



444 Green Street  
Gardner, MA 01440-1000  
(978) 632-6600  
[mwcc.edu](http://mwcc.edu)



SSS Health Science Program  
Room 134  
(978) 630-9297  
[mwcc.edu/rx](http://mwcc.edu/rx)


## Rx Program Application

Thank you for your interest in the Rx Program. Please follow the instructions below to complete this application

To complete the application, please select **one** of these options:

A. Print the application, use a blue or black pen to answer the questions, and mail it to  
Rx Program  
Mount Wachusett Community College  
444 Green St.  
Gardner, MA 01440

B. Use Adobe Acrobat Reader to edit the document (**We recommend that you select this option if you have access to a computer**)

- Open this file with “Adobe Acrobat Reader” to view the document
- Select Fill & Sign (under the “Tools” option). Then click on the  icon. This will allow you to click and fill in the different sections of the application.
- Complete the application using the Fill & Sign option.
- Save a copy of this document to your computer.
- Email the copy to [rx@mwcc.mass.edu](mailto:rx@mwcc.mass.edu)

C. Request a copy to be mailed to you.

Email your name, ID and email address to [rx@mwcc.mass.edu](mailto:rx@mwcc.mass.edu)

You'll receive a printed copy of the application and a self-addressed stamped envelope.

Mailing requests will be processed once a week so there may be a lag in your receipt of the application materials

If you have any questions or need additional assistance, please do not hesitate to reach out to us at [rx@mwcc.mass.edu](mailto:rx@mwcc.mass.edu) or call 978-630-9297.



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### STUDENT APPLICATION

**Personal Information** (Please Print)

Name \_\_\_\_\_ ID# \_\_\_\_\_  
                                Last  First  M.I.

Permanent Address \_\_\_\_\_  
  Street, Route, or Post Office Box

\_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_  
  City  State                                Zip

MWCC Email Address \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Date of Birth \_\_\_\_\_ Sex:    Male        Female  
                                Month                  Day                  Year

**Citizenship:**        U.S. Citizen                       Permanent Resident                       Other

**Ethnicity:** *Please select one*        Hispanic or Latino                       Not Hispanic or Latino

**Race:** *Please select all that apply*        American Indian or Alaskan Native        Asian        White  
    Black or African-American                       Native Hawaiian or other Pacific Islander

**MWCC Educational Plans and Transfer Plans**

Indicate the Health Science Major/Program in which you are enrolled or are pursuing:

Enrollment Status:     Part Time                       Full Time  
 Have you applied for financial aid at MWCC?     Yes                       No  
 Do you intend to complete a degree or certificate at MWCC?     Yes                       No  
 Do you intend to transfer to a four-year college?     Yes                       No

**Prior Education**

High School Attended \_\_\_\_\_

City/State \_\_\_\_\_

Graduation Year: \_\_\_\_\_

Prior TRIO Participation (Visions, Gear Up, Talent Search, Upward Bound)

Yes  No

HiSET/GED  Yes  No Where? \_\_\_\_\_

Year Received: \_\_\_\_\_

Other College(s) Attended \_\_\_\_\_

Year(s) \_\_\_\_\_

\_\_\_\_\_

Year(s) \_\_\_\_\_

Transfer Credits: Have you arranged for transcripts to be sent to MWCC?

Yes  No

Do you hold a bachelor's degree?  Yes  No

Year \_\_\_\_\_

**Eligibility:**

**Parents' Educational Background**

Did either of your natural or adoptive parents complete a 4-year (bachelor's) degree?  Yes  No

If **Parent 1** earned a four-year degree, did s/he complete it before you turned 18?  Yes  No

If **Parent 2** earned a four-year degree, did s/he complete it before you turned 18?  Yes  No

At age 18, were you living with your natural or adoptive parents?  Yes  No

Please specify which parent:

Parent 1  Parent 2  Parent 1 & 2  Other \_\_\_\_\_

**Disability Disclosure**

Do you have a disability?  Yes  No

Have you provided documentation to the Coordinator of Disability Services?  Yes  No

Specific disability (optional) \_\_\_\_\_

**Academic Need**

A. Rate each item to indicate your **challenges** in each area.

**0 - no problem      1 - slight difficulty      2 - moderate difficulty      3 - extreme difficulty**

\_\_\_\_ Job Responsibilities

\_\_\_\_ Reading

\_\_\_\_ Family Responsibilities

\_\_\_\_ Writing Skills/Papers

\_\_\_\_ Time Management

\_\_\_\_ Math

\_\_\_\_ Interpersonal Communication Skills

\_\_\_\_ Science

\_\_\_\_ Computer Skills (Microsoft Office, internet)

\_\_\_\_ Exams

\_\_\_\_ Taking Notes

\_\_\_\_ Stress

**Academic Need**

B. In the space provided, or on a separate page, please answer the following questions fully. Your answers will help us determine how we will be able to support you in your educational journey.

What drives you to pursue an education at MWCC? What are your educational, transfer and career goals?

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Write about an obstacle or barrier you have overcome. How were you able to overcome this challenge?

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Why are you applying to the Rx Program? What challenges (work, family, academic outlook, etc.) do you face? What are you looking for in your support system that you hope to find in the Rx Program?

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Do you have access to a reliable computer and printer at home?  Yes  No

Do you have reliable internet access at home?  Yes  No

Do you often receive encouragement from the important people in your life (family, friends) for pursuing your college degree?  Yes  No

**Consent for Student Record Review**

I certify that I am at least 18 years old and authorize the Rx Program (TRIO Student Support Services Health Science) to access any and all financial and academic information and/or disability documentation in order to determine my eligibility for services, track my academic progress, and for other legitimate purposes related to my participation in the Rx Program. I understand this information will remain confidential. By signing below, I also certify that the information I have provided on this application is true and correct to the best of my knowledge. I may be photographed during Rx Program events and such photographs may be used by MWCC under the college model release policy. A copy of the MWCC model release policy is available on request. The Rx Program may contact me via voice or text at the phone numbers provided.

Date \_\_\_/\_\_\_/\_\_\_

Student's Signature \_\_\_\_\_

Date \_\_\_/\_\_\_/\_\_\_

Parent's Signature \_\_\_\_\_

For students under the age of 18, a parent's signature is required.

**Income Information**

The information you supply on this form is important in determining your eligibility for the program. Please make sure to read below and complete it accurately.

Please indicate your status as **Dependent** or **Independent** using the criteria listed below:

**Independent Student:** *You must meet at least one of the following conditions*

- You are over 24 years of age.
- You are married, a veteran, or otherwise legally emancipated.
- You have legal dependents, other than a spouse, who you support at least 50% of the time.
- Because of special circumstances, you were not required to submit your parents' income information on the FAFSA for the 2020-2021 academic year.

**Dependent Student:** *None of the above criteria applies to you*

Independent Student: Use your 2019 federal income tax return	Dependent Student: Use your parents' 2019 federal income tax return
1a. Were you required to <u>file 2019 taxes</u> ? Yes <input type="checkbox"/> No <input type="checkbox"/> ***If you answered no, skip to <b>certification</b>	1a. Was your family required to <u>file 2019 taxes</u> ? Yes <input type="checkbox"/> No <input type="checkbox"/> ***If you answered no, skip to <b>certification</b>
1b. What was your taxable income for <b>2019</b> ? (Form 1040, line 11b)? _____	1b. What was your family's taxable income for <b>2019</b> ? (Form 1040, line 11b)? _____
2. What was the household size as reported on the <b>2019</b> taxes? _____	2. What was the household size as reported on the <b>2019</b> taxes? _____

**CERTIFICATION:**

I certify that the above information is true and accurate to the best of my knowledge. I understand that this information is confidential and will be used to document my eligibility status for the Rx Program at Mount Wachusett Community College.

\_\_\_\_\_  
Student Name (Print)

\_\_\_\_\_  
Student ID

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

Parent/Guardian signature is required for dependent student.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**STAFF USE ONLY**

Interview Notes:

**Assessment Scores**

Subject	Scores	Dates	Scores	Dates
ENG OVR				
Essay				
Reading				
<b>PLACEMENT</b>				
Math OVR				
QAS				
AAF				
<b>PLACEMENT</b>				

Date Received \_\_\_\_\_  
 Grant \_\_\_\_\_  
 Cohort \_\_\_\_\_  
 First Generation  Yes  No  
 Low Income  Yes  No  
 Disability \_\_\_\_\_  Yes  No  
 Academic Need Code \_\_\_\_\_  
 GPA \_\_\_\_\_  
 Credits Completed \_\_\_\_\_  
 Transfer Credits \_\_\_\_\_  
 Eligibility Verified by \_\_\_\_\_

Fundamental Courses  Yes  No

**Application Processing:**

Status:  Accepted  Not Accepted  Ineligible Date \_\_/\_\_/\_\_

Comments \_\_\_\_\_

Intake completed by \_\_\_\_\_ Date \_\_/\_\_/\_\_

Data Entry: BANNER APP \_\_/\_\_/\_\_ Advisor \_\_/\_\_/\_\_ Cohort Year \_\_/\_\_/\_\_

Eligibility \_\_/\_\_/\_\_ Student Access \_\_/\_\_/\_\_

Mount Wachusett Community College seeks to provide equal educational and employment opportunities and does not discriminate on the basis of race, color, religious creed, age, physical or mental disability, sex, national origin or ancestry, marital status, sexual orientation, genetic information or veteran status.

If you have a disability and may require accommodations in order to participate fully in Program activities, please contact the Director of the Program at (978) 630-9297 to discuss your specific need.

The Rx Program (TRIO Student Support Services Health Science) is funded by the U.S. Department of Education.

