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
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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 CHILD 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:_____

Case History:

Mother/Guardian:_____ **Lives with child? Yes_____ No_____**

Last Name First Name

Primary Language: _____ **Highest Grade or Degree Completed:**_____

Address (If different from child address):_____

Preferred Phone:_____ **Other Phone:**_____

Email:_____

Father/Guardian:_____ **Lives with child? Yes_____ No_____**

Last Name First Name

Primary Language: _____ **Highest Grade or Degree Completed:**_____

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Address (If different from child address):_____

Preferred Phone:_____ **Other Phone:**_____

Email:_____

Siblings:

Name:	Date of Birth:	Speech/Hearing Disabilities? (Explain)	Lives with client?

Educational/Social History:

Current School/Daycare:_____ **Grade:**_____

Language(s) Spoken at School/Daycare:_____

Have teachers mentioned concerns regarding speech, language, social skills, or education? If so, please explain:

Does the child receive special services at home or school? If so, which type and how often? (Please provide copy IFSP/IEP)

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How does the child behave at school? Please describe if there are difficulties with specific subjects.

In any setting, how does the child behave when socializing with other children?

Interests/Hobbies:

Organizations in which child participates:

<u>Check all that apply of your technology equipment and support for the child's online sessions at home:</u>

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

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Birth History

Delivered Premature: _____ Full Term:_____

Describe any complications with pregnancy and/or delivery:

Developmental History

Primary Language:_____ Spoken % of the day:_____

Secondary Language:_____ Spoken % of the day:_____

At what age did your child master the skills below? (please be as specific as possible)

Sat without support:		**Said 3-5 words:**	
Began to say single words:		**Put 2 words together:**	
Said sentences of 3 words:		**Followed 1-step directions:**	
Followed 2-step directions:		**Told a story with 3+ parts:**	

Approximately how many words are in your child's vocabulary? _____

Does your child understand what you say without gestures? Yes_____ No_____

At what age did you notice a communication issue with your child?_____

Have other people or family members noticed the issue as well? Yes_____ No_____

Please explain:

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Please provide any additional information and/or concerns regarding the child's development including speech, language, hearing, attention, and/or motor development.

Medical History:

Pediatrician or Doctor Name:_____ Phone: _____

Hospital or Facility Name: _____ Phone: _____

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

Has the child had any surgeries? Yes_____ No_____

If yes, please list and provide the date and reason.

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

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

Does the child have a hearing loss? Yes_____ No_____

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

Does the child take any medications? Yes _____ No_____

Please list each medication and the reason for taking below.

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

Glasses_____ Hearing aids_____ Braces/Retainer_____ Other_____

Service History:

Has the child 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 child 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 child'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:_____

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CLIENT CONSENT FOR TELEPRACTICE

- **Initial _____ I give permission to leave messages with specific information (identification, in regards to therapy/assessment, time and date of appointment) in the following methods:_____**
- **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 e-mail.**
- **Initial_____I understand that "telepractice" includes diagnosis and treatment using interactive audio, video, or data communications. I understand that telepractice also involves the communication of my medical information, both orally and visually.**
- **Initial_____ I understand that if invited to participate in telepractice, I am responsible for providing the necessary computer, telecommunications equipment (camera and microphone) and internet access for my child's telepractice sessions.**
- **Initial_____I understand that for certain patients, an adult facilitator will be required to be present in the room for assisting with technical difficulties, or keeping a patient on task.**
- **Initial_____I understand that there are benefits, risks, and possible consequences associated with telepractice, including, but not limited to, the possibility, despite reasonable efforts on the part of KACCD, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons. I have read and understand the information provided above and have had my questions answered to my satisfaction. I have read this document carefully, and understand the risks, benefits, and my rights related to telepractice and I am hereby electively giving my informed consent to participate in a telepractice service through KACCD under the terms described herein. I hereby state that I have read, understood, and agree to the terms of this application.**

Signature of Parent/Guardian:_____ Date:_____

Preferred phone:_____ Other phone:_____

Email:_____

5/10/2020

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