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

Language and Literacy Services Application

IDENTIFYING INFORMATION Today's Date ________________________

Name: ____________________________________ Age: _______ Sex: _______ M _______ F

Address: __________________________________ Birthdate: __________________________

____ Home Phone #: ______________________

Email: ____________________________________ Cell Phone #: ________________________

BACKGROUND INFORMATION

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

Please explain: ____

____
_

I am concerned about my:

___ understanding of language ___ ability to communicate ___ speech
___ reading ___ writing ___ spelling
___ math ___ social interaction ___ 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 and 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: _____________________________

PROFESSIONAL SERVICES (Please provide information on any services that you have 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: ____________________
____

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.**