



Every child has something to say

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SEE LOGO+



About 1 in 10 children aged 3–6 experiences speech, language, or communication difficulties.

~1 in 10 – consistent across national studies. CDC / NCHS NHIS: 10.8% of U.S. children ages 3–6 with a voice, speech or language disorder (2012; reaffirmed NIDCD, 2025). RCSLT (UK): more than 10% of children with speech, language and communication needs. Speech and Language UK, 2023: 1.9M UK children behind with talking and understanding.

~1.6M

U.S. children ages 3–6 with a speech or language disorder

CDC / NCHS, National Health Interview Survey, 2012 · 10.8%

~40%

of affected U.S. children received no intervention in the past year

CDC / NCHS, NHIS, 2012 · Data Brief 205, Fig. 5

79%

of U.S. school-based SLPs report more job openings than job seekers

ASHA, 2024 Schools Survey

OUR STORY

The problem started at home.

“What should we do with our child today?”

The gap wasn't another therapy session. It was everything between sessions.

OLGA KUNO • MAX KUNO — FOUNDERS



SOLUTION

LOGO+ tells families what comes next.

Personalized speech-development activities that adapt to each child's progress — not another exercise library to search.

AN EXERCISE LIBRARY

The parent searches for content.

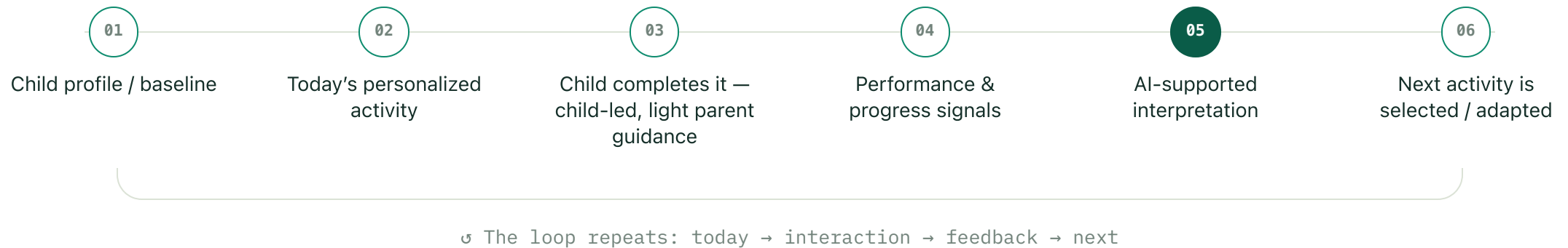


LOGO+

The pathway guides what comes next, based on the child's progress.

PLANNED MVP CAPABILITY

Every activity helps decide what the child should do next.



Built on a professional speech-language framework. LOGO+ supports speech-language professionals — it does not replace them.

The adaptive layer is a planned MVP capability, to be validated.

Personalization is the product — not a feature.

SIGNALS IN

- activity completion
- accuracy & attempts
- pace
- progress over time
- parent-reported ease



INTERPRETED

- where the child is on the pathway
- what's working
- what's too hard
- what to reinforce next



NEXT ACTIVITY CHANGES

- difficulty
- focus skill
- sequencing
- — adapted to that child

Why not static rules: every child's path differs, it shifts week to week, and the skill-and-activity space is large. **Where the expertise lives:** the speech-language framework, the content, the safety guardrails. **Where defensibility can come from:** accumulated progression data, refined adaptation logic, the two-way home-professional loop.

Rules can start it; learning from real progression is what makes it better over time. Architecture to be defined; capabilities to be validated.

Three shifts make an adaptive home pathway possible now.

01

SLP CAPACITY CONSTRAINTS

The specialist workforce cannot absorb demand. Families wait — and practice stalls between visits.

79% of U.S. school-based SLPs report more job openings than job seekers. ASHA, 2024 Schools Survey.

02

SUPPORT HAS MOVED BETWEEN SESSIONS

Care increasingly happens between appointments — but families have no system for the days in between.

03

AI + SPEECH TECHNOLOGY

Content can now move from static libraries toward progression that adapts to each child.

From finding exercises → knowing what comes next.

A global problem — validated first where we can move fastest.

GLOBAL PROBLEM

~50M children aged 3–6 worldwide experiencing speech, language, or communication difficulties.

LOGO+ estimate based on UN WPP 2024 × ~10% prevalence proxy · ~1.6M in the U.S. alone (CDC / NCHS, 2012).

INITIAL VALIDATION MARKET

Ukrainian families — direct access to families and speech professionals, faster iteration, a real early-user base.

A starting point, not the company's ceiling.

LONG-TERM SCALE

English-speaking markets, with the U.S. as a primary expansion opportunity, alongside selected Central and Eastern European (CEE) language markets.

→ English-speaking markets / U.S. & UK

→ CEE-language markets

No immediate U.S. launch.

Planning model (LOGO+ internal, not a published market figure): ~1.6M U.S. children × ~\$234 / yr planning ARPU ≈ ~\$375M need-based value. Full methodology in appendix.

BUSINESS MODEL

Recurring subscription — pricing to be validated.

DIRECT TO PARENT

\$15 / mo Basic

\$25 / mo Personalized

THERAPIST-CONNECTED

\$40 / mo

Home practice linked to a therapist's goals, with progress shared back.

\$19.50 blended monthly ARPU — planning assumption (mix 70 / 20 / 10), not observed customer behavior. Pricing hypothesis, to be validated.

20

PARENT INTERVIEWS

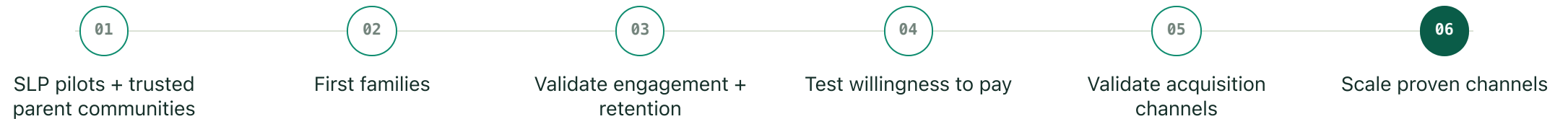
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SLP INTERVIEWS

Parents don't need more information. They need to know what to do next.

Customer discovery – not traction. LOGO+ has no launched product, revenue, or paying customers yet. The initial MVP is founder-funded.

Start where trust already exists.



Begin with the people families already rely on. Prove the daily loop works. Then scale only the channels that pay back.

No paid acquisition at scale before the product is validated.

COMPETITION

Others provide content. LOGO+ guides progression.

	ONE SPECIFIC NEXT ACTIVITY	ADAPTS TO CHILD PROGRESS	THERAPIST-CONNECTED	CLOSED HOME-PROFESSIONAL FEEDBACK LOOP
Speech Blubs / Pro	Partial	No	Yes	Partial
Otsimo Speech Therapy	Yes	Partial	No	No
Kokolingo	Yes	No	Partial	Partial
Articulation Station	Partial	No	Yes	Partial
LOGO+ — planned MVP	Yes	Yes	Yes	Yes

Competitor capabilities per publicly described product features. LOGO+ column = planned MVP, not shipped features.

Lived insight + clinical depth + operating execution

OK

Olga Kuno

CO-FOUNDER, PRODUCT

- Lived problem insight
- Product validation
- Strategy + partnerships

—

TECHNICAL CO-FOUNDER

- 8 yrs as Staff Engineer at a language-learning startup that became a unicorn
- Built its adaptive speech AI — live transcription, language assessment (grammar, fluency, vocabulary, pronunciation), progress tracking, personalized recommendations and practice
- Production STT / LLM / TTS at scale — hundreds of live prompts, custom cost-optimized models, hundreds of lessons an hour
- Engaged under NDA, building the MVP with us now; named to investors under NDA, identity public at pre-seed close

MK

Max Kuno

CO-FOUNDER, CEO

- 10+ yrs leading companies & startups
- Operating model
- Scale

IK

Inna Kuprikova

LEAD SPEECH & LANGUAGE EXPERT

- 15+ yrs in speech therapy
- 300+ developed exercises
- Professional framework + content

THE ASK

\$300K

PRE-SEED

To turn a working MVP into a validated, adaptive product.

Self-funded MVP → initial validation → \$300K pre-seed

DEEPEN

Product + adaptive AI

PROVE

Engagement, retention, willingness to pay

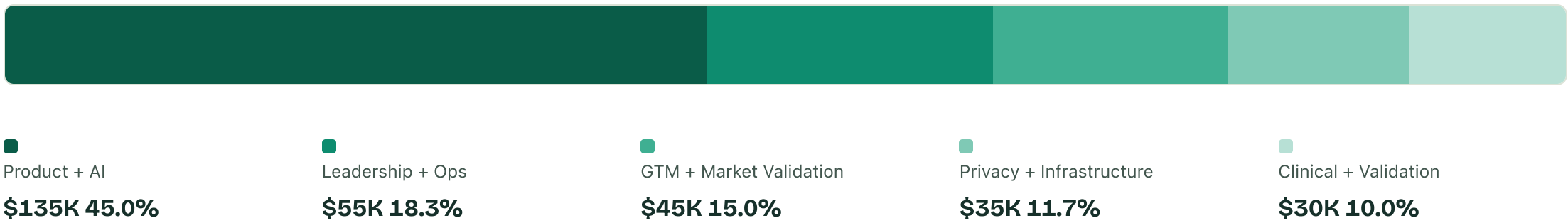
PREPARE TO SCALE

Repeatable GTM + international expansion path

Appendix

USE OF FUNDS · ROADMAP · MARKET METHODOLOGY · SOURCES

\$300K — allocated for the next stage, not the first MVP.

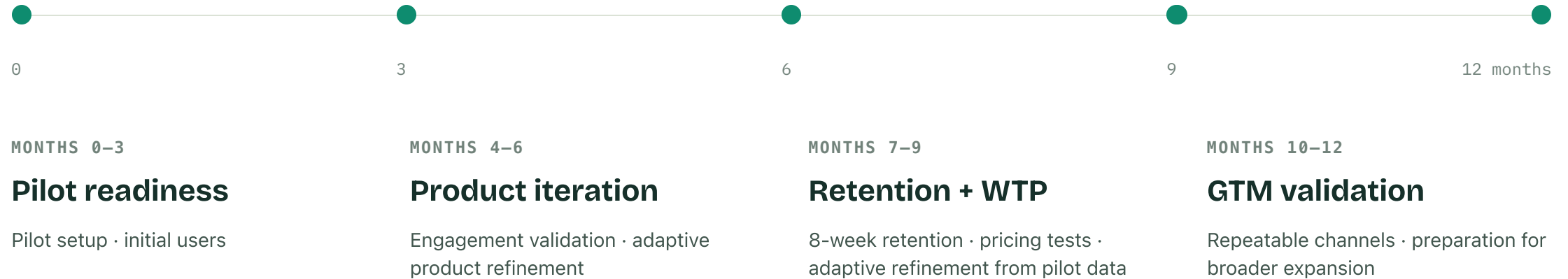


Product + AI (\$135K) — not the base MVP (founder-funded). The next technical stage: adaptive personalization, progress interpretation, recommendation / adaptation logic, iteration from pilot data, relevant speech technology, scalable infrastructure.

GTM + Market Validation (\$45K) — acquisition experiments, early pilots, partnerships, willingness-to-pay testing, channel validation, early CAC / payback learning. Not large-scale advertising before product-market fit.

135 + 55 + 45 + 35 + 30 = 300 · allocation per current LOGO+ plan.

12 months: from pilot-ready to expansion-ready.



Starting point: founder-funded MVP. Future milestones – not achievements. Sequencing subject to pilot learnings. No committed U.S. launch date.

External evidence vs LOGO+ internal model.



This is a LOGO+ extrapolation, not a published worldwide prevalence figure.

EXTERNAL POPULATION EVIDENCE	LOGO+ ESTIMATE & INTERNAL MODEL
— U.S. ages 3–6: 10.8% ≈ 1.6M — CDC / NCHS NHIS, 2012; reaffirmed NIDCD, 2025 — Intervention gap: 59.8% of affected U.S. children ages 3–6 received services → ≈ 40% did not — CDC / NCHS NHIS, 2012 — DLD: 7.58% of children aged 4–5 — Norbury et al., 2016 (SCALES, n = 7,267, England). Narrower condition; contextual only — Context: 317M children (0–19) worldwide live with a developmental disability (broad umbrella) — WHO–UNICEF, 2023	— Planning ARPU: \$19.50 / mo → \$234 / yr (70%×\$15 + 20%×\$25 + 10%×\$40) — assumption, to be validated — ~1.6M U.S. children × \$234 ≈ ~\$375M need-based value — internal bottom-up model, not a published TAM — Illustrative: 10,000 paying families ≈ 0.6% of the U.S. pool → ~\$2.34M ARR

Prevalence studies concentrate in high-income countries; identification practices vary internationally.

Sources, definitions & limitations.

TOPIC	SOURCE · YEAR · POPULATION	LIMITATION
01 DLD prevalence	Norbury et al., J. Child Psychol. Psychiatry (SCALES) · 2016 · children 4–5, England	Single-country cohort; narrower condition (DLD only) — contextual, not the basis for the 1-in-10 figure
02 Prevalence (~1 in 10)	CDC / NCHS NHIS — 10.8% of U.S. children ages 3–6 (2012; NCHS Data Brief 205, 2015; reaffirmed NIDCD, 2025). RCSLT (UK) — >10% of children with SLCN. Speech and Language UK, 2023 — 1.9M UK children behind with talking & understanding. CDC NHIS 2019–21 — ~1 in 10 U.S. children (3–17) with a diagnosed developmental disability.	No 2020s U.S. survey isolates speech / language prevalence in this age band; ~1 in 10 is a convergent estimate, not one published worldwide figure. U.S. 2012 data parent-reported.
03 Intervention gap	CDC / NCHS NHIS, 2012 (Data Brief 205, Fig. 5) · U.S. children 3–6	Parent-reported; 2012 survey
04 Global DD context	WHO–UNICEF, Global Report on Children with Developmental Disabilities · 2023 (2019 data) · 0–19 worldwide	Broad umbrella — not speech / language specific
05 Global child population	UN Population Division, World Population Prospects 2024 · world, ages 3–6	Model-based estimate
06 SLP workforce	ASHA, Schools Survey · 2024 · U.S. school-based SLPs	Self-reported by respondents
07 Clinical content	LOGO+ Lead Speech & Language Expert · 2026	Internal; 15+ yrs practice, 300+ exercises
08 Pricing / ARPU / mix	LOGO+ internal planning · 2026	Assumption, not validated; no customers
09 Market model	LOGO+ bottom-up (population × ARPU) · 2026 · U.S. need-based pool	Internal model, not a published TAM
10 Global estimate	LOGO+ calculation: UN WPP 2024 population aged 3–6 × approximately 10% prevalence proxy; rounded to ~50M	Extrapolation from available prevalence evidence; not a published worldwide count; identification practices vary internationally

Blue = external evidence. Amber = internal planning assumption.