things are hard…  **(How I relax/cope)**

1.

2.

Three favorite learning subjects or themes…  **(Things I love to learn about)**

1.

2.

3.

Three jobs I'm curious about or interested in…  **(Work/jobs I might like to do)**

1.

2.

3.

Three people who believe in me…  **(People who think I'm beyond cool)**

1.

2.

3.

Is there anything else you'd like to tell us about you? (Use as much space as necessary!)

Family/Guardian Information:

First Parent/Guardian Information:

Name of Parent/Guardian:	
Address if different from member:	☐ Same as Member ☐ Different from Member Street:_____ _____ City:_____ State: _____ ZIP: _____
Parent/Guardian's Phone Number:	
Parent/Guardian's Email Address:	
Preferred Method of Contact:	☐ Phone/Text ☐ Email

Second Parent/Guardian Information:

Name of Parent/Guardian:	
Address if different from member:	☐ Same as Member ☐ Different from Member Street:_____ _____ City:_____ State: _____ ZIP: _____
Parent/Guardian's Phone Number:	
Parent/Guardian's Email Address:	
Preferred Method of Contact:	☐ Phone/Text ☐ Email

Family Information:

Current status of parents/guardians

☐ Married ☐ Divorced ☐ Single Parent ☐ Separated	☐ Widowed ☐ Domestic Partnership ☐ Parent 1 Remarried ☐ Parent 2 Remarried

Name of step-parent(s):

_____

Siblings

Name:	**Sex:**	**Age:**

Please indicate other siblings and/or important family dynamics of which we should be aware or other adults that are in regular contact with the member.

Financial Information

Individual(s) responsible for financial support of member:

_____

Relationship to Member:	
Phone Number:	
Address (if different from previously listed):	☐ Same as previously listed Street:_____ _____ City:_____ State: _____ ZIP: _____

Other responsible parties (if applicable):

Relationship to Member:	
Phone Number:	
Address (if different from previously listed):	☐ Same as previously listed Street:_____ _____ City:_____ State: _____ ZIP: _____

Daring to Dream

1. Please describe your family member's social and emotional development. What are their current needs in this area?

2. What do you see as your family member's strengths?

3. What do you see as areas of vulnerability for your family member? How might these challenges present themselves?

4. What are your hopes and goals for your family member's future? Describe any areas of concern?

5. What strategies or supports are most effective for helping your family member feel supported and happy? Can they access these supports independently or do they need assistance?

6. Anything else you would like to share with us about your family member?

References

Who should you include? Look at our infographic to find out!

References for 3LPlace Member Application

WHO CAN I USE?

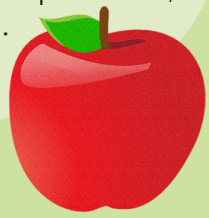
As part of the 3LPlace application process, we want to capture the voices of people that know you or your applicant the best. Here are the types of references we ask for you to include and who, specifically, those individuals might be!

1 Clinical Reference

Individuals with medical and therapeutic backgrounds such as... PTs, OTs, SLPs, talk therapists, psychiatrists, etc.

2 Educational Reference

Individuals such as... Current/former teachers, reading/math specialists, tutors, transition specialists, etc.



3 Relationship Reference

Whoever else knows you or your applicant best, such as...
Bosses, religious leaders, music instructors, coaches, etc.

For all references, we ask for them to be individuals that you or your applicant sees or has seen on a frequent basis.

For more information, email admissions@3lplace.org

Clinical Reference:

Name:	
Title:	
Address:	Street:_____ _____ City:_____ State: _____ ZIP: _____
Phone Number:	
Email Address	

Educational Reference:

Name:	
Title:	
Address:	Street:_____ _____ City:_____ State: _____ ZIP: _____
Phone Number:	
Email Address	

Relationship Reference:

Name:	
Title:	
Address:	Street:_____ _____ City:_____ State: _____ ZIP: _____
Phone Number:	
Email Address	

RELEASE AUTHORIZATION FORM (Health and Educational Records)

Member NAME:

The following professionals or organizations have my permission to speak with one another or release any pertinent information to the Admissions Office at 3LPlace. *(Please note: if there is a current psychiatrist or one has been consulted within the past five years, that individual must be included here).* **This Authorization will automatically expire in two years unless otherwise specified.**

Name: (Contact 1)	Organization
Telephone	Email

Name: (Contact 2)	Organization
Telephone	Email

Name: (Contact 3)	Organization
Telephone	Email

Name: (Contact 4)	Organization
Telephone	Email

Name: (Contact 5)	Organization
Telephone	Email

See next page for signatures:

Continued from previous page:

AUTHORIZATION FOR RELEASE OF SPECIFICALLY PROTECTED OR PRIVILEGED INFORMATION:

I authorize the use/or disclosure of the specific categories of information that I have indicated below (check all applicable):

Mental Health	**Psychotherapy Notes**
☐ Yes	☐ Yes
☐ No	☐ No

☐ I have carefully read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use or disclosure of my health or other information:

Member's Signature: _____ Date: _____

Printed Name: _____

When a member is under legal age or cannot legally give consent, signature of parent, legal guardian, or health care agent (proxy) is required.

Signature of legal representative: _____ Date: _____

Printed Name: _____