# North Dakota Scottish Rite Language Center

**Section I** **Date Received**

| **Name of Child** | | | |
|---|---|---|---|
| | | | |
| **Last** | **First** | **Middle** | |
| **Residence of Child** | | | |
| | | | |
| **Street Address** | **City** | **State** | **Zip** |
| **Phone Number** | | | |
| (        ) | | | |

| **Age:** | **Sex:** | **Birth date:** |
|---|---|---|

| **Name of Father** | | | |
|---|---|---|---|
| | | | |
| **Last** | **First** | **Middle** | |
| **Address** | | | |
| | | | |
| **Street Address** | **City** | **State** | **Zip** |
| **Phone Number** | | | |
| (        ) | | | |

| **Name of Mother** | | | |
|---|---|---|---|
| | | | |
| **Last** | **First** | **Middle** | |
| **Address** | | | |
| | | | |
| **Street Address** | **City** | **State** | **Zip** |
| **Phone Number** | | | |
| (        ) | | | |

| **Name of Legal Guardian if different from above** | | | |
|---|---|---|---|
| | | | |
| **Last** | **First** | **Middle** | |
| **Address** | | | |
| | | | |
| **Street Address** | **City** | **State** | **Zip** |

| **Phone Number** |
|---|
| (        ) |

| **Has your child been evaluated?** | **Yes / No** |
|---|---|
| **If yes, give therapist/location where evaluation took place:** | |

| **Was therapy recommended?** | **Yes / No** |
|---|---|
| **Why?** | |

| **Has previous treatment been received?** | **Yes / No** |
|---|---|
| **If yes, give name of service organization and approximate dates of therapy:** | |
| | |

| **How did you find out about this Language Center?** |
|---|
| |
| |

**Section II**

**THIS SECTION TO BE COMPLETED BY APPLICANT'S PARENT(S) OR LEGAL GUARDIAN**

| **Name of dependent children:** |
|---|
| **Ages:** |

| | **Father/Legal Guardian** | **Mother** |
|---|---|---|
| **Name of Employer:** | ________________ | ________________ |
| **Address of Employer:** | ________________ | ________________ |
| | ________________ | ________________ |
| **Date employed** | ________________ | ________________ |
| **Exact kind of work** | ________________ | ________________ |
| **(Circle one)** | **Full time / Part time** | **Full time / Part time** |
| **Present take home pay in** | **$**________________ | **$**________________ |
| **Each check. (Circle one)** | **Weekly / Bi-Monthly** | **Weekly / Bi-Monthly** |
| **Give yearly income from any Other source. Indicate source.** | **$**________________ | **$**________________ |
| | ________________ | ________________ |
| **Total taxable income According to last year's tax return** | **$**________________ | **$**________________ |

| **List assets of both parents or legal guardian (excluding home and automobile)** |
|---|
| |

| **Do you rent your principal residence?** | **Yes / No** |
|---|---|
| **Monthly rental payment $** | |

| **Do you own your own home?** | **Yes / No** |
|---|---|
| **Monthly mortgage payment $** | |

| **Is this child covered for Speech Therapy by Insurance or Medical Assistance?** | **Yes / No** |
|---|---|
| | |

| **If there is coverage by both parents employers, indicate both companies** |
|---|

**Father's Insurance Company:** **Name of Company**______________________________
**Policy Number**______________________________

**Mother's Insurance Company:** **Name of Company**______________________________
**Policy Number**______________________________

| **Are you responsible for a Deductible?** | **Yes / No** |
|---|---|
| **If yes, how much $ / %** | |

| **Are you responsible for a Co-payment?** | **Yes / No** |
|---|---|
| **If yes, how much $ / %** | |

| **Is there a maximum to your Co-payment?** | **Yes / No** |
|---|---|
| **If yes, how much $ / %** | |

| **Do you presently owe for any medical treatment for this child not covered by insurance?** | **Yes / No** |
|---|---|
| **If yes, indicate amount $** | |

| **Have there been any other medical bills in the family recently?** | **Yes / No** |
|---|---|
| **Remarks:** | |
| | |

| **Please list here any other family situations or debts or obligations not mentioned above which affect your ability to pay for therapy at regular commercial rates:** |
|---|
| |
| |
| |

**Signed**______________________________**Father**

**Signed**______________________________**Mother**

**Signed**______________________________
**Legal guardian or other person or institutional authority legally in control of child**

**Section III**

| **CONDITIONS OF APPLICATION** |
|---|
| **PARENT(S) OR LEGAL GUARDIAN – READ CAREFULLY** |

**Application is hereby made for the treatment of the above-named children at the North Dakota Scottish Rite Language Center. Acceptance of the children for evaluation and/or treatment if upon the conditions, and with the consents in this application stated.**

**I (We) hereby agree as follows:**

**(1) To bring the child to the Center for treatment and parent/adult relative/legal guardian to stay and observe until therapy is over.**
**(2) To waive and relinquish any and all claims or liabilities against the Language Center, their associated, affiliated, appendant or parent bodies.**

(3) **That the report of the therapist who examined the child named herein to determine <u>"was therapy recommended?"</u> may be furnished to and examined by the Scottish Rite Language Center to assist them in determining whether this application should be approved.**

(4) **Further, in connection with the treatment of said child, I hereby consent and authorize: Photographing or televising, and the use, publication and distribution thereof, of the child's therapy or procedures to be preformed, or the results accomplished, for educational purposes or public relations, provided the child's identity is not revealed unless expressly authorized in writing.**

**ALTERING THIS APPLICATION IN ANY WAY WILL RESULT IN DISAPPROVAL**

**Signed______________________________________________________________Father**

**Signed______________________________________________________________Mother**

**Signed______________________________________________________________**
**Legal guardian or other person or institutional authority legally in control of the child**

**Section IV**

**Therapist's recommendations/comments:**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Signature of**
**Therapist_______________________________________________________Date__________________________**

**Section V**

**ACTION OF BOARD OF DIRECTORS OR PRESIDENT**

**Date____________________ Approved_________________________Disapproved_________________________**

**Reason if disapproved____________________________________________________________________________**

______________________________________________________________________________

**Signature__________________________________________________________________**
**Language Center Board President**

**Please mail application to:**

**Masonic Center**
**1405 3rd St. No.**
**Fargo, ND 58102**