

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

## Language and Literacy Services Application

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I am applying for the following programs (please check):

Evaluation

Individual Therapy

Preschool and Communication Therapy (PACT)

Kindergarten First-Grade Starter

Teen Connections

Strategies for Academic Success

### **IDENTIFYING INFORMATION**

Child's name: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_ M \_\_\_ F

Address: \_\_\_\_\_

Birthdate: \_\_\_\_\_

\_\_\_\_\_

Home Phone #: \_\_\_\_\_

### **FAMILY INFORMATION**

Caregiver 1: \_\_\_\_\_

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

(if different from child's)

\_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Education: \_\_\_\_\_

Cell Phone: (\_\_\_\_) \_\_\_\_\_

U of M Employee # \_\_\_\_\_

Email: \_\_\_\_\_

Caregiver 2: \_\_\_\_\_

Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Work Phone: (\_\_\_\_) \_\_\_\_\_

(if different from child's)

\_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_

Education: \_\_\_\_\_

Email: \_\_\_\_\_

U of M Employee # \_\_\_\_\_

Please list children and adults who live in child's home:

NAME	AGE	RELATIONSHIP

Name of person filling out questionnaire: \_\_\_\_\_

Relationship to client: \_\_\_\_\_

Date form completed: \_\_\_\_\_

Does anyone in your family have a history of speech, language or reading difficulties? \_\_\_\_ Yes \_\_\_\_ No

Please explain: \_\_\_\_\_

\_\_\_\_\_

I am concerned about my child's:

- \_\_\_\_ 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 child's language, literacy and/or learning abilities.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. When were the difficulties first noted? \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Are there situations in which your child has particular difficulty?

\_\_\_\_ Yes \_\_\_\_ No If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

5. Did your child ever acquire speech and then slow down or stop talking? \_\_\_\_ Yes \_\_\_\_ No

If yes, how old was your child? \_\_\_\_\_ Describe: \_\_\_\_\_

\_\_\_\_\_

6. Is your child bilingual? \_\_\_\_ Yes \_\_\_\_ No Other Language: \_\_\_\_\_

What is the primary language used at home? \_\_\_\_\_

7. Which of the following does your child use most frequently to communicate?

- |   |   |
|---|---|
| <input type="checkbox"/> complete sentences                       | <input type="checkbox"/> unintelligible speech sounds |
| <input type="checkbox"/> multiple word phrases, but not sentences | <input type="checkbox"/> gestures                     |
| <input type="checkbox"/> single words                             | <input type="checkbox"/> other _____                  |

8. Does your child have difficulty producing specific speech sounds?  Yes  No

If yes, which ones: \_\_\_\_\_

9. How well can your child communicate with:

	<u>Good</u>	<u>Fair</u>	<u>Poor</u>
parents	_____	_____	_____
siblings	_____	_____	_____
strangers	_____	_____	_____
playmates	_____	_____	_____
teachers	_____	_____	_____

10. When you speak to your child s/he seems to understand (check one):

- everything     most everything     very little

Explain: \_\_\_\_\_

11. How has your child's language-learning difficulties affected the following?

Social interactions with peers: \_\_\_\_\_

Willingness to talk to others: \_\_\_\_\_

Participation in the classroom: \_\_\_\_\_

Academic success: \_\_\_\_\_

12. Do you feel that your child's self-esteem has been compromised by his/her language learning abilities?

- Yes  No    If yes, please describe: \_\_\_\_\_

13. Has your child's hearing been tested?  Yes  No

If yes, please provide date and result of testing: \_\_\_\_\_

14. Are there situations in which your child is successful relative to the areas of concern?

- Yes  No    If yes, please describe: \_\_\_\_\_

- a) Please describe what your child does well. \_\_\_\_\_  
\_\_\_\_\_
- b) Please describe your child's interests. \_\_\_\_\_  
\_\_\_\_\_ c
- ) Please describe your child's strengths. \_\_\_\_\_  
\_\_\_\_\_

15. Please describe any current related services that your child receives. \_\_\_\_\_  
\_\_\_\_\_

16. Is your child currently enrolled in language therapy? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, has it helped? \_\_\_\_\_  
# sessions weekly: \_\_\_\_\_ Length of each session: \_\_\_\_\_

17. Please describe your child's current school placement and services. \_\_\_\_\_  
\_\_\_\_\_

School name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ Teacher(s)/Program(s): \_\_\_\_\_

18. What is your impression of your child's learning abilities? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

19. How does your child talk about school? Describe \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

20. For my child to achieve success and self-confidence, I feel the most immediate need is \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

21. Is there anything else you feel we should know about your child? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL AND DEVELOPMENTAL HISTORY**

1. How would you describe your child's health currently?  
\_\_\_\_\_ excellent \_\_\_\_\_ good \_\_\_\_\_ fair \_\_\_\_\_ poor\*

\*Explain: \_\_\_\_\_

2. Were there any unusual circumstances during the mother's pregnancy or delivery?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

3. At approximately what age did your child do the following:

\_\_\_\_\_ sit unassisted

\_\_\_\_\_ walk

\_\_\_\_\_ say first word

\_\_\_\_\_ speak in sentences

4. Has your child had any ear infections? \_\_\_\_\_ Yes \_\_\_\_\_ No

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

5. Has your child had any major illnesses? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe: \_\_\_\_\_

6. Has your child ever had a severe blow to the head (e.g., falling on head, accidentally hit head, etc.)?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, did s/he (check all that apply):

\_\_\_\_\_ lose consciousness \_\_\_\_\_ suffer a concussion \_\_\_\_\_ experience vomiting

7. Please complete the following regarding any medication your child is taking.

Medication	Dosage	Frequency of Administration	Reason for Meds

8. How did you hear about us? \_\_\_\_\_

9. Name of person who referred you to this clinic (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_

Phone # ( \_\_\_\_\_ ) \_\_\_\_\_ Profession: \_\_\_\_\_

**PROFESSIONAL SERVICES** (Please provide information on any services that your child has received.)

**Speech & Language Examination/Therapy**

Person/ Agency \_\_\_\_\_  
Address: \_\_\_\_\_  
Dates: \_\_\_\_\_  
Findings: \_\_\_\_\_  
\_\_\_\_\_

**Reading/Writing Assessment/Services**

Person/ Agency \_\_\_\_\_  
Address: \_\_\_\_\_  
Dates: \_\_\_\_\_  
Findings: \_\_\_\_\_  
\_\_\_\_\_

**Hearing Testing**

Person/ Agency \_\_\_\_\_  
Address: \_\_\_\_\_  
Dates: \_\_\_\_\_  
Findings: \_\_\_\_\_  
\_\_\_\_\_

**Psychological Testing / Counseling**

Person/ Agency \_\_\_\_\_  
Address: \_\_\_\_\_  
Dates: \_\_\_\_\_  
Findings: \_\_\_\_\_  
\_\_\_\_\_

**Behavioral Evaluation / Management**

Person/ Agency \_\_\_\_\_  
Address: \_\_\_\_\_  
Dates: \_\_\_\_\_  
Findings: \_\_\_\_\_  
\_\_\_\_\_

**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.