BISMARCK SERTOMA CLUB
SPEECH AND HEARING ASSISTANCE FORM

Name: ________________________________ DOB: ________________

Parents: ____

Address: ____

Phone Number: ____

Number of Siblings and Ages: _________________________________

Diagnosis: ____

PARENTS EMPLOYER: Father: ___________________________________
Telephone Number: ___________________________
Monthly Income: _____________________________
Mother: _____________________________________
Telephone Number: ___________________________
Net Monthly Income: _________________________

Medical Insurance and Policy Number: _________________________

DO YOU OWN YOUR OWN HOME: Yes _____ No _____

MONTHLY PAYMENT: $_______________

DO YOU HAVE A SAVINGS ACCOUNT: Yes _____ No _____

MONTHLY EXPENSES:

____
____
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____
____
____
____

DESCRIBE YOUR FINANCIAL NEED:

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____
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____

DOES YOUR CHILD RECEIVE SPEECH THERAPY IN THE SCHOOL SETTING?

Yes ______ No ______

HAVE YOU COMPLETED A SCOTISH RITE APPLICATION?

Yes ______ No ______

SCHOOL ____

PARENT SIGNATURE: ____

DATE: ____________________