



Sertoma Kids Speech/Language Therapy Application

Patient Information

Child's name _____ Date of birth: _____

Address: _____ City, State, Zip: _____

How was your child referred to the Sertoma Speech Clinic? _____

What are your primary concerns? _____

Has your child received speech/language therapy in the past?

Do you receive any Financial Assistance for Therapies, i.e VPK voucher or Step Up for Students? _____

Do you have medicaid or other health insurance if so does your insurance cover speech evaluation or speech language therapy?
(if you are unsure, please call your insurance company and ask)

Mother Information

Father Information

Name:	Name:
Address:	Address:
City, State, Zip:	City, State, Zip:
Daytime phone:	Daytime phone:
Cell phone:	Cell phone:
Email address:	Email address:

Person completing application: _____

How many children are living in your home? _____

Child is living with _____



Financial Information

To apply for financial assistance you must provide a copy of your W-2 form or last 3 paycheck stubs to verify income.

Mother

Father

Employer:	Employer:
Address:	Address:
Phone:	Phone:
Position:	Position:
Gross Monthly Income:	Gross Monthly Income:
Savings	Savings

Other Monthly Income

Alimony:	Child Support:
Commissions:	Rental Income:
Disability:	Interest:
Pension:	Stocks
Shared Living:	Other:

Financial Liabilities/Monthly Expenses

Are there extenuating circumstances that effect your ability to pay for services? (child care, medical expenses; other living expenses)

Note: All information supplied herein will remain part of the confidential records of Sertoma Kids Speech Therapy and will not be distributed to or released to anyone outside organization or agency for any reason.

I certify that the information contained in this financial review and assistance request is true to the best of my knowledge. I further understand the Sertoma Kids Speech Therapy may verify any of the above information. I grant my permission for such verification, and agree to assist in any way requested. I understand that Sertoma Kids Speech Therapy reserves the right to cancel my assistance and collect full fees for services in the event of fraudulent financial status while involved with the program.

Signature

Date



PERSONAL FINANCIAL STATEMENT
OF GUARANTOR(S)

Patient Name: _____

I, _____, certify that my gross household income (before taxes) for the past twelve (12) months has been \$ _____, and there are _____ people in my household. I understand that the income information I provide will be verified by Sertoma Kids. Please include Proof of Income such as W-2, Paystub or Tax Return.

The out-of-pocket medical expenses over the last twelve (12) months for the above named patient total \$ _____. **

Signature of Guarantor/Legal Guardian

Date

**Documentation is required.