FSU | L.L. SCHENDEL SPEECH & HEARING CLINIC
COMMUNICATION SCIENCE & DISORDERS

Application for Adjusted Payment

Please provide bank statements from the last 2 months to process your application. Without this information a determination cannot be made.

The following is to be completed for the person seeking a scholarship/fee reduction for Speech or Language services.

Date_____

Client Name_____ Birth date_____

Parents/Guardian (IF applicable)_____

Address_____

Telephone (h)_____(w)_____(C)_____

Number of People in Household_____

Monthly Gross Income

Head of Household $_____ Secondary (spouse, child support, etc.) $_____

Itemized Deductions & Monthly Expenditures

1. Medical (doctor visits, copays, prescriptions, medical supplies, etc.)$_____
2. Dependent Care $_____
3. Home Health Care $_____
4. Education $_____
5. Mortgage or rent $_____
6. Utilities (Electric, gas, water, phones) $_____
7. Car payment(s) $_____
8. Insurance (health, car, life) $_____
9. Emergencies in past calendar year $_____

I certify that the information contained herein is true and correct to the best of my knowledge. The clinic is authorized to verify the information shown on this application.

Signature of Applicant_____Date_____

Clinic Personnel Only

File Number_____

Diagnosis_____

Final disposition per reimbursement committee_____

Approved by_____

Expiration Date_____