

UNIVERSITY of **HOUSTON**

Presents:

Pre-School Social Skills (PSS) Group

Fall and/or Spring

Speech & Language Therapy Program

at the

University Speech, Language and Hearing Clinic:

A United Way Agency

ENROLLMENT PACKET



PSS meet twice weekly for three hours each session.

Tuesday & Thursday 9 AM – 12 noon

For Children ages 2 years to 5 years of age

Call 713-743-0915 for further enrollment information



United Way of Greater Houston

UNIVERSITY of HOUSTON

Pre-School Social Skills (PSS) Group **2016 Fall and/or 2017 Spring Program Packet**

We are excited that you are considering our Pre-School Social Skills Group for fall 2016 and/or spring 2017. Our goal is to provide quality and intensive social language treatment for your child.

The Pre-School Social Skills Group provides intensive social language stimulation children ages two to five years that demonstrate at-risk for or already diagnosed with a social communication disorder. The treatment teams for the program include parents, graduate clinicians in the Communication Disorders department, and Clinical Educators who are licensed and certified speech-language pathologists and a family support specialist.

The environment of the program allows parents to get hands on training on how to best meet the needs of their children. The parents can observe the therapy through a one-way mirror or interact directly with their child with coaching from the graduate clinicians. Parents also have an opportunity to talk with other parents in an informal setting through parent workshops.

The Pre-School Social Skills Group is an Early Childhood program designed to improve social communication development in a nurturing environment while helping the children develop joint attention, imitation, and toy play skills. This early intervention program integrates a relationship-focused developmental model with well-validated teaching practices including Social Thinking, Hanen and Greenspan Floortime along with other evidence based approaches.

PSS meets two times a week (Tuesday and Thursday) for three hours (9am to 12pm). PSS has a maximum enrollment of four children with a 1:1 adult to child ratio.



APPROXIMATE DATES:

Fall semester: September to November (before Thanksgiving)

Spring semester: mid-January to end of April. A week for spring break in March (calendar will typically coincide with UH and HISD) will be observed.

Specific dates will be available at the beginning of each semester.

FEES:

- Tuition is \$2400 per semester plus a \$25 supply fee for each semester.
- A \$250 deposit is required to hold a place for your child each semester. This deposit will be applied to the total tuition.

A sliding scale based on financial information is available for qualifying families. Full tuition is due on the first day of therapy.

Please contact the front office for your billing needs. 713-743-0915.

TESTING:

If you have recent speech and language evaluations/progress report or pediatrician reports, please include them with the forms in this enrollment packet. This information will provide us with a better understanding of your child's speech and language, social communication, and medical needs.

Fax to 713-743-2926, please.



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Checklist of items to submit for PSS

2016 Fall and/or 2017 Spring Program Registration Packet

Client Name: _____

- Enrollment Form
- Client Contact Information Form
- Photo Policy Form
- Observation Release
- Emergency Contact Information Form
- Contract for Services
- Method of Payment Form
- All About Me Page
- \$250 deposit to hold a spot
- For New Clients:
 - Previous speech/language testing reports
 - Case History form

Please complete forms and return to:

University Speech, Language and Hearing Clinic PSS

100 Clinical Research Center,

Houston Texas 77204-6018

Office: 713-743-2898 Fax: 713-743-2926

email: sbourgeois-clark@uh.edu

Enrollment Applications will not be accepted once the program enrollment slots are filled. Submit your child's enrollment packet and deposit early to preserve a space for your child in PSS.

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2016-2017 PSS Program Enrollment Form

Client's name: _____

Date of Birth: _____

Parent's Name: _____

Home Phone: _____ Work/Cell: _____

Address: _____

Email: _____

How did you hear about USLHC?

Please write two specific communication goals for your child:

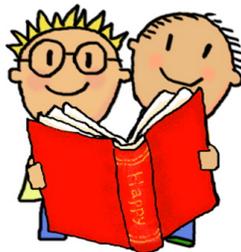
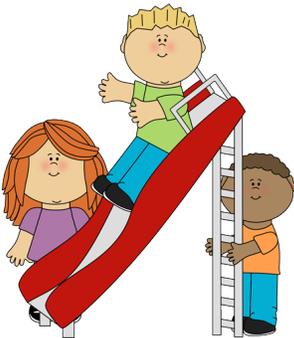
1.

2.

Are there any days or weeks that you will miss due to vacations or other events?

If so, specify: _____.

Please submit any evaluations completed that would give us a better understanding of your child and his/her medical history and language skills.



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Client Contact Information/ Información de Contacto del Cliente

(client name)/(nombre del cliente)

(guardian name/relationship)/(nombre del tutor/relación con el cliente)

(guardian name/relationship)/(nombre del tutor/relación con el cliente)

(street address)/(dirección)

(city, state, zip)/(ciudad, estado, código postal)

(home phone)/(teléfono de casa)

(work phone)/(teléfono de trabajo)

(cell phone)/(teléfono móvil)

(email)/(correo electronico)

Date/Fecha

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Photo Policy: USLHC PSS may use any photo, slide, or quote for publicity/marketing purposes.

Please initial _____

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Observation Release

As you know, the University Speech, Language, and Hearing Clinic: *A United Way Facility* is a training facility of the Department of Communication Sciences and Disorders.

For training purposes, students in the department may observe treatment or assessments. The purpose of observations is to enhance the student's education. Observations are also required by our accrediting agency.

Also, because of the way our observation room is arranged, there may be other families observing at the same time you are observing. You need to know that others may be in the observation room, but only you and the supervisor may observe your family member.

The purpose of this form is to ensure that you understand that we cannot always provide the most confidential environment for assessment and treatment. We do the best we can, given the physical limitations.

I have read and understand that:

1. treatment/assessment may be observed by a Communication Sciences and Disorders student.
2. there may be other individuals in the observation room while I am observing a session.

Signature

Date

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Emergency Information Form

The University Speech, Language and Hearing Clinic personnel ask that you provide the following information to be kept on file at the clinic. In the event that you experience a medical emergency during your clinic visit, this information will be supplied to the medical emergency team.

The university's procedures for responding to a medical emergency are as follows. The UH Police Dept. (UHPD) will be called and, in turn, send medical emergency personnel to the clinic to provide assistance. UHPD can be reached by dialing 911.

Date Submitted: _____

Name: _____

Physician's Name: _____

Address: _____

Physician's Phone #: _____

Current medical conditions: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Allergies: _____

Medications I currently take:

Name of Medication	Amount
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

In the event of an emergency, please notify:

(Name)

(Relationship to Client)

(Phone number)

Other information I would like the clinic staff to have regarding my medical condition:

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Contract for Service

TO WHOM IT MAY CONCERN:

I understand that the University Speech, Language, and Hearing Clinic provides treatment by students who are supervised by university personnel. These students are required to accumulate a minimum number of hours of clinical experience for credit toward their degree in Speech-Language Pathology. Therefore, they must depend upon your promptness and regular attendance. If more than 2 unexcused absences occur, the client's treatment sessions will be suspended and it will be necessary to place the client on the waiting list for enrollment consideration the following semester.

Thank you for your cooperation.

Signature

Date

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Method of payment

_____ Amount of payment

_____ \$250 Deposit for each semester

_____ \$25 Materials Fee

___ Cash

___ Check number

___ Credit card

Account number: _____

Expiration date: _____

Signature of cardholder: _____



All About Me

Please complete this form with your child.

Name: _____

During the day, I _____.

My favorite activities are _____.

I learn best when _____.

My speech teacher's name is _____.

I see her/him ___ time(s) a week to work on my _____.

I like to snack on _____.

I am allergic to _____.

When I am happy, I _____.

When I am upset, I _____.

At home, I play _____.

I have (few many) friends. We like to play _____.

My hobbies are _____.

The pets I have are _____.

Please tell any more information or draw a picture on the back.