Application and Intake Packet – Communication For Life Program

WELCOME to the University of Washington Speech and Hearing Clinic. The mission of our clinic is to be a center of excellence in education, research, and clinical practice serving speech, language, and hearing needs within the University and the community.

As a teaching and research facility, the services offered in the clinic are provided by our graduate student clinicians working toward advanced degrees. Graduate student clinicians are supervised by Audiologists and Speech-Language Pathologists who are nationally certified by the American Speech-Language-Hearing Association (ASHA) and licensed by the Washington State Department of Health. In addition, our dispensing Audiologists are certified by the Washington State Department of Health.

As a part of an academic program, the UW Speech and Hearing Clinic is a non-traditional outpatient clinic. Scheduling of services, type of services offered, and the length of services received depends upon the academic needs and availability of our students, balanced with the needs of our clients. Clients are eligible for up to 4 quarters of therapy services.

The following information will acquaint you with our unique outpatient clinic and answer many of your questions. For more information, visit our web site at: sphsc.washington.edu/clinic.

Application and Intake Packet: The intake form below can be completed online by using the free Adobe Acrobat Reader (available at Acrobat.Adobe.com) The intake forms should be completed and returned to the clinic before your appointment. Your answers to the many questions will help us understand your special needs. Usually we must receive your intake forms before we can schedule an appointment. In some cases we will schedule the initial appointment prior to receiving the intake forms, but the intake forms must be received by the clinic prior to your first visit. Please assist us by filling out the intake forms as completely as possible. In addition, include copies of reports and records (i.e., school reports, medical records) that you feel would be beneficial to us and would help us to know your history and current needs. With your permission, we may request additional records when necessary.

Consent: Carefully read the "Consent Form" so that you are informed of your obligations, the services we provide, and the type of recordings that may take place. The consent form must be signed and on file in the clinic prior to the initiation of services. If you have any questions about this form, please call us prior to your visit. You may bring it unsigned to the first visit and we will take time then to address your questions.

Confidentiality: Only after having the client's written permission, or the permission of the client's parent/legal guardian, will we provide information to or request information from an outside agency. We respect and protect client privacy.

Location & Parking: The Speech & Hearing Clinic is located on the west side of the University of Washington campus at 4131 - 15th Avenue NE and is in the School of Social Work/Speech & Hearing building. Please refer to the attached map and instructions for information on parking options, disabled access, and alternative transportation details.

Fees for Services: We are a no-fee, donation-based community clinic. Evaluation and therapy services are provided free of charge. We encourage you to consider making a donation to help support the Clinic in providing services to others with communication needs. A donation is not required to receive services.

Fees for Devices (Hearing Aids, Ear Plugs, Alternative Communication Devices) and Associated Services: There are charges for devices such as hearing aids, ear plugs, alternative communication devices, etc., and for the services related to the fitting and repair of these devices. We are not a Medicare provider and we do not bill insurance companies, Medicare/Medicaid or other third-party providers. **We ask our clients to pay at the time of receipt of the device. We welcome payment by cash, check or major credit cards including Heath Savings Account cards.** The client or legal guardian is responsible for the cost of the device provided and payment is required before receiving the device. Upon payment for devices, the Clinic Office will provide you with a receipt. In addition, an Insurance Summary statement is available upon request and may assist you in seeking reimbursement from your insurance company or employer. Our Office Manager will be able to assist you if you have questions regarding payment or financial hardship.

Academic Calendar: As we are part of the University of Washington, our clinic follows the University of Washington academic calendar. The clinic is open during the four academic quarters of the year and closed for holidays and vacation breaks that are observed by the University of Washington. The Hearing Aid Fitting and Dispensing program does maintain "on-call" hours during vacation breaks.

For our clients who receive multiple quarters of services, they should anticipate having a different graduate clinician each quarter. Our graduate students rotate through clinical experiences as part of their degree program. To assure continuity of client care, the same Clinical Supervisor typically oversees a client's services.

Attendance: Please call us 24 hours in advance of your appointment if you need to cancel or reschedule. After business hours, you are welcome to leave a voice mail message. When a client has three appointment "no shows" or "cancellations", the graduate clinician's educational program is adversely impacted. Therefore, services for that client may need to be deferred.

Contacting Us:

Mail address: U.W. Speech & Hearing Clinic
4131 15th Avenue NE
Seattle, WA 98105

Phone: (206) 543-5440
Fax: (206) 616-1185
Email: shclinic@uw.edu

You are an integral part of who we are and we welcome you to our clinic. We pride ourselves on providing exceptional services. The Department of Speech and Hearing Sciences is ranked as a top program in the nation in its preparation of graduate students in Audiology and Speech-Language Pathology. We know you'll be pleased that you have selected our clinic.

Respectfully,

Martin Nevdahl, M.S., CCC-SLP
Clinic Director

Julianne Siebens
Clinic Office Manager

Application & Intake Form: Communication For Life Program

Please address applications to UW Speech and Hearing Clinic - Attn: CFL

In order to determine eligibility for the program, an evaluation must first be completed at this clinic. Please contact the clinic if you have questions about this requirement

Client Information			
Last Name		**First Name**	
Date of Birth	**Age**	**Gender**	**Primary Language**
Street Address		**City, State, Zip**	
Primary Phone		**Secondary Phone**	
Email Address		Please put a * in front of your preferred method of contact - phone, email, etc.	
Name of person completing this application if other than client and relationship to the client.			
I give my consent for a Voicemail/Text to be left on the telephone numbers listed above	**Yes** ☐	**No** ☐	
I understand that email communication may not be secure. I give my consent to be contacted via email regarding clinic services via the email above	**Yes** ☐	**No** ☐	
Has client been seen in our clinic before?	**No** ☐	**Yes** ☐	**If yes, when?**
Why is client applying for services?			

Family Members/ Caregivers/POA	"X" if Legal Guardian(s)	Relationship (e.g., mother, father, husband, wife, sister, son, etc.)	Phone number	"X" if lives with client

Health History			
Medical Provider			
Current Physician			
Address			
Phone		**Fax**	

Please explain any current medical concerns (or check none): ☐ **None**

Please list all current medications (or check none): ☐ **None**

Has the client had any recent hospitalizations (or check none): ☐ **None**

If yes, please explain:

Hearing	No	Yes	Please Comment/Explain if yes
Have you ever had concerns about the client's hearing?	☐	☐	
Does the client use any amplification or other devices to aid hearing?	☐	☐	
Vision	**No**	**Yes**	**Please Comment/Explain if yes**
Have you ever had concerns about the client's vision?	☐	☐	
Does the client currently wear corrective lenses?	☐	☐	

Communication Diagnosis, if known: Please check all that apply			
☐	**Expressive/Receptive Language Disorder**	☐	**Voice Dysfunction**
☐	**Apraxia of Speech**	☐	**Social Communication Disorder**
☐	**Speech Sound Disorder**	☐	**Fluency/Stuttering**
☐	**Cognitive-Communication Deficit**	☐	**Other:**
Please give a brief description of the specific challenges associated with the above diagnosis:			

Communication Skills: Please check all areas that describe the client and provide additional information as needed			
Understanding		**Speaking**	
☐	**Follows conversation all of the time**	☐	**Communicates primarily in complete sentences**
☐	**Follows conversation some of the time**	☐	**Puts 2-3 words together**
☐	**Does not usually understand conversation**	☐	**Uses some words**
☐	**Understands short, simple directions**	☐	**Unable to say words**
		☐	**Uses a communication device**
☐	**Other:**	☐	**Other:**

Reading		Writing	
☐	**Reads books**	☐	**Writes notes and letters** (rarely**)**
☐	**Reads magazines and newspapers** (rarely**)**	☐	**Writes sentences**
☐	**Reads sentences (e.g., headlines, labels)**	☐	**Writes words**
☐	**Reads words**	☐	**Writes name** (barely)
☐	**Does not read**	☐	**Does not write**
☐		☐	**Types or uses a computer**
☐	**Other:**	☐	**Do not know**
Digital Literacy			
☐	**Uses social media (e.g. Twitter, Facebook, Instagram)**	☐	**Uses a cell phone**
☐	**Communicates via email**	☐	**Uses a tablet**

Daily Living and Transition Readiness:	
Please indicate if you have had in the past or currently have any concerns in the following areas:	
☐	Vocational Skills (readiness to work
☐	Self-help (e.g., dressing, toileting)
☐	Transportation
☐	Leisure/Social (friendships, hobbies, interests)
☐	Safety
☐	Learning new routines/Skills
☐	Remembering important information
☐	Making appropriate judgments and decisions
☐	Paying attention
☐	Managing time
Please explain any concerns indicated:	

School/Vocation Information				
Is the client currently in any kind of school/transition/employment program?			No ☐	Yes ☐
Name of School/Agency		Grade		
Teacher/Job Coach Name				
Teacher/Job Coach Email				
Agency Address				
Agency Phone		Fax		
Type of Classroom/ Program*				

* Transition Program through school district, DVR, School-to-Work

Does the Client currently have an IEP?	**No** ☐	**Yes** ☐	**<u>If yes, please provide a copy of most recent IEP and most recent special education re-evaluation (including Transition plan).</u>**

Other Services/Providers (e.g. psychiatrist, mental health counselor, social worker, life coach) *Please provide any available reports from these sources*		
Service:	**Dates:**	**Provider Name and Contact Info**
Comments:		

Service:	**Dates:**	**Provider Name and Contact Info**
Comments:		

Additional comments or information you would like to share with us (e.g., scheduling information/conflicts, pending surgeries, etc.):

Whom may we thank for referring you to us?	
Name:	**Profession**:

Thank you for taking the time to complete this application. It will help us provide you with the best services possible. Upon receipt of your application, your application will be reviewed by the appropriate clinical supervisor to determine what services are needed. You will then be contacted to inform you of your application status. Return this application including the Consent for Care and Clinic Policies Form and Mutual Exchange of Information Form (if we need to request records from other providers). You can email, fax, or mail these documents

UW Speech & Hearing Clinic
4131 - 15th Ave. NE
Seattle, WA 98105
206-616-1185 (Fax)
shclinic@uw.edu (Email)

Consent for Care and Clinic Policies Agreement Form

Please read each section of this form below and initial that you have read and understand each policy. Then provide a signature at the end of this form confirming that you have read and understand each section.

CONSENT FOR CARE

I hereby authorize the UW Speech and Hearing Clinic to provide evaluation and treatment services for the above named client. Additionally, if the faculty, staff, and/or other clinic personnel determine that the client is in need of emergency medical care, the clinic is hereby authorized to obtain the care required, at the expense of the undersigned.

I have read and understand the Consent for Care statement: _____ (initials)

SUPERVISION OF MINORS POLICY

Under state law, individuals under the age of 18 are considered minors. Parents/guardians are asked not to leave the clinic while a minor under the age of fourteen is in therapy at this clinic. For clients ages 14 to 17, parents/guardians may choose whether or not to accompany the minor to their appointment. Parents/guardians are solely responsible for determining how their children may safely travel to the UW Speech & Hearing Clinic for their appointment (e.g. bus, drive, walk, bike, etc).

I have read and understand the Supervision of Minors Policy: _____ (**initials)**

MOBILITY TRANSFERS AND RESTROOM POLICY

Clinicians, faculty and staff are not allowed to assist with transfers and toileting. A caregiver or family member of the individual receiving services must be present when the client needs physical assistance with transferring from wheelchair to chair, during ambulation in the clinic, or for bathroom assistance.

I have read and understand the Mobility Transfers and Restroom Procedures Policy: _____ (**initials)**

DISABILITY ACCOMMODATIONS

Both front and back entrances to our clinic are accessible. Both entries have automatic openers, as do our restrooms. Please let us know if you need any accommodations to facilitate receiving services from our clinic.

Accommodations needed:

OBSERVATION AND RECORDING POLICY

The services offered to individuals seen in the Clinic are part of the University's education program. University of Washington faculty, staff, and students receive educational benefits from observing diagnostic, treatment, and other services offered in the University facilities.

Basic Consent: I understand that by accepting services from the Clinic I consent to observation by UW faculty, staff, and students, either live, via recording, or via closed circuit television when I (or the client) receive services.

I understand that I (or the client) may be observed: _____ (**initials)**

Full Consent: In addition, I give my consent to the UW Speech and Hearing Clinic to make audio and/or video recordings of me (or the client) while receiving services to be used for educational purposes, provided the name of the client or other personal identification information is not revealed. These data are only available for educational training purposes. All uses for commercial or research purposes are prohibited unless a separate permission is obtained. Segments of the digital recording with accompanying transcriptions may be presented in the context of academic symposia, university classes, and professional, family or client training activities.

I give my consent to be recorded for educational purposes: _____ (**initials)**

CONSENT TO BE CONTACTED FOR RESEARCH POLICY

UW Speech & Hearing Sciences and the UW Speech & Hearing Clinic are committed to advancing clinical research to improve the lives of people living with communication disorders. Please initial below if you are interested in being contacted by faculty in this department about research studies for which you might be an appropriate participant. You can decline to participate even if you are contacted, you can rescind this offer at any time with no repercussions, your information will not be shared with anyone else on campus or in the community, and you will not be contacted unless you fit the criteria for a specific study.

I give my consent to be contacted about research: _____ (**initials)**

By signing this page, I acknowledge that I have read and agreed to the terms of this Consent for Care and Clinic Policy Agreement Form:

Name of Client: **Date of Birth:**

_____ _____

Signature of Client or Person Responsible for Care **Date of Signature**