Scott F. McLaughlin Speech and Hearing Clinic
100 N. University Drive
Edmond, OK 73034
405-974-5705

Attached you will find the application for financial assistance. Please provide one or more of the forms listed to give written documentation of the income you earn/receive from a salary, rental property, or from a government agency. The amount of assistance given is determined by a sliding scale based on your total household income and the number of people in your family.
The information we collect is confidential and will not be shared with other agencies or departments.
We strive to ensure that our services are accessible and affordable to anyone that qualifies for intervention. We will re-evaluate your need each year before the fall semester.
After we review your application, we will meet with you and institute a payment plan.

* Paycheck stub (a copy will suffice).
* Copy of your most recent W-2 form
* Copy of income tax return for the most recent year or quarter.
* Copy of Social Security award letter.
* Copy of letter awarding food stamps.
* Copy of an award letter for any government support
* Letter signed by an employer (on company letterhead) stating how much you make and how often you receive that payment
* Forms approving or denying unemployment compensation or worker's compensation
* Signed letter that states you are not receiving any income and why. If you have been employed during the past year, please send a copy of your paycheck stub or letter from your former employer.
* Bank statement showing direct deposits from social security, paycheck deposit, or any other deposits from income earned.

University of Central Oklahoma
Scott F. McLaughlin Speech and Hearing Clinic
Sliding Fee Discount Application

Client:_____

Address:_____

City:_____ State:_____ Zip:_____

Head of Household:_____

Place of Employment:_____

Occupation:_____

Name	Date of Birth	Name	Date of Birth
Self		Dependent	
Spouse		Dependent	
Dependent		Dependent	
Dependent		Dependent	

Total number in household:_____

Fee Adjustment Information: (All Fields Required)

Source	Self	Spouse	Other	Total
Gross wages, salaries, tips, etc				
Income from business, self-employment, and dependents				
Unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income				
Interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household and other miscellaneous sources				
Total Income				

I certify that all the information shown above is true and correct to the best of my knowledge.

Print Name:_____

Signature:_____ Date:_____

Clinic Use Only:

Evaluation normal fee: $_____

Adjustment Level:_____

Adjusted Fee: $_____

Therapy normal fee: $_____

Adjustment Level:_____

Adjusted Fee: $_____