VERIFICATION GUIDELINES FOR CHILDREN WITH DISABILITIES

Technical Assistance Document

Nebraska Department of Education
Special Education Office
September 2008

Verification Guidelines for Children With Disabilities
Technical Assistance Document

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Introduction

INTRODUCTION

The purpose of this technical assistance document is to provide assistance to multidisciplinary evaluation teams as they assess each child who is referred for an evaluation to determine if he/she is a child with a disability and in need of special education services. Nebraska state law declares, "The board of education of every school district shall provide or contract for special education programs and transportation for all resident children with disabilities who would benefit from such programs." Neb. Rev. Stat. 79-1127

The verification of children with disabilities is one of the most important aspects of both federal law and state special education regulation. It is important that children who need special education services receive them. The verification process is the means for determining those children who are in need of special education services.

The development of this document has involved much research, discussion, planning and development by many parents, educators, administrators, and Nebraska Department of Education Special Education Office staff during the past several years. The process began in the late 1990's when discussions were initiated to develop a verification process that would be a decision-making process by the multidisciplinary evaluation team (MDT) rather than simply a decision based on standardized testing.

Committee History

On October 17, 2000, Gary Sherman, NDE Director of Special Education sent a letter to the following 24 special parents and educators across Nebraska inviting them to serve on a Verification Criteria Steering Committee to determine children eligibility for special education. The following members served on that committee: Julia Allen, Sharon Bloechle, Denise Burbach, Linda Comfort, Kim Cooper, Paula Daharsh, Linda Douglas, Teresa Frields, Gladys Haynes, Linda Jespersen, Theresa McFarland, Kyle McGowan, Barb Newell, Kathy Peterson, Sandy Peterson, Russell Pierce, Margie Simineo, Charlene Snyder, Jeff Stec, Brenda Tracy, Stan Vasa, Cinde Wendell, Jim Werth, and George Young.

In his initial letter, Gary reminded members that the verification criteria were originally developed in 1987 and have seen only minor modifications since that time. He stated that the steering committee would determine if verification criteria should remain in Rule 51 or should be considered for inclusion in a technical assistance document, which could provide guidance for multidisciplinary evaluation teams.

The first meeting of the Verification Criteria Steering Committee was held on November 6, 2000. During this meeting, the committee determined some common beliefs about verification, as follows:

"To best serve Nebraska children with disabilities and their families, our verification system must. ..." (Ideal)

- Meet individual needs of all children; verify appropriately
- Lead to appropriate services
- Be consistent from district to district and be consistent over time for individual children
- Early identification is essential (children don't have to fail before identification, but also efforts are made to try to keep them in assisted general education before pulling them out to special classes)

"Our current verification system..." (Real)

- Disproportional identification of certain groups
- Deficit-driven model
- Too reliant on standardized testing
- Inflexibility of entire process

"In order to go from Real to Ideal, we must..."

- Identify a process that results in meaningful information for the instructional process
- Provide training for functional evaluation process, training of teachers, parents, and administrators
- Allow for flexibility and professional judgment
- Provide opportunity for regular education and special education to work together in development of verification process

"The purposes of verification criteria should be..."

- Determine eligibility and establish criteria
- Identify strengths and weaknesses
- Protect children from misidentification
- Provide blueprint for intervention/remediation

Following this meeting and discussion, a survey was mailed to each committee member requesting them to rate the relative importance of each item in an ideal system and status of each within the current Nebraska verification criteria. Results of the survey were discussed at the committee's next meeting on January 25, 2001. Those items identified by committee members as most important to Nebraska were as follows:

- Identifying children requiring special education
- Assuring early discovery
- Applying criteria consistently across the state
- Yielding instructionally relevant data
- Identifying strengths

During the next committee meeting on March 6, 2001, the committee came to consensus on the following purposes of verification criteria:

The purposes of the special education verification criteria in Nebraska are to enable the MDT team to:

- Identify those children with disabilities, who require special education programs and services;

- Identify children at the earliest point at which such services are needed and appropriate;

- Provide useful information that helps guide programs and services delivery for these children;

- Assure that both areas of strength and need are carefully considered for each child, and which also can be described in the child's present level of educational performance;

- Provide a structure that assures that these purposes meet federal and state requirements; and

- Identify any additional modifications and/or accommodations to the special education and related services needed to enable the child to meet measurable annual goals in the child's IFSP/IEP and to participate in the general curricula.

During the next meeting on May 10, 2001 the committee reached consensus on the following recommendations to be submitted to the Special Education Advisory Committee:

1. The multidisciplinary evaluation team (MDT) should be given increased responsibility, ensuring flexibility and accountability. The MDT should carry out its duties with the full participation of all MDT members. To fully implement this recommendation, training will be provided for all members of the MDT.

2. The levels of severity should be removed from the categories of Mental Handicap and Visual Impairment (i.e., MH: Mild, Moderate, and Severe-Profound and VI: Blind, Legally Blind, and Partially Sighted).

3. A Process (versus Formula) Approach should be used to determine eligibility in all disability categories. The criteria should include all steps to be considered in the child's evaluation. Specific scoring should be referred to in guidelines. Training should be provided to the Multidisciplinary Team (MDT) to assure implementation with integrity.
4. Evaluation and verification should assure that intervention would occur at the earliest point in time. Information regarding the intervention at the earliest point will be included in the technical assistance guidelines.

5. The verification criteria for children below age five should not be more stringent than the criteria for school-aged children.

6. The issue of overrepresentation of minorities in special education should be studied further and a plan developed to address such overrepresentation.

The committee further recommended that specific workgroups be selected to review the verification criteria. These workgroups will research current trends in identification and revise the criteria where necessary. The workgroups will identify elements of the verification criteria to be included in Rule 51 as well as the elements that should be included in technical assistance guidelines.

Six workgroups were formed: (1) Speech-Language Impairment and Specific Learning Disability, (2) Mental Handicap and Multiple Disabilities, (3) Behavioral Disorder, (4) Hearing Impairment, (5) Visual Impairment and Deaf-Blindness, (6) Other Health Impairment, Traumatic Brain Injury, and Orthopedic Impairment. The disability categories of Developmental Delay and Autism had recently been revised; therefore, a work group was not formed for these categories.

The two responsibilities of each workgroup were: (1) to review and revise, if necessary, Nebraska's verification criteria for determining eligibility for special education; and (2) to determine what language should be included in Rule 51 and what language should be placed in a verification guidelines technical assistance document. The members of each workgroup were as follows:

<u>Group 1 – Speech-Language Impaired and Specific Learning Disability</u>
Suzanne Baker, Ann Bird, Jan Bolliger, Mary Ells, Nancy Grimes, Paula Hopkins, Linda Jespersen, Mardell Larson, Bob Meyers, Ande Olson, Jolene Rewerts, Peg Roush, Margie Simineo, Jenise Straight, Jerry Tieger, Kelly Wanzenried, Carla Wardrobe, Beth Wierda

<u>Group 2 – Mental Handicap and Multiple Disabilities</u>
Mary BeckBest, Mike Bossard, Sig Eigenberg, Teresa Frields, Jim Havelka, David Hammond, Valerie Hammond, Jeanne Heaston, Janey Henkel, Susanna Johnston, Sue Kenealy, Kathy & Chris Olson (reviewers only), Mark Smith, Joy Stoltenberg, Elaine Werth, Sr. Deanna Wolcott

<u>Group 3 – Behavioral Disorder</u>
Dan Allison, Adria Bace, Jennifer Brockman, Jean Culey, Brenda Fletcher, Jennifer Fowler, Pam Gallagher, Linda Liebendorfer, Pat Little, Kraig Lofquist, Reece Peterson, Pam Prochaska, Susan Safarik, Paula Sharman, Bob Uhing

<u>Group 4 – Hearing Impaired</u>
Jill Bird, Mr. & Mrs. Jon Bloomquist, David Conway, Rhonda Fleischer, Robert Hill, Michelle Hoier, Mary Kay Kimmons, Diane Meyer, Ruth Mueller, Dale Robinson

Group 5 – Visually Impaired and Deaf-Blind
Pam Almon, Teresa Coonts, Marie Dougherty, Lissa Hegg, Donna Hultman, LeAnna MacDonald, Barb Remmen, Cherie Roberts, Barbara Schliesser, Julie Slaymaker, Susan Weber

Group 6 – Other Health Impaired, Traumatic Brain Injury, and Orthopedic Impairment
Jackie Anderson, Pam Brown, Mark Cunningham, Genenne Didier, Cindy Fisher, Greg Gaden, Deborah Gottner, Libby Hauser, Judy Lefeber, Donna Moss, Kathy Peterson, Mike Queen, Andy Rikli, Gina Simanek

During the first meeting of the workgroups on February 27, 2002, the following objectives for each workgroup were established:

1. Review and revise, if appropriate, the verification criteria in NDE Rule 51.

2. Identify for inclusion in the revised Rule 51 the verification process for each disability category. Identify the team membership of each MDT.

3. Identify for inclusion in a technical assistance document (guidelines) all numeric criteria, formulae, and additional recommendations to be considered in determining the eligibility of children with disabilities.

Workgroups met several times during the summer and fall of 2002. On November 19, 2002, recommendations from each of the six workgroups were presented to the Nebraska Department of Education, Special Education Office regarding the objectives established for each workgroup.

On September 13, 2006 the workgroups met again to review and make final recommendations to a draft of the technical assistance verification guidelines document. Copies of the draft technical assistance verification guidelines document were provided to participants at the fall NASES and SEAC meetings and fall 2006 NDE Regional Workshops. Recommendations and comments to the draft were received from special education providers, parents, and administrators for further refinement of the technical assistance document.

Thank you to each member of each workgroup for all their time and effort to make the verification process for children with disabilities more meaningful.

A special thank you goes to Annie Bird, a former staff member in the Special Education Office, for her diligent guidance of this work.

Technical Assistance Document Organization

This document is divided into thirteen major sections, one for each primary disability category: autism, behavior disorder, deaf-blindness, developmental delay, hearing impaired, mental handicap, multiple disabilities, orthopedic impairment, other health impairment, specific learning disability, speech-language impairment, traumatic brain injury, and visual impairment. Each of these sections is divided into the following components:

- Section 1: Introduction
- Section 2: Federal and State Definitions
- Section 3: Multidisciplinary Evaluation Team (MDT) Composition
- Section 4: Verification Guidelines
- Section 5: Procedures to Determine Adverse Effect on Development/ Educational Performance
- Section 6: Related Definitions
- Section 7: Frequently Asked Questions
- Section 8: References and Resources

For Additional Information

For more information or questions about the verification of children with disabilities, please contact the Special Education Office at the Nebraska Department of Education.

Telephone: 402-471-2471
Web address: www.nde.state.ne.us/SPED/sped.html

Identification of Children with Disabilities

Multidisciplinary Teams and Reporting to Diagnostic Data 92 NAC 51- 006

Following is the overall verification process that is included in Rule 51 for the identification of children with disabilities.

- Child Find
  - All children with disabilities, residing in the state, including children with disabilities who are homeless children or wards of the State and children with disabilities attending nonpublic schools, regardless of the severity of their disabilities, and who are in need of special education and related services, shall be located, identified, and evaluated. A practical method shall be developed and implemented to determine which children with disabilities are currently receiving needed special education and related services. For infants and toddlers, districts shall demonstrate targeted efforts to meet the needs of children from historically underserved populations, particularly minority, low-income, inner-city and rural populations, and children with disabilities who are wards of the state.
    - The child find requirements apply to highly mobile children with disabilities including migrant children and to children under the age of three who are involved in a substantiated case of child abuse or neglect; who are identified as affected by illegal substance abuse, or withdrawal symptoms resulting from prenatal drug exposure.
    - The child find requirements also apply to a child who is suspected of being a child with a disability 92 NAC 51-003.10 and in need of special education, even though the child is advancing from grade to grade.

- Within 45 calendar days after a public agency which includes the Nebraska Department of Health and Human Services and the Nebraska Department of Education and any other political subdivisions that are responsible for providing early intervention services to children and their families receives a referral concerning an infant or toddler, the school district shall:
  - Complete the multidisciplinary evaluation and,
  - Participate in an IFSP meeting.

- Student Assistance Team (SAT) or comparable Problem Solving Team
  - For a school age child, a general education student assistance team or a comparable problem solving team shall be used prior to referral for multidisciplinary team evaluation.
  - The SAT or comparable problem solving team shall utilize and document problem solving and intervention strategies to assist the teacher in the provision of general education.
  - If the child's assistance team or comparable problem solving team feels that all viable alternatives have been explored, a referral for multidisciplinary evaluation shall be completed. A referral shall include information from the SAT or

comparable problem solving team and a listing of the members of the SAT or comparable problem solving team.

- Consistent with the consent requirements in 92 NAC 51-009.08A, a parent of a child, the Nebraska Department of Education, another State agency or a local school district or approved cooperative or nonpublic school may initiate a request for an initial evaluation to determine if the child is a child with a disability.
  - The screening of a child by a teacher or specialist to determine appropriate instructional strategies for curriculum implementation shall not be considered to be an evaluation for eligibility for special education and related services.
  - The school district shall conduct a full and individual initial evaluation within 45 school calendar days from receiving consent from the parent for evaluation. A formal evaluation must be completed for each child being considered for special education and related services before the initial provision of special education and related services may be provided to a child with a disability. The initial evaluation shall determine whether a child is a child with a disability and the educational needs of the child. For infants and toddlers, early intervention services may begin prior to completion of a full and individual initial evaluation.
    - In implementing the requirements for infants and toddlers, the school district shall ensure that:
      - The evaluation is conducted in accordance with the federal and state laws.
      - The results of the evaluation are used by the child's IFSP/IEP team in meeting the requirements of a Free Appropriate Public Education.
  - School districts shall ensure, at a minimum, that the following requirements are met:
    - Evaluation and other assessment materials used to evaluate a child:
      - Are selected and administered so as not to be discriminatory on a racial or cultural basis; and
      - Are provided and administered in the child's native language or other mode of communication and form most likely to yield accurate information on what the child knows and can do academically, developmentally, and functionally, unless it is not feasible to provide or administer;
        - For infants and toddlers, tests and other evaluation materials and procedures are administered in the native language of the parent or other mode of communication, unless it is clearly not feasible to do so.
      - Are used for purposes for which the evaluations, assessments, or measures are valid and reliable.
    - Assessments of children with disabilities who transfer from one school or approved cooperative to another school or approved cooperative in the same academic year are coordinated with such children's prior and subsequent schools, as necessary and as expeditiously as possible, to ensure prompt completion of full evaluations.
    - Materials and procedures used to evaluate a child with limited English proficiency (LEP) are selected and administered to ensure that they measure

the extent to which the child has a disability and needs special education, rather than measuring the child's English language skills.

- A variety of assessment tools and strategies are used to gather relevant functional performance, developmental, and academic achievement information about the child, including information provided by the parent, and information related to enabling the child to be involved in and progress in the general education curriculum (or for a preschool child, to participate in appropriate activities), that may assist in determining:
  - Whether the child is a child with a disability; and the child's educational needs and content of the child's IEP/IFSP.
- Any standardized tests that are given to a child:
  - Have been validated for the specific purpose for which they are used; and
  - Are administered by trained and knowledgeable personnel in accordance with any instructions provided by the producer of the assessments.
    - If an assessment is not conducted under standard conditions, a description of the extent to which it varied from standard conditions (e.g., the qualifications of the person administering the test, or the method of the test administration) must be included in the evaluation report.
- Tests and other evaluation materials include those tailored to evaluate specific areas of educational need and not merely those that are designed to provide a single general intelligence quotient.
- Tests are selected and administered so as best to ensure that if a test administered to a child with impaired sensory manual or speaking skills, the test results accurately reflect the child's aptitude or achievement level or other factors the test purports to measure, rather than reflecting the child's impaired sensory, manual, or speaking skills (unless those skills are the factors that the test purports to measure).
- No single measure or evaluation tool is used as the sole criterion for determining whether the child is a child with a disability and for determining an appropriate individualized family service plan (IFSP) or individualized educational program (IEP) for the child.
- The child is assessed in all areas related to the suspected disability, including, if appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities.
- In evaluating each child with a disability, the evaluation is sufficiently comprehensive to identify all of the child's special education and related services needs, whether or not commonly linked to the disability category in which the child has been verified.
- The school district or approved cooperative uses technically sound instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or development factors.

- The school district uses evaluation tools and strategies that provide relevant information that directly assists personnel in determining the educational needs of the child.
- In interpreting evaluation data for the purpose of determining if the child is a child with a disability and the special education needs of the child, each school district or approved cooperative shall:
  - Draw upon information from a variety of sources, including aptitude and achievement tests, parent input, teacher recommendations, physical conditions, social or cultural background, and adaptive behavior; and
  - Ensure that information obtained from all of these sources is documented and carefully considered.
- Evaluation and assessment for infants and toddlers:
  - An evaluation is conducted to determine eligibility for services including determining the status of the child in each of the developmental domains.
  - After a child has been verified the district must conduct an assessment of the unique needs of the child in terms of each of the developmental areas to identify services appropriate to meet the needs of the child.

- Multidisciplinary Evaluation Team (MDT) Requirements
  - The multidisciplinary evaluation team (including the child's parents) shall be responsible for the evaluation, analysis, assessment and documentation of educational and developmental abilities and needs of each child referred for the purpose of determination of eligibility for special education. The MDT shall make all verification decisions. Documented information shall be collected to facilitate the development of a statement of present level of development and educational performance on the IFSP or IEP.
  - For children attending nonpublic schools, an administrator of the nonpublic school or a designated representative of the nonpublic school shall be a member of the MDT.
  - In making a determination of eligibility, a child shall not be determined to be a child with a disability if the determining factor is limited English proficiency, lack of appropriate instruction in math, or lack of appropriate instruction in reading, including in the essential components of reading instruction as defined in the Individuals with Disabilities Education Act of 2004.
  - If a determination is made that a child has a disability and needs special education and related services, an IFSP or IEP must be developed for the child in accordance with state special education regulations.
  - Multidisciplinary Evaluation Team Written Report (for all suspected disabilities <u>except</u> specific learning disabilities).
    - The team shall prepare a written report of the results of the evaluation. The report shall include a statement of:
      - Whether the child qualifies as a child with a disability;
      - The child's educational needs;
      - The basis for making the determination; and

- A listing of the team members.
- Each team member shall certify in writing if the report reflects his or her conclusion. If it does not reflect his or her conclusions, the team member shall submit a separate statement presenting his or her conclusion.
- A copy of the evaluation report and the documentation of determination of eligibility shall be given to the parent at no cost.

- Multidisciplinary Evaluation Team Written Report for a Child <u>with</u> a Suspected Specific Learning Disability
  - The MDT shall prepare a written report of the results of the evaluation.
  - The report shall include a statement of:
    - Whether the child has a specific learning disability based on the criteria and definition contained in 92 NAC 51-006.04K
    - The child's educational needs;
    - The basis for making the determination;
    - The relevant behavior, if any, noted during the observation of the child; And the relationship of that behavior to the child's academic functioning;
    - The educationally relevant medical findings, if any;
    - The determination of the team concerning the effects of a visual, hearing, or motor disability; mental handicap; behavior disorder; cultural factors; environmental or economic disadvantage; or limited English proficiency on the child's achievement level; and
    - If the child has participated in a process that assesses the child's response to scientific, research-based intervention then the instructional strategies used and the child-centered data collected; and the documentation that the child's parents were notified about:
      - The state's policies regarding the amount and nature of the child's performance data that would be collected and the general education services that would be provided;
      - Strategies for increasing the child's rate of learning; and
      - The parent's right to request an evaluation.
  - A listing of team members.
    Each team member shall certify in writing whether the report reflects his or her conclusion. If the report does not reflect his or her conclusions, the team member shall submit a separate statement presenting his or her conclusion.
- A copy of the evaluation report and the documentation of determination eligibility shall be given to the parent at no cost.

- For a child who after the initial MDT evaluation does not qualify for special education services or for a child with a verified disability who upon reevaluation no longer qualifies for special education services, a problem-solving team shall document a plan to assist the teacher(s) in the provision of regular education.

Source: 92 NAC 51-006.01A-006.03G

DISABILITY CATEGORY:

Autism

DISABILITY CATEGORY: Autism

SECTION 1: INTRODUCTION

These verification guidelines were written to provide parents, teachers, special education personnel, administrators, and other professionals with information on the identification, verification, and determination of eligibility for special education services for children with autism.

This category of children has been defined by both federal and state regulations. A three-part eligibility requirement for a child to be verified as a child with autism is as follows:

- Meet verification criteria (92 NAC 51.006);
- Documentation of adverse effect on educational performance;
- Determination that a need for special education is evident.

SECTION 2: STATE DEFINITION

- **Autism** -To qualify of special education services in the category of autism the child must have a developmental disability which significantly affects verbal and nonverbal communication and social interaction, is generally evident before age three, and that adversely affects a child's educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual response to sensory experiences.

  Autism does not apply if a child's educational performance is adversely affected primarily because the child has a behavioral disorder as defined in 92 NAC 51-006.04C

  A child who manifests the characteristics of autism after age three could be identified as having autism if the other criteria in 92 NAC 51-006.04B1 are met.

Guidelines Definition

In order to provide a broad base of understanding of autism and the continuum of behavioral characteristics of children with **Autism Spectrum Disorders (ASD)**, the term **Autism** will be used throughout this technical assistance guide.

Autism Spectrum Disorders (ASDs) is an umbrella term used to describe a group of lifelong neurodevelopmental disorders that affect the functioning of the brain with resultant combinations of distinct behaviors. Children with ASDs present unique neurological and behavioral characteristics. In addition, there is a spectrum of involvement within the disability group. The range of categories under ASD may include Autistic Disorder, Rett Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS).

The terms ASD and PDD are sometimes used interchangeably. PDD includes the following disorders from the Diagnostic and Statistical Manual of Mental Disorders (4th Edition), American Psychiatric Association (DSM-IV): Autistic Disorder, Rett Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder-Not Otherwise Specified (PDD-NOS).

ASDs are behaviorally defined and commonly recognized by the manifestation of behavioral characteristics across multiple areas of functioning. Characteristics are observed, to varying degrees, in social relationships, communicative competence and pattern and range of interests. Although ASDs are defined by a certain set of behaviors, children may exhibit any combination of the behaviors in any degree of severity. These characteristics are generally evident during the child's early years, and must adversely affect educational performance.

Autism is an educational verification and is a term used to facilitate early identification by public school personnel. The term Autism Spectrum Disorder can be used to verify children who demonstrate behaviors consistent with a medical diagnosis of Pervasive Developmental Disorders (PDD) from the Diagnostic and Statistical Manual of Mental Disorders (4th) Edition, American Psychiatric Association (DSM-IV). A medical diagnosis is not required in order for the child to be verified under the Autism disability category. However, medical reports and information may be considered by the MDT.

SECTION 3: MULTIDISCIPLINARY EVALUATION TEAM (MDT) COMPOSITION

The Multidisciplinary Team (MDT) should include at least the following members:

- The child's parent(s);
- A school psychologist or licensed psychologist;
- The child's teacher(s) or a teacher qualified to teach a child that age;
- A speech-language pathologist;
- A school district administrator or designated representative.

SECTION 4: VERIFICATION GUIDELINES

In order for a child to be verified as having Autism, the evaluation should include the analysis and documentation of the manifestation of developmental and educational problems exhibited in varying degrees of atypical behavior in each of the following areas:

- **Atypical development of social competence.** The child displays difficulties in social relationships.
  - The child often has difficulty establishing and maintaining reciprocal relationships with others. This may be evidenced through few quality peer relationships and a general lack of social conventions.
  - The child may rarely initiate social interactions or enjoy social games.
  - In young children, characteristics most frequently observed include lack of or limited use of gestures, eye contact, joint attention, and/or shared affect.

- **Atypical development of communication.** The child exhibits a qualitative impairment in expressive and receptive communication skills.
  - There may be an absence of spoken language, without an attempt to compensate by using gestures or other conventional forms of communication, such as eye contact, joint attention or facial expressions. This may include little response to language, echolalia, mechanical or stilted speech, pronoun reversals, and difficulty expressing emotions. Even when verbal language is age-appropriate, oddities may be observed in the communicative process and social use of language and ability to express emotions.
  - The child may demonstrate difficulties in initiating, sustaining, and/or taking turns in conversations.
  - For young children, imitative and symbolic play skills also may be delayed.

- **Atypical range of interests and patterns of behavior.** The child displays a narrow, encompassing preoccupation with objects, parts of objects, sensations, rituals, topics or routines.
  - The child may display stereotyped or repetitive body movements and/or motor mannerisms.

- The child may display an intense circumscribed interest in certain items, topic or activities, and may have difficulty changing their focus to other topics. While the specific interests may change over time, the child's narrow focus of interests tend to dominate the content of social exchanges.
- The focus or intensity of these interests and patterns is abnormal and the child may display marked distress over changes, disruption, or interference with these interests and patterns of behavior.

In addition, the following indicators may be observed in children with Autism:

- Unusual or repetitive responses to sensory stimuli. The child may exhibit these atypical responses to any or all of the following sensory modalities: sight, hearing, smell, taste, touch, balance, body awareness, and pain. The intensity of the response to these stimuli can range from unusually high levels to unusually low levels.

- Differences in the rate of cognitive skill development

- Uneven rate or out-of-sequence skill development

- Extreme or deregulated behavioral characteristics – hyperactivity, short attention span, impulsiveness, emotional outbursts, verbal/physical aggressiveness, or self-injurious behaviors

- Difficulties with judgment, as evidenced by apparent lack of danger or potential harm; or excessive and unwarranted fearfulness

- Difficulties with abstract thinking

Educational evaluation should include a combination of:

- Medical assessments, including medications

- History of developmental milestones

- Parent interviews/rating scales

- Individual achievement testing

- Classroom assessment data

- Norm-referenced testing data

- Criterion-referenced assessments

- State and District-wide assessments
- Curriculum-based assessments
- Observation and analysis of behavior
- Teacher anecdotal records
- History of interventions and response
- Analysis of academic performance of social/emotional performance

SECTION 5: PROCEDURES TO DETERMINE ADVERSE EFFECT ON DEVELOPMENT/EDUCATIONAL PERFORMANCE

FACTORS TO CONSIDER

In observing, assessing, and evaluating the child's behavioral characteristics, the following questions are to guide documentation and determination of whether the disability has an adverse effect on the child's developmental/educational performance:

Atypical Development of Social Competence

- Does the child appropriately use nonverbal communication and gestures; exhibit a smiling response; exhibit stranger anxiety; exhibit response to gestures and familiar routines; exhibit eye contact and facial responsiveness?
- Does the child follow a point or use a forefinger point with the intent of directing the attention of a peer or adult toward the object?
- Does the child show awareness of the essential components of social interactions, i.e., nonverbal and verbal communication, empathy, reciprocity, social negotiation and repair?
- Does the young child demonstrate reciprocal routines or social games such as peek-a-boo, patty-cake, or waving good-bye?
- Does the young child demonstrate age appropriate play skills including using objects for intended purpose, pretending, and/or imitating (other than scenarios from movies and cartoons)?
- Does the child demonstrate cooperative play in response to social cues and/or direct instruction?
- Does the child prefer to be alone and/or show little interest in others?
- Does the child fail to develop relationships with significant caregivers?

- Does the child have difficulty relating to others?
- Does the child attempt social interactions that are ineffective, inappropriate, and thus unsuccessful?
- Does the child exhibit giggling, laughing, or crying without identifiable reasons?

Atypical Development of Communication

- Is the child's speech echolalic?
- Does the child have difficulty using language in fluent, interactive communication?
- Does the child use nonverbal language, i.e., gestures, gestures that relate to language, and symbolic meaning of gestures?
- Is the child's use of language concrete and literal; does the child seem to be confused by words and expressions that depend on the context for meaning, such as space and time words, i.e., here/there/later; homonyms, i.e., blue/blew; pronouns, jokes, sarcasm, and figurative language?
- Does the child display loss of speech, delayed onset of speech, immature or disordered syntax, and/or articulation?
- Does the child use formal or stilted speech to communicate, i.e. addressing others formally, including people they know well, or using higher level awkward vocabulary instead of more comfortable slang or language children usually display?
- Is the child's voice quality flat or mechanical with little variation of pitch and volume?
- Does the child have difficulty using language in fluent, interactive communication?

Atypical Range of Interests and Patterns of Behavior

- Does the child use objects in idiosyncratic, stereotypic, and/or perseverative ways, and does interference with this use of objects result in expressions of discomfort and/or panic?
- Does the child exhibit awareness of the sequence of events and exhibit discomfort and/or panic when this sequence is disrupted or changed?
- Does the child have complex routines or rituals for particular activities and does the child exhibit distress if he/she is unable to carry out these routines, i.e., lining up objects,

needing to have his/her desk in the same position, following rigid routines (bed time, mealtime, getting dressed, reading a book)?

- Does the child engage in self-injurious behaviors, i.e., hair pulling, head banging, or hitting/biting parts of the body?

- Does the child exhibit stereotypic and repetitive movements of limbs or the entire body i.e., hand flapping, hand wringing, or spinning?

- Does the child demonstrate perseverative thinking, preoccupation with certain sounds, words, phrases, ideas, or does the child have difficulty switching the focus of attention?

- Does the child demonstrate a skill in a particular setting or situation or with a specific person, but have difficulty generalizing that skill to another setting, situation, or person?

- Does the child show memory for specific visual detail, facts, or rote lists, but fail to demonstrate a general understanding of the topic?

- Does the child focus on small details and demonstrate little awareness of critical elements or information?

This list is not exhaustive. Examination of these behaviors may lead to additional behaviors to consider. Psychologists, teachers with appropriate background and training in autism, speech-language pathologists (SLPs), and other primary professionals can sort out how these behaviors may impact the child. Parents, medical professionals, classroom teachers, and the child him/herself can also provide information important in determining the impact of these behaviors.

Parent involvement in the evaluation process is of utmost importance.

Strategies for Evaluation

- **Direct Behavior Observations**
  Direct observation of each domain should be a primary source of information in the evaluation. When class observations are not possible, or when the child is preschool age or not yet in a classroom, the parent-child interactions should be observed, preferably in the natural, i.e., home or day care, environment.

- **Verbal Report**
  Parents or caregivers are excellent sources of information regarding behaviors within each of the domains. Because age of onset is an important consideration in the verification of Autism, a developmental history should be obtained. Important information can also be gathered from reviewing medical and school records. This history is especially important when conducting an evaluation of the older child, as the behavioral presentation of features of ASDs changes throughout an individual's lifespan.

- **Behavioral Rating Scales**
  It is best practice to have behavior ratings completed by multiple observers (e.g., mother, daycare provider, and teacher). These can be used in combination with direct observations in a variety of settings.

- **Direct Interaction**
  Another method of gathering information is through direct interaction with the child. Informal and formal measures may be used during direct interaction. The validity of any standardized assessment for children with Autism should be viewed with caution since most standardized assessment tools require prerequisite social and communication skills, which are typically problems for children with Autism.

  - **Cognitive Evaluation:** Cognitive evaluation is a common type of direct testing, but is not required for a verification of Autism. As children must be evaluated in all areas of suspected disability, cognitive evaluation may be of value in determining whether or not a child suspected of Autism has a mental handicap.

    Note: Cognitive evaluation also may be helpful in establishing an intellectual functioning baseline. Information concerning educational strengths and areas of weakness may help in determining areas for educational goal setting.

  - **Communication Evaluation**
    Evaluation of communication skills for children with Autism should include verbal and nonverbal communication. The evaluation of expressive and receptive language should be completed, including analysis of the child's spontaneous communication, i.e., speech, language, gesture, picture-symbols, with both adults and peers. It is important to document the child's communicative intent and the communicative functions the child can express. The three areas of communicative intent are behavioral regulation, joint attention, and social interaction, each of which can be expressed through a variety of means, i.e., crying, physically signing, speaking, PECS. Children whose general language skills are adequate should also be assessed in the area of pragmatics–functional social use of language, including the ability to initiate, maintain, change, and terminate topics in conversations appropriately, as well as understanding non-literal language.

SECTION 6: RELATED DEFINITIONS

The following definitions were retrieved from the National Alliance for Autism Research web site: www.autismspeaks.org

Applied behavior analysis (ABA) (Encyclopedia of special education; 2nd ed.) – An approach for changing behavior that involves the systematic application of a set of principles derived from psychological theories of learning.

Assessment (Dictionary of mental handicap, M Lindsey) – A systematic and thorough evaluation of the strengths, weaknesses, and problems of a person.

Asperger's Disorder – This neurobiological disorder differs from autistic disorder, in that individuals with Asperger Syndrome do not have a delay in spoken language development. However, they can have serious deficits in social and communication skills. People with Asperger Syndrome often have obsessive, repetitive routines, and preoccupation with a particular subject matter.

Assistive technology (Encyclopedia of special education; 2nd ed.) – A wide range of highly specialized mechanical, electronic, and computer-based tools commonly used in rehabilitation and special education settings.

Attention (Handbook of autism and pervasive developmental disorders, DJ Cohen and FR Volkmar eds; 2nd ed.) – The ability to concentrate or attend.

Autism (Autistic Disorder) – Also known as "classic autism," autistic disorder affects a person's ability to communicate, form relationships with others, and respond appropriately to the environment. Some people with autistic disorder are high functioning and have the ability to speak and interact with others, while others are more severely affected, nonverbal, and/or mentally retarded.

Childhood Disintegrative Disorder – Also known as "regressive autism", children with childhood disintegrative disorder typically develop normally for two to four years before developing a condition that resembles autistic disorder. Typically language, interest in the social environment, and often toileting and self-care abilities are lost, and there may be a general loss of interest in the environment.

Echolalia – Repetition of words, phrases, intonation, or sounds of the speech of others. Delayed echolalia may occur several minutes, hours, days, or weeks after the original speech was heard.

Executive Function (Children with autism, Trevarthen et. al.) – Ability to plan complex cognitive tasks; this ability is interfered with by dysfunction in the frontal lobes of the brain.

Functional Analysis (Dictionary of mental handicap, M Lindsey) – Careful observation of a previously defined behavior in a previously defined environment to understand the relationship between the behavior and the environment.

Hyperlexia (Dictionary of mental handicap, M Lindsey) – Mechanical reading skills developed in excess of comprehension and verbal expression skills.

Imitation (Thesaurus of psychological index terms) – Mimicking to learn a model's behavior or responses.

Joint Attention Deficit (Autism: the facts, S Baron Cohen and P Bolton) – Unresponsive behavior where there is no attempt to find out whether things of interest to the child are also of interest to others; the lack of behaviors such as pointing to objects, or showing and giving objects to other people.

Nonverbal Communication (CARS) – Communication through use of facial expression, posture, gesture, and body movement.

Pervasive Developmental Disorder Not Otherwise Specified (PDD-NOS) – Also known as "atypical autism", PDD/NOS is a diagnosis often considered for children who show some symptoms of autistic disorder, but who do not meet the specific diagnostic criteria for the other Pervasive Developmental Disorders.

Pragmatics (Encyclopedia of special education; 2nd ed.) – Study of language use independent of language structures, rules and principles, which relates to the structure of language and its use.

Regression (Dictionary of mental handicap, M Lindsey) – To go backwards. This usually refers to the loss of skills previously acquired, especially those basic skills related to early childhood.

Repetitive Behavior (The early origins of autism, P M Rodier Scientific American, 2000, 282 (2) pp 38-45) – Abnormally intense preoccupation with one subject or activity; distress over change; insistence on routines or rituals with no purpose; repetitive movements, such as hand flapping.

Rett Disorder – Rett Disorder is a complex neurological disorder that affects mainly girls, but there are reports of males who have this disorder. Rett Disorder is genetic in origin and is among the most common genetic causes of profound intellectual and physical disability in girls, occurring more commonly than 1 in 10,000 births. Individuals with Rett Disorder develop normally until 6 to 18 months of age followed by a developmental regression. This regression is followed by a deceleration of head growth, loss of purposeful hand movements, and followed by the appearance of midline, stereotypic hand movements. A gene associated with Rett Disorder was identified in 1999.

Self Injurious Behavior (Physical interventions: a policy framework, J Harris et. al.) – Self-directed violence including hitting the head with a clenched fist, banging the head against hard objects, skin picking, and eye gouging.

Self Stimulation (Dictionary of mental handicap, M Lindsey) – Behaviors which are thought to be used to provide stimulation to the individual.

Stereotypic Movement Disorder – Identified in the DSM-IV as characterized by repetitive, seemingly driven and nonfunctional motor activity that markedly interferes with normal activities and, for certain individuals may result in self-injury.

SECTION 7: FREQUENTLY ASKED QUESTIONS

1. What is the difference between a medical diagnosis and an educational verification?

   A medical diagnosis is usually given by a doctor or clinical psychologist. The diagnosis is established to guide medical treatment and decision-making, not to address educational needs.

   An educational verification is a process conducted by a school district to determine if a child has a disability and to plan appropriate services to address the child's individual needs. The verification will reflect assessments done by a multidisciplinary team. Verification is based on an educational model.

2. Is a medical diagnosis required in order for a child to be verified educationally as a child with Autism?

   No. While many states do require documentation of a medical diagnosis, Nebraska does not. A child may have an educational verification of Autism irrespective of any medical diagnosis.

3. At what age should a child suspected of having Autism be evaluated?

   At any age. Research shows that early intervention has a significant impact in development for children with Autism. If there are concerns that a child is not developing appropriate social and communication skills, those concerns should be discussed with professionals for consideration of a referral to the MDT team.

4. Can a child with an Autism disability also have other disabilities?

Yes. It is possible for a child with Autism to be verified and/or diagnosed with other disabilities.

5. Should the multidisciplinary (MDT) request and consider medical information from the child's physician as part of the assessment?

Yes. Collecting information from a variety of sources can be beneficial in the verification process. If the MDT agrees that medical information will be helpful, this information may be requested. Parents, who are part of the MDT, should sign a release of information and/or provide this information themselves.

6. If assistance is needed with verification and/or program planning for a child suspected of having Autism, where can the school find help?

The Nebraska Autism Spectrum Disorder (ASD) Network is funded through the Nebraska Department of Education to provide training and technical assistance to school teams with verification and educational program planning. There are also resource libraries across the state where books, videos, and other materials related to ASDs may be checked out. Visit the ASD Network web site (www.nde.state.ne.us/autism) to find information on how to contact the regional coordinator.

SECTION 8: REFERENCES AND RESOURCES

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WEB SITES

Autism National Committee www.autcom.org

Autism Research Institute www.autism.com/ari

Autism Resources Links www.autism-resources.com/links.html

Autism Society of America www.autism-society.org

Autism Speaks Out www.autismspeaksout.org

ASD Network www.nde.state.ne.us/autism

Center for the Study of Autism www.autism.org

Clearinghouse on Disability Information Office of Special Education and Rehabilitation Services (OSERS) www.ed.gov/about/offices/list/osers/index.html

Education Resources Information Center (ERIC) www.ed.gov/EdFed/ERIC.htm
Guide to Disability Resources on the Internet www.disabilityresources.org

iCAN: Interactive Collaborative Autism Network http://autnet-dev.altec.org/

Indiana Resource Center for Autism www.iidc.indiana.edu/irca/IRCAarticles/fgeneralarticles.html

National Center on Birth Defects and Developmental Disabilities Centers for Disease Control. www.cec.gov/ncbddd/dd/ddautism.htm

National Dissemination Center for Children with Disabilities (NICHCY) www.nichcy.org

National Rehabilitation Information Center (NARIC) www.NARIC.com

The Professional Development in Autism Center (PDA) http://depts.washington.edu.pdacent/

DISABILITY CATEGORY:

Behavior Disorder

DISABILITY CATEGORY: Behavior Disorder

SECTION 1: INTRODUCTION

These verification guidelines were written to provide parents, teachers, special education personnel, administrators, and other professionals with information on the identification, verification, and determination of eligibility for special education services for children with a behavior disorder.

This category of children has been defined by both federal and state regulations. A three-part eligibility requirement for a child to be verified as a child with a behavior disorder is as follows:

- Meet verification criteria (92 NAC 51.006);
- Documentation of adverse effect on educational performance;
- Determination that a need for special education is evident.

SECTION 2: DEFINITION

Behavior disorder (referred to in the 2004 Amendments to the IDEA as "Emotional Disturbance") In order to qualify for special education in the category of behavior disorder the child must have a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance or, in the case of children below age five, development:

(A) An inability to learn that cannot be explained by intellectual, sensory, health factors.
(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
(C) Inappropriate types of behavior or feelings under normal circumstances.
(D) A general pervasive mood of unhappiness or depression.
(E) A tendency to develop physical symptoms or fears associated with personal or school problems.

The term includes schizophrenia. The term does not apply to children with social maladjustments, unless it is determined that they have a behavior disorders. This definition parallels the federal definition of emotional disturbance in the regulations implementing IDEA 2004.

SECTION 3: MULTIDISCIPLINARY EVALUATION TEAM (MDT) COMPOSITION

The Multidisciplinary Team (MDT) should include at least the following members:

- The child's parent(s);
- A school psychologist or licensed psychologist;
- One of the child's teachers or a teacher qualified to teach a child of that age;
- A special educator; and
- A school district administrator or a designated representative.

SECTION 4: VERIFICATION GUIDELINES

A child who is verified as having a behavior disorder has a disability characterized by behavioral or emotional responses in school so different from appropriate age, cultural, or ethnic norms that they adversely and significantly affect academic, social, vocational, or personal skills or developmental performance, including readiness to learn. A child with a behavior disorder exhibits responses which are not age appropriate expected responses to stressful events in the environment and are consistently exhibited in two or more different settings, at least one of which is school related.

A child who is verified with a behavior disorder shall demonstrate patterns of situational inappropriate behavior which deviates substantially from the behavior of his or her age or peer group. The~~se~~ behaviors may vary from peers in their frequency, intensity, and/or duration and are unresponsive to direct intervention applied in general education, or the child's condition is such that general education interventions would be insufficient or unsustainable using regular education resources.

Delinquency, discipline problems, substance abuse, social maladjustment, and/or conditions resulting from a culturally incompatible learning environment are not sufficient evidence of a behavior disorder:

Evaluation methods must yield evidence that supports one or more of the five conditions that constitute a behavior disorder:

(A) An inability to learn that cannot be explained by intellectual, sensory, or health factors;

(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;

(C) Inappropriate types of behavior or feelings under normal circumstances;

(D) A general pervasive mood of unhappiness or depression;
(E) A tendency to develop physical symptoms or fears associated with personal or school problems.

- Evaluation components by the evaluation team should include:
  - Observation behavior data
    There will be quantifiable measures of actual behavior which include the specific recording, thorough systematic formal observations of the child's behavior including the frequency, duration, and intensity of the behaviors of concern. Careful documented observation of the varied activities and situations should be completed by at least one member of the multidisciplinary team other than the classroom teacher or the early childhood teacher. Documented observations should include:
    - Identification of behaviors and operational definition of concern, including identification of age or situational inappropriate behaviors;
    - Frequency of behaviors, i.e., the rate at which the behaviors occur within a specific length of time;
    - Intensity of behaviors, i.e. length of time the behavior occurs, level or severity of the behaviors;
    - Duration of the behaviors, i.e., occurrence of behaviors through time;
    - Comparable data for randomly selected non-identified peers in comparable situations.

  - Indirect measures of behavior
    There should also be measures of reported behavior that might include information gathered through checklists or rating scales and critical incidence interviews which document the perceptions of school personnel and the parent or guardian regarding the behavioral pattern of the referred child.

  - Social-affective data
    Social functioning data should be gathered from sources such as parent and teacher interviews and socio-metric measures to identify how the referred child interacts with his or her peers. For a school age child prior attempts to modify the child's educational program so as to make educational progress possible (for example, Student Assistance Team reports) should be documented. When the child's condition is such that the implemented general education interventions were insufficient and /or unsustainable with general education resources, the SAT should provide a description of the interventions, modifications made, and child response data to assist in the determination of a behavior disorder.

    Information about the social and emotional development of the child, including unique personal attributes (e.g., self-concept inventories), personal feelings (affective assessment of anger, frustration, isolation, etc.), attitudes, social interactions, perceptions, and thought processes should be identified through child, parent, and teacher interviews and other relevant procedures.

  - Setting analysis data

Information regarding a child's educational environments should be gathered through direct observation, anecdotal record review, setting checklists, and interviews. Data from other environments should also be gathered. Characteristics of environments, i.e. location, sounds, lighting, degree of structure, or supervision, number of children, types of social interaction expected should be considered in the analysis of data. Documentation of environmental modifications and/or accommodations (i.e. academic and behavioral supports) should be included.

- Academic achievement data
  For a school age child, there should also be an assessment of the child's academic achievement and educational strengths and needs.

- Developmental data for a child birth to age five
  The child must demonstrate a deficit of 1.3 standard deviations or greater in at least one of the following areas: (1) intellectual functioning; (2) communication; or (3) at least one component of adaptive behavior.

- Intervention outcome data
  The child's responses to SAT interventions are considered in the comprehensive evaluation process.

- A behavior disorder may coexist with any other educational disability or mental health diagnosis (i.e., specific learning disability, speech-language impairment).

- When behavior problems can be attributed primarily to another disability, the child's primary disability verification should be that disability, rather than a behavior disorder.

A behavior disorder may include children with schizophrenic disorders, affective disorders, anxiety disorders, or other sustained disorders of conduct or adjustment when they adversely affect educational performance.

A behavior disorder is an educational verification and is a term used to facilitate early identification by public school personnel. Educational evaluation includes a combination of but not limited to:

- Functional behavioral assessments

- History of developmental milestones

- Parent interviews/rating scales

- Individual achievement testing

- Classroom assessment data

- Norm-referenced testing data

- Criterion-referenced assessments
- District-wide assessments
- Curriculum-based assessments
- Observation and analysis of behavior
- Teacher anecdotal records

The MDT shall be responsible for the consideration of all available data, including data provided by parents or evaluations from outside agencies (i.e. psychological evaluations, medical reports, social service agency reports, etc.).

Parent involvement in the evaluation process is of utmost importance.

SECTION 5: PROCEDURES TO DETERMINE ADVERSE EFFECT ON DEVELOPMENT/EDUCATIONAL PERFORMANCE

FACTORS TO CONSIDER

In addition, the MDT must determine whether the adverse effects on educational performance are primarily a result of the behavior disorder or other disabilities. When concomitant learning or developmental needs exist, the team must determine which condition is the primary cause of the need.

Many factors must be considered in determining if a behavior disorder is causing, or can be expected to produce, significant delays in the child's development or educational performance. The factors include, but are not limited to:

- Reports from physician(s) pertaining to the medical/mental health condition of the child
- Developmental assessments
- Checklists/or rating scales
- Critical incidence interviews
- Academic achievement data
- Social-affective assessment data
- Reported behaviors
- Type, degree, duration, and severity of behavior disorder

- Comparable data for randomly selected non-identified peers
- Cause of the behavior disorder (if known)
- Nature/status of the behavior disorder
- Age of child when behavior difficulties initially occurred
- Current age
- History of use of modifications/adaptations
- History of intervention and response
- Relevant family history
- Current educational placement
- Current levels of performance
- State and District-Wide Assessments
- Setting Analysis Data
- Vocational/postsecondary transition needs

This list is not exhaustive. Examination of each of these factors may lead to additional factors to consider. Psychologists, teachers of children with a behavior disorder, and appropriate related services staff are the primary professionals who can determine how these factors may impact the child. Parents, teachers, and the child him/herself can also provide information important in determining the impact of the behavior disorder.

Following is a list of questions for each of the five conditions that constitute a behavior disorder as defined by Federal and State definitions: (A) An inability to learn that cannot be explained by intellectual, sensory, or health factors. (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers. (C) Inappropriate types of behavior or feelings under normal circumstances. (D) A general pervasive mood of unhappiness or depression. (E) A tendency to develop physical symptoms or fears associated with personal or school problems. These questions will guide documentation and determination of whether the disability has an adverse effect on the child's developmental/educational performance:

A. An inability to learn which cannot be explained by intellectual, sensory, or health factors

- Does the child meet district standards (outcomes) for his/her grade level?
- Is the child's learning impaired academically or socially?
- Does the child's progress reflect his/her ability levels?

- Does the child have problem solving skills?
- What is the child's ability to focus on a particular task in which he/she is involved?
- What is the child's ability to complete a given assignment?
- Does the child exhibit an interest in his/her schoolwork and assignments?
- What is the child's ability to complete a given assignment?
- What is the child's level of impulsivity?
- Are the problem behaviors likely to impact success in the community or in later life?

B. An inability to build or maintain satisfactory interpersonal relationships with peers and teachers

- Does the child exhibit an interest in friends, family members, etc.?
- Does the child try to avoid interactions with peers either during play times or classroom work times?
- Does the child eat lunch with friends or does the child eat in isolation by his/her own choice?
- Does the child accept responsibility for his/her own actions?
- Is the child's self-esteem affected by his/her behavior?
- Is the child assertive?
- Does the child have appropriate self-confidence?
- What types of relationships does the child have with peers and family members?
- Is the child able to build and maintain satisfactory interpersonal relationships with peers? with adults?
- Does the child have appropriate peer relationships? With teachers?
- Does the child exhibit a lack of insight in particular situations?
  - Are these situations social situations that involve either another child or an adult?
  - In what ways does the child exhibit this lack of insight?

C. Inappropriate types of behavior or feelings under normal circumstances

- How does the child respond when he/she does not receive his/her expected response to a request, question, etc.?
- Does the child exhibit impulsivity?
  - How often does the child exhibit impulsivity?
  - Are there particular situations (during meals, free time, recess, transition between activities, etc.) in which the child exhibits impulsivity?
  - Is the child able to calm him/herself after exhibiting impulsivity?
- Does the child exhibit poor emotional control?
  - Are there particular situations in which the child exhibits poor emotional control?
  - What are some characteristics of the poor emotional control (crying, shouting, yelling, hiding, etc.)?
- Is the child assertive?
- Does the child have appropriate self-confidence?
- Does the child become angry for no apparent reason?
  - How does the child express his anger or frustration?

- Does the child become agitated easily?
  - How does the child exhibit his/her agitation?
- Does the child often express irritability?
  - What causes this irritability?
  - Is the child able to move away from the situation that is causing the irritability?
  - How does the child express his/her irritability?
- Does the child display aggression?
  - In what ways does the child display aggression, i.e., physical, verbal, etc.?
  - What causes the child to display aggression?
  - Is the child able to calm him/herself after an aggressive act?
- Is the child responsible and accountable for his/her own actions?
- Does the child's behavior interfere with the learning of others?
- Are the child's behaviors dangerous to the child or other children?

D. A general pervasive mood of unhappiness or depression

- What are the general characteristics of the mood of unhappiness or depression?
- Does the child exhibit depression and withdrawal?
- Are there particular situations in which the child exhibits depression and withdrawal?
  - In what ways does the child exhibit depression and withdrawal, i.e., refusing to participate, crying, hiding from others, refusal to work on assignments, etc.?
- Does the child exhibit an attitude of apathy in certain situations or events?
  - Under what circumstances does the child exhibit an attitude of apathy?
  - Is the child able to become motivated in this same situation that has contributed to the attitude of apathy?
- Does the child describe to another person why he/she is unhappy?
- Are there particular situations in which the child exhibits unhappiness or depression?

E. A tendency to develop physical symptoms or fears associated with personal or school problems

- Does the child show evidence of fear?
- Does the child show evidence of physical symptoms?
- Does the child ask to visit the nurse's office frequently?
  - Are there general physical symptoms of which the child complains? Stomachache? Headache? Other?
- What is the child's attendance record?
  - What is the child's attendance pattern?
  - Absent on particular days of the week?
  - Asks to go home at a particular time of the day on a regular basis due to illness or anxiety?
- Does the child avoid recess or other social situations by complaining of illness?

Other Conditions:

In addition to these behavioral characteristics, the Multidisciplinary Evaluation Team should consider the following conditions under which the behavioral characteristics are exhibited:

- Frequency of behaviors
  - How often do the behaviors occur?
  - What times of the day do the behaviors occur?
  - Are there particular ongoing events that seem to trigger the behaviors?
  - Are there particular days of the week in which the behaviors occur? Particular times of the day?
  - How is data recorded regarding the rate at which the behaviors occur?

- Intensity of behaviors
  - How severe are the behaviors?
  - Does the severity of the behaviors escalate over a period of time or does the severity occur instantaneously when an event occurs?
  - What are the events/situations that cause severe behaviors to occur?

- Duration of the behaviors, i.e., occurrence of behaviors through time
  - How long do the behaviors persist at any one time?
  - Does the time differ for particular behaviors, i.e., tantrums vs. crying, withdrawal vs. aggressive actions?
  - Is the duration of the behaviors dependent upon the antecedent event/situation?

- Patterns of inappropriate behaviors or emotional responses
  - Which behaviors appear to cause problems for the child (target behaviors)?
  - What is the frequency, duration, or intensity of these behaviors?
  - What is the frequency, duration, or intensity of these behaviors for other children (non-disabled) in this environment or similar environments?
  - Do these behaviors deviate significantly from the behavior of peers/and or expected standards?
  - Does the behavior occur in more than one setting? What settings? (i.e., playground, cafeteria, small group, classroom, home, etc.?

- Developmental data for a child birth to age five

- Can the child's problematic behavior be attributed solely to another disability?

- Appropriate age, cultural, or ethnic norms

- Does the behavior deviate substantially from the behavior of his/her age peer group in frequency, intensity, or duration?
- Does the cultural or ethnic status of this child explain or support the child's behavior?
- What are the expected standards of behavior of all children in settings where problems occur?
- Are these standards culturally biased?
- Are these standards reasonable?
- Is there evidence of delinquency, discipline problems, substance abuse, social maladjustment, or a culturally incompatible learning environment?

SECTION 6: RELATED DEFINITIONS

- **Academic Achievement** – A child's level of performance in basic school subjects, measured either formally or informally. (Norlin, 2003, p. 1)

- **Achievement Test** – A test that objectively measures educationally relevant skills or knowledge; a test that measures mastery of content in a subject matter area, as opposed to an intelligence test. (Norlin, 2003, p. 3)

- **Adaptive Skill Areas** – Daily living skills needed to function adequately in the community, consisting of: (1) communication, (2) self-care skills, (3) home living, (4) social skills, (5) leisure, (6) health and safety, (7) self-direction, (8) functional academics, (9) community use, and (10) work. (Norlin, 2003, p. 4)

- **Affective Disorder** – A disorder of mood or emotional tone characterized by depression or elation. (Hallahan and Kauffman, 2006, p. 530)

- **Age Appropriate –** In connection with special education, achievement consistent with a disabled child's developmental level and chronological age. (Norlin, 2003, p. 6)

- **Age-Equivalent Score –** A child's raw score or standard score for a test, expressed in the years and months of the chronological age of children for whom that grade is the average. Also called mental age of test age. (Norlin, 2003, p. 7)

- **Aggression –** Behavior that intentionally causes others harm or that elicits escape or avoidance responses from others. (Hallahan and Kauffman, 2006, p. 530)

- **Anxiety Disorder –** A disorder characterized by anxiety, fearfulness, and avoidance of ordinary activities because of anxiety or fear. (Hallahan and Kauffman, 2006, p. 530)

- **At Risk –** Generally, a child or youth about whom one has a higher than usual expectation of future difficulties as a result of circumstances relating to his or her

health status, disability, or family or community situation; typical characteristics of a child who is at risk for reasons other than disability may include being one or more grade levels behind in reading or mathematics achievement, chronic truancy, personal or familial drug or alcohol abuse, or low self-esteem. (Norlin, 2003, p. 14)

- **Behavior Management –** Strategies and techniques used to increase desirable behavior and decrease undesirable behavior. May be applied in the classroom, home, or other environment. (Hallahan and Kauffman, 2006, p. 531)

- **Behavior Modification –** Systematic control of environmental events, especially of consequences, to produce specific changes in observable responses. May include reinforcement, punishment, modeling, self-instruction, desensitization, guided practice, or any other techniques for strengthening or eliminating a particular response. (Hallahan and Kauffman, 2006, p. 531)

- **Brain Injury –** "insult to the brain" resulting in impairment of brain function; categorized types, depending on cause and extent of injury as acquired, closed, and mild. (Norlin, 2003, p. 29)

- **Conduct Disorder –** A disorder characterized by overt, aggressive disruptive behavior or covert antisocial acts such as stealing, lying, and fire setting may include both overt and covert acts. (Hallahan and Kauffman, 2006, p. 532)

- **Curriculum-Based Measurement –** Series of incremental assessments of what a child has learned. (Norlin, 2003, p. 50)

- **Duration of Behavior** - Occurrence of behaviors through time. (Hallahan and Kauffman, 2006, p. 536)

- **Externalizing –** Acting-out behavior; aggressive or disruptive behavior that is observable as behavior directed toward others. (Hallahan and Kauffman, 2006, p. 534)

- **Functional Analysis –** Refers to a variety of behavior assessment methodologies for determining the environmental variables that are setting the occasion for and maintaining challenging behaviors such as self-injury. (Heward, 2003, p. 614)

- **Genetics –** (1) A branch of biology dealing with hereditary and genetic variations; (2) The genetic makeup of an organism or group of organisms. (Encarta World English Dictionary. Retrieved from http://encarta.msn.com)

- **Functional Behavioral Assessment (FBA) –** Evaluation that consists of finding out the consequences (what purpose the behavior serves), antecedents (what triggers the behavior), and settings events (contextual factors) that maintain inappropriate behaviors; this information can help teachers plan educationally for children. (Hallahan and Kauffman, 2006. p. 535)

- **Frequency of Behaviors** - the rate at which the behaviors occur within a specific length of time. (Hallahan and Kauffman, 2006, p. 536)

- **Impulsivity –** An approach to problem-solving associated with attention deficit hyperactivity disorder (ADHD); responding abruptly without consideration of consequences or alternatives. (Norlin, 2003, p. 109)

- **Indirect Measures of Behavior**- Measures of reported information gathered through checklists or rating scales and critical incidence interviews which document the perceptions of school personnel and parents regarding the behavioral pattern of the child.

- **Intensity of Behaviors** - Level or severity of the behaviors. (Hallahan and Kauffman, 2006, p. 536)

- **Internalizing –** Acting-in behavior, anxiety, fearfulness, withdrawal, and other indications of an individual's mood or internal state. (Hallahan and Kauffman, 2006, p. 536)

- **Norm-Referenced Test (NRT) –** Comparison of one child's performance, as measured by the test score, with the performance of the norm allowing fine distinctions among children and identification of where a child stands in relation to that group; typically developed by commercial test companies. (Norlin, 2003, p. 157)

- **Observation Behavior Data –** Quantifiable measures of actual behavior which include the specific recording, thorough systematic formal observations of the child's behavior including frequency, duration, and intensity of the behaviors of concern; comparable data for randomly selected non-identified peers in comparable situations.

- **Personality Disorder –** A group of behavior disorders, including social withdrawal, anxiety, depression, feelings of inferiority, guilt, shyness, and unhappiness as identified by Quay (1975). (Heward, 2003, p. 616)

- **Positive Reinforcement –** Presentation of a stimulus or event immediately after a behavior has been emitted, which has the effect of increasing the occurrence of that behavior in the future. (Heward, 2003, p. 612)

- **Positive Behavior Support (PBS) –** Systematic use of the science of behavior to find ways to support desirable behavior of an individual rather than punishing the undesirable behavior; positive reinforcement (rewarding procedures that are intended to support a child's appropriate or desirable behavior). (Hallahan and Kauffman, 2006, p. 538)

- **Projective Tests –** Psychological tests that require a person to respond to a standardized task or set of stimuli (e.g., draw a picture or interpret an ink blot).

Responses are thought to be a projection of the test taker's personality and are scored according to the given test's scoring manual to produce a personality profile. (Heward, 2003, p. 617)

- **Self-Monitoring –** A type of cognitive training technique that requires individuals to keep track of their own behavior. (Hallahan and Kauffman, 2006, p. 540)

- **Setting analysis data -** Information regarding a child's educational environments should be gathered through direct observation, anecdotal record review, setting checklists, and interviews. Additional data from other environments should also be gathered. Characteristics of environments, i.e., location, sounds, lighting, degree of structure or supervision, number of children, types of social interaction expected. Documentation of environmental modifications and/or accommodations (i.e., academic and behavioral supports) should be included.

- **Social-Affective Assessment Data -** Information about the social and emotional development of the child, including unique personal attributes (e.g., self-concept inventories), personal feelings (affective assessment of anger, frustration, isolation, etc.), attitudes, social interactions, perceptions, and thought processes, identified through child, parent, and teacher interviews and other relevant procedures.

- **Social Maladjustment** --Neither federal nor state guidelines provide definitions for social maladjustment, and there appears to be little consensus among the professional community about the use of this term, since the original definition developed by Eli Bower and later used as the definition of "behavior disorder" was intended as a definition of "social maladjustment".

- **Temperament –** (1) A prevailing of dominant quality of mind that characterizes somebody. (Encarta World English Dictionary. Retrieved from http://encarta.msn.com)

SECTION 7: FREQUENTLY ASKED QUESTIONS

1. Five different behavioral characteristics are listed in the definition of behavior disorder. Are these the only behavioral characteristics that can be considered for the verification of behavior disorder?

   To be verified as a child with a behavior disorder, the child should meet one or more of the five behavioral characteristics. However, in addition to one or more of these behavioral characteristics, there may be other behavioral characteristics that the MDT will take into consideration in the verification of a behavior disorder. If the child does not meet the guidelines for verification of a behavior disorder, the MDT may need to evaluate the child for another disability.

2. Is a medical diagnosis required as a part of the verification process for a behavior disorder?

No. However, if the child is diagnosed with a medical/mental health condition that has a high probability of resulting in a behavior disorder, a report from a physician describing the medical/mental health condition and its implications is required. The Multidisciplinary Evaluation Team (MDT) will consider this report as they complete the comprehensive evaluation.

3. Can a school require that parents seek medication related to the behavior of a child?

No. Recommendation for medication is medical advice, and normally schools should not become involved in recommending, let alone requiring, a child to be on medication. However, educators can provide information to parents and, if authorized, to physicians in order to help them understand the effects and potential side effects of the medication the child is receiving.

4. Is it required that a child have a mental health or medical diagnosis in order to be eligible to meet verification criteria as having a behavior disorder?

No. A medical diagnosis is not required for special education verification in the disability category of behavior disorder. If this information is available, it can be considered by the MDT, but it is not required, and cannot, in itself, be a deciding factor in verification.

5. If a child has a DSM diagnosis, may a school choose to verify the child in the category of "other health impairment" rather than "behavior disorder"?

Assuming that a child would meet the verification criteria of both of these categories of special education, it would seem probable that the child should be identified as having a "behavior disorder" as the primary disability. A DSM diagnosis in itself does not meet the requirements for verification of a disability in either of these categories and does not necessarily identify a chronic or acute health condition as required for "OHI". The only DSM diagnosis mentioned in federal policy is ADD or ADHD. While verification of a child as having "Other Health Impairment" may have less stigma than "behavior disorder", that is not a valid reason for such a verification.

6. If there is suspicion that a mental/medical condition is present, is the school required to pay for the medical/mental health evaluation?

It depends. In many cases, a medical/mental health evaluation will already have been completed and the physician will send a report to the MDT with the parent's written permission. If a medical/mental health evaluation has not been

completed and is needed to determine verification, then the school may be responsible for the evaluation.

7. How severe must the medical/mental health condition be for the child to verify as a child with a behavior disorder?

   The severity of the medical/mental health condition will be documented in a written report from a physical; however, there must be evidence of an adverse effect on the development or educational performance of the child in order for the child to verify with a behavior disorder.

8. Can a child meet the guidelines for having a behavior disorder if he/she is doing well academically in his/her classes?

   Yes. Because the assessment for achievement includes not only academic achievement, but also social/interpersonal skills, adaptive skills, speech/language skills, and any skills considered a part of that child's achievement.

9. Can a child meet the guidelines for a behavior disorder if the child has compensated for the behavior disorder by using medication, counseling, behavior management strategies, etc.?

   It depends. The verification of a behavior disorder is a two-pronged verification including both the behavioral characteristics and achievement. If the child has compensated for the behavior disorder through medications, counseling, behavior management strategies, etc., yet there is an adverse effect on the educational performance of the child, then the child could certainly verify as a child with a behavior disorder.

10. Can a child who has been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) be verified as having a behavior disorder?

    Yes. ADHD and ADD are both a part of the federal and state definitions. However, the child must meet the eligibility guidelines for a child with a behavior disorder, which includes an adverse effect on educational performance/development.

11. If the cultural or ethnic status of the child explains or supports the behavior/s can the child verify as having a behavior disorder?

    Not unless the behavior deviates substantially from the behavior of his or her age peer group in frequency, intensity, or duration.

SECTION 8: REFERENCES AND RESOURCES

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WEB SITES

Alliance for Technology Access www.ataccess.org

American Academy of Pediatrics www.aap.org

American Academy of Child and Adolescent Psychiatry www.aacap.org

American Psychiatric Association www.psych.org

American Psychological Association www.psy.org

Anxiety Disorders Association of America www.adaa.org

Center for Mental Health Services/Knowledge Exchange Network
www.mentalhealth.samsha.org

Center on Positive Behavioral Interventions and Supports www.pbis.org

Child and Adolescent Bipolar Foundation www.bpkids.org

Clearinghouse on Disability Information Office of Special Education and Rehabilitation Services (OSERS) www.ed.gov/about/offices/list/osers/index.html

Council for Exceptional Children (CEC) www.cec.sped.org

Council for Children with Behavior Disorders www.ccbd.net

Education Resources Information Center (ERIC) www.ed.gov/EdFed/ERIC.htm

Family Connections www.familyconnectionsnj.org

FAST: Families and Schools Together www.wcer.wisc.edu/fast

Federation of Families for Children's Mental Health www.ffchmh.org

National Alliance for the Mentally Ill www.nami.org

National Association of School Psychologists www.nasponline.org

National Dissemination Center for Children with Disabilities (NICHCY) www.nichcy.org

National Institute of Child Health and Human Development (NICHD) www.nichd.nih.gov

National Institute of Mental Health (NIMH) www.nimh.org

National Mental Health and Education Center www.naspcenter.org

National Institute on Disability and Rehabilitation Research (NIDRR) www.ed.gov/about/office/

National Organization on Disability www.nod.org

DISABILITY CATEGORY:

Deaf-Blindness

DISABILITY CATEGORY: Deaf-Blindness

SECTION 1: INTRODUCTION

These verification guidelines were written to provide parents, teachers, special education personnel, administrators, and other professionals' information on the identification, verification, and determination of eligibility for special education services for children with deaf-blindness.

Deaf-Blindness or dual sensory impairments should mean a combined hearing and visual impairment, the combination of which causes severe communication and other developmental and educational needs. Deaf-Blindness/dual sensory impairments cannot be accommodated in special education programs solely for children with deafness or blindness, unless supplementary assistance is provided to address the educational needs resulting from the combined disabilities.

Functional deaf-blindness should mean that a child has such severe impairments that the level of sensory (auditory and visual) functioning cannot be adequately determined or the child requires adaptations in both auditory and visual modes.

This category of children has been defined by both federal and state regulations. A three-part eligibility requirement for a child to be verified as a child with deaf-blindness is as follows:

- Meet verification criteria (92 NAC 51.006);
- Documentation of adverse effect on educational performance;
- Determination that a need for special education is evident.

SECTION 2: DEFINITION

- **Deaf-Blindness** - To qualify for special education services in the category of Deaf-Blindness, the child must have concomitant hearing and visual impairments, the combination of which causes: severe communication needs; and other developmental and educational needs. The severity of these needs is such that they cannot be accommodated in special education programs solely for children with deafness or children with blindness.

SECTION 3: MULTIDISCIPLINARY EVALUATION TEAM (MDT) COMPOSITION

The Multidisciplinary Team (MDT) should be composed of those persons required to verify a hearing impairment and a visual impairment.

The MDT should include at least the following members:

- The child's parent(s);
- The child's teacher or teacher qualified to teach a child that age;
- An educator endorsed to teach a child with hearing impairments;
- An educator endorsed to teach a child with visual impairments;
- A speech-language pathologist;
- A school district administrator or designated representative.

In addition, the MDT should consider the following team members:

- An audiologist or an individual qualified to interpret the results of the audiological report.

SECTION 4: VERIFICATION GUIDELINES

The child with deaf-blindness should meet the verification criteria for both hearing impairments and visual impairments.

- **Hearing Impairment**
  In order for a child to be verified with a hearing impairment, the evaluation should include:

  - A written report, with diagnostic documentation, signed by a licensed or certified audiologist verifying a unilateral or bilateral, fluctuating or permanent hearing loss based on a current audiological evaluation.

  - The analysis and documentation of the adverse effects the impairment has or can be expected to have on the development or educational performance of the child in at least one of the following areas:
    - Effective communication;
    - Expressive or receptive language development;
    - Speech reception or production;
    - Cognitive ability;
    - Academic or vocational performance;

- Social or emotional competence.

Children with dual sensory impairments represent a very heterogeneous group. Communication preferences and uses by the parents, child, and family must be considered when planning and conducting evaluations and assessments to determine the child's present levels of functioning, development, or progress in acquiring and using language.

➢ Visual Impairment
A child with a visual impairment should be verified in one of the three categories: blind, legally blind, or partially sighted.

❖ Visual Impairment: Blind
In order to be verified as a child with a visual impairment: blind, the evaluation should include the analysis and documentation of:
- No more than light perception as stated in a signed report by a licensed ophthalmologist or optometrist;
- The need for adapted curriculum, method, materials, and equipment for learning; and
- The educational significance of the visual impairment including:
  - ♦ Documentation of behaviors which appear to impede the child's overall functioning as observed in appropriate settings by someone other than the child's classroom teacher; and
  - ♦ Deficiencies in one or more of the following areas: activities of daily living, social interaction, academic achievement, performance in the educational setting, or orientation and mobility.

❖ Visual Impairment: Legally Blind
In order to be verified as a child with a visual impairment: legally blind, the evaluation should include the analysis and documentation of:
- A visual acuity of 20/200 or less in the better eye after correction or a contiguous field restricted to 20 degrees or less as stated in a signed report by a licensed ophthalmologist or optometrist;
- The need for adapted curriculum, methods, materials, and equipment, or any combination thereof for learning; and
- The educational significance of the visual impairment including:
  - ♦ Documentation of behaviors which appear to impede the child's overall functioning as observed in appropriate settings by someone other than the child's classroom teacher; and
  - ♦ Deficiencies in one or more of the following areas: activities of daily living, social interaction, academic achievement, performance in the educational setting, or orientation and mobility.

❖ Visual Impairment: Partially Sighted
In order to be verified as a child with a visual impairment: partially sighted, the evaluation should include the analysis and documentation of:

- A signed report by a licensed ophthalmologist or optometrist to certify a structural defect, condition, or disease of the eye, which may affect the child's ability to learn visually;
- The educational significance of the visual impairment including:
  - Documentation of behaviors which appear to impede the child's overall functioning as observed in appropriate settings by someone other than the child's classroom teacher;
  - Deficiencies in one or more of the following areas: activities of daily living, social interaction, academic achievement, performance in the educational setting, or orientation and mobility.

In addition to these two criteria, the child should meet the requirements of either criterion listed below:

- An assessment of the child's functional vision. All assessed behaviors should be elicited by both light and pattern. Significant delays in three or more of the visual behaviors could be detrimental to functional vision. The observable visual behaviors should include but are not limited to: peripheral orientation, fixation, ability to shift gaze, ability to track, and ability to converge.

OR

- A visual assessment as stated in a signed report by a licensed ophthalmologist or optometrist to certify at least one of the following:
  - A distant or visual acuity of 20/70 or less, in the better eye after correction;
  - A near visual acuity equivalent to or less than 8 point type at 40 centimeters, in the better eye after correction;
  - A central visual field loss of any degree in both eyes; or
  - A peripheral visual field of 60 degrees or less in the better eye.

In all cases, when making a determination of a dual sensory impairment, the MDT should consider the educational performance of the child to determine if it is below that of peers regardless of modifications and/or accommodations of instruction, curriculum, and environment. In addition, the MDT should consider medical information to determine if there is evidence of a combined hearing and visual impairment. Lastly, the MDT should review functional hearing and vision information to determine if there is evidence of a dual sensory impairment. The MDT must determine whether the deaf-blindness or dual sensory impairment is the primary disability of the child.

SECTION 5: PROCEDURES TO DETERMINE ADVERSE EFFECT ON DEVELOPMENT/EDUCATIONAL PERFORMANCE

FACTORS TO CONSIDER

Many factors should be considered in determining if deaf-blindness is causing or can be expected to produce significant delays in the child's development or educational performance. The factors include, but are not limited to:

- Type and degree of hearing and visual impairments

- Etiology of the hearing and visual impairments
- Age of onset of the hearing and visual impairments
- Age of identification
- Current age
- Nature/status (permanent, stable, progressive, fluctuating, etc.)
- Current medications
- History and use of interventions
- Relevant family/medical history
- Current educational placement
- Educational performance (communication, orientation and mobility, language, academic, social-emotional)

This list is not exhaustive. Examination of each of these factors may lead to additional factors to consider. The educational team, including educators endorsed to teach children with visual and hearing impairments, can determine how these factors may impact the child. Parents, medical professionals, classroom teachers, and the child can also provide information important in determining the impact of the hearing and visual impairments.

It is critical for the MDT to have current medical information in regard to hearing and vision in order to make appropriate evaluation decisions. This medical information should provide evidence of dual sensory impairment (both hearing and vision loss).

A functional vision assessment and a functional hearing inventory should be conducted for those children who have such severe disabilities that they exhibit inconsistent auditory and visual responses. In many cases, the medical personnel for this population cannot determine current and specific medical information regarding vision and hearing; therefore, conducting functional assessments in regard to vision and hearing becomes critical.

When making a determination of the adverse effects of dual sensory impairments, the educational team should consider the child's age; types of communication modality (ies) used by the child; functional use of language; functional use of hearing and vision; and the types of interventions used by the child in orientation and mobility, academic, social interaction, independent living, assistive technology, career education, and recreational and leisure skills.
The following questions are to guide documentation and determination of whether the disability has an adverse effect on the child's developmental/educational performance:

- Compensatory or functional academic skills, including communication modes
  - Does the child meet district standards (outcomes) for his/her grade levels?
  - Does the child's progress reflect his/her ability level?
  - Does the child have access to the curriculum and materials at his/her grade level in the appropriate medium (Braille, large print, auditory and assistive listening devices or tactile formats)?
  - Does the child have opportunities to participate in a functional curriculum?
  - Does the child have an effective way to communicate (speaking, sign language including tactile sign, augmentative communication, and object/touch cues)?

- Orientation and mobility
  - Is the child able to determine where he/she is in the environment?
  - Does the child travel safely and efficiently in the environment?

- Social interaction skills
  - Does the child behave in socially appropriate ways?
  - Does the child initiate interactions with peers and adults?
  - Does the child have peer interactions?

- Independent living skills
  - Does the child perform the tasks that allow him/her to care for personal needs?
  - Does the child have organizational skills?
  - Does the child have the skills needed for adult independence?

- Recreation and leisure skills
  - Does the child have opportunities to participate in an array of age appropriate activities?
  - Does the child participate in movement and physical fitness activities that promote good health?

- Career/vocational education
  - Does the child have information about existing vocations?
  - Does the child have opportunities to participate in a variety of job experiences?
  - Does the child have the skills needed to become meaningfully employed?

- Assistive technology
  - Does the child have access to the specialized technology available (Braille note takers, speech output devices, assistive listening devices)?
  - Does the child have access to an array of technology devices (both low and high tech)?
  - Does the child have access and use specialized technology to access the curriculum?

- Visual and auditory efficiency skills
  - Does the child systematically use residual hearing and vision efficiently?
  - Does the child use assistive devices to supplement hearing and vision effectively?

- Self determination skills
  - Does the child assist in the planning of his/her educational program?
  - Does the child have opportunities to make decisions about his/her educational program?

SECTION 6: RELATED DEFINITIONS

Deaf-Blindness – Concomitant hearing and visual impairments, the combination of which creates such severe communication and other developmental and educational needs that they cannot be accommodated in special education programs solely for children with deafness or children with blindness.

Dual-Sensory Impairment – The presence of a combined and verified vision and hearing impairment, the effects of which are multiplicative and cumulative rather than additive, that limits the access of an individual to visual and auditory information about the world around them and interferes with the ability to gather information, learn, function, communicate, and interact with others in a clear and consistent manner.

Congenitally Deaf-Blind – Refers to individuals who are born with hearing and vision losses.

Congenitally Deaf, Adventitiously Blind – Refers to individuals who are born with deafness and later acquire Blindness.

Congenitally Blind, Adventitiously Deaf – Refers to individuals who are born with blindness and later acquire deafness.

Adventitiously Deaf-Blind (acquired Deaf-Blindness) – Refers to individuals who are born with hearing and vision but later lose both senses to varying degrees. The losses may occur at different times.

For additional definitions relevant to dual sensory impairments refer to the definition sections of hearing and vision impairments.

SECTION 7: FREQUENTLY ASKED QUESTIONS

1. Can children with deaf-blindness have other disabilities?

   Yes, many children with deaf-blindness have additional disabilities. When assessing a child for other disabilities, such as OHI, TBI, SLI, multiple disabilities, it is important to consider dual sensory loss and the impact on educational performance.

2. Why is it important to complete a functional assessment of both hearing and vision when completing assessment for a child with deaf-blindness?

It is important to know the extent that the child is able to utilize his/her ability to hear and see in the school setting. Some children have such severe disabilities that they exhibit inconsistent auditory and visual responses, and in many cases the medical profession for this population cannot determine current degrees of functional hearing and vision. This information will be extremely helpful in planning the curriculum for the child in the classroom.

3. Is there another term for deaf-blindness?

Some people refer to deaf-blindness as a dual sensory impairment because two of the five senses are affected.

4. Do all children with deaf-blindness have the same level of hearing and vision loss?

No. Each individual child with deaf-blindness has varied levels of hearing and vision loss ranging from mild to severe. In fact, research states that most children with deaf-blindness have some ability to hear and see. It is the combined loss of both hearing and vision (the distant senses) which make this population unique in their educational needs. When assessing children with deaf-blindness, the child's progress data will indicate that educational performance is far below that of peers despite modifications and/or accommodations to the instruction, curriculum, and environment.

5. At what age should a child be assessed for deaf-blindness?

At any age in which there are questions about the child's ability to hear and see.

SECTION 8: REFERENCES AND RESOURCES

REFERENCES

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Hallahan, Daniel P. and James M. Kauffman. Exceptional Learners, 10th Edition. Boston: Allyn and Bacon, 2006.

STATE OF NEBRASKA RESOURCES

Boys Town National Research Hospital www.boystownhospital.org

Nebraska Center for the Education of Children Who Are Blind or Visually Impaired (NCECBVI) www.ncecbvi.org

Nebraska Commission for the Blind and Visually Impaired www.ncbvi.ne.gov

Nebraska Commission for the Deaf and Hard of Hearing www.nedhh.ne.gov

Nebraska Department of Education www.nde.state.ne.us

Nebraska Deaf-Blind Project www.nedbp.org

Nebraska Educational Assistive Technology (NEAT) www.neatinfo.net

Nebraska Regional Programs for Children Who Are Deaf or Hard of Hearing www.nde.state.ne.us/SPEDadsites/regdeaf/html

Parent Training and Information (PTI – Nebraska) www.pti-nebraska.org

WEB SITES

American Association of the Deaf-Blind (AADB) www.aadb.org

American Council of the Blind (ACB) www.acb.org

American Foundation for the Blind (AFB) www.afb.org

Helen Keller Nation Center (HKNC) www.hknc.org

National Family Association for Deaf-Blind (NFADB) www.NFADB.org

National Foundation of the Blind (NFB) www.nfb.org

National Information Clearinghouse on Children Who Are Deaf-Blind www.dblink.org

National Technical Assistance Consortium for Children and Young Adults Who Are Deaf-Blind (NTAC) www.ntac.org

DISABILITY CATEGORY:

Developmental Delay

DISABILITY CATEGORY: Developmental Delay

SECTION 1: INTRODUCTION

These verification guidelines were written to provide parents, teachers, special education personnel, administrators, and other professionals with information on the identification, verification, and determination of eligibility for special education services for children with a developmental delay.

This category of children has been defined by both federal and state regulations. There are two important features of the definitions in order for children to verify as having a developmental delay:

- Meet verification criteria (92 NAC 51.006);
- Documentation of adverse effect on educational performance;
- Determination that a need for special education is evident.

SECTION 2: STATE DEFINITION

Developmental Delay- To qualify for special education services in the category of developmental delay, the child shall have significant delay as measured by appropriate diagnostic instruments and procedures in one or more of the following areas and, by reason thereof needs special education and related services: Cognitive development, Physical development, Communication development, Social or Emotional development, Adaptive behavior or skills development, or a diagnosed physical or medical condition that has a high probability of resulting in a substantial delay in function in one or more of such areas.

Developmental delay must be considered as one possible eligibility category for infants and toddlers birth through age four, and is a discretionary option for school districts to use for children ages five through eight.

A child remains eligible for services under the category of developmental delay through the school year in which the child reaches age five; or through the if the school year in which the child reaches age nine, if the district uses the discretionary option in 92 NAC 51-006.04E2.

SECTION 3: MULTIDISCIPLINARY EVALUATION TEAM (MDT) COMPOSITION

The Multidisciplinary Team (MDT) should include at least the following members:

- The child's parent(s);

- Qualified professionals knowledgeable about overall child development and the area(s) of concern (cognitive, intellectual, physical, communicative, social/emotional, and adaptive behavior/skills development); and

- A school district administrator or a designated representative.

SECTION 4: VERIFICATION GUIDELINES

In order for a child to be verified as having a developmental delay, the evaluation should include the analysis and documentation of:

- A significant delay in the function of one or more of the following areas:
  - Cognitive development
  - Physical development
  - Communicative development
  - Social/emotional development
  - Adaptive behavior development

- A significant delay in one or more of the above areas is determined by:
  - Standardized Testing:
    - At least 2.0 standard deviations below the mean in one area of development; or
    - At least 1.3 standard deviations below the mean in two areas of development.

OR

  - Informed clinical opinion of qualified professionals in consultation with the family:
    - When the use of standardized instruments is not applicable due to a child's need for adaptation to perform on a standardized instrument, the informed clinical opinion of qualified professionals will substantiate the significant developmental delay.
    - Informed clinical opinion is defined as an opinion supported by procedures including clinical assessment and observation by qualified professionals to document that a child lags behind other children in reaching expected developmental milestones for a child that age, and is not expected to achieve those milestones on the same schedule as the majority of other children. The developmental delay cannot be determined solely by

standardized measures, or standardized procedures are not available for a given age or developmental area.

- Professionals who are qualified to determine eligibility through informed clinical opinion are those individuals who have current certification, licensure or registration of their specific professions, and who have been trained to use methods and procedures for evaluation and assessment of infants, toddlers, and young children, birth through age eight;

OR

- Identification of a diagnosed condition:
  - Children who are diagnosed as having a physical or medical condition that has a high probability of resulting in developmental delay are also eligible for early intervention or special education and related services. Included in this group are children who need early intervention or special education and related services because of a condition that typically results in developmental delay, even though they may not exhibit a developmental delay at the time of diagnosis.

- The multidisciplinary team (MDT) which includes the family as participants, shall determine if a child has a significant delay in development using multiple sources of information, which shall include at least the following:
  - Information provided by the family;
  - Observations of the child;
  - Developmental history; and
  - Review of records related to the child's current health status and medical history.

Children birth through age two, who may be at risk of substantial developmental delay (i.e. environmental risk if early intervention/special education and related services are not provided), but who currently do not meet the eligibility criteria for developmental delay, are <u>not</u> eligible under this category.

A developmental delay is an educational verification and is a term used to facilitate early identification by public school personnel. Educational assessments and evaluations to identify strengths and limitations may include:

- Individual achievement testing

- Reports from parents

- Medical reports

- Classroom/preschool assessment data

- Norm-referenced testing

- Criterion-referenced assessment
- State and district-wide assessment
- Curriculum-based assessment
- Observation and analysis of behavior
- Teacher anecdotal records

Parent involvement is of utmost importance in the evaluation process. Many children exhibit identified strengths as well as identified delays in both overall cognitive functioning and in adaptive behavior areas.

SECTION 5: PROCEDURES TO DETERMINE ADVERSE EFFECT ON DEVELOPMENT/EDUCATIONAL PERFORMANCE

FACTORS TO CONSIDER

Many factors must be considered in determining if a developmental delay is present or can be expected to produce significant delays in the child's development or educational performance. The factors include, but are not limited to:

- Developmental milestones
- Comprehension and utilization of instructional information
- Consistent generalization of skills
- Fluent communication
- Age-appropriate problem-solving skills when such information is presented in a traditional academic curriculum
- Age of identification
- Current age
- History of cognitive delays
- History of adaptive behavior delays
- History of interventions and response
- Relevant family/medical history

- Current educational placement
- Current levels of performance
- Current language delays
- Current motor delays

Psychologists, teachers of children with developmental delays, and speech-language pathologists (SLP) are the primary professionals who can determine how these factors may impact the child. Parents, teachers, care providers, and medical professionals can also provide information important in determining the impact of the developmental delay.

The MDT should determine whether the adverse effect on the child's communication, language, educational performance, or adaptive behavior skills is primarily a result of the developmental delay. In all cases, when making a determination of the adverse effects of the developmental delay, the team should consider the child's age, cognitive abilities, adaptive behavior skills and current daily living experiences, settings and opportunities.

The following questions are to guide documentation and determination of whether the disability has an adverse effect on the child's developmental/educational performance:

- Cognitive Abilities
  - How does the child respond to change within the home, childcare, classroom or school (schedules, teachers, classrooms, etc.)?
  - What is the child's level of attention?
    - While playing?
    - While completing assignments?
    - While listening to directions?
  - What is the child's memory/learning ability?
    - Short-term memory?
    - Long-term memory?
    - Multiple step directions?
    - Can the child attend to activities long enough to gain meaningful information or pleasure?
    - Does the child's attention change notably in different situations?
  - What are the child's problem solving abilities?
    - Responding to a question?
    - Determining how to complete a task?
    - Responding to a social situation?
    - To solve a problem? or work with others to solve the problem?
  - What is the child's ability in making judgments?
    - Playing safely?
    - Responding to questions?
    - Determining right from wrong?

- What is the child's ability to reason in an abstract manner?
  - Understand jokes?
  - Literal vs. abstract comprehension?

- Academic
  - Does the child exhibit appropriate listening comprehension skills?
  - Does the child use appropriate written expression skills?
  - Does the child use imitation of others to learn new skills?
  - Does the child have pre-reading skills or basic reading skills and use them in reading both for instruction and for pleasure?
  - What is the child's level of reading comprehension and is that level commensurate with his/her age level?
  - What is the child's math calculation ability and is it commensurate with his/her age level?
  - Does the child use mathematics reasoning skills appropriate to his/her age level?
  - Is the child's perception of concepts and topics realistic? accurate?
    - Does the child have the ability to generalize?
  - How appropriate is the child's level of meaningful visual perception?
    - Differentiate between realism vs. animated?
    - Differentiate math symbols?
    - Understand graphs and charts?
    - Differentiate between letters and words?
  - How age appropriate is the child's level of meaningful auditory perception?
    - Differentiate between environmental sounds?
    - Differentiate between levels of sounds?
    - Differentiate between voices?
    - Differentiate between words?

- Physical and Motor Abilities
  - Gross motor skills:
    - What are the child's physical abilities in the following areas?
      - Rolling over?
      - Crawling?
      - Standing?
      - Walking?
      - Running?
      - Jumping?
      - Balance?
      - Hopping?
      - Climbing?
  - Fine motor skills:
    - What are the child's physical abilities in the following areas?
      - Holding and eating with utensils?
      - Manipulation of and transfer of small objects?
      - Holding and using a crayon, pencil, or marker?
      - Cutting with scissors?

        - Folding paper?
        - Picking up small object from table to floor?
    - Perceptual skills:
        - What are the child's perceptual abilities in the following areas?
            - Copying with crayon, pencil, or marker?
            - Putting objects into folders, envelopes or slots?
            - Learning to read?
            - Learning to write?
            - Completing jigsaw puzzles or other board games?
            - Playing games, i.e. four square, jumping, soccer?

- Social and Emotional Behaviors
    - Does the child initiate play with peers/adults?
        - Engage in back and forth play with adult/caregiver?
        - Is the child able to take turns?
        - Understand win/lose in a game?
    - Does the child exhibit difficulties with social relationships?
        - When do these difficulties occur, i.e. recess, mealtime, and neighborhood?
        - What are some characteristics of these difficult social relationships?
    - What is the child's level of attention to:
        - Engage in individual play?
        - Engage in parallel or associative play?
        - Listen to story/discussion?
        - Follow directions?
    - Does the child respond in a positive manner to school demands?
        - Does the child follow simple age-appropriate routines/ rules?
        - Does the child follow rules established for a group of children (playground, school classroom, school building)?
    - Does the child become agitated easily?
        - Is the child able to deal with conflict in a positive manner?
        - How does the child exhibit his/her agitation?
        - Is the child friendly with peers and/or adults?
    - Does the child often express irritability?
        - What causes this irritability?
        - Is the child able to move away from the situation that is causing the irritability?
        - How does the child exhibit his/her irritability?
    - Does the child display aggression?
        - In what ways does the child display aggression, i.e., physical, verbal, etc.?
        - What causes the child to display aggression?
        - Is the child able to calm him/herself after an aggressive act?
    - Does the child exhibit an attitude of apathy in certain situations, events, etc.?
        - Under what circumstances does the child exhibit an attitude of apathy?
        - Is the child able to become motivated in the same situation that has contributed to the attitude of apathy?

- Does the child exhibit insight in particular situations?
  - Are these situations social situations that involve either another child or an adult?
  - In what ways does the child exhibit this insight or lack of insight?
  - Does the child express empathy when another child is hurt or sad?
- Does the child exhibit impulsivity?
  - How often does the child exhibit impulsivity?
  - Are there particular situations (during meals, play, preparation for another activity, etc.) in which the child exhibits impulsivity?
  - Is the child able to calm him/herself after exhibiting impulsivity?
- Does the child exhibit positive self control/regulation?
  - How does the child exhibit positive self control or regulation?
  - Does the child exhibit poor emotional control?
    - What are some characteristics of the poor emotional control (crying, shouting, yelling, hiding, etc.)?
    - Are there particular situations in which the child exhibits poor emotional control?
- Does the child exhibit depression and withdrawal?
  - In what ways does the child exhibit depression and withdrawal, i.e., refusing to participate, crying, hiding from others, refusal to work on assignments?
  - Are there particular situations in which the child exhibits depression and withdrawal?

- Communication Abilities
  - What is the child's ability to communicate?
    - Use vocabulary appropriate to his/her age/grade level?
    - Express needs and wants?
    - Follow simple commands?
  - What is the child's ability to initiate age-appropriate interaction or conversation with others?
    - How does the child prompt communication interactions?
  - Can the child engage in a shared conversation?
    - Does the child only ask and answer questions or does he/she contribute to conversations?
    - Can the child maintain a conversation by adding related information?
    - Can the child stay on topic?
    - What is the child's ability to generalize word meaning?
    - Can the child appropriately transition to a new topic?
    - Can the child initiate and terminate a conversation?
    - Can the child understand and respond to communication signals (vocal and/or body language) by multiple communication partner(s)?
    - Does the child ask questions at the appropriate times?
    - Can the child request clarification?
- Expressive or receptive language development
  - Vocabulary
    - Does the child use vocabulary appropriate for his/her age/grade level?
      - General vocabulary (prepositions, auxiliary verbs, pronouns)?

        - Content specific vocabulary (nouns, verbs, adjectives, adverbs)?
        - Figurative terms?
    - Does the child use and comprehend language appropriately for his/her age/grade level?
        - General vocabulary (prepositions, auxiliary verbs, pronouns)?
        - Content specific vocabulary (nouns, verbs, adjectives, adverbs)?
        - Figurative terms?
- Functional Language
    - Can the child tell a story or retell a recent or past event?
    - Does the child understand and use narrative discourse?
    - Can the child ask questions to get his/her needs met?
    - Can the child follow simple commands/directions?
    - Can the child answer basic questions of who, what, where?
- Academic Language
    - Does the child understand language with embedded concepts?
    - Does the child understand the language of directions (describe, explain, compare)?
    - Can the child follow multiple step directions?

- Speech reception or production
    - Reception
        - Does the child have phonemic/phonological awareness?
        - Does the child have the ability to process individual sounds?
    - Production/Articulation
        - Does the child use speech that is intelligible to an unfamiliar listener?
        - Does the child use appropriate prosodic features in:
            - Inflection?
            - Rate?
            - Pitch?
            - Fluency/rhythm?
            - Volume?
        - Does the child have oral motor problems?
        - Is the child's sound (quality, quantity) production age appropriate?
        - Does the child have clear speech?
        - Does the child have difficulty pronouncing particular sounds?

- Adaptive Skills
    - What is the child's ability to dress, feed, and bathe? Are these skills age-appropriate?
    - What is the child's participation level in and use of community resources?
    - What is the child's ability to initiate and complete familiar tasks at home and at school?
    - What is the child's ability to participate in recreation/leisure activities?

- Does the child meet the developmental milestones for his/her particular age

SECTION 6: RELATED DEFINITIONS

Chromosomal Disorder – Any of several syndromes resulting from abnormal or damaged chromosome(s); can result in mental retardation. (Hallahan and Kauffman, 2006, p. 532)

Criterion-Referenced Testing – Assessment wherein an individual's performance is compared to a goal or standard of mastery; differs from norm-referenced testing wherein an individual's performance is compared to the performance of others. (Hallahan and Kauffman, 2006, p. 533)

Curriculum-Based Assessment (CBA) – A formative evaluation method designed to evaluate performance in the particular curriculum to which children are exposed; usually involves giving children a small sample of items from the curriculum in use in their schools; proponents argue that CBA is preferable to comparing children with national norms or using tests that do not reflect the curriculum content learned by children. (Hallahan and Kauffman, 2006, p. 533)

Daily Living Skills – Skills required for living independently such as dressing, toileting, bathing, cooking, and other typical daily activities of non disabled adults. (Hallahan and Kauffman, 2006, p. 533)

Down Syndrome – A condition resulting from an abnormality with the twenty-first pair of chromosomes; the most common abnormality is a triplet rather than a pair (the condition sometimes referred to as trisomy 21); characterized by mental retardation and such physical signs as slanted-appearing eyes, hypotonia, a single palmer crease, shortness, and a tendency toward obesity. (Hallahan and Kauffman, 2006, p. 534)

Fragile X Syndrome – A condition in which the bottom of the X chromosome in the twenty-third pair of chromosomes is pinched off; can result in a number of physical anomalies as well as mental retardation; occurs more often in males than females; thought to be the most common hereditary cause of mental retardation. (Hallahan and Kauffman, 2006, p. 534)

Functional Academics – Practical skills (e.g., reading a newspaper or telephone book) rather than academic learning skills. (Hallahan and Kauffman, 2006 p. 535)

Hydrocephalus – A condition characterized by enlargement of the head because of excessive pressure of the cerebrospinal fluid. (Hallahan and Kauffman, 2006, p. 535)

Mental Age – Age level at which a person performs on an IQ test, used in comparison to chronological age to determine IQ. IQ = (mental age + chronological age) x 100. (Hallahan and Kauffman, 2006, p. 537)

Metacognition – One's understanding of the strategies available for learning a task and the regulatory mechanisms needed to complete the task. (Hallahan and Kauffman, 2006, p. 537)

Microcephalus – A condition causing development of a small, conical-shaped head; proper development of the brain is prevented, resulting in mental retardation. (Hallahan and Kauffman, 2006, p. 537)

Natural Supports – Resources in person's environment that can be used for support, such as friends, family, co-workers. (Hallahan and Kauffman, 2006, p. 537)

Normal Curve – In connection with a standardized test, the typical distribution of how scores deviate from the mean, also called a bell curve or bell-shaped curve. (Norlin, 2003, p. 156)

Normalization – A philosophical belief in special education that every individual, even the most disabled, should have an educational and living environment as close to normal as possible. (Hallahan and Kauffman, 2006, p. 537)

Norm-Referenced Test (NRT) – Comparison of one child's performance, as measured by the test score, with the performance of the norm, allowing fine distinctions among children and identification of where a child stands in relation to that group; typically developed by commercial test companies. (Norlin, 2003, p. 157)

Prader-Willi Syndrome – Caused by inheriting from one's father a lack of genetic material on the fifteenth pair of chromosomes; leading genetic cause of obesity; degree of mental retardation varies, but the majority falls within the mildly mentally retarded range. (Hallahan and Kauffman, 2006, p. 538)

Self-Determination – The ability to make personal choices, regulate one's own life, and be a self-advocate; a prevailing philosophy in education programming for people with mental retardation; having control over one's life, not having to rely on others for making choices about one's quality of life; develops over one's life span. (Hallahan and Kauffman, 2006, p. 540)

Self-Regulation – Refers generally to a person's ability to regulate his or her own behavior (e.g., to employ strategies to help in a problem-solving situation); an area of difficulty for persons who are mentally retarded. (Hallahan and Kauffman, 2006, p. 540)

Systematic Instruction – Teaching that involves instructional prompts, consequences for performance and transfer of stimulus control; often used with children with mental retardation. (Hallahan and Kauffman, 2006, p. 541)

Systematic Observation of Behavior – An observational method of assessment in which a "trained observer watches behavior in a natural setting, records or classifies each behavior objectively as it occurs or shortly thereafter, ensures that the obtained data are replicable, and converts the data into quantitative information," J.M. Sattler, *Assessment of Children (3rd ed.)*. (Jerome M. Sattler 1986, p. 473) (Norlin, 2003, p. 234)

Williams Syndrome – A condition resulting from deletion of material in the seventh pair of chromosomes; often results in mild to moderate mental retardation, heart defects, and elfin facial features; people affected often display surprising strengths in spoken language and sociability while having severe deficits in spatial organization, reading, writing, and math. (Hallahan and Kauffman, 2006, p. 542)

SECTION 7: FREQUENTLY ASKED QUESTIONS

1. What is Intelligence?

   Intelligence refers to a general mental capability. It involves the ability to reason, plan, solve problems, think abstractly, comprehend complex ideas, learn quickly, and learn from experience. Although not perfect, intelligence is represented by Intelligent Quotient (IQ) scores obtained from standardized tests given by a trained professional. (AAMR). Retrieved from World Wide Web, April 11, 2006. www.aamr.org

2. What is Adaptive Behavior?

   Adaptive behavior is the collection of conceptual, social, and practical skills that people have learned so they can function in their everyday lives. Significant limitations in adaptive behavior impact a person's daily life and affect the ability to respond to a particular situation or to the environment. Limitations in adaptive behavior can be determined by using standardized tests that are normed on the general population including people with disabilities and people without disabilities. Examples of specific Adaptive Behavior skills include:

   - *Conceptual skills: receptive and expressive language, reading and writing, money concepts, self-directions.*
   - *Social skills: interpersonal, responsibility, self-esteem, gullibility (likelihood of being tricked or manipulated), naiveté, follows rules, obeys laws, avoids victimization.*
   - *Practical skills: personal activities of daily living such as eating, dressing, mobility and toileting, instrumental activities of daily living such as preparing meals, taking medication, using the telephone, managing money, using transportation and doing housekeeping activities; occupational skills, maintaining a safe environment. (AAMR) Retrieved from World Wide Web, April 11, 2006, www.aarm.org*

3. Is a medical diagnosis required in order for a child to be verified as a child with a developmental delay?

   No, not usually. If the child is born with a condition that has a high probability to result in developmental delays, i.e. Down Syndrome, a physician's report regarding that condition will be required as a part of the Multidisciplinary Evaluation Team (MDT) process. In addition, if the child does not have a known

medical condition but is experiencing developmental delays, the MDT may request any relevant medical information from the child's physician with the parent's written permission.

4. If the child has not made progress by age nine, can the MDT continue to use the verification of developmental delay?

   No. Both federal and state laws state that the verification of developmental delay can only be used through age eight years. Therefore, before the child reaches age nine years, the IEP team should review the IEP and determine if there continues to be areas of concern. If so, with the parent's written permission, the IEP Team/MDT should begin the re-evaluation process to determine if the child meets the guidelines for verification with another disability.

SECTION 8: REFERENCES AND RESOURCES

REFERENCES

American Association on Mental Retardation (AAMR) www.aamr.org

Berndt, Sandra and Elizabeth Burmaster. "Cognitive Disability Evaluation and Decision-Making". Wisconsin Department of Public Instruction, 2002 (Retrieved from www.dpi.wi.gov/sped 06/12/06).

Hallahan, Daniel P., and James M. Kauffman. Exceptional Learners, 10th Edition. Boston: Ally and Bacon, 2006.

Nebraska Department of Education, Rule 51: Regulations and Standards for Special Education Programs. Title 92, Nebraska Administrative Code, Chapter 51. Revised May 13, 2006.

Norlin, John W. Special Education Dictionary, Revised Edition. Horsham, Pennsylvania: LRP Publications, 2003.

WEB SITES

Children Who Are Mentally Retarded http://www.aacap.org/publications/factsfam/retarded.htm

Clearinghouse on Disability Information Office of Special Education and Rehabilitation Services (OSERS) www.ed.gov/about/offices/list/osers/index.html

Council of Exceptional Children (CEC) www.cec.sped.org

Education Resources Information Center (ERIC) www.ed.gov/EdFed/ERIC.htm

Exceptional Parent www.eparent.com

Guide to Disability Resources on the Internet www.disabilityresources.org

Mental Health Mental Retardation Center http://www.atcmhmr.com

Mental Retardation Among Children http://www.cdc.gov/ncbddd/dd/ddmr.htm

National Dissemination Center for Children with Disabilities (NICHCY) www.nichcy.org

National Down Syndrome Congress www.ndscenter.org

National Rehabilitation Information Center (NARIC) www.NARIC.com

President's Committee on Mental Retardation http://www.acf.dhhs.gov/programs/pcmr

The Arc of the United States http://www.thearc.org

The Association for Severely Handicapped (TASH) www.tash.org/index.htm

DISABILITY CATEGORY:

Hearing Impairment

DISABILITY CATEGORY: Hearing Impairment

SECTION 1: INTRODUCTION

These verification guidelines were written to provide parents, teachers, special education personnel, administrators, and other professionals' information on the identification, verification, and determination of eligibility for special education services for children who have a hearing loss.

This category of children has been defined by both federal and state regulations. A three-part eligibility requirement for a child to be verified as a child with a hearing impairment is as follows:

- Meet verification criteria (92 NAC 51.006);
- Documentation of adverse effect on educational performance;
- Determination that a need for special education is evident.

SECTION 2: STATE DEFINITION

- **Hearing impairment**- To qualify for special education services in the category of hearing impairment, a child must have impairment in hearing which: is so severe that the child is impaired in processing linguistic information through hearing with or without amplification, or is permanent or fluctuating, and adversely affects the child's development or educational performance.

  This term combines the state definition of "deaf" contained in Nebraska Rev. Stat. 79-1118.01(4), the state definition of "hard of hearing" 79-1118.01(7), the federal definition of "deafness" in 34 CFR 300.8(c)(3), and the federal definition of "hearing impairment" in 34 CFR 300.8(c)(5).

Nebraska uses the generic term hearing impairment to include children defined separately under the federal regulations as deaf or hearing impaired. The Nebraska definition would also encompass those children who may be referred to as deaf or hard of hearing. Throughout this document the term deaf or hard of hearing (D/HH) will be used. Nebraska also extends its definition to include permanent and fluctuating losses and recognizes that these losses may have adverse effects on development, as well as educational performance. In those respects, Nebraska has created more flexibility in identifying and serving children with hearing losses.

Under the state definition, any child with a hearing loss, regardless of type, degree, configuration, etiology, or permanency of the loss may be eligible for special education services. The initial task of the Multidisciplinary Evaluation Team (MDT) and the continuing task of the Individual Family Service Plan (IFSP) and Individualized Educational Program (IEP) teams are to determine if the hearing loss has adverse effects on the child's development or educational performance.

SECTION 3: MULTIDISCIPLINARY EVALUATION TEAM (MDT) COMPOSITION

The Multidisciplinary Team (MDT) should include at least the following members:

- The child's parent(s);
- The child's teacher or teacher qualified to teach a child that age;
- An educator endorsed to teach a child with hearing impairments;
- A speech-language pathologist;
- A school district administrator or designated representative.

In addition, the MDT should consider the following team members:

- An audiologist or an individual qualified to interpret the results of the audiological report.

SECTION 4: VERIFICATION GUIDELINES

In order for a child to be verified as a child with a hearing impairment, the evaluation should include:

- A written report, with diagnostic documentation, signed by a licensed or certified audiologist verifying a unilateral or bilateral hearing loss based on a current audiological evaluation.
- The analysis and documentation of the adverse effect the impairment has or can be expected to have on the development or educational performance of the child in at least one of the following areas:
    - Effective communication;
    - Expressive or receptive language development;
    - Speech reception or production;
    - Academic and vocational performance;
    - Cognitive ability;

- ❖ Social or emotional competence;
- ❖ Adaptive behavior skills; or
- ❖ Result in a social/behavioral disability.

Children with a hearing loss represent a heterogeneous group. Communication preferences and uses by the parents, child, and family must be considered when planning and conducting assessments/evaluations to determine the child's present level of functioning, development, or progress in acquiring and using language.

Implications for Assessment/Evaluation:

In observing, assessing, and evaluating the child's communication abilities/levels, the following factors related to the communication modality of the child must be considered:

- ➢ Communication mode(s) used by the child (and parents);
- ➢ Sophistication of language used by child and partners (parents, siblings, teachers, peers) in the preferred communication mode(s);
- ➢ Communication and language used with and by the child and interacting partners in various environments (e.g., home, school, playground, etc.);
- ➢ Amount of exposure/access to and use of language in the chosen communication mode(s).

SECTION 5: PROCEDURES TO DETERMINE ADVERSE EFFECT ON DEVELOPMENT/EDUCATIONAL PERFORMANCE

FACTORS TO CONSIDER

Many factors must be considered in determining if a hearing loss is causing or can be expected to produce significant delays in the child's development or educational performance. These factors include, but are not limited to:

- ➢ Type, degree, and configuration of the hearing loss
- ➢ Cause (if known)
- ➢ Nature/status (permanent, fluctuation, etc.)
- ➢ Age of onset
- ➢ Age of identification

- Current age
- Amplification history
- Intervention history and response
- Communication modes used by parents, child, and family
- Language exposure/access and use
- Relevant family/medical history
- Current educational placement
- Current levels of performance (communication, language, academic, social-emotional)
- Postsecondary/transition needs
- Social/emotional skills
- Adaptive behaviors

Examination of each of these factors may lead to additional considerations. Audiologists, teachers of the Deaf/Hard of Hearing (D/HH), and speech-language pathologists (SLP) are the primary professionals who can determine how these factors may impact the child. Parents, medical professionals, classroom teachers, and the child him/herself can also provide information important in determining the impact of the hearing loss. When concomitant learning or developmental needs exist, the team must determine which condition is the primary cause of the need.

The MDT must determine whether the adverse effects on communication, language, educational performance, or social competence are primarily a result of the hearing impairment.

The following questions are to guide documentation and determination of whether the disability has an adverse effect on the child's developmental/educational performance.

- Effective signed, spoken, or written communication
  - Turn taking
    - Does the child only ask and answer questions or does he/she contribute to a conversation?
    - Does the child ask questions in class at the appropriate times?
    - Does the child initiate and terminate a conversation?
    - Does the child understand and respond to signals (verbal, signed, and/or body language) by multiple communication partner(s)?
    - Does the child know how to respond to signals by a communication partner?
  - Maintaining interaction
    - Does the child stay on topic?
  - Does the child appropriately transition to a new topic?
  - Does the child maintain a conversation by adding related information?

- Register (any of the varieties of a language that the child uses in a particular social context)
  - Does the child use appropriate register for the communication situation?
- Does the child adjust his/her register appropriately for the communication situation?

- Expressive or receptive language development
  - Vocabulary
    - Does the child comprehend and use vocabulary appropriate for his/her age/grade level in:
      - General vocabulary?
      - Content specific vocabulary?
      - Figurative language?
  - Functional Language
    - Does the child tell a story?
    - Does the child understand and use narrative discourse?
    - Does the child ask questions to get his/her needs met?
    - Does the child follow simple commands?
    - Does the child answer basic questions?
    - Does the child code switch to match the modality of the communication partner?
  - Academic Language
    - Does the child understand and use language with embedded concepts?
    - Does the child understand and use the language of directions (describe, explain, compare, etc.)?
    - Does the child follow multiple step directions?
    - Does the child understand and use expository text structures?

- Speech reception or production
  - Reception
    - Phonemic/phonological awareness
      - Does the child have the ability to process individual sounds?
  - Speechreading
    - Is the child skilled at speechreading?
  - Production/Articulation
    - Does the child use speech that is intelligible to an unfamiliar listener?
    - Does the child use appropriate prosodic features in:
      - Inflection?
      - Rate?
    - Does the child have oral motor problems?
    - Is the child's speech production age appropriate?
  - Pre-academic
    - Is the child meeting age appropriate milestones?

- Cognition
  - Critical Thinking/Judgment
    - Does the child compare/contrast, analyze, categorize, differentiate when interpreting data or information?
  - Attention/Focus
    - Does the child focus on tasks in which they are involved?
    - Does the child follow multiple directions?
    - Does the child continue to focus on tasks when distractions are present?
  - Problem Solving
    - Does a child come up with multiple solutions to a problem?
  - Decision Making
    - Does a child consider the possible consequences and make good choice/decisions?

- Academic or vocational performance
  - Academic:
    - Does the child meet district standards (outcomes) for his/her grade level?
    - Does the child's progress reflect his/her ability levels?
    - Reading
      - Does the child have the perceptual, conceptual, and linguistic base to support the reading process?
      - Does the child interpret meaning from print (pictures, words, graphs)?
      - Does the child decode printed materials accurately and fluently?
      - Does the child use contextual cues to help him/her understand passages?
      - Does the child interpret literature?
      - Does the child identify the components of a variety of literary genre?
      - Does the child respond correctly to basic questions about a passage?
      - Does the child apply reading skills to acquire information from print?
    - Math
      - Does the child understand mathematical concepts and processes in:
      - Concept of number?
      - Mathematical language?
      - Mathematical reasoning?
      - Mathematical relationships?
      - Does the child apply the fundamentals of math to everyday life?
      - Does the child organize and interpret graph representations of data (charts, bar graphs, pie-graphs, etc.)?
      - Does the child understand patterns that describe mathematical relationships?
    - Written Language: Consider the following areas:
      - Idea development
      - Organization
      - Word choice
      - Voice
      - Sentence fluency
      - Conventions

- Vocational
  - Does the child have communication skills required to obtain and maintain employment?
  - Does the child advocate for him/herself?

- Social or emotional competence
  - Independent/Self Advocacy Skills
    - Does the child function independently in social situations?
    - Does the child communicate to get his/her educational needs met?
      - Does he/she ask for clarification when needed?
      - Does he/she ask for preferential seating when needed?
    - Does he/she use assistive devices appropriately?
    - Does the child accept responsibility for his/her own actions?
  - Self-esteem
    - Is the child's self-esteem affected by his/her hearing loss?
    - Does the child have appropriate deaf relationships?
    - Does the child have appropriate self-confidence?
    - Does the child have problem solving skills?
    - Is the child assertive?
    - Does the child have appropriate peer relationships?

SECTION 6: RELATED DEFINITIONS

Amplification – Refers to a variety of devices or systems designed to enhance the sound signal, primarily speech, received by the individual with a hearing impairment.

Audiogram – A graphic representation of thresholds of sensitivity to auditory stimuli.

Audiological Evaluation – A series of tests consisting of evaluations designed to determine the presence or absence of hearing impairment for verification purposes. May include, but is not limited to:

- **Pure tone audiometry (air conduction/bone conduction):** threshold evaluation of hearing sensitivity designed to determine the amount, type, and configuration of hearing loss.
- **Acoustic Immittance Measurements:** a series of procedures primarily designed to objectively determine the integrity of the outer and middle ear mechanism. May include, but is not limited to, tympanometry, acoustic reflex testing, reflex decay, and physical volume measurements.
- **Speech reception and recognition:** measures of auditory function utilizing speech stimuli.
- **Otoacoustic Emissions Tests (OAE):** objective evaluation involving measurement of sound emitted from the ear linked in time to a stimulus and measured in the external ear canal. One of the two primary tests used with very young children and the difficult to test population.

- **Auditory Brainstem Response (ABR):** objective evaluation involving measurements of neurological activity in the brain in response to auditory stimuli.
- **Tympanometry:** A method of measuring the middle ear function. An abnormal tympanometry can indicate middle ear dysfunction (fluid in the middle ear due to otitis media, problems with the middle ear bones and muscles, and/or problems with the eardrum).

Audiologist, licensed or certified – An individual who holds a license to practice audiology in Nebraska, or a Nebraska Department of Education Endorsement in Educational Audiology.

Cochlear Implant – A small, complex, electronic device that is surgically placed under the skin behind the ear. A cochlear implant can help to provide a sense of sound to a person who is hearing impaired.

Current Audiogram – An audiogram completed within the previous 12 months. In some instances it may be necessary to have more recent audiological information.

Diagnostic Documentation – Testing results.

Hearing Loss Types:

- **Auditory neuropathy:** a hearing impairment of the auditory nerve with normal sensory function.

- **Conductive hearing loss:** a hearing impairment of the outer or middle ear that prevents sound from being carried to the inner ear. This type of hearing loss often can be medically treated.

- **Sensorineural hearing loss:** a hearing impairment of the inner ear (cochlea or auditory nerve is damaged or defective). This type of hearing loss is usually permanent.

- **Mixed hearing loss:** a hearing impairment involving both a conductive loss and a sensorineural hearing loss. In other words, there may be damage in the outer or middle ear and in the inner ear (cochlea) or auditory nerve.

Hearing Loss Descriptors:

- **Fluctuating hearing loss:** a hearing loss that varies over time.

- **Progressive hearing loss:** a hearing impairment that becomes more severe over time.

- **Bilateral hearing loss:** a hearing impairment existing in both ears.

- **Unilateral hearing loss:** a hearing impairment existing in one ear only.

SECTION 7: FREQUENTLY ASKED QUESTIONS

1. Would a child who has a cochlear implant be verified as a child with a hearing impairment?

   A cochlear implant is an assistive hearing device. An audiological assessment of the child without the cochlear implant should be used for initial verification purposes. If the MDT determines the child meets other verification criteria, the child would be verified as a child with a hearing impairment.

2. If a child has a history of middle ear infections, can the child be verified as a child with a hearing impairment?

   Yes, if the MDT determines that the child has residual hearing loss and meets other verification criteria.

3. Would a child with Auditory Processing Disorder qualify as a child with a hearing impairment?

   No, but the child may qualify as a child with a speech language disorder.

4. Is an evaluation by a school psychologist required for a child to qualify as a child with a hearing impairment?

   Documentation is required of the adverse effects expected that the child's hearing loss has on the six areas described in Section 4 of the Hearing Impaired verification guidelines.

5. Should the MDT request medical information from the child's physician?

   Yes. The Multidisciplinary Evaluation Team (MDT) should determine the information needed from physicians and others.

6. What should happen if the IEP team suspects that a child who is verified SLD has a hearing loss?

   The IEP team gathers information to support the suspicion of hearing loss and submits it to the MDT team for further testing.

SECTION 8: REFERENCES AND RESOURCES

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Matkin, N. (1999, October. *Mild Hearing Loss in Children: When is "Mild" a Misnomer?* Paper presented at the 20th Annual Conference on Mainstreaming Children with Hearing Loss, Springfield, MA.

Moeller, Mary Pat. Boys Town National Research Hospital, Center on Childhood Deafness, 2002.

Nebraska Department of Education. Rule 51: Regulations and Standards for Special Education Programs. Title 92, Nebraska Administrative Code, Chapter 51.

WEB SITES

Alexander Graham Bell Association for Deaf and Hard of Hearing. www.agbell.org

American Hearing Research Foundation (AHRP) www.american-hearing.org

American Speech Language Hearing Association. www.asha.org

Better Hearing Institute www.betterhearing.org

Boys Town National Research Hospital (BTNRH) www.boystownhospital.org

Clearinghouse on Disability Information Office of Special Education and Rehabilitation Services (OSERS) www.ed.gov/about/offices/list/osers/index.html

Education Resources Information Center (ERIC) www.ed.gov/EdFed/ERIC.htm
Gallaudet University www.gallaudet.edu

Guide to Disability Resources on the Internet www.disabilityresources.org

National Association of the Deaf (NAD) www.nad.org

National Dissemination Center for Children with Disabilities (NICHCY) www.nichcy.org

National Institute on Deafness and Other Communication Disorders Information Clearinghouse (NIDCD) www.nidcd.nih.org

National Organization for Hearing Research Foundation (NOHR) www.nohrfoundation.org

National Rehabilitation Information Center (NARIC) www.NARIC.com

Trace Research and Development Center (University of Wisconsin—Madison) www.trace.wisc.edu

NEBRASKA REGIONAL PROGRAMS FOR CHILDREN WHO ARE DEAF OR HARD OF HEARING

Central/Western Partnership: 402-463-5611

Metro Regional Program: 402-339-2090

Northeast Nebraska Regional Program: 402-644-2507

Southeast Nebraska Regional Program: 402-436-1896

DISABILITY CATEGORY:

Mental Handicap

DISABILITY CATEGORY: Mental Handicap

SECTION 1: INTRODUCTION

This technical assistance document was written to provide parents, teachers, special education personnel, administrators, and other professionals with information on the identification, verification, and determination of eligibility for special education services for children with mental handicaps.

This disability category has been defined by both federal and state regulations. A three-part eligibility requirement for a child to be verified as a child with a mental handicap is as follows:

- Meet verification criteria (92 NAC 51.006);
- Documentation of adverse effect on educational performance; and
- Determination that a need for special education is evident.

There are three important components of the definition for children to be verified as having a mental handicap:

1) Intellectual functioning
2) Adaptive behavior
3) Educational/Developmental performance

SECTION 2: STATE DEFINITION

- **Mental handicap-** To quality for special education services in the category of mental handicap, the child must demonstrate: significantly sub average general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period that adversely affects a child's educational or in the case of a child below age five, a child's developmental performance. This term parallels the federal definition of mental retardation in the regulations implementing IDEA 2004.

SECTION 3: MULTIDISCIPLINARY EVALUATION TEAM (MDT) COMPOSITION

The Multidisciplinary Team (MDT) should include at least the following members:

- The child's parents;

- A school psychologist or licensed psychologist;

- At least one of the child's teachers or a teacher qualified to teach a child that age;
- A special educator; and
- A school district administrator or a designated representative.

SECTION 4: VERIFICATION GUIDELINES

In order for a child to be verified as a child with a mental handicap, the evaluation should include the analysis and documentation of functioning in:

- Significantly below average functioning, at least 2.0 standard deviations below the mean (30 standard score points) in adaptive behavior across settings (school, home, and community), based on assessment and analysis of adaptive skills in the <u>three component areas</u> of: adaptive behavior, academic achievement, and intellectual functioning

1. **Adaptive behavior**
    - Communication
    - Self-care
    - Independent living skills
    - Safety
    - Participation and use of community resources
    - Work-related performance skills
    - Travel skills
    - Recreation/leisure
    - Social-interpersonal skills
    - Self-direction
    - Motor skills

2. **Academic achievement**
    - Individual achievement testing
    - Classroom assessment data
        - Oral expression
        - Listening comprehension
        - Written expression
        - Basic reading skills
        - Reading comprehension
        - Mathematics calculation
        - Mathematics reasoning
    - Norm-referenced testing
    - State and district-wide assessment
    - Curriculum-based assessment
    - Teacher anecdotal records

- For a child below age 5, the evaluation shall include the analysis and documentation of significantly below average functioning in basic concepts and pre-academic skills.

3. **Intellectual functioning**
    - Attention
    - Perception
    - Memory
    - Problem solving
    - Logical thought
    - Speed of processing and/or capacity for abstract thinking
    - Other relevant factors which impact learning

- Documentation of adverse effect on development and/or educational performance

- Determination that a need for special education is evident

These characteristics are generally evident during the child's early years and must adversely affect developmental and/or educational performance. A mental handicap is an educational verification and is a term used to facilitate early identification by public school personnel.

The following formal/ informal evaluations and assessments to identify strengths and limitations may include a combination of:

- Information provided by parents

- Individual achievement test

- Classroom assessment data

- Norm referenced testing including
    - Adaptive behavior measures
    - Academic achievement
    - Intellectual assessment

- Criterion-referenced assessment

- Curriculum-based assessment

- State and District-wide Assessment

- Observation and analysis of behavior

- Teacher anecdotal records

- History of interventions and responses
- Medical history and medications
- Developmental inventories
- Speech and language assessments
- Social behavior

Sensory impairments, medical or health conditions, cultural differences, or a lack of instruction may not be the basis for verification of a mental handicap. A medical diagnosis is not required in order for a child to be verified as having a mental handicap.

SECTION 5: PROCEDURES TO DETERMINE ADVERSE EFFECT ON DEVELOPMENT/EDUCATIONAL PERFORMANCE

FACTORS TO CONSIDER

Many factors must be considered in determining if a mental handicap is causing, or can be expected to produce significant delays in the child's development or educational performance. The factors include, but are not limited to:

- Age of identification
- Current age
- History of intellectual delays
- History of adaptive behavior delays
- History of intervention and response
- Relevant family/medical history
- Current educational placement
- Current levels of performance
- Current language delays
- Current motor delays

- Vocational/postsecondary transition needs

Examination of these factors may lead to additional factors to consider. Psychologists, teachers of children with mental disabilities, and speech language pathologists (SLP) are the primary professionals who can determine how these factors may impact the child. Parents, teachers, medical professionals, and the child him/herself can also provide important information in determining the impact of the mental handicap.

The MDT must determine whether the adverse effects on communication, language, educational performance, or adaptive behavior skills are primarily a result of the mental handicap.

The following questions are to guide documentation and determination of whether the disability has an adverse effect on the child's developmental/educational performance.

- Delays in some developmental milestones
  - What is the child's level of attention (i.e., time on task, ability to listen to story/discussion, ability to complete assignments, etc.)?
  - Is the child's perception of concepts and topics realistic (i.e., ability to generalize)?
  - Does the child meet developmental milestones (i.e., emotional, cognitive, language, motor, social) for his/her age?

- Inability to comprehend and utilize instructional information
  - Does the child use appropriate oral expression skills?
  - Does the child exhibit appropriate listening comprehension skills?
  - Does the child use appropriate written expression skills?
  - Does the child have basic reading skills and use those skills in reading both for instruction and for pleasure?
  - What is the child's reading comprehension level and is that level commensurate with his/her age level?
  - What is the child's math calculation ability and is it commensurate with his/her age level?
  - Does the child use mathematical reasoning skills appropriate to his/her age level?

- Ability to generalize skills consistently
  - Does the child follow directions given by the teacher or other adults?
  - Does the child exhibit the ability to work independently?
  - Does the child follow simple rules?
  - Does the child respond in a positive manner to school structure and routines?

- Ability to communicate fluently
  - Does the child interact meaningfully with others?
  - What is the child's ability to generalize word meanings?
  - What is the child's ability to understand questions?

- What is the child's ability to understand and use both nonverbal and verbal communication?
- What is the child's ability to initiate conversation with others?
- In play situations, does the child interact with others?

- Ability to demonstrate problem-solving skills when information is presented in traditional academic curriculum
  - How does the child respond to change within the classroom or school (i.e. schedules, teachers, classrooms, etc.)?
  - When presented with a problem within the classroom setting, what is the child's ability to solve that problem with others?

SECTION 6: RELATED DEFINITIONS

Adaptive Behavior – is the collection of conceptual, social, and practical skills that people have learned so they can function in their everyday lives. Significant limitations in adaptive behavior impact a person's daily life and affect the ability to respond to a particular situation or to the environment. Limitations in adaptive behavior can be determined by using standardized tests that are normed on the general population including people with disabilities and people without disabilities. Examples of specific Adaptive Behavior skills include:

- Conceptual skills: receptive and expressive language, reading and writing, money concepts, self-directions.
- Social skills: interpersonal, responsibility, self-esteem, gullibility (likelihood of being tricked or manipulated), naiveté, follows rules, obeys laws, avoids victimization.
- Practical skills: personal activities of daily living such as eating, dressing, mobility, and toileting; instrumental activities of daily living such as preparing meals, taking medication, using the telephone, managing money, using transportation, and doing housekeeping activities; occupational skills, maintaining a safe environment. (AAMR). Retrieved from World Wide Web, April 11, 2006. www.aarm.org

Chromosomal disorder – Any of several syndromes resulting from abnormal or damaged chromosome(s); can result in mental retardation. (Hallahan and Kauffman, 2006, p. 532)

Criterion-referenced testing – Assessment wherein an individual's performance is compared to a goal or standard of mastery; differs from norm-referenced testing wherein an individual's performance is compared to the performance of others. (Hallahan and Kauffman, 2006, p. 533)

Curriculum-based assessment (CBA) – A formative evaluation method designed to evaluate performance in the particular curriculum to which children are exposed; usually involves giving children a small sample of items from the curriculum in use in their schools; proponents argue that CBA is preferable to comparing children with

national norms or using tests that do not reflect the curriculum content learned by children. (Hallahan and Kaufmann, 2006, p. 533)

Daily living skills – Skills required for living independently such as dressing, toileting, bathing, cooking, and other typical daily activities of nondisabled adults. (Hallahan and Kauffman, 2006, p. 533)

Down Syndrome – A condition resulting from an abnormality with the twenty-first pair of chromosomes; the most common abnormality is a triplet rather than a pair (the condition sometimes referred to as trisomy 21); characterized by mental retardation and such physical signs as slanted-appearing eyes, hypotonia, a single palmer crease, shortness, and a tendency toward obesity. (Hallahan and Kauffman, 2006, p. 534)

Fragile X Syndrome – A condition in which the bottom of the X chromosome in the twenty-third pair of chromosomes is pinched off; can result in a number of physical anomalies as well as mental retardation; occurs more often in males than females; thought to be the most common hereditary cause of mental retardation. (Hallahan and Kauffman, 2006, p. 534)

Functional academics – Practical skills (e.g., reading a newspaper or telephone book) rather than academic learning skills. (Hallahan and Kauffman, 2006, p. 535)

Hydrocephalus – A condition characterized by enlargement of the head because of excessive pressure of the cerebrospinal fluid. (Hallahan and Kauffman, 2006, p. 535)

Intelligence – Refers to a general mental capacity. It involves the ability to reason, plan, solve problems, think abstractly, comprehend complex ideas, learn quickly, and learn from experience. Although not perfect, intelligence is represented by Intelligent Quotient (IQ) scores obtained from standardized tests given by a trained professional. (AAMR). Retrieved from World Wide Web, April 11, 2006. www.aamr.org

Mental age – Age level at which a person performs on an I.Q. test, used in comparison to chronological age to determine I.Q. I.Q. = (mental age + chronological age) x 100. (Hallahan and Kauffman, 2006, p. 537)

Metacognition – One's understanding of the strategies available for learning a task and the regulatory mechanisms needed to complete the task. (Hallahan and Kauffman, 2006, p. 537)

Microcephalus – A condition causing development of a small, conical-shaped head; proper development of the brain is prevented, resulting in mental retardation. (Hallahan and Kauffman, 2006, p. 537)

Natural supports – Resources in person's environment that can be used for support, such as friends, family, co-workers. (Hallahan and Kauffman, 2006, p. 537)

Normal curve – In connection with a standardized test, the typical distribution of how scores deviate from the mean; also called a bell curve or bell-shaped curve. (Norlin, 2003, p. 156)

Normalization – A philosophical belief in special education that every individual, even the most disabled, should have an educational and living environment as close to normal as possible. (Hallahan and Kauffman, 2006, p. 537)

Norm-referenced test (NRT) – Comparison of one student's performance, as measured by the test score, with the performance of the norm allowing fine distinctions among students and identification of where a child stands in relation to that group; typically developed by commercial test companies. (Norlin, 2003, p. 157)

Prader-Willi syndrome – Caused by inheriting from one's father a lack of genetic material on the 15th pair of chromosomes; leading genetic cause of obesity; degree of mental retardation varies, but the majority fall within the mildly mentally retarded range. (Hallahan and Kauffman, 2006, p. 538)

Self-determination – The ability to make personal choices, regulate one's own life, and be a self-advocate; a prevailing philosophy in education programming for people with mental retardation; having control over one's life; not having to rely on others for making choices about one's quality of life, develops over one's life span. (Hallahan and Kaufmann, 2006, p. 540)

Self-regulation – Refers generally to a person's ability to regulate his or her own behavior (e.g., to employ strategies to help in a problem-solving situation); an area of difficulty for persons who are mentally retarded. (Hallahan and Kauffman, 2006, p. 540)

Systematic instruction – Teaching that involves instructional prompts, consequences for performance, and transfer of stimulus control; often used with children with mental retardation. (Hallahan and Kauffman, 2006, p. 541)

Systematic observation of behavior – An observational method of assessment in which "a trained observer watches behavior in a natural setting, records or classifies each behavior objectively as it occurs or shortly thereafter, ensures that the obtained data are replicable, and converts the data into quantitative information." J.M. Sattler, *Assessment of Children (3rd ed.)* Jerome M. Sattler 1986, p. 473 (Norlin, 2003, p. 234)

Williams Syndrome – A condition resulting from deletion of material in the seventh pair of chromosomes; often results in mild to moderate mental retardation, heart defects, and elfin facial features; people affected often display surprising strengths in spoken language and sociability while having severe deficits in spatial organization, reading, writing, and math. (Hallahan and Kauffman, 2006, p. 542)

SECTION 7: FREQUENTLY ASKED QUESTIONS

1. Is a medical diagnosis required in order for a child to be verified as a child with a mental handicap?

   No. A medical diagnosis is not required as part of the Multidisciplinary Team (MDT) process. However, the MDT may request any relevant medical information from the child's physician with the parent's written permission. This information cannot be used as the sole basis for verification.

2. Can children with mental handicaps also have other disabilities?

   Yes. Many times the child will have another disability; however, it is important to determine the primary disability. Related services may be provided for other disabilities.

3. Is there another term that is used for mental handicap?

   Yes. Other states and organizations use several different terms; States use terms that include: Mental Retardation, Cognitive Disability, Cognitive Impairment, and Mental Impairment. The President's Committee on Mental Retardation has used the term Intellectual Disabilities for some time. IDEA 2004 and the Federal IDEA regulations (2006) use the term Mental Retardation.

4. Do all children with a mental handicap have the same I.Q. level?

   No. If you refer to the definition for mental handicap listed earlier in this document, you will find that the I.Q. level can vary from a range of 70 or lower. Characteristics and needs of children will vary across these I.Q. ranges.

5. Can a child who has an Intelligence Quotient in the 71-80 range be verified as a child with a mental handicap?

   No. The American Association on Mental Retardation (now the American Association on Intellectual and Developmental Disabilities), the American Psychiatric Association (see DSM-IV), and the World Health Organization (see ICD-10) require IQs to fall at least 2 standard deviations below the mean for this category. No reputable national or international authority endorses including children who have an IQ in the 71-80 range within the mental handicap category.

   The MDT would be expected to consider the Standard Error of Measurement (SEM) of any test, and it would be a consideration in interpreting the IQ score.

Adaptive behavior and academic achievement scores are also important elements of consideration in a Mental Handicap disability determination.

SECTION 8: REFERENCES AND RESOURCES

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Norlin, John W. Special Education Dictionary, Revised Edition. Horsham, Pennsylvania: LRP Publications, 2003.

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Clearinghouse on Disability Information Office of Special Education and Rehabilitation Services (OSERS) www.ed.gov/about/offices/list/osers/index.html

Council of Exceptional Children (CEC) www.cec.sped.org

Education Resources Information Center (ERIC) www.ed.gov/EdFed/ERIC.htm

Exceptional Parent www.eparent.com

Guide to Disability Resources on the Internet www.disabilityresources.org

Mental Health Mental Retardation Center www.atcmhmr.com/

National Association for Down Syndrome (NADS) www.nads.org

National Dissemination Center for Children with Disabilities (NICHCY) www.nichcy.org

National Rehabilitation Information Center (NARIC) www.NARIC.com

National Syndrome Congress www.ndsccenter.org

President's Committee on Mental Retardation www.acf.dhhs.gov/programs/pcmr

The Arc of the United States www.thearc.org

The Association for Severely Handicapped (TASH) www.tash.org/index.htm

United Cerebral Palsy Association, Inc. (UCP) www.ucp.org

Voice of the Retarded www.vor.net

DISABILITY CATEGORY:

Multiple Impairments

DISABILITY CATEGORY: Multiple Impairments

SECTION 1: INTRODUCTION

These verification guidelines were written to provide parents, teachers, special education personnel, administrators, and other professionals with information on the identification, verification, and determination of eligibility for special education services for children with multiple disabilities. If a child is verified as having multiple impairments the impact of the multiple disabilities will likely occur across all settings and throughout the child's lifetime.

This category of children has been defined by both federal and state regulations. A three-part eligibility requirement for a child to be verified as a child with multiple impairments is as follows:

- Meet verification criteria (92 NAC 51.006);
- Documentation of adverse effect on educational performance;
- Determination that a need for special education is evident.

SECTION 2: STATE DEFINITION

- **Multiple Impairments** –To qualify for special education services in the category of multiple impairments, the child must have concomitant impairments (such as mental handicap-visual impairment, mental handicap-orthopedic impairment), the combination of which causes such severe developmental or educational, or in the case of a child below age five, a child's developmental needs that they cannot be accommodated in special education programs solely for one of the impairments.

  This classification does not include children deaf-blindness.

SECTION 3: MULTIDISCIPLINARY EVALUATION TEAM (MDT) COMPOSITION

The Multidisciplinary Team (MDT) should include at least the following members:

- The child's parents;
- A school psychologist or licensed psychologist;
- A special educator;

- Those personnel required to verify the other suspected disability; and

- A school district administrator or a designated representative.

SECTION 4: VERIFICATION GUIDELINES

The verification process for a child with multiple impairments is a two-pronged eligibility process. In order for a child to be verified as a child with multiple impairments, the evaluation should include the analysis and documentation of:

- Verification of a mental handicap, defined as a standard score of at least 3.0 standard deviations below the mean (45 standard score points) in each of the three areas of functioning according to the guidelines.

In order for a child to be verified as a child with a mental handicap, the evaluation should include the analysis and documentation of the following three areas:

1. Significantly below average functioning in adaptive behavior across settings, to include school, home and community, based on assessment and analysis of adaptive skills in the areas which include, but are not limited to:
   - Communication
   - Self-care
   - Home living
   - Safety
   - Use of community resources
   - Work performance
   - Travel skills
   - Recreation/leisure
   - Social-interpersonal skills
   - Self-direction

2. Significantly below average functioning in academic achievement, based on the assessment and analysis of functional academic skills through a combination of:
   - Individual achievement testing
   - Classroom assessment data
   - Norm-referenced testing

3. Significantly below average functioning on an individually administered standardized intelligence test. Documented evidence of deficits in:
   - Attention
   - Perception
   - Memory
   - Problem solving
   - Logical thought
   - Speed of processing and/or capacity for abstract thinking
   - Other relevant factors, all of which impacts one's learning

Significantly below average functioning is defined as standard scores of at least 3.0 standard deviations below the mean (45 standard score points).

- Verification of one or more additional disabilities

- The multiplicity of disabilities is such that a primary disability cannot be determined.

Sensory impairments, medical or health conditions, cultural differences, or a lack of instruction or life experiences may not be the basis of a verification of a mental handicap.

Areas of Functioning Which May be Affected by Multiple disabilities

Multiple impairments are recognized by the manifestation of behavioral characteristics across the following areas of functioning:

- Limited skills in communication abilities
  - Limited speech
  - Generalization of skills
  - Attention
  - Problem-solving
  - Speed of processing

- Limited skills of independent functioning
  - Limited daily living skills
  - Participation in and use of community resources
  - Dressing skills
  - Eating skills
  - Skills of hygiene

- Limited skills in social-interpersonal interaction
  - Recreation and leisure
  - Self-direction
  - Play skills

- Limited skills in motor areas
  - Travel skills
  - Gross motor skills
  - Fine motor skills

Multiple impairments is an educational verification and a term used to facilitate early identification by public school personnel. Educational and developmental assessments to identify strengths and limitations may include:

- Observations
- Checklists
- Interviews
- Teacher anecdotal records
- Review of medical reports and other available information
- Developmental inventories
- Speech/language assessments
- State and District-wide Assessment
- Social history
- Parental reports and inventories

SECTION 5: PROCEDURES TO DETERMINE ADVERSE EFFECT ON DEVELOPMENT/EDUCATIONAL PERFORMANCE

FACTORS TO CONSIDER

Many factors should be considered in determining if multiple impairments are causing or can be expected to produce significant delays in the child's development or educational performance. The factors include, but are not limited to:

- Age of identification
- Current age
- History of intellectual delays
- History of delays in other areas
- History of interventions and response
- Relevant family/medical history
- Current educational placement

- Current levels of performance
- Current language delays
- Current motor delays
- Current social delays
- Vocational transition needs

Examination of these factors may lead to additional factors to consider. Psychologists, teachers of children with multiple impairments, occupational/physical therapists, and speech language pathologists (SLP) are the primary professionals who can determine how these factors may impact the child. Parents, teachers, medical professionals, and the child him/herself can also provide information important in determining the impact of the multiple impairments.

The Multidisciplinary Team (MDT) must determine whether adverse effects on: daily and independent living skills, leisure/recreational skills, participation in and use of community resources and vocational skills, are primarily the results of the multiple impairments. In all cases, when making a determination of the adverse effects of the multiple impairments, the team should consider the child's age and developmental skill levels.

The following questions are to guide documentation and determination of whether the disability has an adverse effect on the child's developmental/educational performance:

- Daily and independent living skills
  - What is the child's ability to dress himself/herself?
  - What is the child's ability to feed himself/herself?
    - Use eating utensils?
    - Drink from a cup?
  - What is the child's level of independence in his/her daily life?
  - What is the child's ability to take care of his/her personal hygiene?
    - Bathing skills?
    - Brushing teeth?
    - Toileting skills?
  - What is the child's ability to avoid situations that may pose a danger to him/her, i.e., hot stove, electrical outlets, water that is too hot/cold, etc.?
  - What is the child's ability to complete simple tasks around the house, i.e., make his/her bed, wash dishes, sweep/vacuum? Do laundry?
  - What is the child's ability to ask for assistance from an adult when it is needed?
  - What is the child's ability to progress in functional academic skills, i.e., math, reading, writing, science, social studies?

- Leisure/Recreation skills
  - What is the child's ability to play individual games, i.e., puzzles, etc.?
  - What is the child's ability to participate in group activities?
  - What is the child's ability to actively participate in recreational activities?
  - What is the child's ability to participate in spectator recreational activities?
  - What is the child's ability to take turns when playing games, etc.?
  - What is the child's ability to play in a cooperative manner?
  - Does the child understand the concepts of "winning" and "losing"?
  - Does the child understand the concept of sharing play items/toys with others?
  - What is the child's ability to interact with others in a social situation by problem solving, acting in a courteous manner, etc.?

- Participation in and use of community resources
  - What is the child's ability to understand different community resources, i.e., stores, restaurants, doctors, schools, etc.?
  - What is the child's ability to request assistance from different community resources?
  - What is the child's ability to determine where different community resources are located and travel (walking, taking a bus, etc.) to those resources?
  - What is the child's ability to differentiate between types of community resources, i.e., restaurants, stores, etc.?
  - What is the child's ability to ask for assistance from adults in seeking out particular community resources?

- Vocational skills
  - What are the child's career interests and aptitudes?
  - What is the child's ability to understand the responsibilities of different jobs?
  - What is the child's ability to learn work-related tasks?
  - What is the child's ability to complete one task before beginning another task?
  - What is the child's ability to understand a schedule, i.e., time to begin workday, time to end workday, breaks, lunch, etc.?
  - What is the child's ability to work independently, semi-independently, with a job coach, etc.?
  - What is the child's ability to accept direction from a supervisor, etc.?
  - What is the child's ability to work cooperatively and to interact appropriately with others in the work place?

SECTION 6: RELATED DEFINITIONS

Adaptive Behavior – is the collection of conceptual, social, and practical skills that people have learned so they can function in their everyday lives. Significant limitations in adaptive behavior impact a person's daily life and affect the ability to respond to a particular situation or to the environment. Limitations in adaptive behavior can be determined by using standardized tests that are normed on the general population

including people with disabilities and people without disabilities. Examples of specific Adaptive Behavior skills include:

- Conceptual skills: receptive and expressive language, reading and writing, money concepts, self-directions.
- Social skills: interpersonal, responsibility, self-esteem, gullibility (likelihood of being tricked or manipulated), naiveté, follows rules, obeys laws, avoids victimization.

Adaptive Devices – Special tools that are adaptations of common items to make accomplishing self-care, work, or recreation activities easier for people with physical disabilities. (Hallahan and Kauffman, 2006, p. 530)

Anoxia – Lack of oxygen to the brain resulting in brain damage. (Norlin, 2003, p. 10)

Athetosis – Type of cerebral palsy characterized by involuntary and purposeless movements of arms, legs, head and tongue, the last resulting in difficulty in producing understandable speech. (Norlin, 2003, p. 14)

Cerebral Palsy (CP) — Non-progressive disease of the central nervous system that results in abnormal alterations in or limitation of voluntary movement, speech disorders or unintelligible speech, and behavior disorders; children with cerebral palsy typically have normal intelligence but sensory or emotional disorder resulting from motor deficiencies; five types, classified according to particular way movement is affected: (a) spasticity, (b) athetosis, (c) rigidity, (d) ataxia, and (e) mixed. (Norlin, 2003, p. 33)

Chromosomal Disorder – Any of several syndromes resulting from abnormal or damaged chromosome(s); can result in mental retardation. (Hallahan and Kauffman, 2006, p. 532)

Criterion-referenced Testing – An assessment wherein an individual's performance is compared to a goal or standard of mastery; CRT differs from norm-referenced testing wherein an individual's performance is compared to the performance of others. (Hallahan and Kauffman, 2006, p. 533)

Curriculum-based Assessment (CBA) – A formative evaluation method designed to evaluate performance in the particular curriculum to which children are exposed; usually involves giving students a small sample of items from the curriculum in use in their schools; proponents argue that CBA is preferable to comparing students with national norms or using tests that do not reflect the curriculum content learned students. (Hallahan and Kauffman, 2006, p. 533)

Daily Living Skills – Skills needed for personal self-care: on the lowest level include toileting, feeding, and dressing. (Norlin, 2003, p. 53)

Down Syndrome – A condition resulting from an abnormality with the twenty-first pair of chromosomes; the most common abnormality is a triplet rather than a pair (the condition sometimes referred to as trisomy 21); characterized by mental retardation and such physical signs as slanted-appearing eyes, hypotonia, a single palmer crease, shortness, and a tendency toward obesity. (Hallahan and Kauffman, 2006, p. 534)

Fragile X Syndrome – A condition in which the bottom of the X chromosome in the twenty-third pair of chromosomes is pinched off; can result in a number of physical anomalies as well as mental retardation; occurs more often in males than females; thought to be the most common hereditary cause of mental retardation. (Hallahan and Kauffman, 2006, p. 534)

Functional Academics – Practical skills (e.g., reading a newspaper or telephone book) rather than academic learning skills. (Hallahan and Kauffman, 2006, p. 535)

Functional Skills – Generally considered skills for self-care, social skills, domestic maintenance (housekeeping), employment or vocational skills, and recreation. Also called independent living skills. (Norlin, 2003, p. 90)

Generalization – Ability to apply a skill or behavior learned in one setting to another setting or ability to apply a learned skill or behavior in similar situations. (Norlin, 2003, p. 91)

Hydrocephalus – Excess fluid in the cranial capacity creating pressure in the brain and an enlarged head; may be relieved by surgery or a shunt, but if untreated usually results in mental retardation. (Norlin, 2003, p. 105)

Intelligence – Refers to a general mental capability. It involves the ability to reason, plan, solve problems, think abstractly, comprehend complex ideas, learn quickly, and learn from experience. Although not perfect, intelligence is represented by Intelligent Quotient (IQ) scores obtained from standardized tests given by a trained professional (AAMR). Retrieved from World Wide Web, April 11, 2006. www.aamr.org

Mental Age – Age level at which a person performs on an IQ test, used in comparison to chronological age to determine IQ. IQ = (mental age + chronological age) x 100. (Hallahan and Kauffman, 2006, p. 537)

Metacognition – One's understanding of the strategies available for learning a task and the regulatory mechanisms needed to complete the task. (Hallahan and Kauffman, 2006, p. 537)

Microcephaly – The condition in which the brain is markedly smaller than normal, typically due to genetic developmental defects or in utero infections, such as those caused by viruses. (Norlin, 2003, p. 140)

Natural Supports – Resources in person's environment that can be used for support, such as friends, family, co-workers. (Hallahan and Kauffman, 2006, p. 537)

Normal Curve – In connection with a standardized test, the typical distribution of how scores deviate from the mean, also called a bell curve or bell-shaped curve. (Norlin, 2003, p. 156)

Normalization – A philosophical belief in special education that every individual, even the most disabled, should have an educational and living environment as close to normal as possible. (Hallahan and Kauffman, 2006, p. 537)

Norm-referenced Test (NRT) – Comparison of one student's performance, as measured by the test score, with the performance of the norm allowing fine distinctions among students and identification of where a student stands in relation to that group; typically developed by commercial test companies. (Norlin, 2003, p. 157)

Occupational Therapist – A professional who programs and/or delivers instructional activities and materials to help children and adults with disabilities learn to participate in useful activities. (Heward, 2003, p. 616)

Physical Therapist – A professional trained to help people with disabilities develop and maintain muscular and orthopedic capability and make correct and useful movement. (Heward, 2003, p. 617)

Postnatal – Occurring after birth. (Heward, 2003, p. 617)

Prenatal – Occurring before birth. (Heward, 2003, p. 617)

Rigidity – Severe form of spastic cerebral palsy (spasticity), usually quadriplegia. (Norlin, 2003, p. 204)

Self-determination – The ability to make personal choices, regulate one's own life, and be a self-advocate; a prevailing philosophy in education programming for people with mental retardation; having control over one's life; not having to rely on others for making choices about one's quality of life; develops over one's life span. (Hallahan and Kauffman, 2006, p. 540)

Self-regulation – Refers generally to a person's ability to regulate his or her own behavior (e.g., to employ strategies to help in a problem-solving situation); an area of difficulty for persons who are mentally retarded. (Hallahan and Kauffman, 2006, p. 540)

Spasticity – Type of cerebral palsy characterized by tight limb muscles and resulting lack of muscle control, characterized in terms of how many limbs are affected and intensity as: mild spasticity, moderate spasticity, monoplegia, triplegia, quadriplegia, and hemiplegia. (Norlin, 2003, p. 221)

Systematic Instruction – Teaching that involves instructional prompts, consequences for performance and transfer of stimulus control; often used with children with mental retardation. (Hallahan and Kauffman, 2006, p. 541)

Systematic Observation of Behavior – An observational method of assessment in which "a trained observer watches behavior in a natural setting, records or classifies each behavior objectively as it occurs or shortly thereafter, ensures that the obtained data are replicable, and converts the data into quantitative information," J.M. Sattler, *Assessment of Children (3rd ed.)* Jerome M. Sattler 1986, p. 473) (Norlin, 2003, p. 234)

Williams Syndrome – A condition resulting from deletion of material in the seventh pair of chromosomes; often results in mild to moderate mental retardation, heart defects, and facial features; people affected often display surprising strengths in spoken language and sociability while having severe deficits in spatial organization, reading, writing, and math. (Hallahan and Kauffman, 2006, p. 542)

SECTION 7: FREQUENTLY ASKED QUESTIONS

1. In order to verify a child with multiple impairments; does the child have to meet both the guidelines for mental handicap and at least one other disability category?

   Yes. The child should meet the verification guidelines for mental handicap with at least a 3.0 standard deviation deficit in intellectual functioning, as well as the other category(ies) for which the child is being assessed.

2. For a child to be verified with multiple impairments, must those multiple disabilities be present at birth?

   No. Sometimes due to a serious accident or a severe medical condition, the child may have multiple disabilities and be referred for an educational evaluation.

3. Is a physician's report required as a part of the evaluation for multiple impairments?

   No, it is not required. However, many times there may be a medical diagnosis made by a physician. This information will be helpful to the MDT as the team makes decisions regarding the verification and educational needs of the child. This information can be requested from a physician with the written permission from the parents of the child.

SECTION 8: REFERENCES AND RESOURCES

REFERENCES

American Association on Mental Retardation (AAMR) www.aamr.org

Berndt, Sandra and Elizabeth Burmaster. "Cognitive Disability Evaluation and Decision-Making". Wisconsin Department of Public Instruction, 2002.
Hallahan, Daniel P., and James M. Kauffman. Exceptional Learners, 10th Edition. Boston: Ally and Bacon, 2006.

Heward, William L. Exceptional Children. Upper Saddle River, N.J.: Pearson Education, Inc., 2003.

Nebraska Department of Education, Rule 51: Regulations and Standards for Special Education Programs. Title 92, Nebraska Administrative Code, Chapter 51.

Norlin, John W. Special Education Dictionary, Revised Edition. Horsham, Pennsylvania: LRP Publications, 2003.

WEB SITES

Children Who Are Mentally Retarded www.aacap.org/publications/factsfam/retarded.htm

Clearinghouse on Disability Information Office of Special Education and Rehabilitation Services (OSERS) www.ed.gov/about/offices/list/osers/index.html

Council of Exceptional Children (CEC) www.cec.sped.org

Education Resources Information Center (ERIC) www.ed.gov/EdFed/ERIC.htm

Exceptional Parent www.eparent.com

Guide to Disability Resources on the Internet www.disabilityresources.org

Mental Health Mental Retardation Center www.atcmhmr.com/

Mental Retardation Among Children www.cdc.gov/ncbddd/dd/ddmr.htm

National Dissemination Center for Children with Disabilities (NICHCY) www.nichcy.org

National Rehabilitation Information Center (NARIC) www.NARIC.com

National Syndrome Congress www.ndsccenter.org

President's Committee on Mental Retardation www.acf.dhhs.gov/programs/pcmr

The Association for Severely Handicapped (TASH) www.tash.org/index.htm

United Cerebral Palsy Association, Inc. (UCP) www.ucp.org

Voice of the Retarded www.vor.net

DISABILITY CATEGORY:

Orthopedic Impairment

DISABILITY CATEGORY: Orthopedic Impairment

SECTION 1: INTRODUCTION

These verification guidelines were written to provide parents, teachers, special education personnel, administrators, and other professionals with information on the identification, verification, and determination of eligibility for special education services for children with an orthopedic impairment.

This category of children has been defined by both federal and state regulations. A three-part eligibility requirement for a child to be verified as a child with an orthopedic impairment is as follows:

- Meet verification criteria (92 NAC 51.006);
- Documentation of adverse effect on educational performance;
- Determination that a need for special education is evident.

SECTION 2: STATE DEFINITION

- **Orthopedic impairment –** To qualify for services in the category of orthopedic impairment, the child must have a severe orthopedic impairment that adversely affects a child's educational, or in the case of a child below age five, a child's developmental performance.

  The category includes impairments caused by a congenital anomaly, impairments caused by disease (e.g., poliomyelitis, bone tuberculosis), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns that cause contractures).

SECTION 3: MULTIDISCIPLINARY EVALUATION TEAM (MDT) COMPOSITION

The Multidisciplinary Team (MDT) should include at least the following members:

- The child's parent(s);
- The child's teacher(s) or a teacher qualified to teach a child of that age;
- A special educator;

- A physical therapist or an occupational therapist, or both, when appropriate; and

- A school district administrator or a designated representative.

SECTION 4: VERIFICATION GUIDELINES

Children with an orthopedic impairment represent a heterogeneous group. As an example, within the category of muscular or neuromotor impairments, no two children have the same characteristics or the same needs. A child may not be verified with an orthopedic impairment based solely on a physical disability.

In order for a child to be verified as a child with an orthopedic impairment, the evaluation should include the analysis and documentation of:

- A signed, written report from a physician which describes the severity of the motor impairment and any medical implications; i.e., stamina, pain level, fatigue, etc.

- The child's level of development or educational performance that is adversely affected; and

- A muscular or neuromotor impairment, or skeletal deformity that limits the ability to:
  - Move about,
  - Maintain postures,
  - Manipulate materials required for learning, or
  - Perform activities of daily living

An orthopedic impairment is an educational verification and is a term used to facilitate early identification by public school personnel. Educational evaluation and assessments include a combination of:

- Medical assessments, including medication history

- History of developmental milestones

- Orthopedic or neuromuscular assessment

- Individual achievement testing

- Classroom assessment data

- Norm referenced testing

- Criterion-referenced assessment

- District-wide assessment

- Curriculum-based assessments
- Observation and analysis of behavior
- Teacher-anecdotal records

Parent involvement in the evaluation process is of utmost importance. Many children exhibit identified strengths as well as identified delays in both motor skill development and achievement areas.

SECTION 5: PROCEDURES TO DETERMINE ADVERSE EFFECT ON DEVELOPMENT/EDUCATIONAL PERFORMANCE

FACTORS TO CONSIDER

Many factors must be considered in determining if an orthopedic impairment is causing, or can be expected to produce significant delays in the child's development or educational performance. The factors include, but are not limited to:

- Reports from physician(s) pertaining to the orthopedic impairment
- Current motor delays
- Type, degree, and severity of orthopedic impairment
- Cause of the impairment (if known)
- Nature/status of the impairment (permanent, temporary, progressive)
- Age of occurrence of the impairment
- Current age
- History of modifications and/or accommodations used
- History of interventions and responses
- Relevant family history
- Current educational placement
- Current levels of performance
- Vocational/postsecondary transition needs

This list is not exhaustive. Examination of each of these factors may lead to additional factors to consider. Occupational therapists, physical therapists, teachers of children with an orthopedic impairment, and psychologists are the primary professionals who can determine how these factors may impact the child. Parents, medical professionals, teachers, and the child him/herself can also provide information important in determining the impact of the orthopedic impairment.

In addition to motor and physical disabilities, the MDT must determine whether the adverse effect on motor development/movement and educational performance are primarily a result of the orthopedic impairment. When concomitant learning or developmental needs exist, the team must determine which condition is the primary cause of the need.

In all cases, when making a determination of the adverse effect of the orthopedic impairment, the team should consider the child's age and his/her current motor/movement difficulties.

The following questions are to guide documentation and determination of whether the disability has an adverse effect on the child's developmental/educational performance.

- Expressive or receptive language development
  - Vocabulary
    - Does the child comprehend and use vocabulary appropriate for his/her age/grade level in:
      - General vocabulary?
      - Content specific vocabulary?
      - Figurative language?
      - Expressive language?
  - Functional Language
    - Can the child express one-step, two-step directions?
    - Can the child tell a story?
    - Does the child understand and use narrative discourse?
    - Can the child ask questions to get his/her needs met?
    - Can the child follow simple commands?
    - Can the child answer basic questions?
  - Academic Language
    - Does the child understand and use language with embedded concepts?
    - Does the child understand and use the language of directions (describe, explain, compare, etc.)?
    - Can the child follow multiple step directions?
    - Does the child understand and use expository text structures?

- Speech reception or production
  - Reception
    - Phonemic/phonological awareness
      - Does the child have the ability to process individual sounds?
  - Production/Articulation

- Does the child use speech that is intelligible to an unfamiliar listener?
- Does the child use appropriate prosodic features in:
  - Inflection?
  - Rate?
  - Pitch?
  - Fluency?
- Does the child have oral motor problems?
- Is the child's speech production age appropriate?

- Pre-academic
  - Is the child meeting age appropriate milestones?

- Academic or Vocational Performance
  - Academic
    - Does the child meet school district standards (outcomes) for his/her grade level?
    - Does the child's progress reflect his/her ability levels?
  - Reading
    - Does the child have the perceptual, conceptual, and linguistic base to support the reading process?
    - Can the child interpret meaning from print (pictures, words, etc.)?
    - Can the child decode printed materials accurately and fluently?
    - Can the child use contextual cues to help him/her understand passages?
    - Can the child interpret literature?
    - Can the child identify the components of a variety of literary genre?
    - Can the child answer basic questions about a passage?
    - Can the child apply reading skills to acquire information from print?
  - Math
    - Does the child understand mathematical concepts and processes in:
      - Concept of numbers?
      - Mathematical language?
      - Mathematical reasoning?
      - Mathematical relationships?
    - Does the child understand patterns that describe mathematical relationships?
    - Written Language - Consider the following areas:
      - Idea development
      - Organization
      - Word choice
      - Voice
      - Fluency
      - Sentence fluency
      - Conventions

- Vocational
  - Does the child have communication skills required to obtain, and maintain employment?
  - Can the child advocate for him/herself?

- Social or Emotional Competence
  - Independent/Self Advocacy Skills
    - Can the child function independently in social situations?
    - Does the child communicate to get his/her educational needs met?
      - Will he/she ask for clarification when needed?
      - Does he/she use assistive devices/prosthetic devices appropriately?
    - Does the child accept responsibility for his/her own actions?
  - Self-esteem
    - Is the child's self-esteem affected by his/her physical disability?
    - Does the child have appropriate self-confidence?
    - Does the child have problem solving skills?
    - Is the child assertive?
    - Does the child have appropriate peer relationships?
    - Is the child responsible and accountable for his/her own actions?

- Adaptive Skills
  - What is the child's ability to take care of his/her daily and independent living skills?
  - What is the child's participation level in and use of community resources?
  - What is the child's ability to participate in work and work-related performance skills?
  - What is the child's ability to participate in recreation/leisure activities?

- Motor Development
  - Gross Motor Skills
    - What are the child's abilities in the following:
      - Rolling over?
      - Crawling?
      - Standing?
      - Walking?
      - Running?
      - Jumping?
      - Balance?
      - Hopping?
      - Climbing?
  - Fine Motor Skills
    - What are the child's abilities in the following:
      - Holding and eating with utensils?
      - Picking up and manipulation of small objects?
      - Holding and using a crayon? Pencil? Marker?
      - Copying with crayon or pencil or marker?
      - Cutting with scissors?
      - Folding paper?
      - Picking up small object from table or floor?

- Transferring of objects between hands or from surfaces?

SECTION 6: RELATED DEFINITIONS

Adaptive Devices – Special tools that are adaptations of common items to make accomplishing self-care, work, or recreation activities easier for people with physical disabilities. (Hallahan and Kauffman, 2006, p. 530)

Athetosis – Type of cerebral palsy characterized by involuntary and purposeless movements of arms, legs, head and tongue, the last resulting in difficulty in producing understandable speech. (Norlin, 2003, p. 14)

Cerebral Palsy (CP) – Non-progressive disease of the central nervous system that results in abnormal alterations in or limitation of voluntary movement, speech disorders or unintelligible speech, and behavior disorders; children with cerebral palsy typically have normal intelligence but sensory or emotional disorder resulting from motor deficiencies; five types, classified according to particular way movement is affected: (a) spasticity, (b) athetosis, (c) rigidity, (d) ataxia, and (e) mixed. (Norlin, 2003, p. 33)

Criterion-referenced Testing – Assessment wherein an individual's performance is compared to a goal or standard of mastery; differs from norm-referenced testing wherein an individual's performance is compared to the performance of others. (Hallahan and Kauffman, 2006, p. 533)

Curriculum-based Assessment (CBA) – A formative evaluation method designed to evaluate performance in the particular curriculum to which students are exposed; usually involves giving students a small sample of items from the curriculum in use in their schools; proponents argue that CBA is preferable to comparing students with national norms or using tests that do not reflect the curriculum content learned by students. (Hallahan and Kauffman, 2006, p. 533)

Diplegia – A condition in which the legs are paralyzed to a greater extent than the arms. (Retrieved from http://iris.peabody.vanderbilt.edu 5/20/06)

Generalization – Ability to apply a skill or behavior learned in one setting to another setting or ability to apply a learned skill or behavior in similar situations. (Norlin, 2003, p. 91)

Hemiplegia – 1. Paralysis on one side of the body. 2. Form of spastic cerebral palsy affecting either the right or left side of one's body. (Norlin, 2003, p. 100)

Hydrocephalus – Excess fluid in the cranial cavity creating pressure in the brain and an enlarged head; may be relieved by surgery or a shunt, but if untreated usually results in mental retardation. (Norlin, 2003, p. 105)

Juvenile-rheumatoid Arthritis (JRA) – A chronic form of arthritis consisting of inflammation of the joints, resulting in stiffness and muscle pain. (Norlin, 2003, p. 122)

Metacognition – One's understanding of the strategies available for learning a task and the regulatory mechanisms needed to complete the task. (Hallahan and Kauffman, 2006, p. 537)

Microcephaly – The condition in which the brain is markedly smaller than normal, typically due to genetic developmental defects or in utero infections, such as those caused by viruses. (Norlin, 2003, p. 140)

Muscular Dystrophy (MD) – A hereditary disease for which there is no cure in which muscle tissue is replaced by fatty tissue, resulting in weakness and wasting away of muscle tissues, progressive deterioration of functioning, and a loss of vitality. (Norlin, 2003, p. 150)

Muscular/Skeletal Conditions – Conditions affecting muscles or bones and resulting in limited motor functioning. (Retrieved from http://iris.peabody.vanederbilt.edu 5/20/06)

Neural Tube Disorders – Another name for spinal cord disorders, which always involve spinal column and usually the spinal cord. (Retrieved from http://iris.peadbody.vanderbilt.edu 5/20/06)

Neuromotor Impairment – Condition involving the nerves, muscles, and motor functioning. (Retrieved from http://iris.peabody.vanderbilt.edu 5/20/06)

Normal Curve – In connection with a standardized test, the typical distribution of how scores deviate from the mean, also called a bell curve or bell-shaped curve. (Norlin, 2003, p. 156)

Normalization – A philosophical belief in special education that every individual, even the most disabled, should have an educational and living environment as close to normal as possible. (Hallahan and Kauffman, 2006, p. 537)

Norm-referenced Test (NRT) – Comparison of one student's performance, as measured by the test score, with the performance of the norm allowing fine distinctions among students and identification of where a student stands in relation to that group; typically developed by commercial test companies. (Norlin, 2003, p. 157)

Occupational Therapist – A professional who programs and/or delivers instructional activities and materials to help children and adults with disabilities learn to participate in useful activities. (Heward, 2003, p. 616)

Paraplegia – Condition in which both legs are paralyzed. (http://iris.peabody.vanderbilt.edu 5/20/06)

Physical Therapist – A professional trained to help people with disabilities develop and maintain muscular and orthopedic capability and make correct and useful movement. (Heward, 2003, p. 617)

Postnatal – Occurring after birth. (Heward, 2003, p. 617)

Prenatal – Occurring before birth. (Heward, 2003, p. 617)

Prosthesis – Device that replaces a missing or malfunctioning body part or function, such as communication prosthesis for an individual who lacks adequate speaking or writing ability. (Norlin, 2003, p. 184) Device examples: laryngeal synthesizer, artificial leg.

Quadriplegia – Type of spasticity (cerebral palsy) affecting all four limbs. (Norlin, 2003, p. 191)

Rigidity – Severe form of spastic cerebral palsy (spasticity), usually quadriplegia. (Norlin, 2003, p. 204)

Spasticity – Type of cerebral palsy characterized by tight limb muscles and resulting lack of muscle control, characterized in terms of how many limbs are affected and intensity as: mild spasticity, moderate spasticity, monoplegia, triplegia, quadriplegia, and hemiplegia. (Norlin, 2003, p. 221)

Spina Bifida – A congenital malfunction of the central nervous system (CNS) in which the lower end of the CNS fails to close completely and the contents of the spinal column protrude from a sac in the lower back; usually results in paralysis of the lower extremities, lack of bladder and bowel control and hydrocephalus. (Norlin, 2003, p. 225)

Spinal Cord Disorders – Injury or disease of the spinal column, usually both the nerves and muscles. (Retrieved from http://iris.peadbody.vanderbilt.edu 5/20/06)

Universal Design – Barrier free architectural and building designs that meet the needs of everyone, including people with physical challenges. (Retrieved from http://iris.peabody.vanderbilt.edu 5/20/06)

SECTION 7: FREQUENTLY ASKED QUESTIONS

1. Several types of physical disabilities are listed in the definition for orthopedic impairment. Are these the only physical disabilities that can be considered for verification of orthopedic impairment?

   No. These are only examples of physical disabilities. A child with any type of physical disability may verify as having an orthopedic impairment if he/she meets

the two-pronged eligibility guideline listed in this document (a physical disability and its adverse effect on development or educational performance).

2. Would a physical disability that may not result in a permanent disability such as a broken arm, broken leg, or after-surgery difficulty be considered an orthopedic impairment for educational purposes?

   It depends. Usually a child who has a temporary physical disability will qualify under Section 504 for modifications and/or accommodations within the school setting during the recovery period. However, if the child who has a temporary physical disability experiences adverse effects on educational performance, the child may be referred for evaluation for an orthopedic impairment.

3. Is a medical report required as a part of the verification process for an orthopedic impairment?

   Yes. A report from a physician describing the medical condition of the child is required.

4. Is the school required to pay for the medical evaluation?

   It depends. In many cases, a medical evaluation will already have been completed and the physician will send a report to the MDT with the parent's written permission. In other situations, the school may have a team of professionals, i.e., physician, occupational therapist, physical therapist who conduct evaluations as a part of the MDT process. This team will conduct the evaluation and write the report. If neither of these situations exists, then the school could be responsible for the evaluation.

5. How severe must the physical disability be for the child to verify as a child with an orthopedic impairment?

   The severity of the physical disability will be documented in a written report from a physician. However, there must be documentation of an adverse effect on the development or educational performance of the child in order for the child to verify with an orthopedic impairment.

6. Can a child meet the guidelines for having an orthopedic impairment if he/she is doing well academically in his/her classes?

   Yes. Because the assessment for achievement includes not only academic achievement, but also social/interpersonal skills, adaptive skills, speech/language skills, and any skills considered a part of that child's achievement.

7. Can a child meet the guidelines for orthopedic impairment if the child has compensated for the physical disability by using orthopedic equipment, i.e., braces, adaptive equipment, etc.?

It depends. The verification of orthopedic impairment is a two-prong verification including both motor skills and achievement. If the child has compensated for the physical disability through adaptive equipment or prosthesis, yet there is an adverse effect on the educational performance of the child, then an evaluation for orthopedic impairment should be completed.

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DISABILITY CATEGORY:

Other Health Impairment

DISABILITY CATEGORY: Other Health Impairment

SECTION 1: INTRODUCTION

These verification guidelines were written to provide parents, teachers, special education personnel, administrators, and other professionals with information on the identification, verification, and determination of eligibility for special education services for children with other health impairment.

This category of children has been defined by both federal and state regulations. A three-part eligibility requirement for a child to be verified as a child with other health impairment is as follows:

- Meet verification criteria (92 NAC 51.006);
- Documentation of adverse affect on educational performance;
- Determination that a need for special education is evident.

SECTION 2: STATE DEFINITION

- **Other Health Impairment-** To qualify for special education services in the category of other health impairment, the child must have: limited strength, vitality or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that is due to chronic or acute health problems which adversely affects the child's educational, or in the case of a child below age five, a child's developmental performance such as: asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, Tourette syndrome.

SECTION 3: MULTIDISCIPLINARY EVALUATION TEAM (MDT) COMPOSITION

The Multidisciplinary Team (MDT) should include at least the following members:

- The child's parent(s);
- The child's teacher(s) or a teacher qualified to teach a child of that age;
- A special educator; and
- A school district administrator or a designated representative.

SECTION 4: VERIFICATION GUIDELINES

In order for a child to be verified as a child with other health impairment, the evaluation should include the analysis and documentation of:

- A signed, written report from a physician which describes the current health status and gives any medical implications of the impairment;
- Limited strength, vitality, or alertness due to a chronic or acute health impairment or heightened alertness to environmental stimuli; and
- The child's adversely affected development or educational performance.

Chemical or alcohol dependency alone should not be sufficient basis for verification of other health impairment.

Children with other health impairment represent a heterogeneous group. A child may not be verified with a other health impairment based solely on a medical disability.

Educational evaluation and assessments should include a combination of:

- Medical assessments, including medications
- History of developmental milestones
- Parent interviews/rating scales
- Individual achievement testing
- Classroom assessment data
- Norm-referenced testing data

- Criterion-referenced assessments
- District-wide assessments
- Curriculum-based assessments
- Observation and analysis of behavior
- Teacher anecdotal records
- Analysis of academic performance of social/emotional performance

Parent involvement in the assessment process is of utmost importance.

SECTION 5: PROCEDURES TO DETERMINE ADVERSE EFFECT ON DEVELOPMENT/EDUCATIONAL PERFORMANCE

FACTORS TO CONSIDER

Many factors must be considered in determining if other health impairment is causing, or can be expected to produce, significant delays in the child's development or educational performance. The factors include, but are not limited to:

- Reports from physician(s) pertaining to the medical/health condition of the child including medications
- Type, degree, and severity of medical/health impairment
- Cause of the impairment (if known)
- Nature/status of the impairment (permanent, temporary, progressive)
- Age of child when impairment initially occurred
- Current age
- Inability to complete tasks due to fatigue and/or lack of energy
- Inability to perform and/or participate in activities due to acute flare-ups of disease process
- History of modifications and/or accommodations used
- History of interventions and response
- Medical history, including medications

- Relevant family history

- Current educational placement

- Current levels of performance

- State and District-wide Assessment
- Vocational/postsecondary transition needs

This list is not exhaustive. Examination of each of these factors may lead to additional factors to consider. Psychologists, teachers of children with other health impairment and appropriate related services staff are the primary professionals who can determine how these factors may impact the child. Parents, medical professionals, teachers, and the child him/herself can also provide information important in determining the impact of the medical/health impairment.

In addition to the medical and health conditions, the MDT must determine whether the adverse effects on educational performance are primarily a result of the medical/health impairment. When concomitant learning or developmental needs exist, the team must determine which condition is the primary cause of the need.

In all cases, when making a determination of the adverse effects of the other health impairment, the team should consider the child's age and his/her current educational difficulties.

The following questions are to guide documentation and determination of whether the disability has an adverse effect on the child's developmental/educational performance:

- Expressive or receptive language development
  - Vocabulary
    - Does the child comprehend and use vocabulary appropriate for his/her age/grade level?
      - General vocabulary?
      - Content specific vocabulary?
      - Figurative language?
      - Expressive language?
  - Functional Language
    - Can the child express one-step, two-step directions?
    - Can the child tell a story?
    - Does the child understand and use narrative discourse?
    - Can the child ask questions to get his/her needs met?
    - Can the child follow simple commands?
    - Can the child answer basic questions?
  - Academic Language
    - Does the child understand and use language with embedded concepts?
    - Does the child understand and use the language of directions (describe, explain, compare, etc.)?

        - Can the child follow multiple step directions?
        - Does the child understand and use expository text structures?

- Speech reception or production
    - Reception
        - Phonemic/phonological awareness
            - Does the child have the ability to process individual sounds?
    - Production/Articulation
        - Does the child use speech that is intelligible to an unfamiliar listener?
        - Does the child use appropriate prosodic features in:
            - Inflection?
            - Rate?
            - Pitch?
            - Fluency?
        - Does the child have oral motor problems?
        - Is the child's speech production age appropriate?
    - Pre-academic
        - Is the child meeting age appropriate milestones?

- Academic or Vocational Performance
    - Academic
        - Does the child meet district standards (outcomes) for his/her grade level?
        - Does the child's progress reflect his/her ability levels?
    - Reading
        - Does the child have the perceptual, conceptual, and linguistic base to support the reading process?
        - Can the child interpret meaning from print (pictures, words)?
        - Can the child decode printed materials accurately and fluently?
        - Can the child use contextual cues to help him/her understand passages?
        - Can the child interpret literature?
        - Can the child identify the components of a variety of literary genre?
        - Can the child answer basic questions about a passage?
        - Can the child apply reading skills to acquire information from print?
    - Math
        - Does the child understand mathematical concepts and processes?
        - Does the child understand concept of numbers?
        - Does the child understand mathematical language?
        - Does the child understand mathematical reasoning?
        - Does the child understand mathematical relationships?
        - Can the child apply the fundamentals of math to everyday life?
        - Can the child organize and interpret graph representations of data (charts, bar graphs, pre-graphs, etc.)?
        - Does the child understand patterns that describe mathematical relationships?
    - Written Language- consider the child's skills in:
        - Idea development
        - Organization
        - Word choice

        - Voice
        - Sentence fluency
        - Conventions
    - Vocational
        - Does the child have the skills required to obtain and maintain employment?
        - Can the child advocate for him/herself?

- Social or Emotional Competence
    - Independent/Self Advocacy Skills
        - Can the child function independently in social situations?
        - Does the child communicate to get their educational needs met?
            - Will he/she ask for clarification when needed?
        - Does the child accept responsibility for his/her own actions?
    - Self-esteem
        - Is the child's self-esteem affected by his/her physical disability?
        - Does the child have appropriate self-confidence?
        - Does the child have problem solving skills?
        - Is the child assertive?
        - Does the child have appropriate peer relationships?
        - Is the child responsible and accountable for his/her own actions?

- Motor Development
    - Gross Motor Skills
        - What are the child's abilities in the following:
            - Rolling over?
            - Crawling?
            - Standing?
            - Walking?
            - Running?
            - Jumping?
            - Balance?
            - Hopping?
            - Climbing?
    - Fine Motor Skills
        - What are the child's abilities in the following:
            - Holding and eating with utensils?
            - Picking up and manipulation of small objects?
            - Holding and using a crayon? pencil? marker?
            - Copying with crayon or pencil or marker?
            - Cutting with scissors?
            - Folding paper?
            - Picking up small object from table or floor?
            - Transferring of objects between hands or from surfaces?

- Adaptive Skills
    - What is the child's ability to take care of his/her daily and independent living skills?

- What is the child's participation level in and use of community resources?
- What is the child's ability to participate in work and work-related performance skills?
- What is the child's ability to participate in recreation/leisure activities?

- Attention and Focus Skills
  - Does the child focus on a particular task in which he/she is involved?
  - Does the child complete a given assignment involving more than one direction?
  - Does the child "stay with a task" until its completion?
  - What is the child's ability to continue on a task when there is distractibility in the environment, i.e., music, others talking, television?
  - What is the child's level of impulsivity?

A child with a other health impairment may not meet all of the above listed criteria. However, these criteria/questions may serve as guidelines for determining first, if the child has a disability and secondly, does the child need special education services.

SECTION 6: RELATED DEFINITIONS

Acute – Severe and of short duration- describes a disease that is brief, severe, and quickly comes to a crisis. (Retrieved from Encarta World English Dictionary http://encarta.msn.com 06-06-06)

Adaptive Skill Areas – Daily living skills needed to function adequately in the community, consisting of: (1) communication, (2) self-care skills, (3) home living, (4) social skills, (5) leisure, (6) health and safety, (7) self-direction, (8) functional academics, (9) community use, and (10) work. (Norlin, 2003, p. 4)

Asthma – Chronic respiratory condition marked by episodes of breathing difficulty; identified as a health problem that could be an "other health impairment" for purposes of IDEA eligibility. (Norlin, 2003, p. 14)

Attention Deficit Disorder (ADD) – A mental disorder, the typical characteristics of which are: short attention span, distractive behavior, difficulty following directions, difficulty staying on task, and inability to focus behavior; frequently presents when the child attends school because it compromises many skills needed for academic success, including starting, following through with and completing tasks, moving from task to task and following directions; distinct from a learning disability and somewhat different from attention deficit hyperactivity disorder (ADHD). (Norlin, 2004, p. 15)

Attention Deficit Hyperactivity Disorder (ADHD) – A mental disorder, the typical characteristics of which are: short attention span; distractibility; impulsivity; flight of idea; poor organizational skills; social immaturity; variable performance; inflexibility; mood swings; poor short-term memory; excessive activity; fidgetiness and difficulty

staying seated. Disorders that mimic ADHD include conduct disorder, learning disability, and manic-depression. (Norlin, 2003, p. 16)

Cerebellum – A division of the brain, in the back part above the neck, that is responsible for integrating movements. (Norlin, 2003, p. 33)

Chronic Illnesses in Children – Most common are cystic fibrosis, diabetes, epilepsy, leukemia, juvenile rheumatoid arthritis, muscular dystrophy, and sickle cell anemia; may result in eligibility under Part B on the basis of having an "other health impairment," provided the disability results in a need for special education. (Norlin, 2003, p. 37)

Congenital Anomaly – An irregularity (anomaly) that is present at birth; might or might not be due to genetic factors. (Hallahan and Kauffman, 2006, p. 532)

Criterion-referenced Testing – An assessment, wherein an individual's performance is compared to a goal or standard of mastery; differs from norm-referenced testing wherein an individual's performance is compared to the performance of others. (Hallahan and Kauffman, 2006, p. 533)

Curriculum-based Assessment (CBA) – A formative evaluation method designed to evaluate performance in the particular curriculum to which students are exposed; usually involves giving students a small sample of items from the curriculum in use in their schools; proponents argue that CBA is preferable to comparing students with national norms or using tests that do not reflect the curriculum content learned by students. (Hallahan and Kauffman, 2006, p. 533)

Cystic Fibrosis – Common hereditary childhood disease affecting most organs and body functions; generally does not affect intellectual functioning but is increasingly debilitating and may be considered an "other health impairment" under the IDEA. (Norlin, 2003, p. 51)

Diabetes – A metabolic disorder relating to a failure to secrete sufficient amounts of insulin or to properly absorb insulin; in more severe cases can result in water and electrolyte loss; may be an "other health impairment" under the IDEA and may entitle the student to school health services under either the IDEA or Section 504. (Norlin, 2003, p. 59)

Distractibility – Generally, a child's attention to or interest in things other than what he or she should be concentrating on, responsiveness to irrelevant stimulation, high distractibility, a characteristic of attention-deficit hyperactivity disorder (ADHD) or attention deficit disorder (ADD). (Norlin, 2003, p. 64)

Epilepsy – Common neurological disease characterized by brief recurrent seizures; resulting loss of consciousness presents a safety hazard in a school environment. (Norlin, 2003, p. 77)

Executive Functions – The ability to regulate one's behavior through working memory, inner speech, control of emotions and arousal levels, and analysis of problems and communication of problem solutions to others; delayed or impaired in people with ADHD. (Hallahan and Kauffman, 2006, p. 534)

Fetal Alcohol Syndromes (FAS) – Abnormalities associated with the mother's drinking alcohol during pregnancy; defects range from mild to severe, including growth retardation, brain damage, mental retardation, hyperactivity, anomalies of the face, and health failure; also called *alcohol embryopathy.* (Hallahan and Kauffman, 2006, p. 534)

Frontal Lobes – Two lobes located in the front of the brain; responsible for executive functions; site of abnormal development in people with ADHD. (Hallahan and Kauffman, 2006, p. 534)

Generalization – Ability to apply a skill or behavior learned in one setting to another setting or ability to apply a learned skill or behavior in similar situations. (Norlin, 2003, p. 91)

Hemophilia – An inherited deficiency in blood-clotting ability, which can cause serious internal bleeding. (Heward, 2003, p. 614)

Impulsivity – An approach to problem-solving associated with attention deficit hyperactivity disorder (ADHD); responding abruptly without consideration of consequences or alternatives. (Norlin, 2003, p. 109)

Juvenile-rheumatoid Arthritis (JRA) – A chronic form of arthritis consisting of inflammation of the joints, resulting in stiffness and muscle pain. (Norlin, 2003, p. 122)

Leukemia – A type of cancer in which white blood cells displace normal blood. This leads to infection, shortage of red blood cells (anemia), bleeding, and other disorders, and often proves fatal. (Retrieved from Encarta World English Dictionary http://encarta.msn.com 06-01-06)

Metacognition – One's understanding of the strategies available for learning a task and the regulatory mechanisms needed to complete the task. (Hallahan and Kauffman, 2006, p. 537)

Muscular Dystrophy (MD) – A hereditary disease for which there is no cure in which muscle tissue is replaced by fatty tissue, resulting in weakness and wasting away of muscle tissues; progressive deterioration of functioning and a loss of vitality. (Norlin, 2003, p. 150)

Nephritis – Severe inflammation of the kidney, caused by infection, degenerative disease, or disease of the blood vessels. (Encarta World English Dictionary http://encarta.msn.com)

Neuromotor Impairment – Condition involving the nerves, muscles, and motor functioning. (Retrieved from http://iris.peadbody.vanderbilt.edu 05/20/06)

Normal Curve – In connection with a standardized test, the typical distribution of how scores deviate from the mean. Also called a bell curve or bell-shaped curve. (Norlin, 2003, p. 156)

Normalization – A philosophical belief in special education that every individual, even the most disabled, should have an educational and living environment as close to normal as possible. (Hallahan and Kauffman, 2006, p. 537)

Norm-referenced Test (NRT) – Comparison of one student's performance, as measured by the test score, with the performance of the norm allowing fine distinctions among students and identification of where a student stands in relation to that group; typically developed by commercial test companies. (Norlin, 2003, p. 157)

Rheumatic Fever – A disease largely affecting children and young adults involving acute episodes of fever and inflammation and swelling of the tissues around joints and also heart valves; identified as a health problem that could be an "other health impairment" for purposes of IDEA eligibility. (Norlin, 2003, p. 203)

Short-term Memory – The ability to recall information after a short period of time. (Hallahan and Kauffman, 2006, p. 540)

Sickle Cell Anemia – A genetic blood disorder, generally prevalent among African-Americans, that causes low vitality and pain; identified as a condition that may result in IDEA eligibility under the category of "other health impairment". (Norlin, 2003, p. 215)

Toxins – Poisons in the environment that can cause fetal malformations; can result in cognitive impairments. (Hallahan and Kauffman, 2006, p. 541)

SECTION 7: FREQUENTLY ASKED QUESTIONS

1. Several types of medical/health conditions are listed in the federal and state definitions for other health impairment. Are these the only medical disabilities that can be considered for verification of other health impairment?

   No. These are only examples of medical conditions that may be verified as other health impairment. A child with any type of medical/health disability may verify as having other health impairment if he/she meets the two-pronged eligibility guideline listed in this document (1. a medical/health disability, and 2. its adverse effect on development or educational performance).

2. Would a medical/health disability that may not result in a permanent disability such as asthma, teenage pregnancy difficulties, or after-surgery difficulty be considered a other health impairment for educational purposes?

   It depends. Usually a child who has a temporary medical or health disability will qualify under Section 504 for modifications and/or accommodations within the school setting during the recovery/recuperation period. However, if the child who has a temporary medical or health disability experiences adverse effects on educational performance, the child may be referred for evaluation for an other health impairment. The Multidisciplinary Evaluation Team (MDT) then makes the verification decision.

3. Is a medical report required as a part of the verification process for the disability classification Other Health Impairment?

   Yes. A report from a physician describing the medical condition and its implications is required.

4. Is the school required to pay for the medical evaluation?

   It depends. In many cases, a medical evaluation will already have been completed and the physician will send a report to the MDT with the parent's written permission.

5. How severe must the medical disability be for the child to verify as a child with a other health impairment?

   The severity of the medical disability will be documented in a written report from a physician. However, there must be documentation of an adverse affect on the development or educational performance of the child in order for the child to verify with a other health impairment.

6. Can a child meet the guidelines for having other health impairment if he/she is doing well academically in his/her classes?

   Yes. Because the assessment for achievement includes not only academic achievement, but also social/interpersonal skills, adaptive skills, speech/language skills, and any skills considered a part of that child's achievement.

7. Can a child meet the guidelines for a other health impairment if the child has compensated for the medical disability by using medication, behavior management strategies, etc.?

It depends. The verification of other health impairment is a two-pronged verification including both the medical condition and achievement. If the child has compensated for the medical disability through medications, behavior management strategies, etc., yet there is an adverse effect on the educational performance of the child, then the child could certainly verify as a child with a other health impairment.

8. Can a child who has been diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD) be verified as having an other health impairment?

Yes. ADHD and ADD are both a part of the federal and state definitions for other health impairment. However, the child must meet the two-pronged eligibility guidelines. The child must be diagnosed with a medical condition (ADHD/ADD) ***and*** *must experience an adverse effect on educational performance/development due to the ADHD/ADD condition.*

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DISABILITY CATEGORY:

Specific Learning Disability

DISABILITY CATEGORY: Specific Learning Disability

SECTION 1: INTRODUCTION

This technical assistance document was written to provide parents, teachers, special education personnel, administrators, and other professionals with information on the identification, verification, and determination of eligibility for special education services for children with specific learning disabilities.

This category of children has been defined by both federal and state regulations. A three-part eligibility requirement for a child to be verified as a child with a specific learning disability is as follows:

- Meet verification criteria (92 NAC 51.006);
- Documentation of adverse effect on educational performance;
- Determination that there is a need for special education.

Since 1975, when the first federal special education law (P.L. 94-142) was authorized by Congress and the Nebraska Rule 51 was written and approved, children with specific learning disabilities in Nebraska have been verified by using a "Severe Discrepancy" between intellectual ability (IQ) and achievement. In recent years the validity and reliability of this process have been questioned at the federal, state, and local educational levels.

When the federal law was reauthorized in 2004 (IDEA 2004) the developers allowed states more flexibility in the verification of children with specific learning disabilities. The following language, which provides states with three different options in the verification of specific learning disabilities, is included in IDEA 2004:

Additional Procedures for Evaluating Children with Specific Learning Disabilities: Sec. 300.307 Specific learning disabilities.

(a) General. A State must adopt, consistent with Sec. 300.309, criteria for determining whether a child has a specific learning disability as defined in Sec. 300.8. In addition, the criteria adopted by the State—

*(1) Must <u>not</u> require the use of a **severe discrepancy** between intellectual ability and achievement for determining whether a child has a specific learning disability as defined in Sec. 300.8 (c) (10);*

(2) Must permit the use of a process based on the child's ***response to scientific, research-based intervention****. Section 300.304; and*

(3) May permit the use of ***other alternative research-based procedures*** *for determining whether a child has a specific learning disability as defined in Sec. 300.8 (c)(10).* (Referred to in this document as RtI)

(b) Consistency with State criteria. A public agency must use the State criteria adopted pursuant to paragraph (a) of this section in determining whether a child has a specific learning disability.

(1221e-3; 1401(30); 1414(b) (6))

Nebraska Department of Education, Special Education Office, has determined that school districts in the state of Nebraska should adopt the following verification processes:

In determining whether a child has a specific learning disability, the team may use:

1. A process that determines if the child responds to scientific, research-based intervention as a part of the evaluation procedures (Response to Intervention (RtI), or

2. A process that may include an evaluation process that demonstrates a severe discrepancy between intellectual ability and achievement (Severe Discrepancy Process).

SECTION 2: STATE DEFINITION

- **Specific Learning Disability-** To qualify for special education services in the category of specific learning disability the child must have a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. The category includes conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia.

  The category does not include children who have learning problems that are primarily the result of visual, hearing, or motor disabilities; of mental handicaps; of behavioral disorders; or of environmental, cultural, or economic disadvantage.

SECTION 3: MULTIDISCIPLINARY EVALUATION TEAM (MDT) COMPOSITION

The Multidisciplinary Team (MDT) should include at least:

- The child's parents;
- For a school age child, the child's regular teacher(s) or a regular classroom teacher qualified to teach a child of that age;
- For a child below age 5, a teacher qualified to teach a child below age 5;
- Special educator with knowledge in the area of specific learning disabilities;
- A school district administrator or a designated representative.
- At least one person qualified to conduct individual diagnostic examinations of children in their specific area of training, i.e., speech language pathologist, or remedial teacher; and
- *A school psychologist or licensed psychologist (recommended)*

SECTION 4: VERIFICATION GUIDELINES

The MDT may determine that a child has a specific learning disability if:

(1) The child does not achieve adequately for the child's age or to meet State-approved grade-level standards in one or more of the following areas, when provided with learning experiences and instruction appropriate for the child's age or State-approved grade-level standards:
- (i) Oral expression.
- (ii) Listening comprehension.
- (iii) Written expression.
- (iv) Basic reading skill.
- (v) Reading fluency skills.
- (vi) Reading comprehension.
- (vii) Mathematics calculation.
- (viii) Mathematics problem solving.

(2) (i) The child does not make sufficient progress to meet State-approved grade level standards in one or more of the areas identified 92 NAC 51-006.04K3a when using a process based on the child's response to scientific, research-based intervention; or

(ii) The child exhibits a pattern of strengths and weaknesses in performance, achievement, or both, relative to age, State approved grade-level standards, or intellectual development, that is determined by the team to be relevant to the identification of a specific learning

disability, using appropriate assessments consistent with 92 NAC 51-006.02; and

(3) The MDT determines that its findings under 92 NAC 51-006.04K3a and 006.04K3b are not primarily the result of—
   (i) A visual, hearing, or motor disability;
   (ii) Mental handicap;
   (iii) Behavior disorder;
   (iv) Cultural factors;
   (v) Environmental or economic disadvantage;
   (vi) Limited English Proficiency.

(b) To ensure that underachievement in a child suspected of having a specific learning disability is not due to lack of appropriate instruction in reading or math, the MDT must consider, as part of the evaluation described in 92 NAC 51-006.02:
   (1) Data that demonstrates that prior to, or as a part of, the referral process, the child was provided appropriate instruction in regular education settings, delivered by qualified personnel; and
   (2) Data-based documentation of repeated assessments of achievement at reasonable intervals, reflecting formal assessment of the child's progress during instruction, which was provided to the child's parents.

(c) The school district or approved cooperative must promptly request parental consent to evaluate the child to determine if the child needs special education and related services, and must adhere to the timeframes described in 51-009.04A1, unless extended by mutual written agreement of the child's parents and a team of qualified professionals, as described in 006.04K2:
   (1) If, prior to a referral, a child has not made adequate progress after an appropriate period of time when provided instruction, as described in NAC 51-006.04K5a and b; and
   (2) Whenever a child is referred for an evaluation.

<u>Observation</u>

(a) The school district or approved cooperative must ensure that the child is observed in the child's learning environment (including the regular classroom setting) to document the child's academic performance and behavior in the areas of difficulty.

(b) The MDT, in determining whether a child has a specific learning disability, must decide to:
   (1) Use information from an observation in routine classroom instruction and monitoring of the child's performance that was done before the child was referred for an evaluation; or
   (2) Have at least one member of the MDT described in 92 NAC 51-006.04K2 conduct an observation of the child's academic performance in the regular classroom after the child has been referred for an evaluation and parental consent, consistent with NAC 51-009.08, is obtained.

(3) In the case of a child of less than school age or out of school, an MDT member must observe the child in an environment appropriate for a child of that age.

Specific documentation for the eligibility determination

(a) For a child suspected of having a specific learning disability, the documentation of the determination of eligibility must contain a statement of:

(1) Whether the child has a specific learning disability based on the criteria and definition contained in 92 NAC 51-006.04K, the child's education needs;

(2) The basis for making the determination, including an assurance that the determination was been made in accordance with 92 NAC 51-006.02D;

(3) The relevant behavior, if any, noted during the observation of the child and the relationship of that behavior to the child's academic functioning;

(4) The educationally relevant medical findings, if any;

(5) Whether-

(i) The child does not achieve progress commensurate with the child's age; or to meet state-approved grade level standards consistent with 92 51-006.04K3a and

(ii)(A) The child does not make sufficient progress to meet age or state-approved grade-level standards consistent with 92 NAC 51-006.04K3b or

(B) whether the child exhibits a pattern of strengths and weaknesses in performance, achievement, or both, relative to age, state-approved grade-level standards or intellectual development consistent with 92 NAC 51-006.04K3b(i);

(6) The determination of the MDT concerning the effects of visual, hearing, or motor disability; mental handicap; behavior disorder; cultural factors; environmental or economic disadvantage; or limited English proficiency on the child's achievement level; and

(7) If the child has participated in a process that assesses the child's response to scientific, research-based intervention, then

(i) the instructional strategies used and the child-centered data collected; and

(ii) the documentation that the child's parents were notified about:

(A) The school district's or approved cooperative's policies regarding the amount and nature of student performance data that would be collected and the general education services that would be provided;

(B) Strategies for increasing the child's rate of learning; and

(C) The parent's right to request an evaluation.

(b) Each MDT member must certify in writing whether the report reflects the member's conclusion. If it does not reflect the member's conclusion, the team member must submit a separate statement presenting his/her conclusions.

The evaluation of a child suspected of having a SLD must include a variety of evaluation and assessment tools to gather relevant functional developmental and academic information about the child, including information provided by the parent that may assist in determining eligibility. No single measurement or assessment may be used as the sole criterion for determining whether the child has a disability and for determining an appropriate educational program for the child.

Response to Intervention (RtI) Process

The legal basis for Response to Intervention (RtI) is found in the 2004 reauthorization of the Individuals with Disabilities Education Act which allows schools to "use a process which determines if a child responds to a scientific, research-based intervention" as part of a comprehensive evaluation to determine eligibility for a specific learning disability.

RtI, as defined by the National Association of State Directors of Special Education (NASDSE), is "The practice of providing high-quality instruction and interventions matched to student need, monitoring progress frequently to make decisions about changes in instruction or goals and applying child response data to important educational decisions" (Batsche, G., Elliott, J., Graden,J.L., Grimes, J., Kovaleski, J.F., Prasse, D., Reschly, D. J., Schrag, J., & Tilly, W. D., III. (2005). *Response to Intervention Policy Considerations and Implementation. Alexandria, VA: National Association of State Directors of Special Education, Inc. 2005*

RtI provides a framework for guiding instruction for all children. The RtI process is a multi-tiered approach that provides interventions to struggling children at increasing levels of intensity. The problem-solving model serves as the over-arching structure that organizes assessment and intervention activities (*Response to Intervention Technical Assistance Document*, Nebraska Department of Education & the University of Nebraska, June, 2006, page 4). The problem-solving process includes:

- Problem Identification: "Is there a discrepancy between current and expected performance of the child?"
- Problem Analysis: "Why is there a problem?"
- Goal Setting: "By how much should the child grow?"
- Plan Implementation: "What will be done to resolve the problem?"
- Plan Evaluation: "Did it work? What do we do next?"

Universal screening identifies children at risk for academic difficulties (*Response to Intervention Technical Assistance Document*, Nebraska Department of Education & the University of Nebraska, June, 2006, page 5. Data-based decision making involves frequent progress monitoring and ongoing evaluation of the child's responsiveness to high quality instruction and/or sequences of customized evidence-based interventions. Child outcome data are used to make educational decisions and serves as a guide for instructional intervention and eligibility decisions.

Essential Elements

To implement RtI adequately, schools must first have the organizational capacity to guarantee that the process can be followed. School-wide buy-in and a core team with clearly defined roles, authority and administrative support as well as communication and interaction among school personnel in regular and special education and alignment with existing initiatives are crucial.

The Essential Elements of a quality RtI process include:

- Team Leadership
- Parent involvement
- Universal Screening Procedures and Assessments
- Scientifically or Research-Based Core Instruction and Interventions
- Individual Progress Monitoring
- Planned Service Delivery Decision Rules
- Intervention Delivery
- Fidelity of Instruction
- SLD Verification

When a school building/district decides to implement an RtI process as part of the comprehensive eligibility evaluation, the District's RtI Plan must be submitted to an RtI Review Panel through the NDE RtI Consortium website. Upon approval of the Plan, the RtI Review Panel will send a letter to the school building or school district indicating their RtI Plan is adequate for implementation. The district will attach the letter to the Policies and Procedures and submit it to the NDE Office of Special Education. The District will also indicate in the Statement of Assurances that this process is being followed.

For additional information regarding Response to Intervention (RtI), please refer to the RtI Consortium website at www.nde.state.ne.us/rti

Severe Discrepancy Model

As part of the comprehensive eligibility evaluation, the Multidisciplinary Evaluation Team (MDE) may employ the severe discrepancy model. The severe discrepancy model may be used until such time that the school district has made the transition to full implementation of the Response to intervention (RtI) process as part of the comprehensive evaluation required by IDEA for verification of a child with a disability. School districts should develop a plan for the implementation of RtI for Reading for Kindergarten through Grade 6 by August 2012.

- All test scores used in verifying a child with suspected specific learning disabilities shall assume a mean of 100 and a standard deviation of 15 points.

  - In order for a child to be verified as a child with specific learning disabilities under the Severe Discrepancy Process the child must demonstrate a severe discrepancy between achievement and intellectual ability in one or more of the major areas: oral expression, listening comprehension, written expression, basic reading skills, reading comprehension, reading fluency, mathematics calculation and mathematics reasoning, if provided with learning experiences appropriate for the child's age and ability levels. When the team uses a Severe Discrepancy Process, the evaluation shall include the analysis and documentation of:
    - Observations conducted by at least one team member other than the child's classroom teacher of the child's academic functioning, educational environment, and the child's interaction with that environment (basic psychological educational processes) in the regular classroom.
      - In the case of a child of less than school age or out of school, a team member shall observe the child in an environment appropriate for a child of that age.
    - Individual test of intelligence.
      - The test must have adequate reliability for the total test score (i.e., reliability at or above .90) (Salvia & Ysseldyke, 2007)
      - If composite scores are used, they must also have adequate reliability (i.e., reliability at or above .90) and be valid for the decision being made. If there is a discrepancy of more than one (1.0) standard deviation (16 points or more) between major composite scores, then the higher score may be used as the indicator of the child's intellectual ability.
    - Assessed achievement level that results in a standard score in one or more major academic area(s) that is at least 1.3 standard deviations (20 standard score points) below the child's assessed intellectual level. In addition, the standard score in the major academic area which is used to establish the qualifying discrepancy shall fall at or below a standard score of 84, regardless of the discrepancy between assessed ability level, and the major academic area.
      - The test must have adequate reliability for the total test score (i.e., reliability at or above .90) (Salvia & Ysseldyke, 2007)
    - If composite scores are used, they must also have adequate reliability (i.e., reliability at or above .90) and be valid for the decision being made.
    - Discrepancies shall be verified in terms of age-based standard score rather than age or grade equivalents.

SECTION 5: PROCEDURES TO DETERMINE ADVERSE EFFECT ON DEVELOPMENT/EDUCATIONAL PERFORMANCE

FACTORS TO CONSIDER

Many factors should be considered in determining if a specific learning disability is causing, or can be expected to produce, significant delays in the child's development or educational performance. The factors include, but are not limited to:

- Child Characteristics
  - Medical history, current health status, medications
  - Social skills and behavior
  - Communication skills
  - Physical health
  - Motor skills
  - Mental health
  - Cognitive skills
  - Motivation
  - Current age
  - History of developmental milestones

- Educational Variables
  - Current educational placement
  - Classroom environment
  - Instruction
  - Curriculum
  - History of modifications and/or accommodations used
  - Intervention and response
  - Results of previous assessments/evaluations

- Relevant family history
  - Culture
  - Language

Examination of each of these factors may lead to additional factors to consider. Psychologists, teachers of children with learning difficulties, and speech language pathologists are the primary professionals who can determine how these learning difficulties may impact the child. Parents, medical professionals, teachers, and the child him/herself can also provide information important in determining the impact of the learning difficulties.

The team needs to consider data that are accurate, consistent, comprehensive, and objective. Possible assessment approaches for obtaining information about the child are:

- Review of existing records and work samples
  - Teacher-anecdotal notes
  - Grades
  - Cumulative file review

- Class assignments and homework

- Interviews
  - Parent interviews/rating scales
  - Teacher interviews/rating scales
  - Child interviews/rating scales

- Observations (in setting(s) where concern is occurring)

- Tests
  - Criterion-referenced tests
  - Norm-referenced tests
  - District-wide assessments
  - Curriculum-based assessments
  - State and District-wide Assessment

Professional judgment must be used by the team as they analyze the data to determine if the child meets the verification guidelines for a child with a specific learning disability.

The team must review the following areas to rule out those circumstances other than a specific learning disability that may be the primary contributor to the child's low achievement.

The following questions are to guide documentation and determination of whether the disability has an adverse effect on the child's developmental/educational performance:

- Behavior disorder
  - Are there particular behaviors that are interfering with the child completing assignments, tasks?
    - Has a functional behavioral assessment been completed for the child's behaviors?
    - Does the child have a behavior intervention plan? What is the plan? How is the child responding to this plan?
  - Does the child exhibit a lack of particular social skills that affect his/her interpersonal relationships?
  - In what types of social skills instruction has the child participated?

- Mental handicap
  - Has the child been verified with a mental handicap?
  - Is the child receiving special education services as a child with a mental handicap?

- Speech/language impairment
  - Is the child verified as having speech/language impairment?
  - What is the speech/language impairment?
  - What type of intervention is the child receiving?

- Vision/Hearing/Orthopedic Impairment
  - Has the child been diagnosed with a medical/health condition? If so, what is the medical/health condition?
  - What types of interventions/treatments is the child receiving?

- Lack of previous opportunities to learn
  - Have the child's previous opportunities to learn been limited?
  - What are the causes of the lack of opportunities (extended illness, frequent transfers between schools, etc.)?

- English Language Learners (ELL)
  - What is the child's level of language in his/her native language?
  - Is the child enrolled in English Language Learner (ELL) classes/Limited English Proficiency (LEP)?
  - What is the child's mastered ELL level?

- Environmental, cultural, and economic factors
  - Has a determination been made that the child's environmental, cultural, and/or economic factors contributed to the child's low achievement?

- Other Factors
  - Is performance inconsistent across academic, social, and behavioral areas?
  - Did the child make progress when provided scientific, research-based instructional practices and interventions?
  - Are the interventions needed for progress so intense that they cannot be sustained in a general education setting?

SECTION 6: DEFINITION OF TERMS

Academic Achievement – A child's level of performance in basic school subjects, measured either formally or informally. (Norlin, 2003, p. 1)

Achievement Test – Test that measures what students have been taught and learned. (Salvia & Ysseldyke, 1998, p.682)

Accommodation – Accommodations are practices and procedures in the areas of presentation, response, setting, and timing/scheduling that provide equitable access during instruction and assessments for children with disabilities. Accommodations are intended to reduce or even eliminate the effects of a child's disability; they do not reduce learning expectations. (Nebraska Department of Education Accommodations Guidelines, 2006, p.4)

Acquired Apraxia – As in Developmental Apraxia, there are problems in motor planning such that the child has difficulty in producing speech sounds and organization

words and word sounds for effective communication. However, the problem is known to be caused by neurological damage. (Hallahan and Kauffman, 2006, p. 530)

Achievement Test – A test that objectively measures educationally relevant skills or knowledge; a test that measures mastery of content in a subject matter area, as opposed to an intelligence test. (Norlin, 2003, p. 3)

Age Appropriate – In connection with special education, achievement consistent with a disabled child's developmental level and chronological age. (Norlin, 2003, p. 6)

Age-Equivalent Score –"A derived score that expresses a person's performance as the average (the median or mean) performance for that age group; age equivalents are expressed in years and months." (Salvia & Ysseldyke, 2007, p. 682)

Aphasia – A receptive language disorder, more commonly expressive language disorder, in children with normal intelligence and adequate sensory and motor skills; two basic types relate the onset to acquisition of language: acquired aphasia and developmental aphasia. (Norlin, 2003, p. 10)

At Risk – Generally, a child or youth about whom one has a higher than usual expectation of future difficulties as a result of circumstances relating to his or her health status, disability, or family or community situation; typical characteristics of a student who is at risk for reasons other than disability may include being one or more grade levels behind in reading or mathematics achievement, chronic truancy, personal or familial drug or alcohol abuse, or low self-esteem. (Norlin, 2003, p. 14)

Brain Injury – "Insult to the brain" resulting in impairment of brain function; categorized types, depending on cause and extent of injury as acquired, closed, and mild. (Norlin, 2003, p. 29)

Criterion Referenced Test (CRT) – Test that measures a person's skills in terms of absolute levels of mastery. (Salvia & Ysseldyke, 2007, p. 683)

Curriculum-Based Measurement (CBM) – Series of incremental assessments of what a student has learned. (Norlin, 2003, p. 50)

Developmental Aphasia – (1) A congenital receptive language disorder or, more commonly, expressive language disorder in children with normal intelligence and adequate sensory and motor skills that prevents acquisition of language. (2) Identified in IDEA regulations...as a "specific learning disability." (Norlin, 2003, p. 57)

Developmental Apraxia – A disorder of speech or language involving problems in motor planning such that the child has difficulty in producing speech sounds and organizing words and word sounds for effective communication. The cause may be unknown. (Hallahan and Kauffman, 2006, p. 533)

Dyslexia – (1) Receptive disorder in written language typically resulting in reading disabilities experienced by children of otherwise normal intellectual capacity who have received adequate instruction. (2) Identified in IDEA regulations…as a "specific learning disability." (Norlin, 2003, p. 67)

ELL – English Language Learner; English is the child's second language.

Evidence-Based Practice – An educational intervention that is backed by rigorous evidence of effectiveness. U.S. Department of Education. Retrieved September 20, 2006 www.ed.gov/rschstat/research/pubs/rigorousevid/index.html

Functional Behavior Assessment (FBA) – Evaluation that consists of finding out the consequences, what purpose the behavior serves, antecedents (what triggers the behavior), and setting events (contextual factors) that maintain inappropriate behaviors; this information can help teachers plan educationally for students. (Hallahan and Kauffman, 2006, p. 534)

Grade Equivalent Score – "A derived score that expresses a student's performance as the average (the median or mean) performance for a particular grade; grade equivalents are expressed in grades and tenths of grades …". (Salvia & Ysseldyke, 2007, p. 684)

Intelligence Quotient (I.Q.) – Norm-reference test designed to measure learning ability or intellectual capacity by measuring cognitive behaviors associated with mental ability, such as discrimination, generalization, vocabulary, comprehension, abstract thinking or reasoning, memory and sequencing. (Norlin, 2003, p. 116)

Limited English Proficient – Children from language backgrounds other than English who need language assistance services in their own language or in English in the schools. (Norlin, 2003, p. 132)

Minimal Brain Dysfunction – (1) Generally, a once common term in medical or scientific literature describing an occurrence of impaired attention and memory and resulting learning problems without a known insult to the brain. (2) Identified in IDEA regulations…as a "specific learning disability," but not further defined. (Norlin, 2003, p. 144)

Norm-Referenced Test (NRT) – Comparison of one student's performance, as measured by the test score, with the performance of the norm allowing fine distinctions among students and identification of where a student stands in relation to that group; typically developed by commercial test companies. (Norlin, 2003, p. 157)

Phoneme – The smallest unit of an individual's speech that distinguishes one utterance from another like a syllable; the English language has 24 consonant and 12 vowel phonemes. (Norlin, 2003, p. 174)

Phonemic Awareness – Ability to recognize phonemes and put their sounds together to form words and phrases quickly, accurately, and automatically; essential for decoding. (Norlin, 2003, p. 174)

Phonics – The relationship of speech sounds to their written symbols; an instructional method for teaching reading by helping students recognize words by sounding them out; as opposed to the whole language method of reading instruction. (Norlin, 2003, p. 174)

Phonological Awareness – Awareness of how words sound and how they are represented in written language or print; ability to identify and manipulate the sounds of language. Many children with learning disabilities cannot readily learn how to relate letters of the alphabet to the sounds of language. These students must be explicitly taught the process of phonological awareness. (Norlin, 2003, p. 174)

Reading Comprehension – The ability to understand what one has read. (Hallahan and Kauffman, 2006, p. 539)

Reading Fluency – The ability to read effortlessly and smoothly, consists of the ability to read at a normal rate and with appropriate expression, influences one's reading comprehension. (Hallahan and Kauffman, 2006, p. 539)

Receptive Language – Understanding communication from others, as distinguished from expressive language. (Norlin, 2003, p. 196)

Receptive Language Disorder – Presents as an inability to understand spoken or written language that may affect reading, writing, and problem-solving in arithmetic. (Norlin, 2003, p. 196)

Response to Intervention (RtI) – "the practice of providing high-quality instruction and interventions matched to student need, monitoring progress frequently to make decisions about changes in instruction or goals and applying child response data to important educational decisions." (Batsche et. al., Response to Intervention Policy Considerations and Implementation, 2006, p. 5)

Scientific, Research-Based Intervention – Scientifically based research is defined in the No Child Left Behind Act (NCLB) as research that involves the application of rigorous, systematic, and objective procedures to obtain reliable and valid knowledge relevant to education activities and programs. U.S. Department of Education. September 20, 2006 www.ed.gov/nclb/overview/intro/edpicks.jhtml?src=ov

Semantics – The study of meanings attached to words and sentences. (Hallahan and Kauffman, 2006, p. 540)

Standard Score – "The general name for a derived score that has been transformed to produce a distribution with a predetermined mean and standard deviation." (Salvia & Ysseldyke, 2007, p. 688)

Standard Deviation – "A measure of the degree of dispersion [or spread] in a distribution of scores; the square root of the variance." (Salvia & Ysseldyke, 2007, p. 688)

SECTION 7: FREQUENTLY ASKED QUESTIONS

1. Can an eligibility determination of SLD be made using only information that was collected through an RtI process?

   The RtI process includes the need for comprehensive evaluation. The MDT must use a variety of data gathering tools and strategies even if an RtI process is used. The results of an RtI process will be one component of the information reviewed as part of the evaluation procedures required.

2. If a child's learning problems are primarily the result of a sensory impairment can the child be verified as a child with a specific learning disability?

   No. Specific learning disability does not include learning problems that are primarily the result of a visual impairment, hearing impairment, orthopedic impairment, mental handicap, or behavior disorder, environmental, cultural, or economic disadvantage. For example, a child may have a speech language impairment which may result in the provision of speech as a related service.

3. At what age should a child be assessed for a specific learning disability?

   One of the goals of Response to Intervention (RtI) is to provide intervention for at-risk children at an early age. If with intense intervention, the child does not make appropriate progress in his/her learning, then the child may be evaluated to determine if the child has a specific learning disability.

4. How can progress monitoring data be used in the SLD verification process?

   Progress monitoring data are critical for determining whether a child has made sufficient progress in response to a scientific, research-based intervention process; however, they are not the sole basis for identifying a specific learning disability.

5. There are eight achievement areas listed in federal and state laws in which children may verify as having a specific learning disability. Are these the only areas in which the child may verify?

Yes. Both federal and state laws state that the child must meet the verification guidelines for one or more of these eight areas of achievement:
(i) Oral expression
(ii) Listening comprehension
(iii) Written expression
(iv) Basic reading skill
(v) Reading fluency skills
(vi) Reading comprehension
(vii) Mathematics calculation
(viii) Mathematics problem solving

If the child has other difficulties, the child may be evaluated to determine if he/she may have a different disability.

6. Must a child have average or higher intelligence in order to be verified as a child with a disability in the category of specific learning disability?

No, but if there is reason to suspect that the child may have a mental handicap, then that verification category must be ruled out.

SECTION 8: REFERENCES AND RESOURCES

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WEB SITES

Access Unlimited http://www.accessunlimited.com/

Alliance for Technology Access www.ataccess.org

American Academy of Pediatrics www.aap.org

Clearinghouse on Disability Information Office of Special Education and Rehabilitation Services (OSERS) www.ed.gov/about/offices/list/osers/index.html

Council for Learning Disabilities (CLD) http://www.cldinternational.org

Council of Exceptional Children (CEC) www.cec.sped.org

Disability-Related Resources on the Internet http://www.washington.edu/doit/Brochures/DRR/

Division for Learning Disabilities (DLD) www.dldcec.org

Exceptional Parent www.eparent.com

Family Voices www.familyvoices.org

Guide to Disability Resources on the Internet www.disabilityresources.org

IDEA Practices www.ideapractices.org

International Dyslexia Association http://www.interdys.org/

Learning Disabilities Association of America http://www.ldanatl.org/

Learning Disabilities Online http://www.ldanatl.org/

LD Resources www.ldresources.com

National Association of School Psychologists (NASP) www.nasponline.org

National Center for Learning Disabilities (NCLD) www.LD.org

National Center for Research on Learning Disabilities www.nrcld.org

National Dissemination Center for Children with Disabilities (NICHCY) www.nichcy.org

National Institute of Child Health and Human Development (NICHD): www.nichd.nih.gov

National Institute on Disability and Rehabilitation Research (NIDRR) www.ed.gov/about/office/

National Organization on Disability www.nod.org

National Rehabilitation Information Center (NARIC) www.NARIC.com

National Research Center on Learning Disabilities (NRCLD) http://nrcld.org

Nebraska Department of Education RTI www.nde.state.ne.us/RTI

Office of Special Education and Rehabilitation Services, Office of Special Education Programs (OSEP) www.ed.gov/about/offices/list/osers/osep/index.html

Recording for the Blind and Dyslexic (RFB) http://www.rfbd.org/

DISABILITY CATEGORY:

Speech - Language Impairment

DISABILITY CATEGORY:
Speech - Language Impairment

SECTION 1: INTRODUCTION

These verification guidelines were written to provide parents, teachers, special education personnel, administrators, and other professionals with information on the identification, verification, and determination of eligibility for special education services for children with speech language impairment.

This category of children has been defined by both federal and state regulations. A three-part eligibility requirement for a child to be verified as a child with a speech-language impairment is as follows:

- Meet verification criteria (92 NAC 51.006);
- Documentation of adverse effect on development or educational performance;
- Determination that a need for special education is evident.

SECTION 2: DEFINITION

- **Speech or Language Impairment** – To qualify for special education services in the category of speech-language impairment, the child must have: a communication disorder, such as: stuttering; impaired articulation; language impairment; or voice impairment. This disorder must adversely affect the child's educational, or in the case of a child below age five, a child's developmental performance.

SECTION 3: MULTIDISCIPLINARY EVALUATION TEAM (MDT) COMPOSITION

The Multidisciplinary Team (MDT) should include the following members:

- The child's parents;
- The child's teacher(s) or a teacher qualified to teach a child that age;
- A speech-language pathologist; and

- A school district administrator or a designated representative.

SECTION 4: VERIFICATION GUIDELINES

In order for a child to be verified as a child with a speech-language impairment the evaluation must demonstrate below average performance in **language** or **articulation**, or abnormal patterns in **voice** or **fluency**.

Documentation of a speech-language impairment must demonstrate a pattern of deficits that has an adverse effect on the child's development or educational performance in the areas of communication, social-emotional, or academics, based on the analysis of multiple data sources from among the following:

- Results of standardized and criterion-referenced assessments of speech or language
- Results of criterion-based speech-language sampling
- Results of criterion-based communication measures
- Direct observation of the child in the natural environment or classroom
- The child's response to short-term scientific, research-based intervention
- Measurement of the child's intellectual ability
- Results of criterion-referenced assessments related to the general curriculum
- Description of communication supports provided at home or at school
- Relevant medical data
- Information from child, parent and/or other caregivers, and teachers

Verification of a speech-language impairment shall be based on a pattern of communicative performance which is below the average range and documentation of significant adverse effect on the child's development or educational performance.

A child shall not be determined to have speech-language impairment if the determining factor is a lack of instruction or limited English proficiency.

- **Language** refers to the rule-based use and comprehension of spoken, written and/or other symbolic systems. The basic elements of language are:
  - Content: *semantics*, the meanings of words and word combinations
  - Form:
    - *Phonology*, speech sounds, sound patterns and rules of sound organization
    - *Morphology*, units of meaning
    - *Syntax*, rules governing word order and word combinations to form sentences
  - Use/Function: *pragmatics*, the social aspects of language

A language disorder is impaired comprehension and/or use of spoken, written, and/or other symbol systems which may involve content, form and/or use. It may be developmental or acquired.

- **Articulation** (speech sound production) refers to the movements of the speech organs involved in the production of speech sounds/phonemes.

  An articulation disorder (speech sound production disorder) is the atypical production of speech sounds characterized by substitutions, omissions, additions, or distortions that may interfere with intelligibility.

- **Voice** refers to the production of pitch, loudness, resonance and vocal quality appropriate for an individual's age and/or gender.

  A voice disorder is characterized by the abnormal production of vocal quality, pitch, loudness, resonance and/or duration, which is inappropriate for an individual's age and/or gender.

- **Fluency** refers to the smooth, uninterrupted, effortless flow of speech; normal rate and rhythm of speech.

  A fluency disorder (stuttering) is an interruption in the flow of speaking, characterized by atypical rate, rhythm, and repetitions in sounds, syllables, words, and phrases. This may be accompanied by excessive tension, struggle behavior and secondary mannerisms, as well as by negative covert attitudes toward and perception of the communication process.

Definitions adapted from ASHA website: http://www.asha.org/docs

Considerations Regarding Culturally and Linguistically Diverse Children

Interpreting the communicative behavior of culturally and linguistically diverse children during assessment is not substantially different from the process for native English speakers. However, it does require consideration of both the structure of their language/dialect and the cultural values that affect communication. Materials and procedures used to assess a child with limited English proficiency must be selected and administered to ensure that they measure the extent to which the child has a disability and needs special education, rather than measuring the child's English language skills.

- Some considerations:
  - Stage of primary language development when English was introduced
  - Quality of English speech-language models
  - Child-rearing practices that may affect communication development (i.e. amount of parent-child vs. peer-peer talk)
  - Attitudes of family and child to English language culture

Considerations for Continued Eligibility

According to the Individuals with Disabilities Education Act (IDEA, 2004), a child is eligible for special education and related services when it is determined that:

1. A disability exists—the child's performance meets criteria under NAC 51; and
2. The disability has an *adverse effect* on the child's educational performance or development; and
3. The child *needs* special education and related services to address the adverse effect.

When determining continued eligibility, it is recommended that the MDT/IEP Team consider the following**:**

- Does the communication disorder continue to exist? (#1 above)
- Do the child's communication skills continue to constitute a disabling condition? (#1 OR #2 above)
- Do the child's communication skills interfere with his/her development or educational functioning? (#2 above)
- Does the child continue to need speech-language intervention in order to benefit from his/her educational program? (#3 above)
- Are the child's present communication skills within the expected range, commensurate with his/her cognitive abilities/developmental level? (#1, #2, or #3 above)

SECTION 5: PROCEDURES TO DETERMINE ADVERSE EFFECT ON DEVELOPMENT/EDUCATIONAL PERFORMANCE:

FACTORS TO CONSIDER

The following procedures and analysis of assessment information are recommended in the Multidisciplinary Evaluation Team's (MDT) determination of adverse effect on development or educational performance as it relates to **language**, **articulation, voice** or **fluency**.

- **LANGUAGE**
  - Referral information
    - Analysis of data collected by Student Assistance Team (for children of school-age)
    - Parent/caregiver information (for children ages birth to five)
  - Educationally/developmentally relevant medical information
    - Medical history
    - Medication which may adversely affect language
    - Medical information relevant to language development
    - Hearing screening results
  - Formal and informal assessments
    - Standardized or criterion-referenced assessment of language in one or more of the following areas, as indicated by the referral for assessment:
      - Receptive language including auditory processing, where appropriate
      - Expressive language
      - Vocabulary
      - Syntax, morphology
      - Pragmatics
      - Phonology
      - Phonemic awareness
      - Narrative language
      - Word retrieval
      - Intellectual ability, when questioned
      - Parent/caregiver information on the child's developmental milestones and language skills through interviews and rating scales (for children ages birth to five)
  - Language sample
    - Consistency of language performance across structured and unstructured contexts
    - Information on nonverbal communication during spontaneous conversation
    - Ability to express a variety of communicative functions within the following areas:
      - Behavioral Regulation—communication intended to manipulate the behavior of others
        - Requesting object
        - Requesting action
        - Protesting/rejecting
      - Social Interaction—communication intended to relate to/interact with others
        - Requesting social routine
        - Requesting comfort
        - Greeting
        - Calling

        - Requesting permission
        - Showing off
    - Joint Attention—communication intended to share focus with others
        - Commenting
        - Requesting information
        - Providing information
    - Developmentally/age-appropriate interactions of language content/form/use
- Observational data/input from:
    - Natural environment or classroom
    - Student Assistance Team (SAT)
    - Classroom teacher
    - Parents/Caregiver
    - Child
- Response to scientific, research-based intervention

Children should not be verified for services based on low scores on a single test. Generally, all areas of language should be considered – structure, content, and use, including understanding and use of language, syntax, morphology, semantics, phonemic awareness, phonology, language formulation and retrieval, auditory processing, oral narratives, and pragmatics. When assessing a child with a mental handicap, the child's "developmental age" should be a major consideration. The speech-language pathologist will need to apply professional judgment to the analysis of the child's pattern of phonological development.

The information in the following chart is designed to provide a descriptive continuum from typical development through disordered performance for selected linguistic elements.

Language Disorder Assessment Continuum

STANDARD SCORE (formal measures of content, form & use)	85 to 115 SS -1 SD to +1 SD 16 to 85%ile	78 to 84 SS >1 SD to –1.5 SD 7 to 15%ile	70 to 77 SS >1.5 SD to –2 SD 2 to 6%ile	Below 70 SS >-2 SD Below 2%ile
EFFECT ON COMMUNICATION	No adverse impact	Language deficits may be obvious to familiar others; may impact academics	Language deficits impact ability to communicate orally, process oral language, read and write	Language deficits are linked to deficits in preliteracy/literacy skills and/or social relationships
PRAGMATICS (where no standard scores are available)	Able to maintain topic, take turns, and express all communicative functions age-appropriately	Does not adapt speaking style, give feedback, maintain topic appropriate to age	Difficulty initiating, requesting information, maintaining topic, making repairs, using eye contact, controlling prosody for meaning	Does not use language appropriately for behavioral regulation, social interaction, and joint attention
PHONOLOGY (where no standard scores are available)	Age appropriate phonological skills Phonological processes evident are within age range for typical development	One or two phonological processes evident that do not exceed the age-range for expected suppression Processes improve over time	Consistent phonological processes evident that exceed age-range for expected suppression by no more than 1 year Intelligibility may be adversely affected	Consistent phonological processes evident that exceed age-range for expected suppression by more than 1 year Intelligibility is adversely affected
PHONEMIC AWARENESS (where no standard scores are available)	Age-appropriate awareness of phonemic features: rhyming, isolating, blending, segmenting, etc.	Below average awareness of phonemic features: rhyming, etc. on criterion-referenced testing	Inability to manipulate phonemic features resulting in significantly below average literacy skills in classroom, on criterion-referenced and/or formal testing	Pervasive inability to manipulate phonemic features resulting in significantly below average literacy skills in the classroom

Phonological processes describe what children do in the normal developmental process of acquiring speech to simplify adult productions. (Shipley & McAfee, 2004) Typically, children outgrow or suppress such processes as they learn to produce the correct adult targets by around eight years of age. (Stoel-Gammon & Dunn, 1985).

Stoel-Gammon and Dunn (1985) reviewed a number of studies of phonological process occurrence and identified processes that are typically suppressed by age 3 years and those that typically persist after 3 years:

Processes Disappearing by 3 Years	Processes Persisting after 3 Years
* Unstressed syllable deletion	* Cluster reduction
* Final consonant deletion	* Epenthesis
* Consonant assimilation	* Gliding
* Reduplication	* Vocalization
* Velar fronting	* Stopping
* Prevocalic voicing	* Depalatalization
	* Final devoicing

Phonological process analysis compares a child's productions to standard adult productions. Different researchers describe a number of phonological processes.

It is important to note that there is limited research on when specific patterns of phonological processes are outgrown. The speech-language pathologist will need to apply professional judgment to the analysis of the child's pattern of phonological development.

Commonly used assessment batteries for evaluating phonological processes include:

- *Assessment Link Between Phonology and Articulation* (Lowe, 1986)
- *Assessment of Phonological Processes—Revised* (Hodson, 1986)
- *Bankson-Bernthal Test of Phonology* (Bankson & Bernthal, 1990)
- *Khan-Lewis Phonological Analysis* (KLPA-2) (Khan & Lewis, 2003)

(Shipley & McAfee, 2004)

Determination of Adverse Effect

The following questions are to guide documentation and determination of adverse effects of language deficits on a child's developmental/ educational performance and need for special education in the areas of communication, social-emotional, and academics:

- Communication
  - Does the child demonstrate:
    - Difficulty identifying and understanding important ideas and details in conversations?
    - Limited understanding of word meanings; limited vocabulary compared to peers?
    - Difficulty defining and describing actions, objects, and events?
    - Difficulty in the production of complex utterances; simplified sentence structure that requires the individual to produce multiple simple sentences rather than one complex utterance?

- Difficulty conveying ideas; talking around a topic, using gestures in attempt to get point across, making irrelevant remarks?
- Difficulty with word retrieval?
- Difficulty with topic maintenance in conversation?
- A speech-sound system characterized by phonological processes beyond the normal age for suppression of such processes?

♦ Is the child unable to:
- Make requests and ask questions to meet his/her needs?
- Respond appropriately to age-appropriate requests and questions?

❖ Social-emotional

♦ Does the child demonstrate:
- Difficulty establishing and maintaining interpersonal relationships with peers and adults due to language deficits?
- Difficulty organizing, initiating, and sustaining social conversations?
- Difficulty following conversational rules – turn taking, personal space, reciprocity?
- Difficulty understanding jokes, puns, and riddles?
- Difficulty recognizing, interpreting, and using nonverbal cues?

❖ Academics

♦ Does the child demonstrate:
- Difficulty understanding or using basic concepts, i.e. descriptors and colors?
- Difficulty with comprehension of oral/written information and directions due to language deficits?
- Difficulty remembering information that was previously learned?
- Difficulty asking coherent questions to clarify information?
- Difficulty responding appropriately to questions?
- Difficulty identifying main ideas and relevant details in reading; distinguishing fact from opinion; predicting or inferring information; understanding multiple-meaning words?
- Difficulty analyzing and manipulating sounds in phonemic awareness activities – blending, segmentation, deletion, etc.?
- Difficulty organizing and editing written work, reflecting oral expression deficits in vocabulary and in written work?
- Difficulty understanding and using figurative language?
- Difficulty with space, time, and quantity concepts in math?
- Difficulty with sequencing tasks?
- Decreased participation in classroom discussions?

<u>In no case should below average performance on a single measure be accepted as demonstrating a pattern of deficit.</u>

- **ARTICULATION**
  - Referral information
    - Analysis of data collected by Student Assistance Team (for children of school-age)
    - Parent/caregiver information (for children ages birth to five)
  - Oral peripheral examination
    - Assessment of the structures and functions of the oral-motor mechanism for speech
  - Educationally/developmentally relevant medical information
    - Medical history
    - Medication which may adversely affect articulation
    - Examination of medical information relevant to the production of speech
    - Hearing screening or results of previous hearing screening
  - Formal and informal measures
    - Tests of articulation of both vowels and consonants at the single word, phrase, sentence, and conversational levels
    - Stimulability at the isolation, nonsense syllable, word, phrase, and sentence levels
    - Intelligibility of connected speech in known contexts
    - Parent/caregiver information on the child's developmental milestones and language skills through interviews and rating scales (for children ages birth to 5)
    - Results of articulation testing compared to the Iowa-Nebraska Articulation Norms or other scientific, research-based articulation norms
  - Speech sample
    - Consistency of articulation across structured and unstructured contexts
  - Observational data/input from:
    - Natural environment or classroom
    - Student Assistance Team
    - Classroom teachers
    - Parents/caregivers
    - Child

The information in the following chart is designed to provide a descriptive continuum from typical development through disordered performance.

Articulation Disorder Assessment Continuum

SPEECH SOUND PRODUCTION	Child's articulation is developmentally appropriate	Child's chronological age (or developmental age) does not exceed acquisition age for the error phoneme(s). *(See IA-NE Articulation Norms)*	Child's chronological age (or developmental age) exceeds the acquisition age for the error phoneme(s) by no more than 1 ½ years. *(See IA-NE Articulation Norms)*	Child's chronological age (or developmental age) exceeds the acquisition age for the error phoneme(s) by 2 or more years. *(See IA-NE Articulation Norms)*
STIMULABILITY	Stimulability for phonemes indicates good prognosis for normal development	Sound errors are stimulable in at least one context	Sound errors may or may not be stimulable with effort	Sound errors are not generally stimulable
INTELLIGIBILITY	Intelligibility acceptable for age.	Connected speech at least 75% intelligible, although noticeably in error	Intelligibility of connected speech in unknown contexts may be adversely affected	Intelligibility of connected speech in both known and unknown contexts is generally severely affected
TYPES OF ERRORS	Developmental.	Generally single phoneme errors, primarily distortions	Single or multiple phoneme errors, primarily substitutions or distortions	Generally multiple phoneme errors, often omissions.
CONSISTENCY OF ERRORS	N/A	Speech sound errors are generally inconsistent	Speech sound errors are generally consistent across all contexts	Speech sound errors are consistent across all contexts
EFFECT ON COMMUNICATION	Able to express all communicative functions in natural environment or classroom settings	Child is able to express all communicative functions Communication breakdowns are infrequent, confined to speech that is non-contextual	Frequent communication breakdowns which the child is able to repair Child is aware of speech difficulty and may occasionally withdraw and/or show frustration	Communication breakdowns without successful repair Child is aware of speech difficulty and withdraws and/or shows frustration often

Iowa-Nebraska Articulation Norms

Listed below are the recommended ages of acquisition for phonemes and clusters, based generally on the age at which 90% of the children correctly produced that sound. These recommended ages are for phonetic acquisition only. These data may be used when evaluating children suspected of having a speech-language impairment.

Phoneme	Age of Acquisition: Females	Age of Acquisition: Males
/ m/	3;0	3;0
/ n/	3;6	3;0
/-ŋ /	7;0	7;0
/ h-/	3;0	3;0
/ w-/	3;0	3;0
/ j-/	4;0	5;0
/ p/	3;0	3;0
/ b/	3;0	3;0
/ t/	4;0	3;6
/d/	3;0	3;6
/k/	3;6	3;6
/g/	3;6	4;0
/f-/	3;6	3;6
/-f/	5;6	5;6
/ v/	5;6	5;6
/θ/	6;0	8;0
/ð-/	4;6	7;0
/s/	7;0	7;0
/z/	7;0	7;0
/ʃ/	6;0	7;0
/tʃ/	6;0	7;0
/dʒ/	6;0	7;0
/l-/	5;0	6;0
/-l/	6;0	7;0
/r-/	8;0	8;0
/-ɚ/	8;0	8;0
Word-Initial Clusters		
/tw kw/	4;0	5;6
/sp st sk/	7;0	7;0
/sm sn/	7;0	7;0
/sw/	7;0	7;0
/sl/	7;0	7;0
/pl bl kl gl fl/	5;6	6;0
/pr br tr dr kr gr fr/	8;0	8;0
/θr/	9;0	9;0
/skw/	7;0	7;0
/spl/	7;0	7;0
/spr str skr/	9;0	9;0

Note regarding phoneme positions: e.g.

/ m / refers to prevocalic & postvocalic positions

/ h- / refers to prevocalic position

/ -f / refers to postvocalic position

Note: Lateralized variants are not considered to be developmentally appropriate and therefore are not to be considered within the parameters of these data.
Decisions regarding intervention with children should take into consideration the dental development, motor maturation, and social/emotional welfare of the child.

(Smit, et al. 1990)

Iowa Nebraska Articulation Norms
Predictive Assessment Considerations

The following variables should be taken into consideration when using predictive assessment of phonetic errors on /s/ and/z/:

A. Nature of the error:

Lateralization of /s, z/ does not undergo spontaneous improvement with age and therefore "should not be considered developmental."

B. Consistency of the error:

It is recommended that "a child exhibiting inconsistency (i.e.: if the /s, z/ could be produced correctly in any context) would not usually be considered for intervention unless the so-called inconsistency was governed by a phonological rule or was powerfully conditioned by phonetic context."

C. Dentition:

Dental conditions, such as the lack of eruption of the upper incisors, are important diagnostic considerations for the /s, z/ phonemes.

Smit et al, in their findings from the Iowa Articulation Norms Project and its Nebraska Replication (JSHD, Nov. 1990) make the following recommendations:

1. Consider intervention for lateralized variants, other rare variants, and variants that appear to have damaging social consequences at or before age 7.0. In these cases early intervention is indicated, even for preschoolers, provided that (a) the child appears to respond favorably to treatment (a decision that might be based on the outcome of a brief period of diagnostic remediation); and (b) there are no indicators of spontaneous or impending improvement.

2. For any other kinds of phonetic errors, evaluate at age 7.0, but delay intervention if the deviation is considered slight or if any one of the following positive indicators is present: (a) acceptable /s/ or /z/ is used in any single or clustered context, even if the acceptable sound is used in only one or a few words; (b) the child is stimulable for acceptable /s/ or /z/; or (c) the permanent upper incisors have not erupted.

3. Recheck the child at 8.0. Provide intervention only if there has been no change in indicators or if there has been a negative change.

4. Recheck at age 9.0 and provide intervention for children who still have clinically significant errors on /s, z/.

5. Use the same kinds of criteria for each word-initial cluster with /s/ IF the primary error on the cluster involves the /s/. If the primary error on the cluster involves another element, for example, /r/ in /spr str skr/, then use age 9.0 as the age of acquisition. (Smit et al,1990)

See additional information on phonological processes in **Section 8, References and Resources-** Additional Information on Articulation and Phonological Disorders; and **Web Sites- Net** Connections for Communication Disorders and Sciences, Judith Kuster

Determination of Adverse Effect

The following questions are to guide documentation and determination of adverse effects of articulation deficits on a child's developmental/ educational performance and need for special education in the areas of communication, social-emotional, and academics:

- Communication
  - Do the articulation errors call attention to the child's speech or distract from the message?
  - Does the child experience:
    - Difficulty speaking effectively in classroom discussions, cooperative group activities, and presentations?
    - Difficulty talking on the telephone?
    - Frequent communication breakdowns without successful repair due to sound errors?
  - Are the speech sound errors consistent across all contexts?
  - Is the child stimulable for correct production of the speech sound errors?
- Social-emotional
  - Does the child demonstrate:
    - Difficulty establishing and maintaining interpersonal relationships due to multiple speech sound errors?
    - Reluctance to speak to peers and adults?
    - Avoidance of peers and social situations?
    - Difficulty making wants and needs known due to unintelligible speech?
    - Speech which results in making the child appear less mature, or less knowledgeable?
- Academics
  - Does the child demonstrate:
    - Limited and/or reluctant participation in classroom discussions?
    - Difficulty making oral presentations?
    - Difficulty reading aloud due to articulation problems?
    - Reluctance to participate in cooperative learning group activities due to problems communicating?
    - Reluctance to ask questions for clarification or help?
  - Have the child's speech sound errors limited coursework attempted or career paths selected?

- **VOICE**
  - Referral information
    - Analysis of data collected by Student Assistance Team (for children of school-age)
    - Parent/caregiver information (for children ages birth to five)

  - Oral peripheral examination
    - Assessment of the structures and functions of the oral-motor mechanism for speech
  - Educationally/developmentally relevant medical information
    - Medical history
    - Medication which may adversely affect voice
    - Hearing screening results
    - Efficacy of medical intervention
    - Consider effects of allergies, chronic upper respiratory infection, insufficient respiratory function, etc.
  - Formal and informal assessment measures
    - Sustained speech, phonation (with and without voicing) in both speaking and reading tasks
    - Interviews of the child, parent/caregiver, and teacher(s), including information on child's use of voice – sports, singing, performing, crying, shouting, cheering, talking over loud noise, exposure to noxious elements, etc.
    - Parent/caregiver information on the child's developmental milestones and language skills through interviews and rating scales (for children ages birth to five)
    - Analysis of times/settings in which the voice is best/worst
    - Evaluation of:
      - Intensity (loudness, ability to control loudness)
      - Frequency (pitch, pitch range, inflection, appropriateness for age and gender)
      - Resonation (hyper- or hypo-nasality, velopharyngeal functioning)
      - Phonatory quality (breathiness, hoarseness, glottal attack, intermittent aphonia, etc.)
  - Speech sample
    - Consistency of voice performance across structured and unstructured settings
    - Information from at least two settings
  - Observational data/input from:
    - Natural environment or classroom
    - Student Assistance Team
    - Classroom teachers
    - Parents/caregivers
    - Child

<u>If vocal fold pathology is suspected, the child's physician shall be consulted prior to the initiation of voice therapy.</u>

Information in the following chart is designed to provide a descriptive continuum of disordered performance.

VOICE DISORDER ASSESSMENT CONTINUM

The normal voice is unremarkable: its quality, pitch, resonance, and intensity are appropriate to the individual's age, gender, and cultural group. These vocal parameters do not call attention to themselves.

EVALUATION Quality	Normal glottal attack. Prolongation of /a/ for 10 seconds. Inconsistent voice breaks. S/z ratio: >1.0. May exhibit hypo-/hypernasality. Pitch may be too high or low. Loudness and pitch range may or may not be affected	Evidence of deviant glottal attack. Prolongation of /a/ for 6-9 seconds with voice breaks or diplophonia. S/z ratio: >1.4. Reduced pitch range. Inappropriate pitch level, loudness, and/or nasality	Weak or absent voluntary phonation. Prolongation of /a/ less than 6 seconds with voice breaks or diplophonia. S/z ratio: >1.4. Probable adverse effect on pitch level, pitch range, loudness, and nasality
Resonation	Evidence of assimilative nasality; does not adversely affect intelligibility	Hypernasality adversely affects intelligibility, especially vowels and vowel-like consonants; may misarticulate high pressure consonants	Pervasive hypernasality; articulation errors on high pressure consonants – omissions and unusual substitutions – pharyngeal fricatives and glottal stops; facial grimacing, nasal snorting may occur
	(Evidence of hyponasality is usually organically based, a chronic disorder of resonance resulting from obstruction in posterior portion of nasal passages or nasopharyngeal area. Referral should be made for medical management.)		
Intensity	Evidence of problem in controlling loudness appropriate for message and setting	Evidence of insufficient neuromuscular support for appropriate loudness across settings	Weak or absent ability to produce adequate loudness for intelligible speech
Pitch	Habitual pitch inappropriate to children's age or gender; pitch calls attention to itself	Difficulty controlling pitch; restricted pitch range; habitual pitch and optimal pitch differ by 2 tones	Weak ability to control pitch; restricted pitch range; habitual pitch and optimal pitch differ by >2 tones
EFFECT ON COMMUNICATION	Voice is noticeably different; does not interfere with communication	Voice is noticeably deviant, may interfere with communication	Interferes with intelligibility of message; restricts communication

The child must exhibit chronic, persistent impairment(s) in connected speech in at least one of the following areas, with accompanying adverse effect on educational performance:

*Phonation
*Resonance
*Prosody

<u>No child should receive voice therapy without prior medical examination.</u> Neither a prescription for voice therapy nor the presence of a medical condition (e.g. vocal nodules) automatically means that the child is eligible for speech-language services.

Determination of Adverse Effect

The following questions are to guide documentation and determination of adverse effects of voice deficits on a child's developmental/educational performance and need for special education in the areas of communication, social-emotional, and academics:

- Communication
  - Does the child demonstrate:
    - Reduced intelligibility due to inadequate voice?
    - Atypical voice which calls attention to itself, distracting from the message?
    - Vocal dysfunction which limits the child's ability to express a variety of communicative functions through variations in loudness, stress, and pitch?
    - Evidence of deviant glottal attack?
    - Weak or absent voluntary phonation?
    - Pervasive hypernasality with articulation errors on high pressure consonants?
    - Does the child experience chronic discomfort and/or fatigue subsequent to use of voice for routine activities?
- Social-emotional
  - Are the acoustic properties of the child's voice aesthetically unpleasant to listener?
  - Do the acoustic properties fail to reflect accurately the child's gender or age?
  - Does the child's vocal dysfunction limit participation in extracurricular activities – debate, theatre, choir, etc.?
- Academics
  - Does the vocal dysfunction prevent or limit the child's participation in public speaking, reporting, singing, class discussions, reading aloud, etc.?
  - Is the child reluctant or unable to ask questions for clarification or help due to the vocal dysfunction?
  - Does the vocal dysfunction limit choices in terms of career paths?

- **FLUENCY**
  - Referral information
    - Analysis of data collected by Student Assistance Team (for children of school-age)
    - Parent/caregiver information (for children ages birth to five)
  - Oral peripheral examination
    - Assessment of the structures and functions of the oral-motor mechanism for speech
  - Educationally/developmentally relevant medical information
    - Parent/caregiver information on the child's development and language skills through interviews and rating scales (children ages birth to five)
    - Medical history
    - Medication which may adversely affect fluency
    - Hearing screening results
    - Analysis of previous intervention for dysfluency, where appropriate
  - Formal and informal measures
    - Standardized test of fluency
    - Standardized test of language skills
    - Structured interviews with the child, parent/caregiver, and teacher(s)
    - Types and frequency of dysfluencies
    - Adaptation effect and consistency effect
    - Social-emotional impact rating scales
    - Parent/caregiver information on the child's developmental milestones and language skills through interviews and rating scales (for children ages birth to five)
  - Speech sample
    - Consistency of fluency performance across structured and unstructured contexts
    - Information on secondary behaviors and avoidance behaviors
    - Information from at least two settings
  - Observational data/input from:
    - Natural environment or classroom
    - Student Assistance Team
    - Classroom teachers
    - Parent/caregiver
    - Child
    - Parent/child interaction (for children birth to five)

Information in the following chart is designed to provide a descriptive continuum of disordered performance.

Fluency Disorder Assessment Continuum

Normal fluency is characterized by the smooth, uninterrupted, effortless flow of speech. The individual's rate and rhythm do not call attention to themselves.

FREQUENCY OF DYSFLUENCIES	**Less than 5%**	**5% to 10%**	**Greater than 10%**
TYPES OF DYSFLUENCIES	Primarily whole word and phrase repetitions; may be easy sound prolongations and/or occasional interjections	Primarily phrase, whole word or sound/syllable repetitions. Little tension and struggle behavior	Predominantly "fixed articulatory" type of dysfluencies (i.e. audible and inaudible prolongation). Generally visible tension and struggle behavior. May use sounds or words as "starters"
DESCRIPTION OF TYPES OF DYSFLUENCIES	REPETITIONS: Rhythmic, effortless whole word repetition: "I-I-I have a new puppy." Rhythmic, effortless phrase repetitions: "She went – she went to the store." PROLONGATIONS: Brief, easy prolongations: "I>>want one." INTERJECTIONS: "Uh, um"	REPETITIONS: Phrase repetitions: "I like – I like – I like ice cream." Whole word repetitions: "I heard what she – she – she said." Sound/syllable repetitions: "He ga—ga—ga—gave me a puppy." REVISIONS: "She ate – I mean he ate the cookies." INTERJECTIONS: "Uh, um, er," etc. CIRCUMLOCUTIONS (i.e. using an excess of words in order to avoid the more direct, but difficult word)	PROLONGATIONS: Audible prolongations: "I want some m>>>>>ore cake." Silent blocks: (Silence) "Throw me the ball."
CONSISTENCY OF DYSFLUENT BEHAVIOR	Episodic; more dysfluent in times of stress, excitement	Dysfluency fluctuates – may be related to situational demands	Dysfluency is present in most speaking situations and is consistent and non-fluctuating
NUMBER AND VARIETY OF ASSOCIATED BEHAVIORS	Not present	If present, not considered significant	Severely detracts from the content of communication. Some or all of the following behaviors present: tension, struggle, frustration, and/or avoidance
EFFECT ON COMMUNICATION	Repetitions are noticeable, but do not interfere with communication	Reluctance to speak; dysfluency calls attention to itself; embarrassment and self-consciousness; anxious and fearful in some speaking settings; may interfere with participation in school or family activities	Difficulties in most speaking situations; avoids speaking; may have difficulty establishing and maintaining peer relationships; fearful about certain sounds, words, settings; interferes with school/family/community participation – academic, social, and emotional areas

MULTIPLE SAMPLE METHOD (preferred): Obtain a representative 100-300 word sample from at least two environments/settings – home, school, with peers, etc. Determine the number of dysfluencies in each 100 word sample. Compute the "average" from the samples obtained. (This method yields both a "mean" and a "range.") Example: three 100-word samples with 4, 9, and 8 dysfluencies. The average would be 7 (7%) and the range would be 4-9 dysfluencies. Samples could be obtained from a variety of settings.

SINGLE SAMPLE METHOD: Divide the number of dysfluencies by the total number of words in sample; multiply result by 100 (this yields a percentage). Sample results should be confirmed with parents and/or teachers as representative of typical performance.

Adaptation Effect—the tendency for overall stuttering to decrease with repeated reading or speaking of the same material. Adaptation is measured by having the child repeat a short passage or series of sentences five times (readers can read the material orally). Adaptation is calculated by subtracting the number of dysfluencies in the fifth recitation from the number of dysfluencies in the first, and then dividing this difference by the number of dysfluencies in the first. Multiplying this quotient by 100 creates a percentage. Adaptation measurements of 50% or higher indicate greater adaptation; scores lower than 50% indicate the individual has not significantly reduced the frequency of dysfluencies with repeated recitations.

Consistency Effect—the tendency for stuttering to occur on the same sounds or words during repeated reading or speaking of the same material. Consistency is measured by comparing the dysfluencies produced in the first three recitations only. Three indices are computed: Comparison of Recitations 1 and 2, 1 and 3, and 2 and 3. The indices for each comparison are computed by dividing the proportion of dysfluent words in one recitation that also are produced in the second recitation by the number of dysfluent words in the second reading. The consistency effect is present if the individual exhibits an index of 1.0 or higher. Indices higher than 1.0 reflect greater consistency. Indices less than 1.0 reflect that the individual did not reveal consistency in the location of dysfluencies within the recitation.

Determination of Adverse Effect

The following questions are to guide documentation and determination of adverse effects of fluency deficits on a child's development/ educational performance and need for special education in the areas of communication, social-emotional, and academics:

- Communication
  - Does the dysfluency call attention to itself, distracting from the message?
  - Does the child experience difficulty speaking to peers and adults?
  - Does the child demonstrate problems expressing opinions and ideas in classroom discussions due to dysfluencies?

- Does the child experience difficulty speaking on the telephone? Does the child avoid speech sounds, words, or situations?
- Are the dysfluencies primarily part-word repetitions, blocks, or prolongations?
- Is there evidence of tension or struggle behavior?
- Are the dysfluencies present in most speaking situations?

- Social-emotional
  - Does the child demonstrate:
    - Difficulty introducing self and others?
    - Difficulty establishing and maintaining interpersonal relationships due to the child's perceptions about communication?
    - Avoidance of social situations?
  - Does the child perceive him/herself as having difficulty speaking?
- Academics
  - Does the child demonstrate:
    - Difficulty communicating in family or community events?
    - Difficulty reading aloud and speaking in class due to dysfluent speech?
    - Reluctance to ask questions for clarification or help due to dysfluent speech?
    - Reluctance to participate in class discussions?
    - Avoidance of coursework or career paths based on the verbal communication required?
    - Reluctance to participate in cooperative learning group activities?

SECTION 6: RELATED DEFINITIONS

Academic Achievement – A student's level of performance in basic school subjects, measured either formally or informally. (Norlin, 2003, p. 1)

Achievement Test – A test that objectively measures educationally relevant skills or knowledge; a test that measures mastery of content in a subject matter area. (Norlin, 2003, p. 3)

Aphasia – A language disorder resulting from damage to the brain in which the person loses some ability to understand speech, formulate speech, read, write, calculate, or some combination of these abilities. (Silverman, 2006, p. 89)

- **Developmental Aphasia** – (1) A congenital receptive language disorder or, more commonly, expressive language disorder in children with normal intelligence and adequate sensory and motor skills that prevents acquisition of language. (2) Identified in IDEA regulations…as a "specific learning disability." (Norlin, 2003, p. 57)

Behavioral Regulation – Communication intended to manipulate the behavior of others - requesting an object, requesting action, or protesting/rejecting.

Communication Disorder – Impairment in the ability to receive, send, process, or comprehend concepts or verbal, non-verbal, and graphic symbols systems. A communication disorder may be evident in the processes of hearing, language and/or speech. A communication disorder may range in severity from mild to profound. It may be developmental or acquired. Individuals may demonstrate one or any combination of communication disorders. A communication disorder may result in a primary disability or it may be secondary to other disabilities. (ASHA 1993)

Dysarthria – A speech disorder caused by neuromuscular impairment in respiration, phonation, resonation, and/or articulation. (Heward, 2003, p. 613)

Dysfluency – Includes hesitations, repetitions, mispronunciations, and interjections in one's speech. (Silverman, 2006, p.153)

Dysphonia – A voice disorder characterized by faulty resonance, phonation, or pitch. (Norlin, 2003, p. 67)

Echolalia – Repetition of what other people say as if echoing them; characteristic of some children with delayed development, autism, and communication disorders. (Heward, 2003, p. 613)

Expressive Language – An individual's written, oral, or symbolic communication. (Norlin, 2003, p. 81)

Inflection – The change in pitch or loudness of the voice to indicate mood or emphasis. (Heward, 2003, p. 614)

Joint Attention – Communication intended to share focus with others -- commenting, requesting information, or providing information.

Language Delay – A child's language is developing in the right sequence, but at a slower rate. http://www.med.umich.edu/1Libr/yourchild/speech.

Limited English Proficiency – Refers to language differences that are found in some individuals who are learning English as a second language. Differences do not in themselves constitute language impairments. (Owens, Metz and Haas, 2007, p. 94)

Morpheme – Refers to the smallest unit of meaningful language. (Norlin, 2003, p. 1148)

Phoneme – Refers to the smallest unit of an individual's speech that distinguishes one utterance from another like a syllable; the English language has 24 consonant and 12 vowel phonemes. (Norlin, 2003, p. 174)

Phonemic Awareness – Is the ability to manipulate sounds, such as blending sounds to create new words or segmenting words into sounds. (Owens, Metz and Haas, 2007 p.145)

Phonological Awareness – The awareness of how words sound and how they are represented in written language or print; ability to identify and manipulate the sounds of language. Many children with learning disabilities cannot readily learn how to relate letters of the alphabet to the sounds of language. (Norlin, 2003, p. 174)

Receptive Language – The language understood; listening is receptive. (Hegde, (2001)

Receptive Language Disorder – Presents as an inability to understand spoken or written language that may affect reading, writing, and problem-solving in arithmetic. (Norlin, 2003, p. 196)

Social Interaction – Communication intended to relate to/interact with others - requesting social routine, requesting comfort, greeting, calling, requesting permission, or showing off.

SECTION 7: FREQUENTLY ASKED QUESTIONS

1. Does a child have to be verified as having a speech-language impairment in order to receive speech-language services?

   No. If the child needs speech-language intervention in order to benefit from his/her educational program, that intervention can be provided as a related service. The child must, however, be verified under at least one other disability category.

2. Is a child's communication problem a disability?

   Whether the problem is considered a deficit or disability depends on the individual child. In determination of a disability, it is critical to document whether or not the problem is having an adverse effect on the child's social, emotional, or academic performance. If the MDT is unable to document adverse effect on the child's development or educational performance, the eligibility criteria have not been met, and the child does not have a disability.

3. If the child's articulation is not within the normal range, but there is no adverse effect on communication, academics, or social-emotional development, does the child meet eligibility criteria of a speech-language impairment?

   No. The disability category of Speech-Language Impairment requires documentation of both the articulation errors relative to the Iowa-Nebraska Articulation Norms or other scientific research-based articulation norms <u>and</u> adverse effect on development or educational performance.

4. Can a child with chronic hoarseness, whose performance meets criteria for Speech-Language Impairment in the area of voice, be eligible for speech and language services without examination by a physician?

   Yes, the child may be eligible. Although the criteria for a speech-language impairment does not require an evaluation by a physician, that examination is strongly recommended prior to the delivery of services if vocal fold pathology is suspected. There are a number of laryngeal pathologies that pose significant health risks, although they are rare in children. In order to rule out the presence of a more serious disorder, the child's family should seek an examination by a physician prior to the initiation of voice therapy to rule out the existence of a more serious medical condition.

5. For a child who demonstrates dysfluent speech, is it necessary to obtain a speech sample from the home environment?

   Yes, it is important to obtain a representative sample of the child's speech fluency from at least two settings, one of which may be the home environment. The MDT can ask the parents to audiotape or videotape a sample of the child's speaking behavior within the home environment.

6. Once the child with Limited English Proficiency has acquired basic conversational skills, can s/he be expected to perform at grade level academically?

   It is the contention of many authorities in the field of second language acquisition that conversational fluency is often acquired to a functional level within about two years of initial exposure to the second language. At least five years is typically required to master the academic aspects of the second language. The acronyms BICS and CALP refer to these distinctions between basic interpersonal communicative skills and cognitive academic language proficiency. Refer to: http://www.iteachilearn.com/cummins/bicscalp.html. Or, search the internet: Limited English Proficiency.

7. Can a child with Limited English Proficiency have a speech-language impairment?

   If the child has acquired average skills in his/her primary language, the limited proficiency in English is considered a language difference, not a disability. However, if the child has deficits in his/her primary language, the individual may have a language impairment. Since second language acquisition is similar, though not identical, to first language acquisition, a language disorder in the primary language may predict difficulty in learning English as a second language and a potential for a language impairment. The child may exhibit a speech language impairment in the areas of voice or fluency.

8. Can a child with Limited English Proficiency qualify for special education and related services?

Yes, if it can be established that the child's deficits are not primarily the result of his/her primary language, culture, or lack of opportunities to learn.

9. How can the English-speaking speech-language pathologist evaluate the articulation (speech-sound system) of a child with Limited English Proficiency?

The speech-language pathologist can utilize a process of comparative phonology to assess the speech-sound system of the child with Limited English Proficiency. Refer to http://convention.asha.org/2005/handouts/293-Bauman-Waengler-Jacqueline-073861-111605063800.doc. Or, for more references on Limited English Proficiency, refer to http://ww.asha.org

SECTION 8: REFERENCES AND RESOURCES

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Smit, A.B., L. Hand, J.J. Freilinger, J.E. Bernthal, and A. Bird, "The Iowa articulation norms project and its Nebraska replication." *Journal of Speech and Hearing Disorders, 55* (1990): 779-798.

Stoel-Gammon, C., and C. Dunn, *Normal and Disordered Phonology in Children*. Baltimore: University Park Press, 1985.

Resources

Commonly Used Assessment Batteries for Evaluating Phonological Processes

Assessment Link Between Phonology and Articulation (Lowe, 1986)

Assessment of Phonological Processes—Revised (Hodson, 1986)

Bankson-Bernthal Test of Phonology (Bankson & Bernthal, 1990)

Khan-Lewis Phonological Analysis (KLPA-2) (Khan & Lewis, 2003)
(Shipley & McAfee, 2004)

Additional Information on Articulation and Phonological Disorders:

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Bleile, K. M., *Manual of Articulation and Phonological Disorders*. Clifton Park, NY: Delmar Learning, 1995.

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WEB SITES

American Academy of Pediatrics www.aap.org

American Speech Language Hearing Foundation (ASHA Foundation) www.asha.org

IDEA Practices www.ideapractices.org

National Aphasia Association (NAA) www.aphasia.org

National Institute on Deafness and Other Communication Disorders (NIDCD) www.nidch.nih.gov

National Stuttering Association (NSA) http://westutter.org

Net Connections for Communication Disorders and Sciences (Judith Kuster): http://www.communicationdisorders.com

Resources and Information for Speech-Language Pathologists (Caroline Bowen): http://www.slpsite.com

Stuttering Foundation of America (SFA) www.stutteringhelp.org

The Voice Foundation www.voicefoundation.org

DISABILITY CATEGORY:

Traumatic Brain Injury

DISABILITY CATEGORY: Traumatic Brain Injury

SECTION 1: INTRODUCTION

These verification guidelines were written to provide parents, teachers, special education personnel, administrators, and other professionals with information on the identification, verification, and determination of eligibility for special education services for children with traumatic brain injury.

This category of children has been defined by both federal and state regulations. A three-part eligibility requirement for a child to be verified as a child with a traumatic brain injury is as follows:

- Meet verification criteria (92 NAC 51.006);
- Documentation of adverse effect on educational performance;
- Determination that a need for special education is evident.

SECTION 2: STATE DEFINITION

- **Traumatic Brain Injury**- To qualify for special education services in the category of traumatic brain injury, the child must have: an acquired injury to the brain caused by an external physical force resulting in total or partial functional disability or psychosocial impairment, or both that adversely affects a child's educational, or in the case of a child below age five, a child's developmental performance.

  The category includes open or closed head injuries resulting in impairments in one or more areas, such as: cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem solving; sensory, perceptual, and motor abilities; psychosocial behavior; physical functions; information processing; and speech.

  The category does not include brain injuries that are congenital or degenerative, or brain injuries induced by birth trauma.

SECTION 3: MULTIDISCIPLINARY EVALUATION TEAM (MDT) COMPOSITION

The Multidisciplinary Team (MDT) should include, at least the following members:

- The child's parents;
- A school psychologist or licensed psychologist;
- The child's teacher(s) or a teacher qualified to teach a child of that age;
- A special education teacher or appropriate related services provider; and
- A school district administrator or a designated representative.

SECTION 4: VERIFICATION GUIDELINES

In order for a child to be verified as having a traumatic brain injury, the evaluation should include the analysis and documentation of:

- A description of an event that has resulted in an acquired insult to the brain (generally provided by medical personnel or other specialist with knowledge of traumatic brain injury);
- Evidence of impaired functioning in one or more of the following areas that has been determined to produce an adverse effect on the child's educational or developmental performance:
  - Cognition (should include, but not be limited to attention, memory/learning, organization, problem solving, abstract reasoning, communication, judgment, visual perception, and auditory perception);
  - Sensory functioning;
  - Motor functioning (should include, but not be limited to motor sequencing, planning, and execution);
  - Behavior (should include, but not be limited to agitation, irritability, aggression, apathy, lack of insight, impulsivity, poor emotional control, disinhibition, secondary depression and withdrawal, and difficulties with social relationships)
- The severity of the impaired functions, which may vary across situations, activities and time. Where appropriate, the team must consider and document these variations.

Children with a traumatic brain injury represent a heterogeneous group. A physician's report alone is not sufficient to verify a child with traumatic injury. There must be documented evidence that there is an adverse effect in the educational performance/development for a child to be verified with traumatic brain injury.

Educational evaluation and assessment include a combination of, but are not limited to:

- Medical assessments
- History of developmental milestones
- Speech/language assessments
- Personality assessments
- Parent interviews/rating scales
- Individual achievement testing
- Classroom assessment data
- Norm-referenced testing data
- Criterion-referenced assessments
- District-wide assessments
- Curriculum-based assessments
- Observation and analysis of behavior
- Teacher anecdotal records
- Analysis of pre-injury academic performance and social/emotional performance

Parent involvement in the assessment process is of utmost importance.

SECTION 5: PROCEDURES TO DETERMINE ADVERSE EFFECT ON DEVELOPMENT/EDUCATIONAL PERFORMANCE

FACTORS TO CONSIDER

- Type (open head injury, closed head injury), degree and severity of the brain injury
- Cause of the traumatic brain injury
- Nature/status of the traumatic brain injury
- Age of the traumatic brain injury occurrence

- Medical history, including medications
- Current age
- History of interventions and response
- Current educational placement
- Current levels of performance (language, communication, academic, social-emotional)
- Vocational/Postsecondary transition needs

Examination of each of these factors may lead to additional factors to consider. Psychologists, speech-language pathologists, and teachers are the primary professionals who can determine how these factors adversely impact the child's educational performance. Parents, medical professionals, teachers, and the child him/herself can also provide information important in determining the impact of the traumatic brain injury.

In all cases, when making a determination of the adverse effects of the traumatic brain injury, the team should consider the child's age, communication abilities, social abilities, language, and pre-injury education performance.

The following questions are to guide documentation and determination of whether the disability has an adverse effect on the child's developmental/educational performance:

- **Cognition**
  - What is the child's level of attention in different situations?
    - While playing?
    - While completing assignments?
    - While listening to directions, etc.?
  - What is the child's memory/learning ability?
    - Short-term memory?
    - Long-term memory?
    - Multiple step directions?
  - What are the child's organizational abilities?
    - Preparation to complete an assignment?
  - What are the child's problem-solving abilities?
    - Responding to a question?
    - Determining how to complete a task?
    - Responding to a social situation?
  - What is the child's ability to reason in an abstract manner?
    - Understand jokes?
    - Literal vs. abstract comprehension?
  - What is the child's ability to communicate?
    - Use vocabulary appropriate to his/her age/grade level?
    - Express needs and wants?

        - Follow simple commands?
    - What is the child's ability in making judgments?
        - Playing safely?
        - Responding to questions?
        - Determining right from wrong?

    - What is the child's level of visual perception?
        - Differentiate between realism vs. animated?
        - Differentiate math symbols?
        - Understand graphs and charts?
        - Differentiate between letters and words?

- Sensory Functioning
    - What is the child's awareness level of sensory stimuli?
    - Does the child exhibit a specific sensory aversion to certain tastes, smells, sounds, touch?
    - Does the child under or over react to sensory stimuli, i.e., class dismissal bell, fire alarm, tornado alarm, and other signals?

- Perceptual and motor abilities
    - Gross motor skills
        - What are the child's physical abilities in the following:
            - Rolling over?
            - Crawling?
            - Standing?
            - Walking?
            - Running?
            - Jumping?
            - Balance?
            - Hopping?
            - Climbing?
    - Fine motor skills
        - What are the child's physical abilities in the following:
            - Holding and eating with utensils?
            - Picking up and manipulation of small objects?
            - Holding and using a crayon? pencil? marker?
            - Cutting with scissors?
            - Copying with crayon or pencil?
            - Folding paper, etc.?
            - Picking up small object from table to floor?
            - Transferring objects between hands or from one surface to another?
    - Perceptual skills
        - What are the child's perceptual abilities in the following:
            - Learning to read?
            - Learning to write?
            - Completing jigsaw puzzles or other board games?

- Playing games, i.e., four square, jump rope, soccer?

- Psychosocial Behavior
  - Does the child become agitated easily?
    - Is the child able to deal with conflict in a positive manner?
    - How does the child exhibit his/her agitation?

  - Does the child often express irritability?
    - What causes this irritability?
    - Is the child able to move away from the situation that is causing the irritability?
    - How does the child exhibit his/her irritability?
  - Does the child display aggression?
    - In what ways does the child display aggression, i.e., physical, verbal?
    - What causes the child to display aggression?
    - Is the child able to calm him/herself after an aggressive act?
  - Does the child exhibit an attitude of apathy in certain situations, events?
    - Under what circumstances does the child exhibit an attitude of apathy?
    - Is the child able to become motivated in this same situation that has contributed to the attitude of apathy?
  - Does the child exhibit insight in particular situations?
    - Are these situations social situations that involve either another child or an adult?
    - In what ways does the child exhibit this lack of insight?
  - Does the child exhibit impulsivity?
    - How often does the child exhibit impulsivity?
    - Are there particular situations (i.e., during meals, play, preparation for another activity, etc.) in which the child exhibits impulsivity?
    - Is the child able to calm him/herself after exhibiting impulsivity?
  - How does the child handle changes to routines?
    - How does the child react (i.e., no reaction, crying, shouting, yelling, hiding)?
    - Are there particular situations in which the child exhibits poor emotional control?
  - Does the child express disinhibition at particular times?
    - What are the situations in which the child exhibits disinhibition?
    - What are the ways in which the child shows disinhibition, i.e., removal of clothing at inappropriate times, use of inappropriate language?
  - Does the child exhibit depression and withdrawal?
    - In what ways does the child exhibit depression and withdrawal, i.e., refusing to participate, crying, hiding from others, refusal to work on assignments?
    - Are there particular situations in which the child exhibits depression and withdrawal?
  - Does the child develop social relationships with peers and adults?
    - When do these occur, i.e., recess, mealtime, classroom free time, etc.?
    - What are some characteristics of these social relationships?
  - Does the child accept responsibility for his/her own actions?
    - How does the child respond?
    - Are there particular situations that are problems?

- Speech Language and Information Processing Skills
  - Does the child only ask and answer questions or does he/she contribute to a conversation?
  - Does the child ask questions in class at the appropriate times?
  - Can the child initiate and terminate a conversation?
  - Can the child understand and respond to signals (verbal and/or body language) by multiple communication partner(s)?
    - Maintaining interaction
      - Can the child stay on topic?
      - Can the child appropriately transition to a new topic?
      - Can the child maintain a conversation by adding related information?

- Expressive or receptive language development
  - Vocabulary
    - Does the child comprehend and use vocabulary appropriate for his/her age/grade level?
      - General vocabulary?
      - Content specific vocabulary?
      - Figurative language?
  - Functional Language
    - Can the child tell a story?
    - Does the child understand and use narrative discourse?
    - Does the child ask questions to get his/her needs met?
    - Can the child follow simple commands?
    - Can the child answer basic questions?
  - Academic Language
    - Does the child understand and use language with embedded concepts?
    - Does the child understand and use the language of directions (describe, explain, compare, etc.)?
    - Can the child follow multiple step directions?
    - Does the child understand and use expository text structures?

- Speech reception or production
  - Reception
    - Phonemic/phonological awareness
      - Does the child have the ability to process individual sounds?
  - Production/Articulation
    - Does the child use speech that is intelligible to an unfamiliar listener?
    - Does the child use appropriate prosodic features in:
      - Inflection?
      - Rate?
      - Pitch?
      - Fluency?
    - Does the child have oral motor problems?
    - Is the child's speech production age appropriate?

- Does the child have clear speech?
- Does the child have difficulty pronouncing particular sounds?

A child with a traumatic brain injury may not meet all of the above listed criteria. However, these criteria/questions may serve as guidelines when determining first, if the child has a disability and secondly, does the child need special education services.

SECTION 6: RELATED DEFINITIONS

The following definitions were taken from the National Institute of Neurological Disorders and Stroke (NINDS) web site: www.ninds.nih.gov/disorders/tbi/detail-tib-pr.htm on 06/08/06

Absence Seizure – A seizure that takes the form of a staring spell. A brief loss of awareness which can be accompanied by blinking or mouth twitching.

Aneurysm – A blood-filled sac formed by disease-related stretching of an artery or blood vessel.

Anoxia – A lack of oxygen to the brain resulting in brain damage.

Aphasia – Difficulty understanding and/or producing spoken and written language. (See also non-fluent aphasia.)

Apoptosis – Cell death that occurs naturally as part of normal development, maintenance, and renewal of tissues within an organism.

Apraxia –Inability to speak purposefully that is not a result of a motor impairment.

Arachnoid Membrane – One of the three membranes that cover the brain; it is between the pia mater and the dura. Collectively, these three membranes form the meninges.

Brain Death – An irreversible cessation of measurable brain function.

Broca's Aphasia – See non-fluent aphasia.

Cerebrospinal Fluid (CSF) – The fluid that bathes and protects the brain and spinal cord.

Closed Head Injury – An injury that occurs when the head suddenly and violently hits an object but the object does not break through the skull.

Coma – A state of profound unconsciousness caused by disease, injury, or poison.

Complex Seizure –An episode of abnormal activity in a part of the brain which causes changes in attention, movement, and/or behavior.

Compressive Cranial Neuropathies – Degeneration of nerves in the brain caused by pressure on those nerves.

Computed Tomography (CT) – A scan that creates a series of cross-sectional X-rays of the head and brain; also called computerized axial tomography or CAT scan.

Concussion – Injury to the brain caused by a hard blow or violent shaking, causing a sudden and temporary impairment of brain function, such as a short loss of consciousness or disturbance of vision and equilibrium.

Coup – A sudden effective move.

Contracoup – A contusion caused by the shaking of the brain back and forth within the confines of the skull.

Contusion – Distinct area of swollen brain tissue mixed with blood released from broken blood vessels.

Craniotomy – Surgical opening through the skull.

CSF Fistula – A tear between two of the three membranes – the dura and arachnoid membranes – that encase the brain.

Deep Vein Thrombosis — Formation of a blood clot deep within a vein.

Dementia Pugilistica – Brain damage caused by cumulative and receptive head trauma; common in career boxers.

Depressed Skull Fracture – A fracture occurring when pieces of broken skull press into the tissues of the brain.

Diffuse Axonal Injury – See shearing.

Disinhibition – A temporary loss of inhibition caused by an unrelated stimulus, such as a loud noise.

Dysarthria – Inability or difficulty articulating words due to emotional stress, brain injury, paralysis, or spasticity of the muscles needed for speech.

Dura – A tough, fibrous membrane lining the brain; the outermost of the three membranes collectively called the meninges.

Early Seizures – Seizures that occur within one week after a traumatic brain injury.

Epidural Hematoma – Bleeding into the area between the skull and the dura.

Executive Function – A set of cognitive abilities that control and regulate other abilities and behaviors. Executive functions allow for anticipation of outcomes and adapt to changing situations.

Fluent Aphasia – A condition in which patients display little meaning in their speech even though they speak in complete sentences. Also called Wernicke's or motor aphasia.

Glasgow Coma Scale – A clinical tool used to assess the degree of consciousness and neurological functioning – and therefore, severity of brain injury – by testing motor responsiveness, verbal acuity, and eye opening.

Global Aphasia – A condition in which patients suffer severe communication disabilities as a result of extensive damage to portions of the brain responsible for language.

Hematoma – Heavy bleeding into or around the brain caused by damage to a major blood vessel in the head.

Hemorrhagic Stroke – Stroke caused by bleeding out of one of the major arteries leading to the brain.

Hypermetabolism – A condition in which the body produces too much heat energy.

Hypothyroidism – Decreased production of thyroid hormone leading to low metabolic rate, weight gain, chronic drowsiness, dry skin and hair, and/or fluid accumulation and retention in connective tissues.

Hypoxia – Decreased oxygen levels in an organ, such as the brain; less severe than anoxia.

Immediate Seizures – Seizures that occur within 24 hours of a traumatic brain injury.

Intracerebral Hematoma – Bleeding within the brain caused by damage to a major blood vessel.

Intracranial Pressure – Build-up of pressure in the brain as a result of injury.

Ischemic Stroke – Stroke caused by the formation of a clot that blocks flow through an artery to the brain.

Labiality – Displaying inappropriate affect by exhibiting unstable emotional control with rapid shifts in mood and emotional overreactions.

Locked-in Syndrome – A condition in which a patient is aware and awake, but cannot move or communicate due to complete paralysis of the body.

Magnetic Resonance Imaging (MRI) – A noninvasive diagnostic technique that uses magnetic fields to detect subtle changes in brain tissue.

Meningitis – Inflammation of the three membranes that envelop the brain and spinal cord, collectively known as the meninges; the meninges include the dura, pia mater, and arachnoid.

Motor Aphasia – See non-fluent aphasia.

Neural Stem Cells – Cells found only in adult neural tissues that can develop into several different cell types in the central nervous system.

Neuroexcitation – The electrical activation of cells in the brain; neuroexcitation is part of the normal functioning of the brain or can also be the result of abnormal activity related to an injury.

Neuron – A nerve cell that is one of the main functional cells of the brain and nervous system.

Neurotransmitters – Chemicals that transmit nerve signals from one neuron to another.

Non-fluent Aphasia – A condition in which patients have trouble recalling words and speaking in complete sentences. Also called Broca's or motor aphasia.

Oligodendrocytes – A type of support cell in the brain that produces myelin, the fatty sheath that surrounds and insulates axons.

Partial Complex Seizures – Brief and temporary alteration in brain function caused by abnormal electrical activity in a specific area of the brain.

Penetrating Head Injury – A brain injury in which an object pierces the skull and enters the brain tissue.

Penetrating Skull Fracture – A brain injury in which an object pierces the skull and injures brain tissue.

Persistent Vegetative State – An on-going state of severely impaired consciousness, in which the patient is incapable of voluntary motion.

PET Scan – Position emission tomography scan that provides a cross sectional image.

Plasticity – Ability of the brain to adapt to deficits and injury.

Pneumocephalus – A condition in which air or gas is trapped within the intracranial cavity.

Post-concussion Syndrome (PCS) – A complex, poorly understood problem that may cause headache after head injury; in most cases, patients cannot remember the event that caused the concussion and a variable period of time prior to the injury.

Post-traumatic Amnesia (PTA) – A state of acute confusion due to a traumatic brain injury, marked by difficulty with perception, thinking, remembering, and concentration; during this acute stage, patients often cannot form new memories.

Post-traumatic Dementia – A condition marked by mental deterioration and emotional apathy following trauma.

Post-traumatic Epilepsy – Recurrent seizures occurring more than one week after a traumatic brain injury.

Prosodic Dysfunction – Problems with speech intonation or inflection.

Pruning – Process whereby an injury destroys an important neural network in children, and another less useful neural network that would have eventually died takes over the responsibilities of the damaged network.

Second Impact Syndrome – Occurs when the head receives a second blow before the original concussion is totally healed.

Seizures – Abnormal activity of nerve cells in the brain causing strange sensations, emotions, and behavior, or sometimes convulsions, muscle spasms, and loss of consciousness.

Sensory Aphasia – See fluent aphasia.

Shaken Baby Syndrome – A severe form of head injury that occurs when an infant or small child is shaken forcibly enough to cause the brain to bounce against the skull; the degree of brain damage depends on the extent and duration of the shaking. Minor symptoms include irritability, lethargy, tremors, or vomiting; major symptoms include seizures, coma, stupor, or death.

Shearing (or Diffuse Axonal Injury) – Damage to individual neurons resulting in disruption of neural networks and the breakdown of overall communication among neurons in the brain.

Stupor – A state of impaired consciousness in which the patient is unresponsive but can be aroused briefly by a strong stimulus.

Subdural Hematoma – Bleeding confined to the area between the dura and the arachnoid membranes.

Subdural Hygroma – A build-up of protein-rich fluid in the area between the dura and the arachnoid membranes, usually caused by a tear in the arachnoid membrane.

Syndrome of Inappropriate Secretion of Antidiuretic Hormone (SIADH) – A condition in which excessive secretion of antidiuretic hormone leads to a sodium deficiency in the blood and abnormally concentrated urine; symptoms include weakness, lethargy, confusion, coma, seizures, or death if left untreated.

Thrombosis or Thrombus – The formation of a blood clot at the site of an injury.

Vasospasm – Exaggerated, persistent contraction of the walls of a blood vessel.

Vegetative State – A condition in which patients are unconscious and unaware of their surroundings, but continue to have a sleep/wake cycle and can have periods of alertness.

Ventriculostomy – A surgical procedure that drains cerebrospinal fluid from the brain by creating an opening in one of the small cavities called ventricles.

SECTION 7: FREQUENTLY ASKED QUESTIONS

1. Is a medical report required as a part of the verification process for traumatic brain injury?

   No. A report from a physician describing the medical condition of the child and the implications of the brain injury is not required. However, knowledge about the specific incident causing traumatic brain injury is needed as well as documentation from someone knowledgeable about TBI stating that the child displays behaviors/characteristics consistent with those typical of TBI survivors and impacting educational performance.

2. Is the school required to pay for the medical evaluation?

   It depends. In many cases, a medical evaluation will already have been completed and the physician will send a report to the MDT with the parent's written permission.

3. How severe must the brain injury be for the child to verify as a child with a traumatic brain injury?

   The severity of the brain injury can range from mild concussion to profound injury. Regardless, the severity will be documented in a written report from a physician, or someone knowledgeable about TBI. There must be documentation of the injury's adverse effect on the development or educational performance of the child for the child to verify for special education because of a traumatic brain injury.

4. Can a child meet the guidelines for having a traumatic brain injury if he/she is doing well academically in his/her classes?

   Yes, assessment of achievement includes not only academic achievement, but also social/interpersonal skills, motor/perceptual skills, adaptive skills, speech/language skills and any skills considered as a part of that child's achievement.

5. Can a child meet the guidelines for a traumatic brain injury if the child has compensated for the brain injury by participating in therapeutic counseling, behavior management strategies, etc.?

   It depends. The verification of traumatic brain injury is a two-pronged verification including both the traumatic injury and achievement. If the child has compensated for the brain injury through therapeutic counseling, behavior management strategies, etc., yet there is an adverse effect on the educational performance of the child, then the child could certainly verify as a child with a traumatic brain injury.

6. Can a child who has a congenital or degenerative brain disorder or have a brain injury that was acquired by birth trauma verify as having a traumatic brain injury?

   No. Both federal and state laws require that the injury to the brain be the result of an external physical force which results in total or partial functioning disability or psychosocial impairment, or both. However, the child may verify under another disability category.

SECTION 8: REFERENCES AND RESOURCES

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WEB SITES

Alliance for Technology Access www.ataccess.org

American Academy of Pediatrics www.aap.org

Brain Injury Association of American Inc. www.biausa.org

Brain Trauma Foundation www.braintrauma.org

Clearinghouse on Disability Information Office of Special Education and Rehabilitation Services (OSERS) www.ed.gov/about/offices/list/osers/index.html

Council of Exceptional Children (CEC) www.cec.sped.org

Education Resources Information Center (ERIC) www.ed.gov/EdFed/ERIC.htm

Epilepsy Education Association www.iupui.edu

Epilepsy Foundation www.epilepsyfoundation.org

Exceptional Parent www.eparents.com

Family Voices www.familyvoice.org

Guide to Disability Resources on the Internet www.disabilityresources.org

Head Injury Hotline www.headinjury.com

National Dissemination Center for Children with Disabilities (NICHCY) www.nichcy.org

National Institute of Child Health and Human Development (NICHD) www.nichd.nih.gov

National Institute of Neurological Disorders and Stroke (NINDS) www.ninds.nih.gov

National Institute on Disability and Rehabilitation Research (NIDRR) www.ed.gov/about/office

National Organization on Disability www.nod.org

National Rehabilitation Information Center (NARIC) www.NARIC.com

National Resource Center for Traumatic Brain Injury (NRCTBI) www.neuro.pmr.vcu.edu

National Stroke Association www.stroke.org

DISABILITY CATEGORY:

Visual Impairment

DISABILITY CATEGORY: Visual Impairment

SECTION 1: INTRODUCTION

These verification guidelines were written to provide parents, teachers, special education personnel, administrators, and other professionals information on the identification, verification, and determination of eligibility for educational services for children with visual impairments including blindness.

This category of children has been defined by both federal and state regulations. A three-part eligibility requirement for a child to be verified as a child with a visual impairment is as follows:

- Meet verification criteria (92 NAC 51.006);
- Documentation of adverse effect on educational performance;
- Determination that a need for special education is evident.

SECTION 2: STATE DEFINITION

- **Visual impairment, including Blindness-** To qualify for special education services in the category of visual impairment, including blindness, the child must have: an impairment in vision that, even with correction, adversely affects a child's educational, or in the case of a child below age five, a child's developmental performance. This category includes children who have partial sight or blindness.

Both federal and state special education laws use the term visual impairment, including blindness, to describe children who are blind, legally blind, or partially sighted. Throughout this document the term visual impairment will be used. Under the state definition, any child with a visual impairment, including blindness, will experience deficiencies in one or more of the following areas: activities of daily living, social interaction and academic achievement, performance in the educational setting, or orientation and mobility. The task of the Multidisciplinary Evaluation Team (MDT) is to determine if the visual impairment has an adverse effect on the child's development or educational performance.

SECTION 3: MULTIDISCIPLINARY EVALUATION TEAM (MDT) COMPOSITION

The Multidisciplinary Team (MDT) should include at least the following members:

- The child's parents;
- The child's teacher(s) or a teacher qualified to teach a child of that age;
- An educator endorsed to teach a child with visual impairments; and
- A school district administrator or a designated representative.

SECTION 4: VERIFICATION GUIDELINES

A child with a visual impairment, including blindness, should be verified in one of the three categories**: blind, legally blind**, or **partially sighted.**

- Visual Impairment: Blind
  In order to be verified as a child with a visual impairment: blind, the evaluation should include the analysis and documentation of:
  - No more than light perception as stated in a signed report by a licensed ophthalmologist or optometrist;
  - The need for adapted curriculum, method, materials, and equipment for learning; and
  - The educational significance of the visual impairment including:
    - Documentation of behaviors which appear to impede the child's overall functioning as observed in appropriate settings by someone other than the child's classroom teacher; and
    - Deficiencies in one or more of the following areas: activities of daily living, social interaction, academic achievement, performance in the educational setting, or orientation and mobility.

- Visual Impairment: Legally Blind
  In order to be verified as a child with a visual impairment: legally blind, the evaluation should include the analysis and documentation of:
  - A visual acuity of 20/200 or less in the better eye after correction or a contiguous field restricted to 20 degrees or less as stated in a signed report by a licensed ophthalmologist or optometrist;
  - The need for adapted curriculum, methods, materials, and equipment, or any combination thereof for learning; and
  - The educational significance of the visual impairment including:
    - Documentation of behaviors which appear to impede the child's overall functioning as observed in appropriate settings by someone other than the child's classroom teacher; and

- Deficiencies in one or more of the following areas: activities of daily living, social interaction, academic achievement, performance in the educational setting, or orientation and mobility.

- Visual Impairment: Partially Sighted

  In order to be verified as a child with a visual impairment: partially sighted, the evaluation should include the analysis and documentation of:

  - A signed report by a licensed ophthalmologist or optometrist to certify a structural defect, condition, or disease of the eye, which may affect the child's ability to learn visually; and
  - The educational significance of the visual impairment including:
    - Documentation of behaviors which appear to impede the child's overall functioning as observed in appropriate settings by someone other than the child's classroom teacher; and
    - Deficiencies in one or more of the following areas: activities of daily living, social interaction, academic achievement, performance in the educational setting, or orientation and mobility.

  In addition to these two criteria, the child should meet the requirements of either criterion listed below:

  - An assessment of the child's functional vision. All assessed behaviors should be elicited by both light and pattern. Significant delays in three or more of the visual behaviors could be detrimental to functional vision. The observable visual behaviors should include but are not limited to: peripheral orientation, fixation, ability to shift gaze, ability to track, and ability to converge.

  OR

  - A visual assessment as stated in a signed report by a licensed ophthalmologist or optometrist to certify at least one of the following:
    - A distant visual acuity of 20/70 or less, in the better eye after correction;
    - A near visual acuity equivalent to or less than 8 point type at 40 centimeters, in the better eye after correction;
    - A central visual field loss of any degree in both eyes; and
    - A peripheral visual field of 60 degrees or less in the better eye.

In all cases, when making a determination of a visual impairment, including blindness, the MDT should consider the educational performance of the child to determine if it is below that of peers regardless of modification of instruction, curriculum, and environment. In addition, the MDT should consider medical information to determine if there is evidence of a visual impairment. Lastly, the MDT should review functional vision information to determine if there is evidence of a visual impairment including blindness. The MDT must determine whether the visual impairment is the primary disability of the child. When concomitant learning or developmental needs exist, the team must determine which condition is the primary cause of the need.

SECTION 5: PROCEDURES TO DETERMINE ADVERSE EFFECT ON DEVELOPMENT/EDUCATIONAL PERFORMANCE

FACTORS TO CONSIDER

Many factors should be considered in determining if a visual impairment, including blindness, is causing, or can be expected to produce, significant delays in the child's development or educational performance. The factors include, but are not limited to:

- Current medical eye information including: eye condition, diseases, or defects and prognosis (progressive, stable, or fluctuating)
- Type and degree of the visual impairment (distance and near acuity, acuity with correction, degrees of the field of vision loss, and status of ocular muscles)
- Etiology of the visual impairment (if known)
- Age of onset of the visual impairment
- Age of identification
- Current medications
- Current age
- History of interventions and response
- Relevant family/medical history
- Current educational placement

There is a broad range of visual functioning in the visual impairment categories, in visual conditions, and in the age(s) of onset for a specific visual impairment: the visual status of a child, and the nature of the visual impairment which may be stable, progressive, or fluctuating. The visual impairment could be congenital (from birth) or adventitious (acquired at some point in the child's life). These factors all need to be taken into consideration when assessing, verifying, and planning the educational program for a child with a visual impairment including blindness.

This list is not exhaustive. An additional group of factors that should be considered are: the child's health, aptitude or ability, motivation, behavior, and the communication system used by the child. Examination of each of these factors may lead to some additional factors to consider. The educational team, including an educator endorsed to teach a child with visual impairments, can determine how these factors may impact the child. Parents, medical professionals, classroom teachers, and the child him/herself can also provide information important in determining the impact of the visual impairment.

The following questions are to guide documentation and determination of whether the disability has an adverse effect on the child's developmental/educational performance.

- Educational Performance
  - Does the child meet district standards (outcomes) for his/her grade levels?
  - Does the child's progress reflect his/her ability level?
  - Does the child have access to the curriculum and materials at his/her grade level in the appropriate medium (Braille, large print, auditory, or tactile formats)?
  - Does the child have opportunities to participate in a functional curriculum?
  - Does the child have an effective way to communicate (speaking, sign language, augmentative communication, object/touch cues)?

- Orientation and mobility
  - Is the child able to determine where he/she is in the environment?
  - Does the child travel safely and efficiently in the environment?

- Social interaction skills
  - Does the child behave in socially appropriate ways?
  - Does the child initiate interactions with peers and adults?
  - Does the child have peer interactions?

- Independent living skills
  - Does the child perform the tasks that allow him/her to care for personal needs?
  - Does the child have organizational skills?
  - Does the child have the skills needed for adult independence?

- Recreation and leisure skills
  - Does the child have opportunities to participate in an array of age appropriate activities?
  - Does the child participate in movement and physical fitness activities that promote good health?

- Career/vocational education
  - Does the child have information about existing vocations?
  - Does the child have opportunities to participate in a variety of job experiences?
  - Does the child have the skills needed to become meaningfully employed?

- Assistive technology
  - Does the child have access to the specialized technology available (Braille notetaker, speech output devices)?
  - Does the child have access to an array of technology devices (both low and high technology)?

- Does the child have access and use specialized technology to access the curriculum?

- Visual efficiency skills
  - Does the child systematically use residual vision efficiently?
  - Does the child use aids to supplement residual vision effectively?

- Self determination skills
  - Does the child assist in the planning of his/her educational program?
  - Does the child have opportunities to make decisions about his/her educational program?

SECTION 6: RELATED DEFINITIONS

The following definitions were taken from Cassin, B., Solomon, S., Rubin, M.L., et. al. Dictionary of Eye Terminology (3rd Edition). Triad Publishing Co, 1997.

Accommodation – The adjustment of the eye for seeing at different distances achieved through changing the shape of the lens.

Acuity – The ability to see clearly and discriminate detail; measurement of the sharpness of vision as it relates to the ability to discriminate detail, including distance and near vision measurement with and without correction.

Adaptations – In materials and environment include but are not limited to color and contrast, illumination, low vision devices, modifications to the larger environment, modifications to a workspace, size and distance, space and arrangement, visual cues and landmarks.

Attention to Light – A characteristic of cortical vision impairment where the child attends to ceiling lights, lamps, or light from windows even in the presence of other visual stimuli.

Blindness – No more than light perception.

Blink Response – The contraction of the eyelid muscle, which spreads tears over eyeball surface and limits the amount of light entering the eye.

Binocularity – The ability to use both eyes together to focus on the same object and see a single three-dimensional object.

Color Perception – The recognition and contrast of color resulting from stimulation of red, green, and blue cons receptors in the retina.

Color Preference – A characteristic of cortical visual impairment where a child fixates, localizes, or alerts to objects of a specific color regardless of the constancy of the object itself.

Communication Modes – Methods of nonsymbolic and symbolic communication such as natural, tactile, and object cues; gestures; pictures or line drawings; miniature objects or tangible symbols; speech; Braille; large print; Sign Language; and tactile communication.

Compensatory Academic Skills – The array of skills necessary for a child to access the identical curriculum as their sighted peers.

Contrast Sensitivity – The ability to detect differences between foreground and background in terms of color or shading which enables items to be seen better.

Convergence – An inward movement of both eyes toward each other usually in an effort to maintain single binocular vision as an object approaches.

Cortical – Related to the cerebral cortex of the brain.

Cortical Vision Impairment (CVI) – A relatively new category indicating blindness or visual impairment due to brain injury or dysfunction. Children in this category manifest unique visual characteristics often found in conditions referred to as neurological, cortical, or cerebral visual impairment. A child whose visual performance is reduced by a brain injury or dysfunction may be considered blind or visually impaired for educational purposes when visual function meets the definition of blindness as determined by an eye care specialist or neurologist. Cortical Visual Impairment may also be referred to in an ocular report as Functional Blindness.

Daily or Independent Living Skills – Activities that include eating, dressing, toileting, clothing care, and food preparation which are necessary to function as independently as possible

Delayed Visual Maturation – A diagnosis used for visually impaired infants with (usually) normal eyes in the first year of life and refers to an absence of visual responsiveness despite apparently normal and intact visual pathways.

Depth Perception – The perception of three dimensions and the relative distance of objects from the viewer (over reaching, under reaching, and figure-ground discrimination).

Eccentric View – A child will direct gaze differently for a best view and will appear not to look at an object directly.

Field of Vision – The entire area that can be seen without shifting the eyes or moving the head; the full extent of the area visible to an eye that is fixating straight ahead measured in degrees from fixation.

Fixation – Eye movements that achieve and maintain the image of objects on the fovea, an area in the back of the eye that produces the sharpest vision; the ability to direct a gaze and hold an object steadily in view.

Focus – The ability of the eyes to adjust giving clear vision.

Functional Vision Assessment – An assessment done to determine the manner in which a child functions visually in the everyday world, particularly in the educational setting, and administered by an educator endorsed to teach in a child with visual impairments.

Gaze – To fix the eyes in a steady and intent look.

Gaze Shift (pursuit mechanism) – A voluntary movement of eyes in an attempt to look at different objects.

Learning Media – Materials and methods that children use in conjunction with their sensory channels to receive information.

Learning Media Assessment – An assessment of the most appropriate learning media (print, Braille, taped materials or a combination of media) administered by a certified teacher of children with visual impairments.

Legal Blindness – Acuity of 20/200 or less in the better eye with best possible correction of a field of 20 degrees or less diameter in the better eye.

Low Vision Considerations – Areas to include are: illumination, magnification, distance, size, depth perception, contrast, and color.

Medical Exam and Report – An eye examination conducted by a licensed ophthalmologist or optometrist.

Mobility – The ability to safely navigate from one position in the environment to another.

Movement/Reflectiveness – A characteristic of cortical vision impairment in which there is visual attentiveness to objects, which are highly reflective and simulate the properties of movement.

Muscle Imbalance – A lack of coordination of the eye muscles.

Nonpurposeful Gaze – A characteristic of cortical vision impairment in which a child does not gaze at a visual stimuli. Instead, the child appears to ignore or “look through” the visual stimuli.

Nystagmus – A functional defect characterized by involuntary, rhythmic side-to-side up and down or rotating eye movements.

Ophthalmologist – Medical doctor who specialized in the diagnosis and treatment of eye diseases and defects, prescribes glasses, contact lenses, prism lenses and/or exercises, and performs surgery.

Optometrist – Non-medical practitioner who measures refractive errors, eye muscle imbalances, prescribes glasses, contact lenses, or prism lenses.

Orientation and Mobility – Field of instruction which teaches systematic techniques of travel and orientation to people who are blind or visually impaired.

Orientation and Mobility Assessment – An assessment of travel, cane, and other safety techniques conducted by a certified orientation and mobility specialist.

Partially Sighted – A distance visual acuity of 20/70 or less in the better eye after correction; a near acuity equivalent to, or less than 8 point type at 40 centimeters in the better eye after correction; a central visual field loss of any degree in both eyes; or a peripheral visual field of 60 degrees or less in the better eye.

Peripheral Orientation – The ability to use side vision.

Photophobia – An abnormal sensitivity to, or discomfort from, light.

Pupillary Response – A decrease or increase in pupil size that occurs with direct light stimulation to the eye.

Reactions to Light – The manner in which the eye reacts to artificial light sources, sunlight, night vision.

Reflexive Responses – Those responses which are innate and are normally present at birth; pupil and blink responses.

Scanning – A systematic and coordinated use of the head and eyes to search for objects in the environment.

Tracking – The ability of the eyes to follow an object with smooth, fluid, and continuous movement; a systematic use of the eyes to follow an object or line of print.

Visual Array – A characteristic of cortical visual impairment in which a child is able to attend to a familiar object in isolation, but does not attend to the same familiar object when placed within multiple objects.

Visual Behaviors – Any behaviors that may indicate a visual deficiency: eccentric viewing, stereotypical behaviors, or fluctuating vision.

Visual Complexity – A characteristic of cortical visual impairment in which the child attends only to objects of one or two colors and to objects without patterns or backgrounds.

Visual Field Deficits – (a) A characteristic of cortical vision impairment in which a child demonstrates increased visual attention primarily in one visual field and is observed to turn head or body to view an object; (b) non-seeing area within the visual field.

Visual Functioning – The manner in which an individual uses the ability to see and interpret what is seen.

Visual Impairment – Identified factors affecting the visual system which are so severe that even after medical and conventional optical intervention, the child is unable to receive an appropriate education within the regular educational setting without special education services.

Visual Latency – A characteristic of cortical vision impairment in which a child exhibits at least a five second or greater delay before alerting, localizing, or fixating on an object.

Visual Motor Response – A characteristic of cortical visual impairment in which a child does not direct the hand to a target while maintaining eye contact with the target. Instead, the child will look at a target; turn the head away from the target, and reach to grasp the target (three-step process).

Visual Novelty – A characteristic of cortical visual impairment in which the child alerts, localizes, or fixates primarily on known toys or objects and will not visually attend to unfamiliar object.

SECTION 7: FREQUENTLY ASKED QUESTIONS

1. Is it necessary to have current vision information from an ophthalmologist or an optometrist to verify a child with a visual impairment including blindness?

   Yes. The documentation of an underlying eye condition, disease, or defect must be provided by an eye care specialist (optometrist or ophthalmologist). However, an eye care specialist cannot verify a visual impairment for the purposes of receiving education services. The verification of a visual impairment including blindness is the responsibility of the multidisciplinary team and must be based upon the adverse effects on the child's educational performance.

2. Should a child have a functional vision assessment to be verified as a child with a visual impairment including blindness, and why is this important?

   Yes. While an optometrist's or ophthalmologist's exam can yield necessary information about a child's eye condition, it is essential for the child's visual performance to be observed and assessed in natural environments with the visual challenges that will be encountered as part of the daily routines. This

assessment helps to identify a child's needs with regard to, but not limited to, lighting, glare, size of print, tracking and searching skills, and efficient use of vision. The functional vision assessment should include details about the child's functioning across all environments.

3. Is it ever possible for a child with a visual acuity better than 20/70 to be verified as a child with a visual impairment including blindness?

   Yes. Some children may have excellent visual acuity, but may have field losses that allow them to be verified as having a visual impairment including blindness.

4. Is it possible to verify infants and toddlers for vision services?

   Yes. An infant or toddler may be verified as having a visual impairment including blindness if an underlying eye condition, disease, or defect can be documented by an eye care specialist and the associated vision loss is likely to cause a delay in meeting developmental milestones.

5. Who should be part of the multidisciplinary team when the verification of visual impairment including blindness is likely?

   The multidisciplinary team should include the child's teacher, an educator endorsed to teach children with visual impairments, a school district representative, and the child's parent(s).

6. Can a child who is verified as having a visual impairment including blindness also have other disabilities?

   Yes, children verified as having visual impairment including blindness may have one or more additional disabilities.

7. What is Orientation and Mobility (O & M) and why does the child need it?

   Orientation refers to knowing where you are by using clues from your environment. Mobility means moving safely from place to place in an efficient manner. An Orientation and Mobility Specialist teaches children who are blind or visually impaired including blind the specific skills needed to travel independently, safely, and efficiently.

SECTION 8: REFERENCES AND RESOURCES

REFERENCES

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Levack, N. Low Vision A Resource Guide with Adaptations for Children with Visual Impairments (2nd Edition). Texas: Texas School for the Blind and Visually Impaired, 1994.

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STATE OF NEBRASKA RESOURCES

Nebraska Center for the Education of Children Who Are Blind or Visually Impaired (NCECBVI) www.ncecbvi.org

Nebraska Commission for the Blind and Visually Impaired www.ncbvi.ne.gov

Nebraska Deaf-Blind Project www.nedbp.org

Nebraska Educational Assistive Technology (NEAT) www.neatinfo.net

Nebraska Library Commission www.nlc.state.ne.us/tbbs/tbbs6.html

Parent Training and Information (PTI-Nebraska) www.pti-nebraska.org

WEB SITES

American Council of the Blind (ACB) www.acb.org

Association for Education and Rehabilitation of the Blind and Visually Impaired (AER) www.aerbvi.org

American Foundation for the Blind (AFB) www.afb.org

Clearinghouse on Disability Information Office of Special Education and Rehabilitation Services (OSERS) www.ed.gov/about/offices/list/osers/index.html

Council of Exceptional Children (CEC) www.cec.sped.org

Council of Schools for the Blind (CoSB) www.cosbl.org/index/html

Education Resources Information Center (ERIC) www.ed.gov/EdFed/ERIC.htm

Guide to Disability Resources on the Internet www.disabilityresources.org

National Association for Parents of Children with Visual Impairments (NAPVI) www.spedex.com/napvil

National Association for Visually Handicapped (NAVH) www.navh.org

National Library Services for the Blind and Physically Handicapped (NLS) www.loc.gov/nls

National Rehabilitation Information Center (NARIC) www.NARIC.com