Center for Speech and Language Disorders

Therapy that makes a difference

Main Office: 310-D S. Main St. • Lombard, IL 60148
Phone: 630-652-0200 ** Fax: 630-652-0300
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Chicago site: 820 N. Orleans St., Ste 208
Phone: 312-335-0453

Application for Scholarship/Fee Adjustment
Center for Speech and Language Disorders

Please complete all pages of this form and return with copies of the first page of your **latest tax return documents** (e.g. Form 1040) to be considered for scholarship/fee adjustment. Please note completion of this form does not in any way guarantee you or your child will receive financial assistance. You will be notified as soon as possible if you are eligible.

Return form to: Center for Speech and Language Disorders
310-D S. Main Street
Lombard, IL 60148

Your Name ___________________________________ Child ________________________
Relationship to Child ____________________________
Address ____
Phone Numbers____
E-Mail ____

Please check the program you are applying for:

1. The total cost for the **Language to Literacy Program** is as follows:
   Supply Kit: $200 (includes binder, books, materials, incentive items, etc.)
   Tuition $2600 (equals 20 sessions at $130.00 per session)

2. The total cost for the **Leap into Literacy Program** is as follows:
   Supply Kit: $200 (includes binder, books, materials, incentive items, etc.)
   Tuition $2600 (equals 20 sessions at $130.00 per session)

3. The total cost for the **Social Communication Program** is as follows:
   Supply Kit: $200 (includes binder, book, materials, sensory items, etc.)
   Tuition $2600 (equals 20 sessions at $130.00 per session)

4. The total cost for **Clinic Therapy** is as follows:
   Per Session Rate: $130 per session X number of sessions attended

What amount do you believe you can contribute? _______________

5. Are you or a responsible adult able to provide transportation for your child to and from therapy? _____Yes _____No

Parent or Guarantor #1:
Relationship to patient: ☐ self ☐ child ☐ spouse
Name: ____
Employer: ____
Insurance Coverage : ____
Major Medical Coverage :____

Parent or Guarantor #2:
Relationship to patient: ☐ self ☐ child ☐ spouse
Name: ____
Employer: ____
Insurance Coverage: ____
Major Medical Coverage: ____
Annual Gross: ______________________ Amount Net : _____________________
Number of Children: at home _________ outside home _______________

6. Please check the box to indicate what insurance company your child has, if any:

- ☐ BlueCross BlueShield
- ☐ Medicaid
- ☐ Other ________________________
- ☐ Policy Number ________________________ Group Number ____________________
- ☐ My child is not covered by insurance

7. Please list if there any other financial hardships/commitments that affect your ability to afford this program that you feel we should know about.

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____

8. Are you willing to commit to spending 15 – 30 minutes for 3 – 4 nights per week working with your child to maximize your child's progress?

____ No. List Reason(s):
____
____ Yes. List Reason(s):
____

9. Additional Comments:

____
____
____
____
____
____

Thank you for applying for financial assistance at Center for Speech and Language Disorders.

- ☐ I certify that all my answers are correct and true to the best of my knowledge.
- ☐ I have enclosed a copy of my most recent tax return documents.

Signature ____ Date ______________

Print Name _______________________________________

For Office Use Only – Do Not Write Below this Line

Date Application Received: ________________

Tax Return Documents Included ____________

Date Reviewed _________________________

- ☐ Application Approved for $_________ Scholarship
- ☐ Application Approved for $_________ Fee Reduction for a total per session rate of $_____
- ☐ Application Denied for ____

Director's Signature _________________________________ Date_______________________