SJSU | CONNIE L. LURIE COLLEGE OF EDUCATION

**Kay Armstead Center for Communicative Disorders**
Dept. of Communicative Disorders and Sciences
One Washington Square, San José, CA 95192-0079
Clinic (408) 924-3679 · Fax: (408) 924-3641
Web: www.sjsu.edu/cds/clinic · E-mail: armstead-center@sjsu.edu

Council on Academic Accreditation
ACCREDITED | Speech-Language Pathology

Dear Prospective Client/Family,

Thank you for your interest in the **Kay Armstead Center for Communicative Disorders (KACCD)**. The **KACCD** is a nonprofit community clinic that has been serving the speech, language and hearing needs of individuals of all ages for over 50 years. The mission of the center is to provide excellent support and services for our clients while enhancing the training of our speech-language pathology student clinicians. The **KACCD** provides services for speech, articulation, language delays and disorders, aphasia, brain injury rehabilitation, social pragmatics, fluency/stuttering, accent modification, voice disorders, transgender voice therapy, augmentative and alternative communication (AAC), hearing, and more.

The **KACCD** is a training facility for students enrolled in the Communicative Disorders and Science Program. Supervision is provided at all times by fully licensed and certified clinicians with extensive experience. Clinics operate as coursework for students and therefore follow the San Jose State University semester schedule. Sessions are not offered year round. Applications for assessments are processed throughout each semester as spaces are available. Applications and invitations for treatment clinics are only offered at the beginning of each semester.

The **KACCD** is committed to the principle of equal opportunity. The University, College, Department and **KACCD** do not discriminate in the delivery of professional services or the conduct of research and scholarly activity with respect to age, citizenship, disability, ethnicity, gender-identity, genetic information, marital status, national origin, physical characteristics, race, religion, sex, sexual orientation, and veteran status.

Again, thank you for your interest in the KACCD. We look forward to serving you and your family soon.

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The KACCD follows state regulations and guidelines set by the American Speech Language Hearing Association (ASHA) for Telepractice. **T**elepractice services at the **KACCD** are conducted online through the secure and HIPAA compliant video conferencing platform **Zoom for Healthcare.** Each client will receive a meeting ID from the Clinical Educator that is password protected.

**HOW TO APPLY FOR TELEPRACTICE SERVICES**

1. Complete the ***Telepractice Application for Child Speech and Language Services*** that is attached to this letter. Email the application to the KACCD email address and our clinic will contact you with further details about your application status.

   KACCD email address: armstead-center@sjsu.edu

2. Mail or fax additional reports, such as IEP's, previous reports from other facilities, and past medical history information that will help us better serve your child to the KACCD:

   Kay Armstead Center for Communication Disorders

   Dept of Communicative Disorders & Sciences

   1 Washington Sq.

   San Jose, CA 95192-0079

   Fax number: (408) 924-3641

3. Most clients will require a comprehensive evaluation at the KACCD prior to receiving an invitation to treatment clinics. At the discretion of the Clinic Director, exceptions to the assessment requirement are made for clients who provide a comprehensive evaluation report from another provider.

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# TELEPRACTICE APPLICATION FOR ADULT SPEECH AND LANGUAGE SERVICES

**Date of Application:**___/___/___

## Client Information:

**Name:**_____ **Date of Birth:** (month/day/year)

Last Name First Name Middle Initial

**Gender:**_____ **Place of Birth:**_____

**Primary Language Spoken at Home:**_____

**Address:**_____ **Preferred Phone:(**___**)**_____

_____ **Other phone: (**___**)**_____

**Who referred you?**_____

**Reason for Referral/Evaluation:**_____

**Name of Person Completing Application:**_____

**Relation to Client:**_____

## Medical History:

**Doctor Name:**_____ **Phone:** _____

**Hospital or Facility Name:** _____ **Phone:** _____

**Please describe any injuries, traumas, or hospitalizations the client has experienced.**

| |
|---|
| |

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**Has the client had any surgeries? Yes_____ No_____**
**If yes, please list and provide the date and reason.**

| |
|---|
| |

**Does the client have any chronic illnesses (seizures, convulsions, fainting, asthma, allergies, etc.) Please list and describe.**

| |
|---|
| |

**Has the client had a hearing evaluation? Yes_____ No_____ Location:_____**

**Does the client have a hearing loss? Yes_____ No_____**

**Describe the findings and recommendations of the evaluation. Please provide a copy of the evaluation.**

| |
|---|
| |

**Does the client take any medications? Yes _____ No_____**

**Please list each medication and the reason for taking below.**

| |
|---|
| |

**Please indicate which devices the client uses. Check all that apply:**

**Glasses_____ Hearing aids_____ Braces/Retainer_____ Other_____**

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**Check all that apply of your technology equipment and support for the online sessions at home:**

| | | | |
|---|---|---|---|
| **Laptop/Desktop (with webcam):** | ❑ **YES**<br>❑ **NO** | **Tablet with webcam (type: e.g. iPad):** | |
| **Smartphone with webcam (type: e.g. iPhone):** | | **High speed internet:** | ❑ **YES**<br>❑ **NO** |
| **Quiet place free of distractions:** | ❑ **YES**<br>❑ **NO** | **Adult ready to assist client during telepractice session (s):** | |

## Emergency Contact:

**Contact Name: _____ Relationship to Client: _____**

**Emergency Contact Phone Number: _____**

## Service History:

**Has the client ever been evaluated by a speech and language pathologist? Yes _____ No_____**
**(Please provide a copy of the report)**

**Name of therapist: _____ Location: _____**

**What recommendations were given? Please explain below.**

| |
|---|
| |

**Has the client ever received speech and language services? Yes _____ No _____**

**What recommendations and goals were given? Please explain below.**

| |
|---|
| |

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**In the space below, please provide any additional information and/or concerns regarding the client's speech, language, and/or hearing problem.**

**Is there anything else you would like us to know?**

## Contact Permissions: Please initial

**_____I do NOT consent to having specific information (identification in regards to therapy/assessment, time and date of appointment) relayed in voicemail, text or email**

**_____I give permission to leave messages with specific information (identification in regards to therapy/assessment, time and date of appointment) in the following methods:**

**Preferred Phone:_____ Email:_____**

**Signature of Self/Parent/Guardian:_____**

**Print Signature:_____ Date:_____**