UNIVERSITY SPEECH, LANGUAGE AND HEARING CLINIC
A UNITED WAY FACILITY
100 Clinical Research Center
Houston, Texas 77204-6018
713-743-2898

Attached is an application for fee reduction for services to be provided by the University Speech, Language and Hearing Clinic. You do not need to provide ALL of the items listed, but we do need to see some written proof of the amount you earn, whether from a salary, from rental property, or some government agency.

Incomplete information will result in a delay of the approval process.

Type of proof of income:

- Paycheck stub (a copy will suffice). State how often you are paid: weekly, monthly or twice a month.
- Copy of your most recent W-2 form.
- Copy of income tax return for the most recent year or quarter.
- Copy of social security award letter: if you do not have this call your case worker or Department of Human Services.
- A letter from the Department of Human Resources concerning food stamps or TANF.
- Letter signed by employer (on company letterhead) stating how much you make and how often you receive that amount.
- Unemployment compensation or worker's compensation forms showing approval or disapproval.
- Financial information from the Head of Household or person providing your support.
- Signed letter from applicant that states you are not receiving any income and why. If you have been employed during the past three months; however, please send a copy of you paycheck stub or letter from your former employer.

Application that do not provide all necessary information for processing will be returned to the applicant.

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APPLICATION FOR: (CIRCLE ONE)

- o **FEE REDUCTION AND HEARING AID ASSISTANCE PROGRAM**
- o **FEE REDUCTION FOR SPEECH THERAPY**

CONFIDENTAIL INFORMATION

PATIENT'S NAME _____ **Date of Birth** _____

1. Head of Household: Name _____ Social Security # _____

Address _____ Home Telephone _____

City _____ State _____ Zip Code _____ County _____

Employer _____ Business Phone _____

Occupation _____ Monthly Salary _____

2. Spouse's Name _____ Social Security # _____

Address _____ Home Telephone _____

City _____ State _____ Zip Code _____ County _____

Employer _____ Business Phone _____

Occupation _____ Monthly Salary _____

3. Other sources of income (child support, rent, food stamps, etc.) $ _____

4. Other dependents within household (specify) _____

I certify the above information is accurate to the best of my knowledge.

_____

Print Name Signature

_____ _____

Date Relation to Patient

OFFICE USE ONLY: Fee Reduction Approved: **YES** _____ % **NO** _____ %

Hearing Aid Assistance Program Approved **YES** _____ % **NO** _____ %

Business Office Representative: _____ Date _____

PLEASE READ INSTRUCTIONS ON BACK OF THE PAGE

Describe any of the above_____

_____

Were there any periods (weeks/months) when the stuttering disappeared? _____

Were there any periods (weeks/months) when stuttering increased? _____

Can you give any explanation for these "bad" periods? _____

_____

Are there any situations that are particularly difficult? _____

_____

List any situations that never cause difficulty _____

_____

Answer the following "yes" or "no" as they apply to your stuttering. Do you stutter when you

Talk to young children? _____ Say you name? _____ Answer direct questions? _____

Talk to adults, superiors at work, teachers? _____ Use new words that are unfamiliar _____

Telephoning? _____ Reading aloud? _____ Reciting memorized material? _____

Ask questions? _____ Talk to strangers? _____ Are tired? _____

Are excited? _____ Talk to family members? _____ Talk to friends? _____

Do you know any stutterers? _____ Describe relationship _____

Do you feel the fact of stuttering alters or already has altered your daily life? _____ Future career _____

Social relationships? _____ Success in school? _____

Describe if you can, what this stuttering looks and sounds like. _____

_____

_____

_____

Return this completed form as promptly as possible. Only after the form has been received in this office will we contact you to set up the evaluation you have requested.

E. Prolongation of the vowel? (caaaaaaaat)_____

F. Visible attempt to speak (e.g. mouth movement) but no sound forthcoming? _____

Was the stuttering always the same or did it occur in several different ways?_____ If so, in what ways did they differ from one another? _____

_____

Did the first blocks seem to be located in the tongue, lips chest, diaphragm or the throat?_____

Approximately how long did each block (on one word) seem to last?_____

Was the stuttering easy or was there force at the time when the stuttering was first noticed?_____

_____

Were the words stuttered upon the words which began the sentences or were they scattered words?_____

_____

When stuttering first began, was there any avoidance of speaking because of it? Give examples, if any_____

_____

At the time when stuttering was first noticed, what was the reaction?

Awareness that speech was different? _____ Indifference to it? _____

Surprise?_____Anger or frustration?_____ Fear of stuttering again?_____

Shame? _____ Other? _____

Describe reaction; give examples and how reaction was shown. _____

_____

What attempts have been made to treat this problem? _____

_____

DEVELOPMENT OF STUTTERING

Since the onset, has there been any change in stuttering symptoms? Check those that are appropriate.

Increase in number of repetitions per word _____

Change in amount of force used _____

Increase in amount of stuttering _____

Increase in length of block _____

Periods of no stuttering_____

More precise in speech attempts_____

Lowered voice_____

Slower rate of speech _____

Change in localization of force_____

Looking away from listener _____

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A UNITED WAY FACILITY
CLINICAL RESEARCH, AND SERVICES BULDING, ROOM 100
4505 CULLEN
HOUSTON, TEXAS 77204-6611
(713) 743-2898

STUTTERING CASE HISTORY FORM – ADULT

Name_____ Birthdate _____Sex _____

Address _____ City_____ , State_____ Zip: _____

Home Phone _____ Office Phone _____

Informant _____ Relationship to the client_____

Referred by _____ Relationship_____

Occupation _____ Marital Status _____

Send reports to _____Address_____ City _____Zip:_____

Social Security Number _____-_____-_____

HISTORY OF STUTTERING

Are there others individuals in your family background or immediate family that stutter? _____

Relationship to you _____

Give approximate age at which stuttering was first noticed _____

Who first noticed or mentioned stuttering _____

In what situation was stuttering first noticed or commented upon _____

_____

Describe any situations or conditions that might be associated with onset _____

_____

Under what circumstances did stuttering occur after initial onset _____

_____

Were the first signs of stuttering:

A. Repetitions of the whole word? (boy-boy-boy) _____

B. Repetitions of the first letter? (b-b-b-boy) _____

C. Repetitions of the first syllable? (ca-ca-cat) _____

D. Complete blocks on the first letter? (b…..oy)_____

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100 Clinical Research Ctr.
Houston, TX 77204-6018

713/743-2898
Fax 713/743-2926

United Way of the Texas Gulf Coast

To Whom It May Concern:

This is in reply to your recent inquiry concerning our Speech, Language and Hearing Clinic. In order to understand a client's problem, we need as much detailed information as possible. Please use the spaces provided on the history form to describe fully anything you feel we should have. All information is for the confidential use of the clinic staff.

If an evaluation is necessary, the examination will consist of various testing and observation procedures, followed by discussion. Please allow 3-4 hours for the testing and discussion during a speech or language evaluation. Completion of the evaluation, however, is not a guarantee that we provide immediate speech/language therapy. Your name may be placed on our waiting list. If an evaluation has been performed within the past six months, please send a copy of the evaluation with the completed history form.

The evaluation fee is $200.00. Individual speech therapy will cost $100.00 per 50-minute session, or by the rate of the sliding scale. Base rates may vary for UH students, staff, and faculty.

If you have any questions please call me at 713-743-2898 between the hours of 8:30am and 4:30pm Monday through Friday.

Sincerely,

Clinic Secretary