

University Center for the Development of Language and Literacy (UCLL)

Language and Literacy Services Application

IDENTIFYING INFORMATION

Name: _____ Today's Date _____
Address: _____ Age: _____ Sex: ___ M ___ F
_____ Birthdate: _____
_____ Home Phone #: _____
Email: _____ Cell #: _____

BACKGROUND INFORMATION

Has anyone in your family had a history of speech, language, or reading difficulties? ___ Yes ___ No

Please explain: _____

I am concerned about my:

___ understanding of language
___ reading
___ math

___ ability to communicate
___ writing
___ social interaction

___ speech
___ spelling
___ academic success

SPEECH, LANGUAGE AND LEARNING INFORMATION

1. Please describe your concerns about your language, literacy, and/or learning abilities.

2. When were your difficulties first noted? _____

3. Has the problem ___ improved ___ worsened ___ remained the same? Please explain:

4. Are there situations in which you have particular difficulty?

___ Yes ___ No If yes, please describe: _____

5. Are you bilingual? ___ Yes ___ No Other Language: _____

What is the primary language used at home? _____

What is the primary language used at work? _____

6. How have your language-learning difficulties affected the following?

Social interactions with peers: _____

Willingness to talk to others: _____

Participation in the classroom: _____

Academic success: _____

Work performance: _____

7. Do you feel that your self-esteem has been affected by your language or learning abilities?

____ Yes ____ No If yes, please describe: _____

8. Has your hearing been tested? ____ Yes ____ No

If yes, please provide date and result of testing: _____

9. a) Please describe what you do well. _____

b) Please describe your interests. _____

c) Please describe your strengths _____

10. Are you currently enrolled in language therapy and/or tutoring? ____ Yes ____ No

If yes, has it helped? _____

of sessions weekly: _____ Length of each session: _____

11. Please describe any other related services that you currently receive. _____

MEDICAL AND DEVELOPMENTAL HISTORY

1. How would you describe your health currently?

_____ excellent _____ good _____ fair _____ poor*

*Explain: _____

2. Have you had any ear infections? _____ Yes _____ No

If yes, # of ear infections _____ Were tubes used to drain fluid? _____ Yes _____ No

3. Have you had any major illnesses? _____ Yes _____ No

If yes, please describe: _____

4. Have you ever had a severe blow to the head (e.g., falling on head, accidentally hit head, etc.)?

_____ Yes _____ No

If yes, did you (check all that apply):

_____ lose consciousness _____ suffer a concussion _____ experience vomiting

5. Please complete the following regarding any medication your currently taking.

Medication	Dosage	Frequency of Administration	Reason for Meds

6. How did you hear about us? _____

7. Name of person who referred you to this clinic (if applicable): _____

Address: _____

Phone # (_____) _____

Profession: _____

FINANCIAL INFORMATION

Name _____

Home Phone () _____ Cell Phone () _____ Work Phone () _____

- UCLL is a non participating provider with all insurance companies, including Medicare and Medicaid. Most insurance carriers will not cover the costs of intensive speech-language therapy. However, if you believe your insurance carrier will reimburse you for all or part of your payment to us, and we have no past history of failure to pay by your insurance carrier, we would be pleased to assist you in filing your claim, at no extra charge. Please contact UCLL’s Business Office at (734) 764-8440 who will direct you to the person who can assist you with this process.
- If any portion of the fees are not covered by your insurance carrier or other funding agencies, will you be able to meet the cost of this program yourself? _____ Yes _____ No
If no, have you made application to any organization for help? _____ Yes _____ No

Name of agency /organization _____

Address _____

Street City State Zip

Person Contacted _____ Title _____

Phone # () _____

INSURANCE INFORMATION (You are responsible for any charges not covered by your insurance company.)

Name of **Primary** Insurance _____

Phone # () _____ Subscriber Name _____

Subscriber SS #. _____ - _____ - _____ Employer _____

Policy/Contract #. _____ Group/Control # _____

Insurance Address _____

Insurance Representative: _____ Phone # () _____



Name of **Secondary** Insurance _____

Phone # () _____ Subscriber Name _____

Subscriber SS #. _____ - _____ - _____ Employer _____

Policy / Contract # _____ Group / Control # _____

Insurance Address _____

Insurance Representative _____ Phone () _____



➤ Please attach a photocopy of your Health Insurance Card(s) ◀

- A letter of medical necessity from your physician is required for billing purposes.
- Written pre-authorization of services must be received from your insurance prior to services.
- Full payment is expected at the time services are rendered regardless of your hopes for reimbursement from your insurance carrier.
- University Center for the Development of Language and Literacy accepts most major credit cards.