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? _____
_____

Name of Health Insurance: _____

Do you have Medicaid?:_____

Does your health 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 may be verified by Sertoma Kids.

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.

Sertoma Kids Speech/Language Clinic

Intake Form

Child's Name:	
Home phone:	
Cell phone:	
Email address:	
Guardian Names:	
Date of Birth:	
Referral Source:	
What is your primary concern with your child's communication:	
Does your child get frustrated with communicating?	
Has your child received speech language therapy in the past? If so, where and when? Do you have copy of speech evaluation?	
Does your child receive speech language therapy at any other agencies?	
Does your child receive speech language therapies at their school?	
What school/daycare does your child attend?	
Has your child had a hearing screening? Date of Screening.	
Does your child have any significant medical history?	
What days and times is your child available for therapy?	

Sertoma Kids Speech Therapy

Therapy Guidelines

1. ***Attendance is important to meet your child's speech goals. Inconsistent attendance will lead to slow progress.***

2. ***We reserve the right to discharge your child from therapy if he/she misses more than 50% of the scheduled sessions per month. Excused absences include: illness, doctor's appointment, vacation, and family emergency or therapist cancellation.***

3. ***You are responsible to pay for a missed therapy session if it is not an excused absence.***

4. ***If you need to cancel your appointment, please call your therapist as soon as possible. Please give 24 hours' notice unless it is an emergency or sudden illness.***

5. ***Payment is due at time of service.***

6. ***Please be on time to your child's appointment so that other children are not disrupted and therapy time lost.***

7. ***Please stay in the waiting area until your therapist comes to get you and your child for therapy. An adult caregiver must remain in the building for the entire time your child is in therapy.***

8. ***Please do not bring your child to therapy with a fever or a contagious condition (chicken pox, lice, pinkeye, a green runny nose, cough, etc.)***

9. ***When your child's therapy session is complete, your therapist will be available to briefly discuss your child's progress. Please refrain from cell phone use during this time and be mindful of therapist's time as they begin another therapy session.***

Please sign below that you have reviewed and agree to the following guidelines. We look forward to working with you and your child.

_____

Child's Name

_____ _____

Parent/Guardian Signature **Date**