Policy on Fee Adjustment and Fee Installment Programs

Fee Adjustment Program (FAP)

1. The Fee Adjustment Program provides general, minimum requirements for a fee adjustment review for clients at the H.A. Leeper Speech and Hearing Clinic.
2. The FAP provides a discount to clients at the H.A. Leeper Speech and Hearing Clinic that applies to a client's self-pay charges for services rendered based on yearly/monthly income and family size.
3. Thorough and consistent guidelines for the FAP will ensure that all clients who request a fee adjustment are treated in a fair and equal manner.
4. The FAP must not duplicate existing government and community support programs. Families should access available community services before submitting an application.
5. The application for FAP must be submitted and approved before the service is purchased or received.
6. The H.A. Leeper Speech and Hearing Clinic ability to fund eligible applications depends on the availability of funds. The amount of the discount may vary, based on cost of the item or service.
7. All sources of income must be declared and supporting documentation provided.

Fee Installment Program (FIP)

1. All client's requesting financial assistance may also request participation on the clinic's Fee Instalment Program.
2. Client receiving **Speech and Language Services** are subject to the following payment schedule.

1. **First** week of therapy	**50 %** of total amount billed
2. **Fifth** week of therapy	**25 %** of the remaining amount
3. **Last** week of therapy	**Remaining balance**

3. Clients receiving **Audiology and Hearing Services** will work directly with the front desk program asssistant staff or clinic manager to develop an appropriate payment schedule.

APPLICATION PROCEDURES

1. Complete the FAP application form. All sections must be completed or marked with N/A if it does not apply to you or your family.
2. Sign and date the application.
3. Provide a copy of your most recent **Notice of Assessment(s)** from the Canada Revenue Agency.
4. If you are receiving any assistance please provide a copy of your most recent cheque stub or statement of benefits, for example Tax Benefits, Ontario Works, Assistance to Children with Severe Disabilities (ACSD), Ontario Disability Services Program (ODSP) Special Services At Home (SSAH), Veterans Affairs Canada (VAC), Workplace Safety & Insurance Board (WSIB) or any others.
5. If no income is declared, provide a letter stating how expenses are being met in the absence of any income.
6. All income will be verified annually for clients who are eligible for the Fee Adjustment Program.
7. Completed applications with supporting documentation will be accepted in person, by mail or email.
8. The Clinic Manager will review the application and communicate the final decision within one week of the date the application was received.

For questions or further information on service fees please contact Romina Yepiz, Clinic Manager by phone at 519.661.2111 Ext. 87680 or by email at Ryepiz@uwo.ca.

Fee Adjustment Application

Contact Information:

Client's Name: _____ **Date:** _____

Name of parent/legal guardian (if applicable): _____

Mailing Address: _____

City: _____ **Prov.:** _____ **Postal Code:** _____

Home Number: _____ **Cell Number:** _____

Email Address: _____

Best way to contact you: ☐ Home Phone ☐ Cell Phone ☐ Email

Please select the clinic service type from the options below:

☐ Audiology Services: (e.g. Initial assessement, earmolds, hearing assessment, etc.)
Specify: _____

☐ Speech and Language Services (e.g. individual or group therapy, voice, fluency, neuro, LSVT, etc.)
Specify: _____

Household Composition:

Name	Relationship	Age	Monthly Income	Currently Employed?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

Household Monthly Total $_____

Government Funding and Services

Please include all assistance you/your family is receiving: (Monthly Amount)

Ontario Works $_____
Tax Benefits $_____
Assistance to Children with Severe Disabilities (ACSD) $_____
Ontario Disability Services Program (ODSP) $_____
Veterans Affairs Canada (VAC) $_____
Workplace Insurance Workplace Safety & Insurance Board (WSIB) $_____

Government Funding and Services (Continued)

Please include all assistance you/your family is receiving: (Monthly Amount)

Other:_____ $_____

Other:_____ $_____

Other:_____ $_____

If you do not receive Ontario Works have you applied?	Yes ☐	No ☐	Not eligible ☐
If you do not receive Tax Benefits have you applied?	Yes ☐	No ☐	Not eligible ☐
If you do not receive ACSD have you applied?	Yes ☐	No ☐	Not eligible ☐
If you do not receive ODSP have you applied?	Yes ☐	No ☐	Not eligible ☐
If you do not receive VAC have you applied?	Yes ☐	No ☐	Not eligible ☐
If you do not receive WSIB have you applied?	Yes ☐	No ☐	Not eligible ☐

Has your family work status or income changed over the past year? Yes ☐ No ☐

If yes, provide details below and how this impacts your financial situation.

_____

_____

_____

_____

I am also interested in the Clinic's Fee Installment Program. Yes ☐ No ☐

Signatures:

I certify that the information provided on this application is true, correct, and complete to the best of my ability.

Client's Signature: _____ Date: _____

Parent/Guardian/Substitute Decision Maker _____ Date:_____

Please provide a copy of your most recent Notice of Assessment(s) from the Canada Revenue Agency and copies of your most recent cheque stub or statement of benefits for all active benefits.

Thank you for completing the application.
The Clinic Manager, Romina Yepiz, will be contacting you within one week of the date the application was received.

Front Office Use ONLY

Reviewed date:_____ Signature:_____

Approval Type: _____

Criteria and eligibility are subject to change without notice by the H.A. Leeper Speech and Hearing Clinic.