



**CALIFORNIA STATE
UNIVERSITY**
E A S T B A Y

**College of Letters, Arts, and Social Sciences
Speech Language and Hearing Clinic**

25800 Carlos Bee Boulevard, Hayward, California 94542-3065

Phone: 510.885.3241 • Fax: 510.885.2186 • www.csueastbay.edu/commsci • www.csueastbay.edu

WHO? We provide services to clients who represent all age groups, from preschool children to senior citizens. All of our clients demonstrate a speech, language, or hearing problem. These problems include, but are not limited to, articulation or phonological problems, language delays or disorders, voice problems, hearing loss, accent modification, dysfluency, aphasia, apraxia, and dysarthria.

Our clinicians are graduate and undergraduate students preparing for careers in speech-language pathology or audiology who have completed appropriate coursework in communication processes and disorders. Students work under the direct supervision of experienced California licensed Speech-Language Pathologists who also hold a Certificate of Clinical Competence from the American Speech-Language-Hearing Association.

The Department of Communicative Sciences and Disorders is committed to the principle of equal opportunity. The University, College and Department do not discriminate in the delivery of professional services or the conduct of research scholarly activity on the basis of race, ethnicity, religion, national origin, gender, gender-identity, sexual orientation, age, marital status, physical characteristics or disability.

WHAT? We conduct comprehensive speech and language evaluations as well as provide speech and language therapy in either individual or group sessions. As part of our therapy services, an individualized home program is designed for each client to assist in maintaining skills acquired during treatment sessions. We utilize a full range of up-to-date equipment and materials with our clients. Students and family members may observe most therapy sessions through observation facilities. We encourage family members to participate in therapy sessions when appropriate. The Clinic also provides speech, language and hearing screenings to several community programs.

WHEN? Most clients are seen twice weekly for hourly sessions. Therapy is typically scheduled on a Monday/Wednesday or a Tuesday/Thursday at the same time on the hour on both days (e.g., on Mon/Wed at 2:00 p.m.; T/Th at 9:00 a.m., etc.). It is arranged according to client preferences and availability of clinicians and supervisors. Since students earn academic credit for providing therapy, a minimum of 15 hours of therapy is **required** each quarter for each client. Evaluation appointments of 2-3 hours in length are scheduled weekly in which days/times will vary quarterly. With very few exceptions, prospective clients are required to complete a one time diagnostic assessment at our clinic prior to their eligibility for therapy. Typically, clients are evaluated one quarter and are enrolled the following quarter in therapy as appropriate, based on scheduling, availability, and diagnostic recommendations.

WHERE? The clinic is located in the Music/Business Building, room 1099 on the Cal State East Bay, Hayward campus.

WHY? Speech-Language Pathology and Audiology services help identify communication problems, assist clients in achieving their maximum potential and increase family understanding, training and support.

HOW? Referrals are accepted from physicians, educators, allied health professionals, and clients or their family members and friends. An application is considered complete when pertinent medical, social, and educational records have been received in full. The applicant is then scheduled for a diagnostic evaluation as soon as an appointment is available. Results are discussed with the client and family, and the finalized evaluation report is sent to the client. If therapy is indicated, the client is advised regarding how to obtain appropriate services.

COST? A fee is charged for services. Fee reductions of 20% are available in cases where financial hardship can be proved and in conjunction with documentation of Social Security, unemployment, disability or other government benefits as only income sources. Fee payment options or reductions can be discussed when being scheduled for evaluation or therapy. See our attachment, *Fee Schedule*, for details. For further information or to initiate a referral, contact the clinic at (510) 885-3241.

THE CALIFORNIA STATE UNIVERSITY

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CALIFORNIA STATE UNIVERSITY, EAST BAY
Department of Communicative Sciences and Disorders
Speech, Language and Hearing Clinic

APPLICATION FOR CLINICAL SERVICES

DATE OF REQUEST: ____/____/____

Please complete all items. Indicate N/A if not applicable. Call the clinic at 510.885.3241 if you need help in completing this application. *Add extra pages if needed.*

***With very few exceptions, all clients must receive a CSUEB evaluation prior to enrollment in therapy. For a complete listing of all clinical services available-, please refer to our *Fee Schedule*.**

I. Prospective Client Information:

Name: (first) _____ (last) _____ Sex: Male Female

Street Address _____ City _____ State ____ Zip _____

Date of Birth: __ __/__ __/__ __ __ __ Age _____

Person completing Application: self other – Name _____ Relationship: _____

Name, telephone number and email of person to contact regarding this application (**please check the main/preferred contact number**)

Name: _____

(Home) _____ (Cell) _____ (Work): _____

Email: _____

Language(s) spoken in the home: _____

For a child's application:

Name of School _____ City and District _____

Grade and/or Special Day Class Placement _____

II. Speech and Language Information

A. Describe the prospective client's communication problem. Be specific and give as much information as you can regarding concerns with ability to speak, use or understand language, produce speech sounds, interact with others, along with any behavioral concerns, including any previously determined diagnosis:

B. Has the prospective client had any previous speech, language or hearing evaluations or treatment?

Yes No

If **YES**, please provide the information below:

	Provider	Dates of Service	Outcome/Recommendations
Evaluation/Therapy:	_____	_____	_____
Evaluation/Therapy:	_____	_____	_____
Evaluation/Therapy:	_____	_____	_____
Evaluation/Therapy:	_____	_____	_____
Evaluation/Therapy:	_____	_____	_____

C. Does the client have a history of chronic ear infections or any chronic illnesses related to hearing or the ear?

Yes No

If **YES**, please explain:

D. Is there any family history of communication difficulties? Yes No

If **YES**, please explain:

E. Why are you requesting services at this time?

F. Please add any information you feel is important (e.g., relevant medical information, education, social history, etc).

III. Medical Information

Name of Primary Physician: _____ Phone #: _____

Facility/Street Address of Physician: _____

City, State and Zip: _____

Food allergies: _____

Does a **specialist** care for the client? (e.g., neurologist, ENT specialist?) Yes No

If **YES**, then:

Name of specialist: _____ Area of Specialty: _____

Facility/Street Address of specialist: _____

City State and Zip: _____ Phone #: _____

Pediatric applicants (if applicable)

Early developmental milestones (*please check*)

Crawling normal delayed unsure

Walking normal delayed unsure

First words normal delayed unsure

Combining words normal delayed unsure

School history

Social skills normal delayed unsure

Academics normal delayed unsure

Adult applicants (if applicable)

Educational history - Last grade completed: _____

Where currently/last employed: _____

Family/Physical Information (*please check*)

Living alone yes no

Walking Independent needs assistance

Personal Care* Independent needs assistance

**Appropriate use of toilet*

II. Referral Information:

How did you hear of our clinic? _____

If this prospective client was seen by us before, please provide date range of service:

From: _____ to _____
month/year month/year

 I have read the Fee Schedule and understand the fees required for Evaluation as well as Therapy services.
(please check)

Advance Beneficiary Notice of Non-Coverage for Medicare Enrollees

As a university training program, the California State University, East Bay Speech, Language and Hearing Clinic cannot comply with Medicare policies and is not a Medicare provider for evaluation or treatment services. Completion of the CSUEB *Speech, Language and Hearing Clinic Application* serves as advance notification to the client or his/her guardian of the Clinic's inability to satisfy the Medicare regulations as an approved Medicare service provider.

Thank you for your application!

We will be in contact with you within 3 weeks if we are able to schedule you for an evaluation.

FEE SCHEDULE

THERAPY FEES FOR ONE QUARTER (17-18 SESSIONS) PER CLIENT

Intensive Therapy (55 min. sessions) – 2/week (3/week in Summer Qtr.)	\$360/quarter
Individual and small group (2 clients) services are charged at the same rate	
Aphasia Treatment Program (ATP) – Mon./Wed. 10:30- 4:00 (Unavailable in Summer Qtr.)	
• Full Program	\$500/quarter
• Transitional Program	\$250/quarter
Aphasia Communication Group or Book Club (2 Hours/Week)	\$120/quarter/each group
(Fee waived for clients enrolled in Intensive Therapy or ATP Program)	

EVALUATION FEES

Comprehensive Speech and/or Language Diagnostic Evaluation	\$300.00/2+ hr. session
Comprehensive Cognitive/Linguistic Diagnostic Evaluation	\$300.00/2+ hr. session
Speech & Language Screening (w/Clinic Director's approval)	\$100.00/.5-1 hr. session
Hearing Screening	Variable dependent upon services

CONSULTATION FEES

Special Services of Licensed & Certified Speech-Pathologists	\$125.00/hour
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FEE POLICIES

Fees are required at the time of the Evaluation and first Therapy sessions, however arrangements may be made to pay therapy fees over the quarter at the discretion of the Clinic Director.

Fee reductions of 20% are extremely limited and considered only in the cases where financial hardship can be proved AND in conjunction with documentation of Social Security, unemployment, disability or other government benefits as only income sources.

We reserve the right to immediately cancel services for unpaid fees. If a client has a history of delays in payment for services, we may consider this in our scheduling decisions for services in the future.

INDIVIDUALS OR ORGANIZATIONS WISHING TO MAKE DONATIONS TO THE
DEPARTMENT OF COMMUNICATIVE SCIENCES AND DISORDERS
ARE ENCOURAGED TO CONTACT THE CLINIC DIRECTOR
(510) 885-3241

Authorization for Release of Information

I authorize Name: _____ Facility: _____
(if applicable)

Street: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

to release to the Speech, Language and Hearing Clinic, Cal State East Bay
SPEECH-LANGUAGE-AUDIOLOGY records and information pertaining to

Name of Client Date of Birth Medical Record Number

Address City State Zip Code Telephone

AUTHORIZATION - You must have legal authority to request information. If you are acting as a legal representative to another individual, you must describe the legal relationship to act for the individual.

DURATION - This authorization shall become effective immediately and remain in effect for one year from the date of signature, unless otherwise indicated below.

REVOCAATION - You may revoke this authorization, in writing, at any time. The written revocation will be effective upon receipt, but will not be effective to the extent that the person requesting information or others have acted in reliance upon this authorization.

REDISCLASURE - You may not lawfully further use or disclose the health information to another unless another authorization is obtained or unless such disclosure is specifically required or permitted by law.

COPIES - You have a right to receive a copy of this release authorization form.

FEES - A fee of \$1.00 per page will be charged for each page in excess of ten.

USE OF INFORMATION: The information will be used for the following purposes:

Printed Name of Person Signing Release Signature Date

Legal Relationship to Client Expiration Date for Authorization
If left blank, this will be one year from the date signed.