



Dear Prospective LEAP Parent,

Thank you for your interest in the Language-Learning Early Advantage Program (LEAP) Preschool in the Department of Hearing and Speech Sciences at the University of Maryland. In order to apply for enrollment to LEAP and/or to be placed on the waiting list, please complete the case history form (attached) and return it to the clinic office along with a comprehensive speech-language evaluation report that is no more than 6 months old at the time of application. If a recent speech-language evaluation is not available, please let the clinic office know that you wish to make an appointment for testing (an additional fee for this service). If you have additional diagnostic reports from related professionals (e.g., psychologist, occupational therapist, special educator), those may be provided as well. No fee is charged at the time of application; however, a \$25 visit fee will be collected once you are invited to visit the classroom.

After review of the application, we will contact you to set up a family visit. If, prior to the family visit, our program does not appear to be the best fit for your child (based on the application information and/or evaluation reports included with your application), you will be contacted. The family visit includes a case history interview and a classroom observation. Visits typically last between 30 and 60 minutes and occur when class is in session. This visit allows you and your child a chance to see the LEAP classroom and allows your child the chance to experience a portion of a typical day in LEAP. Based on information collected from the classroom observation, a determination will be made whether your child is an appropriate fit for the program. You will be notified either during the visit or within a week or so following the visit and will be granted a period of 14 days in order to decide whether to accept the offer of enrollment.

The final step in the application process is submitting a deposit (\$360 for fall/spring and \$100 for the summer) and signing the LEAP contract. The deposit will be deducted from the cost of tuition at the time the tuition balance is submitted.

LEAP is a very special program with a mission of training speech-language pathology graduate and undergraduate students and providing speech and language services in a language rich preschool environment. *The Maryland Association of Higher Education* awarded LEAP the *Distinguished Program Award* in 1997 for LEAP's contribution to Maryland's communication impaired children and for training. In April 2002 LEAP was selected as a model preschool reading program by the *American Speech-Language-Hearing Association (ASHA)*.

We accept children who demonstrate a speech and/or language disorder in the absence of other significant developmental conditions and who are daytime potty-trained. We reserve the right to accept children on the basis of the clinical needs of our students and not necessarily in the order the applications were received. However, we do attempt to contact families as promptly as we are able. Please assist us in being as fair as possible by replying promptly to offers for a classroom visit.

Again, thank you for your interest in LEAP. Feel free to contact me with any additional questions.

Sincerely,

Kay C. Lopez
Business Service Specialist
0110 Lefrak Hall
College Park, MD 20742
301-405-4218
301-314-2023 (Fax)
hespclinic@umd.edu
www.hesp.umd.edu



Language-Learning Early Advantage Program

University of Maryland
College Park, Maryland 20742
(301) 405-4228

CHILD CASE HISTORY FORM

Please answer the following questions as best you can and mail the form to the address given at the top of this page. If there are some questions which you cannot answer, leave them blank. Your answers will help us save time in understanding your child's problem.

I. ROUTINE INFORMATION

Name of your child: First name _____ MI: _____ Last name _____

Preferred Name: _____ DOB: _____ Age _____ Gender _____

Name of parent(s) _____

Address _____ City _____ State _____ Zip _____

Home phone _____ Parent's work phone, 1# _____ 2# _____

Cellphone, 1# _____ 2# _____ Alt # _____

E-mail address _____

Name of person giving information _____

Relationship _____ Phone number if different from above _____

Who referred you to our clinic?: Name: _____ Phone #: _____

Insurance:

We do not participate with any insurer (including Medicaid and Medicare). Therefore, payment is due at the time of service. Because we are a non-participating provider, your insurance company will reimburse you directly. We cannot guarantee that you are eligible for coverage or reimbursement from them. Please contact your insurance company to verify benefits and reimbursement rates. We will provide you with information that you can submit to your insurance company.

Are you affiliated with the University of Maryland Yes : __ Student or __ Faculty/Staff ID # _____
No

Race of the child* _____

- 0 = Not reported
- 1 = American Indian/ Alaska Native
- 2 = Black/ African American
- 3 = Asian/ Pacific Islander
- 4 = Hispanic
- 5 = White/ Caucasian

* This information is requested because the University is a public teaching institution and will be used solely for the purpose of describing caseload diversity. Your response will not affect consideration of your child's application.

Why has a speech evaluation been requested?

II. PRESENT SPEECH AND LANGUAGE STATUS

Does your child understand what you say to her/him? _____ If not describe her/his reactions: _____

Does your child have trouble understanding other people's speech? _____ Give examples: _____

Do you know why your child does not understand? _____ Please explain: _____

Does your child respond consistently to sounds in the home (doorbell, phone, etc.)? _____

Explain: _____

Do you suspect a hearing loss? _____ Why? _____

Does your child attempt to talk? _____ Is the child's speech understood by parents? _____

Siblings? _____ strangers? _____

What is your child's reactions when his/her speech is not understood? _____

What does your child do to express himself when his/her speech is not understood by others? _____

Does your child say as much as most children of the same age? _____ Give an example of a sentence your child might say: _____

Does your child pronounce words well? _____ List sounds or words that your child pronounces incorrectly: _____

Select one skill in each column that best describes your child:

- | | |
|---|---|
| <input type="checkbox"/> responds to only loud sounds | <input type="checkbox"/> makes no vocal sounds |
| <input type="checkbox"/> responds only to sounds in the home | <input type="checkbox"/> babbles only |
| <input type="checkbox"/> understands single words | <input type="checkbox"/> says single words |
| <input type="checkbox"/> understands simple sentences | <input type="checkbox"/> speaks in simple sentences |
| <input type="checkbox"/> understands complex directions and sentences | <input type="checkbox"/> uses complex sentences |
| | <input type="checkbox"/> uses only gestures |

Does your child hesitate and/or repeat sounds or words? _____ How often does it happen? _____

When did you first notice this behavior? _____

Describe any struggle behaviors that accompany the hesitations/repetitions: _____

What, if anything, have you done about it? _____

Is your child's voice too high-pitched? _____ too low-pitched? _____ too weak or quiet? _____

Is your child's voice quality unusual? _____ If so, describe: _____

Is your child's speech too fast? _____ too slow? _____

Are there any physical causes for any of the above answers? _____ If yes. Please explain: _____

III. DEVELOPMENTAL HISTORY

A. Birth History

Mother's condition during pregnancy? _____

Full term? _____ If premature, how many weeks gestation? _____

Birth weight? _____ Any evidence of injury at birth? _____

If so, please describe: _____

Indications of weakness or poor health at birth? _____

Explain: _____

Any difficulty in initiating breathing? _____

B. Growth

During infancy, did your child demonstrate any feeding or swallowing problems? Please describe: _____

Has your child increased in height and weight normally? _____ If not, please describe: _____

C. Motor

Age of sitting up _____ Age of crawling _____ Age of walking _____

Does your child seem to have normal coordination for his/her age? _____ If not, please describe: _____

Which hand does your child use? _____

D. Speech Development

Did your child babble and coo during the first ten months? _____ At what age did your child use single words meaningfully? _____ Age for short phrases/sentences? _____

E. General Development

Does your child have opportunities to play with other children? _____ What ages? _____

How many? _____

Does your child like to play with other children or would your child prefer to play alone? _____

At what age did your child start feeding himself/herself? _____

Dressing himself/herself? _____ Become toilet-trained? _____

Does your child present any special behavior problems? _____ If so, please describe: _____

Check all of the following which describe your child:

University of Maryland Speech and Hearing Clinic

- | | | |
|------------------------------------|---------------------------------------|---|
| <input type="checkbox"/> Friendly | <input type="checkbox"/> Unresponsive | <input type="checkbox"/> Temper Outbursts |
| <input type="checkbox"/> Happy | <input type="checkbox"/> Quiet | <input type="checkbox"/> Shy |
| <input type="checkbox"/> Stubborn | <input type="checkbox"/> Aggressive | <input type="checkbox"/> Tense |
| <input type="checkbox"/> Sensitive | <input type="checkbox"/> Cooperative | <input type="checkbox"/> Talkative |

IV. MEDICAL HISTORY

A. List diseases/conditions and their effects and severity:

Disease/Condition	Age	Severity and Effects
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B. List significant injuries, ages and effects:

Injury	Age	Severity and Effects
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C. List operations and ages for each operation:

Operation	Age	Severity and Effects
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D. Name of child's current pediatrician _____

E. Address _____

F. Please list any conditions for which child is currently taking medication

Name and dosage of each medication _____

Does your child have any allergies or dietary restrictions? _____

V. SCHOOL HISTORY

A. Please complete all of the following that apply to your child:

Name and Location	Age Entered	Dates Attended
Nursery School: _____		
Elementary School: _____		
Junior High: _____		
Senior High: _____		

B. Status

List subjects that are especially difficult for your child _____

Describe any serious behavior problems at school _____

Has your child ever repeated a grade? _____ Which one and why? _____

Has your child's school attendance been regular? _____

Describe your child's participation in after-school activities? _____

VI. SPEECH-LANGUAGE HISTORY

A. Describe any special work in speech and/or language in school _____

Dates _____ Group or individual sessions _____ Frequency _____

Name of therapist and school _____

B. Has your child received any speech/language services at any other clinic or agency? _____

Please list the names of other clinics or agencies where your child has been evaluated or treated for speech-language or hearing difficulties. Please attach copies of any reports to this form.

Name	Location	Dates	Evaluated	Treatment
1.	_____	_____	_____	_____

2.	_____	_____	_____	_____
----	-------	-------	-------	-------

3.	_____	_____	_____	_____
----	-------	-------	-------	-------

4.	_____	_____	_____	_____
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C. Describe any help given to your child by his family, friends, physicians, which has not been reported previously, in attempts to help your child correct his present speaking difficulties.

VII. FAMILY and SOCIAL HISTORY

A. Family
Father's name _____ Age _____

Place of birth _____ Occupation _____

Education completed: _____ 8th grade _____ High school _____ College _____ Other _____

Mother's name _____ Age _____

Place of birth _____ Occupation _____

Education completed: _____ 8th grade _____ High school _____ College _____ Other _____

Names and age of brothers and sisters _____

Others in household _____

Describe any family history of speech/language or hearing difficulties (e.g. learning disabilities, stuttering, articulation impairment, deafness, etc.)

List any languages other than English that are spoken in your child's home or everyday environment _____

Please attach a recent photograph of your child. Since this photograph will not be returned to you, you need not send an expensive one. A snapshot will serve the purpose.



HEARING AND SPEECH CLINIC
Student Involvement, Collection of Video, and Research Contact Consent/Waiver Form

The Hearing and Speech Clinic is a student training facility. As such:

1. Services may be provided by students who are working towards their Master's degree in speech-language pathology or their Doctoral degree in audiology. These students are closely supervised by experienced speech-language pathologists and audiologists, who are faculty members of the Department of Hearing and Speech Sciences, certified by the American Speech-Language and Hearing Association (ASHA) and licensed by the Board of Examiners of the State of Maryland.
2. Your information may be used for educational or training purposes, but will be kept confidential.
3. Recordings of sessions may be taken for training purposes. These videos are not considered part of your medical record, and may be destroyed once no longer useful for training purposes.
4. Authorized students may have access to your medical files.

By signing below, I acknowledge that I have read, understand, and agree to the above.

Signature of patient or personal representative

Date

Printed name of patient or personal representative and his/her relationship to patient

In addition to being a training facility, the Hearing and Speech Clinic is also associated with the Department of Hearing and Speech Sciences, whose mission includes not only clinical training and clinical services, but also research. We would like for students and faculty to be able to review your records for potential study eligibility, and to contact you about research opportunities for which you might be eligible and interested. You may decline to participate in research at any time, and this will have no impact on your treatment in our clinic. Please sign here if you allow our faculty and students to review your files.

Signature

Date



HEARING AND SPEECH CLINIC

Patient Contact Preferences

Name of Patient: _____

I would prefer to be contacted for appointment reminders, etc. via the following mechanisms:

Email: _____
(please note that email is not a secure form of contact)

Phone: _____

You may leave a voicemail message at this number

You may leave a message with another individual at this number

Signature of patient or personal representative

Date

Printed name of patient or personal representative and his/her relationship to patient

**Hearing and Speech Clinic
University of Maryland College Park
Consent to Unencrypted Email Communications for Clinical Progress Reports**

The Hearing and Speech Clinic incorporates informational reports to clients/families about progress and homework assignments (together, "Progress Reports") designed to facilitate therapeutic progress. These reports do not contain Protected Health Information ("PHI") other than the client's name, a brief description of progress, and recommended activities to assist in making additional progress.

Email allows the Clinic to exchange information efficiently for the benefit of our patients and their families. As such, it is an important part of our programming. At the same time, we recognize that email is *not* an encrypted, completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission.

Thus, we view Progress Reports as an integral part of the treatment program. If you would allow us to send you Progress Reports via *unencrypted* and thus potentially *non-secure* email messages, please check the appropriate boxes and sign this consent form below. You are **not** required to authorize the use of email and a decision not to sign this authorization will not affect your care from the Clinic in any way (other than not receiving progress emails).

(Please note that if you authorize email use, HESP and the University are not responsible for disclosures that occur because (1) you have supplied the incorrect email address, and/or (2) the email address you supplied is shared or otherwise available to others.)

I consent to, and authorize the use of, unencrypted email when communicating Progress Reports with me and other authorized individuals as follows (check all that apply):

- Email address that we may use to send Progress Reports to you:

- Email address that we may use to send information to an individual (if any) whom you have authorized to receive Progress Reports: _____

I understand that I am responsible for notifying the Clinic if these email addresses change.

Printed Name of Patient: _____

Printed Name of Parent/Guardian: _____

Signature

Date

YOU MAY REFUSE TO SIGN THIS FORM

----- CLINIC USE ONLY -----

- Yes, email addresses shown above have been verified using the NATO phonetic alphabet.
Verified on _____ (date)
Verified by: _____ (Clinic personnel)

BILLING POLICY (Required Form)

Diagnostic evaluations are scheduled for three-hour time slots and billed at a flat rate (call for Fee Schedule). **Full payment is due at the time of the appointment.** Cancellations must be made more than 24 hours in advance of the scheduled testing date. Clients who cancel diagnostic appointments with less than 24 hours notice will be billed a \$75.00 fee.

Speech therapy fees are billed on a semester basis and are calculated based on the number of sessions per week multiplied by the weeks of service. The weekdays and times identified for you are reserved for the entire semester. Full payment is due on or before the first day of therapy unless specific alternate arrangements are made with the clinic office manager or clinic director.

LEAP preschool tuition is billed on an annual basis. The tuition covers the academic year from September to May. The summer program is billed separately. Full payment is due on or before the first day of therapy unless specific alternate arrangements are made with the clinic office manager or clinic director.

Cancellations: Clients are responsible for paying for every scheduled session. Any sessions cancelled by clients (whether for vacation or illness) are not subtracted from the semester bill. Attempts will be made to arrange make-up sessions at times mutually convenient to both the client and clinician. However, if a make-up session cannot be scheduled, the client will be billed for the cancelled session.

If your clinician cancels a session for any reason or the University of Maryland in College Park closed for severe weather conditions, it is the clinician's responsibility to provide a make-up session. If a mutually convenient date is not available, then the clinic will refund the charge for that therapy session.

LEAP cancellations Unavoidable cancellations due to weather are built into the program. For each full day that LEAP is cancelled beyond 3 days, an additional instructional day will be added to the end of the academic year. For days in which we have delayed openings, or early dismissals, we will have an abbreviated schedule in which we provide therapy only.

Insurance: Our clinic does not participate with any insurance plan (including Medicaid and Medicare). Payment is expected at the time that services are provided.

We encourage clients to investigate the possibility of insurance coverage for speech-language services. However, please note that clients are responsible for paying their bill according to the terms of their payment agreement contract and then requesting reimbursement from their insurance provider. Clients should request that their insurance company reimburse them directly. We cannot guarantee that any of our services are eligible for coverage and reimbursement from your insurance plan. We will provide you with a receipt at the end of your visit (or the semester for Speech clients) with diagnosis codes and service codes for you to submit to your insurance company on your own. If the insurance company sends a direct payment to the clinic, we will return it to the insurance company to be re-issued, to refund the client.

Financial hardship: If individual clients are experiencing financial hardship with payment of clinic fees, they may request consideration for a discount based on a sliding fee scale. Proof of income must be submitted to the clinic director, Colleen Worthington, in the form of the individuals'/family's most recent federal tax return (U.S. tax Form 1040).

Signature and Date

Yes, I read and understand the Clinic's billing policy

POLICY STATEMENT

The purposes of the University of Maryland Speech and Hearing Clinic are:

1. To provide a training facility for those students seeking to become certified speech pathologists and audiologists.
2. To provide an environment for research.
3. To provide speech and hearing services to the public.

Because the clinic is a training facility for students, services are provided to the public at a reduced cost. All students conducting clinical sessions are supervised by Speech-Language Pathologist and Audiologists licensed by the State of Maryland and certified by the American Speech and Hearing Association. The clinic operates by appointment only, and follows the academic calendar of the University of Maryland. Services of this clinic may occasionally be cancelled for professional meetings.

Since we have a commitment to provide varied experiences for students, we cannot assure you of immediate placement in our program following the initial examination. We make every effort to provide the needed rehabilitative services, but it is sometimes necessary for us to place prospective clients on a waiting list. If accepted into the program, clients are expected to maintain regular and punctual attendance. If frequent absence or tardiness occurs, we reserve the right to dismiss the client from our program. If a session is missed due to clinic emergencies, the session will be make up another time or the fee for that sessions refunded. Clients are responsible for payment of sessions they cancel.

We trust that the above policy statements will contribute toward a smooth running, pleasant experience for all those who participate in the program at the University of Maryland Speech and Hearing Clinic.



Authorization for Release of Records from the University of Maryland

Patient Name: _____ DOB: _____

I hereby consent to the release of any and all hearing, language, and speech records for the individual named above to:

Name / Agency: _____

Address: _____

Name / Agency: _____

Address: _____

This information pertains to assessment and treatment by the Speech and Hearing Clinic, University of Maryland, College Park.

Signature: _____ Date: _____

Name: _____

Relationship To Patient _____

Witness: _____

FOR CLINIC USE ONLY – REPORTS TO BE MAILED

Report(s) _____ Reports(s) Date _____ Supv. Sig. _____ Sent _____ Sec _____

Notification of Use of Protected Health Information for Fundraising Purposes

We hope you appreciate the wonderful service you receive from our clinic! We would like to be able to reach out to you in the future both to evaluate your experiences here, and to be a supporter of the clinic. This would allow us to continue providing these valuable services to others in the community who need them.

With that in mind, this form is a courtesy notification to inform you that the administrative staff of the University of Maryland Hearing and Speech Clinic within the Department of Hearing and Speech Sciences and associated development officers of the College of Behavioral and Social Sciences may use your contact information (which constitutes protected health information) for fundraising purposes **in support of the University of Maryland Hearing and Speech Clinic ONLY.**

The health information that we may use for fundraising purposes includes:

- Patient demographic data (name, address, phone/email, date of birth, age, gender, etc)
- Dates of patient services
- General type of department from which the patient/client received services (Speech or Hearing)
- Information about the clinical faculty who supervised your services

This information will only be used to identify and contact you regarding opportunities to support the University of Maryland Hearing and Speech Clinic.

The health information that we will not use or disclose are as follows:

- Health insurance status
- Outcome information
- Diagnosis
- Nature of services
- Treatment

If you do not wish to receive any fundraising information from the University of Maryland Hearing and Speech Clinic, it is your right to opt out of any and all solicitations. If you wish to opt out, please check to box below and provide your name and date; otherwise thank you for your time and consideration.



I do NOT wish to receive fundraising information from the University of Maryland Hearing and Speech Clinic.

Printed Name: _____

Signature: _____ Date: _____