



**Robert E. Asker Scottish Rite
Speech Therapy Center For Children
www.scottishritespeech.org**

Application for Services

Because of the Center's commitment to privacy, this application cannot be filed electronically. Please print this form and mail the completed form to the Center.

- A. Does your child have Medicaid for speech therapy? Yes No
If no, continue. If yes, discontinue this application and call the Center at 258-9132 for assistance.
- B. Does your child have speech therapy insurance benefits? Yes No
If no, proceed to "F" below.
- C. Do you know what your speech therapy co-pays and deductibles are? Yes No
If no, please check with your insurance company.
- D. Do you have written proof of denied speech therapy benefits from insurance? Yes No
- E. Would paying insurance speech therapy co-pays/deductibles be a financial hardship? Yes No
- F. **Statement of Financial Hardship:** *(Please use page 2 of this application, if needed.)*

The Scottish Rite Speech Therapy Center for Children is a charity under the provision of IRS rule 501 c 3. Donations are tax deductible as allowed by law. Donations of all sizes are encouraged and are welcome at all times.

- G. Are you interested in learning more about donation options available to you at the Scottish Rite Speech Therapy Center for Children? Yes No

Date: _____ Name of Child: _____ DOB: _____

Parent(s): _____ and _____ Home #: _____

Mom's Cell: _____ Dad's Cell: _____ Other # _____

Address: _____ Referral Source: _____

Please continue on page 2.

Statement of Parent Concern: During daily activities, is your child's communication or swallowing affecting his or her development in the following areas:

(Please rate the following categories on this Communication Impact Scale[®] on a scale of 0-10, with 0 = no concern and 10 = extreme concern.)

		<u>Please circle</u>	<u>Comments</u>
A. Social?	Yes/No	0 1 2 3 4 5 6 7 8 9 10	_____
B. Emotional?	Yes/No	0 1 2 3 4 5 6 7 8 9 10	_____
C. Educational?	Yes/No	0 1 2 3 4 5 6 7 8 9 10	_____
D. Quality of Life?	Yes/No	0 1 2 3 4 5 6 7 8 9 10	_____
E. Health & Safety?	Yes/No	0 1 2 3 4 5 6 7 8 9 10	_____
F. Independence?	Yes/No	0 1 2 3 4 5 6 7 8 9 10	_____
G. Pain?	Yes/No	0 1 2 3 4 5 6 7 8 9 10	_____

This is the end of your application.

Please mail to:

SCOTTISH RITE SPEECH THERAPY CENTER FOR CHILDREN

Attn: Cindy Neff

PO Box 2094

Bismarck, ND 58502-2094



If you have questions or concerns about your application, please call 258-9132 and leave your name and phone number on the Center's voicemail. Your call will be returned.

This space is for additional comments if needed.

FOR BOARD USE ONLY

Candidate for Scottish Rite (Circle one) YES NO

Board Member's Signature: _____ Date: _____

Candidate for Scottish Rite (Circle one) YES NO

Board Member's Signature: _____ Date: _____