McLean HOSPITAL
HARVARD MEDICAL SCHOOL AFFILIATE

McLean Anxiety Mastery Program Application

The McLean Anxiety Mastery Program (MAMP) is a group-based treatment program for children and adolescents ages 7-19 with anxiety disorders and obsessive compulsive disorder. Examples of the kinds of symptoms we treat include social anxiety, specific phobias, panic attacks, separation anxiety, and obsessions and compulsions.

The program runs for 4 days a week and lasts for a minimum of 4-6 weeks. On Mondays, Wednesdays, and Thursdays, kids participate in a 1.5-hour exposure and response prevention group followed by a 50-minute patient education group. On Mondays and Thursdays, parents participate in a parent guidance group from

3:40-4:30pm, during which parents are provided with anxiety education and a review of treatment skills. On Tuesdays, parents and kids participate in 50-minute family meetings and have the opportunity to have medication management consultations with a program psychiatrist which take place between 1:00 and 5:00pm.

The program is primarily self-pay, but some additional components may be covered by insurance. While the program runs virtually, the cost of the portion of the program that insurance will not cover is $4,800 for four weeks, plus $200 for a one-time treatment planning session. Other additional costs depend on insurance coverage. After the first four weeks, the cost is prorated by week. We ask that the non-insurance component of the program be paid for in full on the day of the first office appointment. We also ask that you put down an additional $100 non-refundable deposit in order to ensure a spot on the wait list.

For further information regarding MAMP, please visit us on the web: **mclean.org/mamp**. With any questions, please email **mcleanmastery@partners.org.**

**Before you proceed with completing this form, please consider the following program requirements:

- You and your child must be interested and willing to participate in group-based treatment
- Your child must be willing to participate in treatment 4 afternoons a week for at least 4-6 weeks.
- You and/or another primary caregiver must be willing to participate in the family work components, weekly on Mondays, Tuesdays, and Thursdays.

Form Submission Instructions During COVID-19

As the McLean Anxiety Mastery Program is currently operating virtually during the COVID-19 pandemic, we have initiated procedures for digital form submission.

We are now accepting application packets via email. You can submit to **mcleanmastery@partners.org**.

By sending us your child's application packet via email, you are accepting any associated potential risks to confidentiality. Email is not secure and could result in the unauthorized use or disclosure of your information. McLean Hospital and Partners HealthCare will not be held responsible for any breaches to confidentiality associated with this means of transmission.

☐ I acknowledge the possible risk of exchanging information via email.

If you prefer to submit this form securely, please send via postal mail to:
McLean Anxiety Mastery Program
115 Mill Street, Mail Stop 303
Belmont, MA 02478

Please note that during the COVID-19 crisis, there will be a delay for forms submitted by postal mail.

With any questions regarding form submission, please email **mcleanmastery@partners.org.**

Before filling out this form, first download it to your computer
and open it in a PDF application (like Adobe Acrobat Reader).

The following pages are the first step in the screening process for MAMP. Once we receive this form, you will receive a confirmation email. Once your application is viewed, a clinical team member will reach out to you to complete a 30-minute phone screening. If after the screening process, your child seems to be a fit for the program, our intake coordinator will call or email you to offer a spot on our wait list.

Date completed: _____

What is your relationship to the patient?

☐ Patient-self ☐ Parent/Guardian ☐ Other (please specify) _____

First and Last Name of Person Completing Form:_____

Call Back Number: _____ Email: _____

Is it ok for us to leave you a detailed voicemail? ☐ Yes ☐ No

Child's First/Last Name: _____ Child's DOB: _____

Child's Preferred Name/Nickname: _____

Child's Age: _____ **Child must be ages 7-19* Height:_____ Weight: _____

Child's Identified Gender: _____

Who Does Child Live With: _____

Primary Address: _____

Insurance Company: _____ Insurance ID#: _____

Subscriber Name/Relationship: _____ Subscriber DOB _____

Is the self-pay cost of the program ($4,800+$200 for the first 4 weeks) viable for your family? ☐ Yes ☐ No

In a few sentences, please state the primary reason you are seeking treatment for your child.

_____

_____

_____

_____

How did you find out about our program?

_____

_____

_____

Referring professional's name, title, and place of employment:

_____

_____

Phone Number: _____ Email: _____

Contact Information

Child's Cell Phone: _____ Messages OK? ☐ Yes ☐ No

Child's Email Address: _____

Guardian 1 Name: _____ Relationship to Child: _____

Guardian 1 Cell Phone: _____ Messages OK? ☐ Yes ☐ No

Guardian 1 Home Phone: _____ Messages OK? ☐ Yes ☐ No

Guardian 1 Work Phone: _____ Messages OK? ☐ Yes ☐ No

Guardian 1 Email Address: _____

Guardian 1 Home Address: _____

Guardian 2 Name: _____ Relationship to Child: _____

Guardian 2 Cell Phone: _____ Messages OK? ☐ Yes ☐ No

Guardian 2 Home Phone: _____ Messages OK? ☐ Yes ☐ No

Guardian 2 Work Phone: _____ Messages OK? ☐ Yes ☐ No

Guardian 2 Email Address: _____

Guardian 2 Home Address
(If different than Guardian 1): _____

Please check Yes/No in response to the following questions. Please include notes and/or examples for clarification.

Does your child have difficulty separating from you or others?	☐ Yes	☐ No
Does your child worry about others judging him/her?	☐ Yes	☐ No
Does your child have rituals to reduce his/her anxiety? *Ex. Hand washing, repeated checking*	☐ Yes	☐ No
Does your child worry about having extremely intense episodes of anxiety that seem to come out of the blue? *Ex. Panic attack: heart racing, sweating, tremor, hard to breathe, choking, chest pain, nausea, dizzy/faint, chills/heat, numbness or tingling, fear of losing control or dying*	☐ Yes	☐ No
Does your child worry about going to certain public places because he/she may be unable to escape?	☐ Yes	☐ No

Does your child fear specific things, such as: animals, heights, or blood? ☐ Yes ☐ No

Has your child been avoiding school? ☐ Yes ☐ No
If so, when was the last time your child attended school consistently?

In the last month how many days, on average, has your child been:
Tardy: _____ Absent:_____ Dismissed: _____

Does your child avoid people, situations, places, or other items not already discussed? ☐ Yes ☐ No

When your child is experiencing heightened anxiety, in which way/s does your child respond?
☐ Fight (hitting, yelling, lashing out) ☐ Flight (running away, avoiding people, places, activities) ☐ Freeze (shutting down)
Please explain specific responses:

What are your goals for MAMP treatment?

For form submission instructions, see page 1.