Speech, Language & Hearing Center
Towson University-8000 York Road-Towson, MD 21252-0001
Voice or TDD: 410-704-3095 - Fax: 410-704-6303

TOWSON UNIVERSITY

REDUCED FEE APPLICATION

Eligibility for reduced fee status is based on individual and/or family income, expenses, medical bills, etc. and number of people in the home. Please complete both sides of this form, sign and date where indicated. Use the space on the other side to provide any additional information that may help us in determining your eligibility for reduced fees.

CLIENT NAME_____ CLIENT D.O.B._____

PARENT(S) _____ CLIENT S.S.N._____

ADDRESS_____ ZIP_____

CELL PHONE_____HOME PHONE_____ WORK PHONE_____

GROSS MONTHLY INCOME $_____ SOURCE (Salary, pension, SSI, etc.) _____

ADDN'L MONTHLY INCOME $_____ SOURCE_____

Please attach as proof of income a copy of most recent income tax form 1040, 1040A, Social Security or SSI award letter.
This application will not be processed without proof of income.

RENT/HOUSE $_____/month GAS/ELECTRIC $_____/month

TELEPHONE $_____/month FOOD & GROCERIES $_____/month

LOAN/CHARGE ACCT. $_____/month STORE/BANK CREDIT CARD_____ OTHER_____

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MEDICAL/DENTAL/HOSPITAL EXPENSES $_____ (Total) MEDICATIONS $_____/month

HEALTH INSURANCE COMPANY_____ POLICY#_____

MARYLAND MEDICAL ASSISTANCE #_____ EXP. DATE_____

ALL INFORMATION IS KEPT STRICTLY CONFIDENTIAL.

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OTHER FAMILY MEMBERS IN THE HOME - ADULTS

NAME	RELATIONSHIP TO CLIENT	GROSS MONTHLY INCOME	INCOME SOURCE

OTHER FAMILY MEMBERS IN THE HOME – CHILDREN

NAME DATE OF BIRTH	NAME DATE OF BIRTH
NAME DATE OF BIRTH	NAME DATE OF BIRTH
NAME DATE OF BIRTH	NAME DATE OF BIRTH
NAME DATE OF BIRTH	NAME DATE OF BIRTH

If client is known to Social Services, please provide:

Case Worker Name _____ Phone_____

FORM COMPLETED BY: (Please print)

_____

SIGNATURE X_____DATE_____

RELATIONSHIP TO CLIENT _____

Once a client qualifies for a reduced fee, the reduced fee applies to ALL clinical services (audiology, speech-language pathology, occupational therapy) for one year. After one year, the client (or client's family) can re-apply for reduced fees. Please sign below that the above information is true and correct to the best of your knowledge.

Signature X _____ Date_____