KU THE UNIVERSITY OF KANSAS

Schiefelbusch Speech-Language-Hearing Clinic
1200 Sunnyside Avenue
2101 Haworth Hall
Lawrence, Kansas 66045
(785) 864-4690

Fee Schedule 2022

Name_____ Date_____

The Schiefelbusch Clinic is a self-sustaining, non-profit agency staffed by students in training and clinical faculty who are certified by the American Speech-Language-Hearing Association. The Schiefelbusch Clinic accepts third party reimbursements. Please speak with the office manager to initiate third party reimbursement process. Proof of income may be required for fee discounts on the sliding scale. We have a limited number of scholarships available for children under the age of 18. Please obtain a scholarship application from the office manager. Please let us know if you have special circumstances that require consideration. We are not a Medicaid provider.

Payment for Services- Please select correct tier based on family size and income	☐ INSURANCE	☐ TIER 1	☐ TIER 2	☐ TIER 3
AAC assessment includes report	$375	$375	$375	$375
Post AAC Assessment Training	$110	$110	$45	$25
Assessment: Student Speech-Language-Pathologist	$200	$200	$200	$200
Individual Intervention	$100/session	$100/session	$40/session	$20/session
Group Intervention	$30/session	$360/ semester	$220/ semester	
Early Connections	----------	$480/ semester	$300/ semester	
Language Acquisition Preschool	----------	$800/ semester	$675/ semester	

2021 Federal Poverty Guidelines (FPG)

Family Size	TIER 1> 450% of FPG	TIER 2 300-450% FPG	TIER 3<300% FPG
1	>$57,961	$38,641-$57,960	$38,640
2	>$78,391	$52,261-$78,390	$52,260
3	>$98,821	$65,881-$98,820	$65,880
4	>$119,251	$79,501-$119,250	$79,500
5	>$139,681	$93,121-$139,680	$93,120
6	>$156,111	$106,741-$156,110	$106,740
7	>$180,541	$120,361-$180,540	$120,360
8	>$200,971	$133,981-$200,970	$133,980

To determine tier level, identify total family size matched with total income level. For example, a family of 4 with a total annual income of $65,000 would identify with TIER 3.

Signature_____

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Updated 12/2021

On the reverse side of this form is the fee schedule for the Schiefelbusch Speech-Language-Hearing Clinic. If you have any questions about the fee schedule please contact your clinical faculty member. In an effort to clarify how to fill out this form, please refer to the following list of methods of payment that will be considered.

1. Insurance: If you or your child are covered by insurance that will be the first method of payment. If you have insurance you are not eligible for the sliding scale or scholarships for ANY portion of your fees, including co-pays or deductibles.

2. Sliding Scale: If you do not have insurance or your insurance company denies our services, you can utilize the sliding scale to pay for services. Please be sure to complete the reverse side of this form. The sliding scale applies discounts based on your household income level and the Federal Poverty Guidelines.

3. Scholarship: If you have insurance that we accept and pays for our services, then you are not eligible to apply for a scholarship. After you have been attending and paying for services for one semester, you become eligible to apply for a partial or full scholarship for up to a maximum of 4 semesters. After 4 semesters of receiving scholarship, you must pay for 2 semesters (sliding scale applies) before you are again eligible for a scholarship. If you would like to apply for scholarship, you may obtain a scholarship application from our website: www.splhclinic.ku.edu. The Sliding Scale discounts cannot be combined with scholarships.

Payment plans are available. Please contact your clinical faculty member or the Schiefelbusch Clinic Office Manager to set-up a payment plan.

Please complete the following information and provide a copy of your insurance card, front and back:

Primary Insurance

Insurance Company: _____
Group Name: _____
Policy Holder's Name: _____
ID Number: _____
Group Number: _____
Policy Holder's Date of Birth: _____

Secondary Insurance

Insurance Company: _____
Group Name: _____
Policy Holder's Name: _____
ID Number: _____
Group Number: _____
Policy Holder's Date of Birth: _____

By my signature below, I am indicating that I have read and understand the fee agreement on the previous page and the guidelines presented above. I confirm that if I have insurance I have provided that information above. I confirm that if I don't have insurance or if insurance doesn't cover services at The Schiefelbusch Clinic, I have indicated the accurate level that the clinic should bill me based on my income and the Federal Poverty Guidelines. This agreement will be in effect for the _____ semester.

Signature_____