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 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, utilizing a full range of up-to-date equipment and materials. Students and family members may observe most therapy sessions through observation facilities. We encourage family members to participate in therapy sessions when appropriate. As part of our therapy services, an individualized home program is designed for each client to assist in maintaining skills acquired during treatment sessions. The Clinic also provides speech, language and hearing screenings to several community programs.

WHEN? Therapy appointments are 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.) over a period of nine weeks of an academic quarter. These appointments are 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, a single session 2-3 hours in length, are scheduled throughout the quarter. With very few exceptions, prospective clients are required to complete an evaluation appointment at our clinic prior to their eligibility for therapy. Typically, clients are evaluated in one quarter and are enrolled in therapy the following quarter, prioritized by clinician training needs, client availability, and other program factors.

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? The clinic provides speech therapy services to the community at no cost. Donations are welcome. Checks are accepted at the reception desk, and can be made out to “CSUEB”. Materials fees are assessed for some activities.

For further information or to initiate a referral, contact the clinic at (510) 885-3241.
APPLICATION FOR CLINICAL SERVICES

<table>
<thead>
<tr>
<th>Client First Name:</th>
<th>Client Last Name:</th>
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Date of birth: _____ / _____ / _________ ___
Age: Sex: □ Male  □ Female

Person to contact regarding this application:

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<tr>
<th>□ Client Contact Info</th>
<th>□ Parent/Spouse/Caregiver/Other Contact Info</th>
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<td>Address:</td>
<td>Name:</td>
</tr>
<tr>
<td>Apt.</td>
<td>Relationship:</td>
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<tr>
<td>City:</td>
<td>Do you have legal authority to sign documents and communicate on behalf of the prospective client?</td>
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<tr>
<td>State:</td>
<td>□ Yes  □ No  □ I don’t know</td>
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<td>Zip:</td>
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Please check the main/preferred phone number(s) below:

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<th>□ Home:</th>
<th>□ Cell:</th>
<th>□ Work:</th>
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Email:

Address:

Apt.

City:

State: Zip:

Language(s) spoken in the home:

For child client, name of school, city, and district:

Child client’s grade and/or special day class placement:

**Speech and Language Information** - Why are you seeking services at this time? Please use the box below. In your own words, what are the concerns about the client’s ability to speak, use or understand language, produce speech sounds, or interact with others? Please include any behavioral concerns.
Has the prospective client had any previous speech, language or hearing **evaluations?**
☐ Yes   ☐ No

Has the prospective client had any previous speech, language or hearing **treatment?**
☐ Yes   ☐ No

If **YES** to either of the questions above, please provide the information below:

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<tr>
<th>Provider</th>
<th>Dates of Service</th>
<th>Outcome/Recommendations</th>
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Does the client have a history of chronic ear infections or any chronic illnesses related to hearing or the ear?
☐ No ☐ Yes – Please provide details below:

Is there any family history of communication difficulties?
☐ No ☐ Yes – Please provide details below:

Please add any information you feel is important:
(Examples include relevant medical information, education, social history, etc.)
Medical Information

Primary Doctor:  
Phone:  

☐ Private Practice  or  ☐ Facility – Name:  

Address:  

City, State and Zip:  

Does a specialist care for the client? (e.g., neurologist, ENT specialist?)  ☐ No  ☐ Yes; see below  

Name:  
Area of Specialty:  

Address:  

City, State and Zip:  
Phone:  

Food allergies:  

Medications:  

For child client

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  

For adult client

Family/Physical Information (please check)

Living alone ........................... ☐ yes  ☐ no  
Walking ................................. ☐ Independent  ☐ needs assistance  
Personal Care*  ....................... ☐ Independent  ☐ needs assistance  
*Appropriate use of toilet  

Last Grade completed:  
Where currently/last employed:  

How did you hear of our clinic?  

Has the client been seen by our clinic before?  ☐ No  ☐ Yes – Please provide the date range below:  

Ex: October 2012 to June 2014  

Advance Beneficiary Notice of Non-Coverage for Medicare Enrollees

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 Medicare regulations as an approved Medicare service provider.  

☐ I have read the Fee Schedule and understand the fees required for Evaluation as well as Therapy services.  
I also understand that the clinic is unable provide services eligible for Medicare reimbursement.  

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.
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.

REVOCATION - 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.

REDISCLOSURE - 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:

Speech-language evaluation and/or therapy preparation.

__________ 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.