DISTRICT OF COLUMBIA
PUBLIC SCHOOLS
Office of Teaching and Learning

School Year 2020-2021

Speech and Language Program Guidebook

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SECTION I
Introduction

A. DCPS Capital Commitment 2017-2022

In shaping DC Public Schools' five-year strategic plan for 2017-2022, A Capital Commitment, we heard from more than 4,500 students, parents, educators, and community members. Their ideas and feedback will guide our work as we strive to become a district of both excellence and equity—a place where every family feels welcome and every child is given the opportunities and support they need to thrive.

VISION: Every student feels loved, challenged, and prepared to positively influence society and thrive in life.

MISSION: Ensure that every school guarantees students reach their full potential through rigorous and joyful learning experiences provided in a nurturing environment.

OUR VALUES:

- STUDENTS FIRST: We recognize students as whole children and put their needs first in everything we do.
- COURAGE: We have the audacity to learn from our successes and failures, to try new things, and to lead the nation as a proof point of PK-12 success.
- EQUITY: We work proactively to eliminate opportunity gaps by interrupting institutional bias and investing in effective strategies to ensure every student succeeds.
- EXCELLENCE: We work with integrity and hold ourselves accountable for exemplary outcomes, service, and interactions.
- TEAMWORK: We recognize that our greatest asset is our collective vision and ability to work collaboratively and authentically.
- JOY: We enjoy our collective work and will enthusiastically celebrate our success and each other.

For additional information regarding the 2017-2022 Capital Commitment, please visit https://dcps.dc.gov/sites/default/files/dc/sites/dcps/publication/attachments/DCPS%20Strategic%20Plan%20-%20A%20Capital%20Commitment%202017-2022-English_0.pdf .

B. DCPS Division of Specialized Instruction (DSI)

DSI Vision and Strategic Goals

In the spring of 2020, the District of Columbia Public Schools (DCPS) Division of Specialized Instruction (DSI) continued the journey of a strategic planning process—a process that ensures we are making the best decisions for our students. DSI is committed to ensuring students receiving special education services and supports have a rigorous and responsive special education program.

Foremost to our strategic plan is our vision: to be the district of choice for students with disabilities. We will achieve this vision by focusing on building the capacity of our schools to ensure that they have the systems, supports, tools, and well-trained staff to address the needs of our students with disabilities, allowing them to access education in their neighborhood schools alongside their typically developing peers. We must also collaborate with our partners within DCPS and throughout the District to develop clear policies and processes for delivering high-quality instruction and supports to improve the academic achievement of our students with disabilities.

Inclusive Programming Division Vision: We will provide a high-quality continuum of services in an inclusive environment so all students with disabilities is prepared for success in college, career and life.

At the time of this publication, DSI's Strategic goals were still in draft and going through the approval process Any updates to the DSI Strategic plan will be provided to providers via email.

Special Education in DCPS

DCPS is committed to ensuring that our schools provide a world-class education that prepares ALL of our students, regardless of background or circumstance, for success in college, career, and life. We believe that students who receive special education services are integral to this commitment. As such, our strategic goals for special education are designed to dramatically improve academic outcomes for students with IEP's. We believe we can achieve this vision by providing high-quality, common core aligned instruction in inclusive settings, meaningfully involving families and keeping students focused on their goals.

Our vision will continue focusing on building the capacity of our schools to ensure that they have the systems, supports, tools, and well-trained staff to address the needs of our students with disabilities, allowing them to access education in their neighborhood schools alongside their typically developing peers.

- We believe that all children, regardless of background or circumstance, can achieve at the highest levels.
- We believe that achievement is a function of effort, not innate ability.
- We believe that we have the power and the responsibility to close the achievement gap.

- We believe that our schools must be caring and supportive environments.
- We believe that it is critical to engage our students' families and communities as valued partners.
- We believe that our decisions at all levels must be guided by data.

DCPS Full-Time Special Education Programs

	Academic Programs	Grade Bands	Student-Staff Ratio
ELS	Early Learning Supports	PK3 – Grade 2	8:2
BES	Behavior & Educational Supports	Grade 1-12	10:3, 12:3 HS
CES	Communication & Educational Supports	Grade K-12	8:3
	Early Childhood CES	PK3-PK4	6:3
ILS	Independence & Learning Supports	Grade 3-12	10:2
MES	Medical & Educational Supports	PK3 – Grade 2	8:3
SLS	Specific Learning Supports	Grade 3-12	12:2, 14:2 HS

Instructional Overview
Academic Programs provide Common Core State Standard (CCSS) aligned instruction in a small group setting. Whole group instruction is rare; learning tends to be individualized or small group and aligned to the IEP. All classroom staff are actively involved in academic instruction, which frequently involves an on-line instructional component (or blended learning). 99% of students in full-time programs participate in the Partnership for Assessment of Readiness in College and Career (PARCC).

DCPS Scope & Sequence
Specific academic programs (see table below) utilize the DCPS Scope & Sequence for ELA, math, science and social studies with accommodations and modifications. Schools may departmentalize full-time program teachers or offer grade level programming. Schools are encouraged to include special education teachers in content and grade level planning. Students in these full-time programs participate in DCPS cornerstone activities for ELA. Finally, academic programs that teach the DCPS Scope & Sequence are designed for students who are or will likely earn a diploma outside of the general education setting.

Attainment Core Content Solutions
Specific academic programs (see table below) utilize Attainment Core Content solutions for ELA, math, science and social studies. Attainment is aligned to CCSS and modified for students with intellectual disabilities and students in the CES program with Autism Spectrum Disorder (ASD). The Division of Specialized Instruction, in collaboration with school leaders, is developing a modified LEAP system to support content delivery and NCSC preparation for students in this population. The National Center & State Collaborative (NCSC) is the alternate state assessment

for students who quality or 1% of the special education population. Attainment Core Content is delivered in grades 3-12. In high school, it is designed primarily for students who are earning a certificate of IEP completion.

AEPS

The medical and educational supports (MES) program utilizes the Assessment, Evaluation and Programming System (AEPS) for infants, toddlers and young children. MES programs serve DCPS students PK3 – second grade. By third grade, students may matriculate to a neighborhood school program or attend the River Terrace Educational Campus, a separate DCPS day school.

	Academic Programs	DC Scope & Sequence	Attainment Core Content Solutions	Graduation Outcome
ELS	Early Learning Supports	✓		N/A
BES	Behavior & Educational Supports	✓		Diploma
CES	Communication & Educational Supports		✓	Certificate
	Early Childhood CES			N/A
ILS	Independence & Learning Supports		✓	Certificate
MES	Medical & Educational Supports		(AEPS)	N/A
SLS	Specific Learning Supports	✓		Diploma

Interventions

Each academic program includes a specific, research-based reading intervention to support struggling readers and facilitate engagement with grade level content. Programs are further designed with a therapeutic framework that is specific to the manifestation of disability.

Reading Interventions

Academic Programs include a menu of options for students who require specific interventions in reading to build or recover basic skills. These research based interventions were selected per program based on demonstrated effectiveness with other students with disabilities in urban settings. Each reading intervention is offered as either (1) one rotation in a 90m or 120m literacy block or (2) as a separate, elective course that is distinct from the ELA block.

Therapeutic Framework

Some academic programs feature a specific, therapeutic framework that guides instruction, student-staff interactions and the classroom environment. A therapeutic framework is set of principles, ideas or agreements to maximize student engagement in instruction, minimize maladaptive behaviors and strengthen the systems of reinforcement. Students who require full-time special education settings tend to rely on these frameworks as a pre-cursor to academic instruction and social interactions.

	Academic Programs	Reading Intervention	Therapeutic Framework
ELS	Early Learning Supports	• FUNdations • Reading Wonders	Individualized
BES	Behavior & Educational Supports	• Reading Wonders • System 44-Read 180	Safe & Civil Schools Safetycare
CES	Communication & Educational Supports	• VB Mapp • STARS • Edmark-Failure Free	Applied Behavioral Analysis (ABA)
	Early Childhood CES	• VB Mapp • STARS	Applied Behavioral Analysis (ABA)
ILS	Independence & Learning Supports	• Edmark-Failure Free	Individualized
MES	Medical & Educational Supports	• AEPS	Individualized
SLS	Specific Learning Supports	• Spell-Read • Lexia • System 44-Read 180	Unstuck & On-target Executive Function

C. Office of Teaching and Learning (OTL) Mission Statement

The Office of Teaching and Learning provides educators with **curricular resources, academic programs,** and **aligned professional development** to ensure **rigorous and joyful learning experiences** for **every student**.

D. DCPS Related Services Team Vision

Related Services (Speech-Language Pathologists, Audiologists, Occupational Therapists and Physical Therapists) and Assistive Technology are committed to increasing the independence of every student in our schools by giving them the strategies, skills and supports they need to be successful in the classroom and their community. We collaborate with parents, students, schools and other stakeholders to provide services that are timely and tailored to the unique needs of each student and are provided in conjunction with classroom instruction.

Motto: Supporting Student Achievement through Related Services (STARS)

E. Speech and Language Pathology Mission

The mission for DCPS Speech and Language Pathologists is to identify and provide therapeutic intervention for students with communication disorders so the students can participate as fully as possible in their academic setting.

F. Contact Numbers for Speech and Language Pathology Department

Office Location Information	
Central Office	**Speech, Language & Hearing Department Office** ** Office Hours: Monday 12 PM – 4 PM**
Office of Teaching and Learning Division of Specialized Instruction 1200 First Street, NE 8th Floor Washington, DC 20002	Emery Elementary School 1721 First Street NE Rooms 102 and 104 Washington, D.C. 20002

Program Manager	Cell Phone Number	Fax Number
GaBriana Dennis, M.A., CCC-SLP	(202) 906-0221	(202)654-6083
Darla Kimbrough, M.S., CCC-SLP	(202) 281-8516	(202) 442-4368
Tiffany A. White, M.Ed., CCC-SLP	(202) 505-0756	(202)535-1391

SECTION II
General Guidelines and Procedures

PURPOSE

To guide the provision of Speech and Language Pathology services in order to support the educational goals of eligible students with disabilities in the District of Columbia Public Schools (DCPS). It is designed with the purpose of assuring that all Speech-Language Pathologists (SLPs) in the District of Columbia Public Schools (DCPS) operate from the same premise, utilize the same procedures and guidelines and are uniform in presentation.

This guidebook is written for special education administrators, school personnel responsible for 504 Plans, Individualized Service Plans (ISPs), and providers of speech and language services. In addition, it may benefit parents, teachers, and other professionals. The elements contained within this guidebook are designed to provide optimal school-based interventions as part of a Free Appropriate Public Education (FAPE) in the Least Restrictive Environment (LRE), following IDEA 2004; while simultaneously maximizing equal access to Speech-Language Pathologists for all of the District of Columbia Public Schools students. Implicit within this document are the following core principles:

- The criteria for eligibility must include both the presence of a composite depressed score and documented impact on the student's access to the academic curriculum
- Services should not be instituted until accommodations have been implemented and given a chance to work
- The intensity and modalities of interventions should dwindle over time
- The default delivery service need not be 1:1, unless otherwise required and justified, as applicable, by the clinician
- Discharge from services should be stated at the first IEP meeting as a desirable and celebrated outcome and not a denial of services; discharge may, and should, occur at any time in the process.

DCPS regulates the practice of Speech-Language Pathology services to the students in public schools of the District of Columbia while the Department of Health, Board of Audiology and Speech-Language Pathology regulates the practice of speech language pathologists. In this guidebook, providers will find guidelines, procedures, suggestions and ideas that should be used on a daily basis to guide them in assuring a high level of professional services for all students and invested stakeholders.

This guidebook is structured according to the Table of Contents above. Appendices are attached with additional useful resources.

This guidebook replaces any guidebook introduced previously. Providers should expect to receive supplemental policy and procedure documents and training throughout the current school year.

A. DUTIES & RESPONSIBILITES

Each week, Speech Language Pathologists are expected to complete activities such as attending meetings (including but not limited to Student Support Team (SST), Student Evaluation Plan (SEP), Multidisciplinary Team (MDT), school-wide, staff, case conference, professional development), providing assessment and intervention services, completing student observations, consulting with others (including but not limited to staff, parents, other service providers, etc…), writing assessment reports, making phone calls to parents, completing "EasyIEP" duties, and various other activities that are necessary to perform as a speech language pathologist. (Please see DCPS DSI job descriptions on the subsequent pages for specific details.)

ET-11 Speech Language Pathologist Job Description (CSO)

INTRODUCTION

This position is located in the District of Columbia Public Schools Office of Specialized Instruction.

TOUR OF DUTY

Tour of duty is from 8:00 am until 4:30 pm for a 12-month timeline. An extended tour of duty may be inclusive of central office assignments, summer school assessments, compensatory education services, extended school year services, non-public assessment completions, HOD/SA specifications and extra duty cases which extend beyond the regular school day hours.

DUTIES AND RESPONSIBILIIES

The below statements are intended to describe the general nature and scope of work being performed by this position. This is not a complete listing of all responsibilities, duties, and/or skills required. Other duties may be assigned.

- The incumbent provides direct and indirect clinical services to students who have been diagnosed with an academically based communication disorder in areas of articulation, language, voice and/or fluency.

- The incumbent completes diagnostic assessments as a means of determining the presence/absence of a specific communication disorder, which adversely impacts on academic progress.

- Serves as a resource to school staff members in the development of a balanced program for oral communication and speech, language and literacy development.
- Provides direct/indirect service to students diagnosed with a swallowing disorder as it relates to the educational environment.
- Provides an implemented therapeutic program to meet individual needs of students with a diagnosed communication impairment.
- Assists and guides teachers in observing, describing and referring suspected and identified speech and language impairments.
- Assists in proper referrals of students to agencies and specialists in the community as appropriate.
- Provides appropriate individualized programs of therapy to meet individual students' needs and correct existing speech or language impairments.
- Provides a comprehensive assessment and diagnosis of speech, voice, and language impairments.
- Keeps thorough records for each student receiving therapy or other school-provided speech-language services.
- Compiles case history data on those cases where additional family history, health history, and early developmental history are deemed appropriate.
- Conducts speech, language and hearing screenings.
- Coordinates assistive technology support services.
- Participates/lends to child study committees.
- Supervises support personnel/ Speech-Language Pathology Clinical Fellows
- Monitoring guidelines, timelines, and completion of student assessments, evaluations, IEP development and renewals according to federal, state, and district guidelines for students with Speech only on IEPs
- Reviewing Hearing Officer Decision/Settlement Agreements requirements, determines assessment needs, and ensures compliance by deadline and standards guidelines for

students with Speech only on IEPs

- Monitoring student's records for accuracy and compliance guidelines for students with IEPs with only speech and language goals/objectives

MINIMUM QUALIFICATIONS

- Master's degree (M.A./M.S.) in Communication Sciences and Disorders or Speech-Language Pathology.
- Eligible for ASHA Certificate of Clinical Competence in Speech-Language Pathology
- District of Columbia Certification as a School Speech-Language Pathologist, which must be maintained throughout employment with DC Public Schools.

KNOWLEDGE REQUIRED BY THE POSITION

- Ability to read, analyze, and interpret general business periodicals, professional journals, technical procedures, or government regulations.
- Ability to write reports, business correspondence, and procedural manuals.
- Ability to effectively present information and respond to questions from groups of managers, clients, customers, and the general public.
- Ability to apply concepts such as percentages, ratios, confidence intervals and proportions to practical situations.
- Ability to solve practical problems and deal with a variety of concrete variables in situations where only limited standardization exists.
- Ability to interpret a variety of instructions furnished in written, oral, diagram, or schedule form.
- Ability to write reports and correspondence and enter and extract data in electronic form.
- Ability to work well in a team environment.
- Knowledge of the procedures and the operations of District of Columbia Public Schools and other agencies of the District of Columbia government.

SUPERVISORY CONTROLS

The incumbent works under the broad general direction and guidance of the Director for Related Services and Non-School Based Programs and specifically under the direction and guidance of the Program Managers of Speech Language Programs. The incumbent consults with the Program Managers of Speech Language Program services on critical problems relative to DCPS divisions and departments, and their compliance with the Individuals with Disabilities Education Act of 2004 and any and all future reauthorizations of the Individuals with Disabilities Education Act.

GUIDELINES

Guidelines include but are not limited to the following: Codes of Federal Regulations, the District of Columbia Board Rules, and District of Columbia Public Schools Guidelines.

The incumbent exercises judgment in determining what guidelines are applicable, in interpreting these, guidelines and in deciding what matters to discuss with the Program Managers of Speech and Language Programs.

COMPLEXITY

The nature of assignments is complex; therefore, the incumbent is expected to identify the area of difficulty and suggest/discuss means and methods to overcome those complexities. The incumbent is expected to use originality and ingenuity in overcoming problem areas.

SCOPE AND EFFECT

The purpose of this position is to eliminate, reduce and/or provide compensatory strategies in the area of speech and language development. The speech language pathologist will support the student's ability to derive full benefit from the District's educational program. The impact of such a position is felt throughout the Office of Specialized Instruction Reform in the District.

PERSONAL CONTACTS

Contacts are with employees throughout DCPS, other District government agencies and offices, parents, constituency groups, advocates, attorneys, vendors and other related agencies.

PURPOSE OF CONTACTS

The purpose of the contacts is to encourage support and understanding of DCPS work regarding Special Education as it relates to Speech-Language Pathology, to serve as a link between DCPS and the parent/guardian to coordinate work activities, to exchange and clarify information and resolve special education problems and concerns.

PHYSICAL DEMANDS

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of the job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is frequently required to stand, walk, sit, talk and/or listen. The employee must occasionally lift and/or move up to 10 pounds. Specific vision abilities required by this job include close vision, distance vision, color vision, peripheral vision, depth perception, and ability to adjust focus. Specific listening abilities required by this job include acute perceptual and physical listening skills.

WORK ENVIRONMENT

The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. The noise level in the work environment is usually moderate.

ET-15 Speech-Language Pathologist Position Description (WTU)

INTRODUCTION

This position is located in the District of Columbia Public Schools Office of Specialized Instruction, Department of School Support.

TOUR OF DUTY

Tour of duty is from 8:00 am until 3:30 pm for a 10 or 12 month timeline. An extended tour of duty may be inclusive of extra duty team assignments, which extend beyond the regular school day.

DUTIES AND RESPONSIBLITIES

The below statements are intended to describe the general nature and scope of work being performed by this position. This is not a complete listing of all responsibilities,

duties, and/or skills required. Other duties may be assigned.

- The incumbent provides direct and indirect clinical services to students who have been diagnosed with an academically based communication disorder in areas of articulation, language, voice and/or fluency.
- The incumbent completes diagnostic assessments as a means of determining the presence/absence of a specific communication disorder, which adversely impacts on academic progress.
- Serves as a resource to school staff members in the development of a balanced program for oral communication and speech, language and literacy development.
- Provides direct/indirect service to students diagnosed with a swallowing disorder as it relates to the educational environment.
- Provides an implemented therapeutic program to meet individual needs of students with a diagnosed communication impairment.
- Assists and guides teachers in observing, describing and referring suspected and identified speech and language impairments.
- Assists in proper referrals of students to agencies and specialists in the community as appropriate.
- Provides appropriate individualized programs of therapy to meet individual students' needs and correct existing speech or language impairments.
- Provides a comprehensive assessment and diagnosis of speech, voice, and language impairments.
- Keeps thorough records for each student receiving therapy or other school-provided speech-language services.
- Compiles case history data on those cases where additional family history, health history, and early developmental history are deemed appropriate.
- Conducts speech, language and hearing screenings.
- Coordinates assistive technology support services.
- Participates/lends to child study committees.

- Supervises support personnel/ Speech-Language Pathology Clinical Fellows

- Monitoring guidelines, timelines, and completion of student assessments, evaluations, IEP development and renewals according to federal, state, and district guidelines for students with Speech only on IEPs

- Reviewing Hearing Officer Decision/Settlement Agreements requirements, determines assessment needs, and ensures compliance by deadline and standards guidelines for students with Speech only on IEPs
- Monitoring student's records for accuracy and compliance guidelines for students with IEPs that only have speech and language goals/objectives

MINIMUM QUALIFICATIONS

- Master's degree (M.A./M.S.) in Communication Sciences and Disorders or Speech-Language Pathology.

- Eligible for AHSA Certificate of Clinical Competence in Speech-Language Pathology.

KNOWLEDGE REQUIRED BY THE POSITION

- Ability to read, analyze, and interpret general business periodicals, professional journals, technical procedures, or government regulations.

- Ability to write reports, business correspondence, and procedural manuals.

- Ability to effectively present information and respond to questions from groups of managers, clients, customers, and the general public.

- Ability to work with mathematical concepts, such as probability and statistical inference, and fundamentals of plane and solid geometry and trigonometry.

- Ability to apply concepts, such as fractions, percentages, ratios, and proportions to practical situations.

- Ability to solve practical problems and deal with a variety of concrete variables in situations where only limited standardization exists.

- Ability to interpret a variety of instructions furnished in written, oral, diagram, or schedule form.

- Ability to write reports, correspondence, enter and extract data in electronic form.

- Ability to work well in a multi-disciplinary team environment.
- Knowledge of the procedures and the operations of District of Columbia Public Schools and other agencies of the District of Columbia government.

SUPERVISORY CONTROLS

The incumbent works under the direction and guidance of the Program Managers of Speech Language Pathology Services. The incumbent consults with the Program Managers of Speech and Language Services on critical problems relative to DCPS divisions and departments, and their compliance with state and federal mandates as they relate to the provision of Speech-Language services. The incumbent receives annual performance assessment reviews ensuring that best practices are regularly implemented.

GUIDELINES

Guidelines include but are not limited to the following: Codes of Federal Regulations (34 CFR Parts 300, 301 and 304), the District of Columbia Board Rules related to the provision of related services, District of Columbia Public Schools Guidelines and the DCPS Speech-Language Eligibility and Dismissal Criteria Standards)

The incumbent exercises judgment in determining what guidelines are applicable, in interpreting these guidelines and in deciding what matters to discuss with the Supervisor of Speech and Language Services.

COMPLEXITY

The nature of assignments is complex; therefore, the incumbent is expected to identify the area of difficulty and suggest/discuss means and methods to overcome those complexities. The incumbent is expected to use originality and ingenuity in overcoming problem areas.

SCOPE AND EFFECT

The purpose of this position is to eliminate, reduce and/or provide compensatory strategies in the area of speech and language development. The speech language pathologist will support the student's ability to derive full benefit from the District's educational program. The impact of such a position is felt throughout the Office of Specialized Instruction in the District.

PERSONAL CONTACTS

Contacts are with employees throughout DCPS, other District government agencies and offices, parents, constituency groups, advocates, attorneys, vendors and other related agencies.

PURPOSE OF CONTACTS

The purpose of the contacts is to encourage support and understanding of DCPS work regarding Special Education as it relates to Speech-Language Pathology, to serve as a link between DCPS and the parent/guardian to coordinate work activities, to exchange and clarify information and resolve Special Education problems and concerns.

PHYSICAL DEMANDS

The physical demands described here are representative of those that must be met by an employee to successfully perform the essential functions of the job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is frequently required to stand, walk, sit, talk and/or listen. The employee must occasionally lift and/or move up to 10 pounds. Specific vision abilities required by this job include close vision, distance vision, color vision, peripheral vision, depth perception, and ability to adjust focus. Specific listening abilities required by this job include acute perceptual and physical listening skills.

WORK ENVIRONMENT

The work environment characteristics described here are representative of those an employee encounters while performing the essential functions of this job. Reasonable accommodations may be made to enable individuals with disabilities to perform the essential functions. The noise level in the work environment is usually moderate.

B. CERTIFICATION & LICENSURE

It is the professional responsibility of providers to maintain their required OSSE certification and DC DOH licensure. Should one's license lapse or not renewed it could impact their ability to provide services within DCPS.

The minimum requirements for certification/qualification as a Speech-Language Pathologist are:

- Current Office of the State Superintendent of Education (OSSE) Certification as a Speech –Language Pathologist
  - For application information (initial and renewal), refer to link: https://osse.dc.gov/ed-credentials
- Current Department of Health (DOH) license from the Board of Audiology and

Speech-Language Pathology
- For application information (initial and renewal), refer to link: http://doh.dc.gov/node/145912)

- Master's degree in Speech Language Pathology or Communication Sciences and Disorders
- Eligibility for the American Speech Language Hearing Association's Certification of Clinical Competence

It is providers' professional responsibility to maintain their OSSE certification and DC DOH licenses. Maintaining licensure and certification is a mandatory requirement as outlined in the job description for SLPs. Providers who do not maintain their certification and licensure are subject to separation. Providers who let their certification and licensure lapse will receive penalty via IMPACT

- Renewal Periods
  - DC DOH Licenses are renewed every 2 years. Must renew by December 31st, 2018. Requires submission of proof of the completion CEUs.
  - OSSE certifications are renewed every 4 years. Requires submission of proof of the completion CEUs.

C. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER

As a result of the Affordable Care Act, the Centers for Medicare and Medicaid (CMS) issued a final rule (42 CFR Parts 424 and 431) on April 12, 2012 requiring all providers of medical services to obtain a National Provider Identifier (NPI). The NPI acts as a unique provider identifier for Medicaid claims submitted to the Medicaid Agency. In order to conduct Medicaid claiming, all providers are rendering services on behalf of DCPS must obtain an NPI. Refer to the document "OSI Provider NPI Requirement for New Employees" in the appendix.

All providers rendering services on behalf of DCPS must obtain a National Provider Identifier (NPI). **DCPS must have record of your NPI before November 1, 2013**. Individuals are eligible to receive one NPI regardless of the number of specialties practiced. Please follow the steps below. If you already have an NPI then please skip section 1 and complete section 2.

Section 1: Apply for an NPI

There are two ways to apply for an NPI: web-based and paper-based

1. Use the web-based NPI application process at https://nppes.cms.hhs.gov/NPPES/Welcome.do
   a. Click on the hyper link National Provider Identifier to apply for an NPI.
      i. **Select Entity type 1**, health care providers who are individuals. Complete sections 2A, 3, 4A, and 5.
   b. Completion of the application takes approximately 20 minutes.
2. Obtain the NPI Application/Update form (CMS 10114).
   a. Complete and mail application to the following address:

i. NPI Enumerator
P.O. Box 6059
Fargo, ND 58108-6059

Section 2: Submit NPI to DCPS Office of Specialized Instruction (OSI)

1. Each new provider will receive an email from a Program Manager with subject line "DCPS NPI form."
2. Click on the link.
3. Providers must sign in using their dc.gov email address.
4. Complete all questions and submit.
5. Once their number has been received, providers should provide the number to their assigned Program Manager **and** bring that number with them to their initial SEDS Training for Related Services Providers.

Gloria VanHook, Eligibility and Enrollment Specialist - Email: gloria.vanhook@k12.dc.gov

D. ASHA CODE OF ETHICS AND SPEECH AND LANGUAGE SERVICES

The Code of Ethics reflects what we value as professionals and establishes expectations for our scientific and clinical practice based on principles of duty, accountability, fairness, and responsibility. The ASHA Code of Ethics is intended to ensure the welfare of the consumer and to protect the reputation and integrity of the professions.

By holding ASHA certification or membership, or through application for such, all individuals are automatically subject to the jurisdiction of the Board of Ethics for ethics complaint adjudication. Individuals who provide clinical services and who also desire membership in the Association must hold the CCC.

The Code is designed to provide guidance to members, applicants, and certified individuals as they make professional decisions. Because the Code is not intended to address specific situations and is not inclusive of all possible ethical dilemmas, professionals are expected to follow the written provisions and to uphold the spirit and purpose of the Code. Adherence to the Code of Ethics and its enforcement results in respect for the professions and positive outcomes for individuals who benefit from the work of audiologists, speech-language pathologists, and speech, language, and hearing scientists.

The fundamentals of ethical conduct are described by Principles of Ethics and by Rules of Ethics. The four Principles of Ethics form the underlying philosophical basis for the Code of Ethics and are reflected in the following areas:

Principle 1	•Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or who are participants in research and scholarly activities, and they shall treat animals involved in research in a humane manner.
Principle 2	•Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence and performance.
Principle 3	•Individuals shall honor their responsibility to the public when advocating for the unmet communication and swallowing needs of the public and shall provide accurate information involving any aspect of the professions.
Principle 4	•Individuals shall uphold the dignity and autonomy of the professions, maintain collaborative and harmonious interprofessional and intraprofessional relationships, and accept the professions' self-imposed standards

IDEA & Ethics

Relates Service Providers (RSPs) are bound by:

- State and federal laws (IDEA and OSSE)
- Professional codes of ethics
- Professional association guidelines
- State professional licensing boards (OSSE and DOH)
- Teacher organizations (WTU and CSO)

Most Frequently Recurring Ethics Issues

- Cultural Competence
    - Discrimination in the provision of services and/or interactions with colleagues and students
    - Lack of competence in the selection, administration and/or interpretation of diagnostic and/or treatment materials or approaches
- Reimbursement for services
    - Misrepresenting services to obtain reimbursement
    - Billing for services provided by a clinician who is not certified and/or does no receive the necessary supervision

  - Intentionally misusing incorrect code numbers or diagnostic labels to qualify for payment
  - Billing for services not provided
  - Billing for unnecessary services
- Professional vs. Business Ethics
  - Solicitation of cases for private practice from your caseload
  - Acceptance of gifts or incentive from manufactures or other individuals
  - Client abandonment and/or disruption of services
  - Failure to report unethical behavior
  - Misuse of professional credentials
- Clinical fellowship supervision

References
Davis-McFarland, Elise (2010) Ethics for School Speech-Language Pathologists and Audiologist; ASHA Schools Conference, Las Vegas, NV

Ethics and School Practice. http://www.asha.org/slp/schools/prof-consult/ethicsschoolspractice.html

Ethics Q and A for School-based Speech Language Pathology practice. Http://www.asha.org/slp/schools/prof-consult/ethicsFAQsforschools.htm

E. WORK HOURS

Tours of Duty

ET-11 (CSO)

Speech Language Pathologists are to report to their schools for an eight and one-half (8.5) workday inclusive of a duty-free lunch period. Staff members should arrive at their assigned schools no later than the time of arrival expected for all school staff.

Arrival Time – 8:00am
Departure Time – 4:30pm

ET-15 (WTU) *

Service providers are to report to their schools for a seven and one-half (7.5) workday inclusive of a duty-free lunch period. Staff members should arrive at their assigned schools no later than the time of arrival expected for all school staff.

Arrival Time – 8:00am
Departure Time – 3:30pm

F. TIME AND ATTENDANCE PROCEDURES

A memorandum from the Deputy Chancellor for Special Education stated that:
"It is vital that time and attendance is accurately reported by all personnel. The erroneous reporting of time is against DCPS policy and grounds for disciplinary action against the employee, his/her supervisor or his/her timekeeper."

"Effective immediately, all staff must sign-in and sign-out on a **daily basis**". If an employee **does not** submit leave slips, sign-in/sign-out sheets or any other required documentation to verify time and attendance, then time and attendance **WILL NOT** be" approved in "PeopleSoft for that employee with **NO EXCEPTIONS."**

Signing In and Out

a. Immediately upon his/her arrival, each service provider shall record in the school business office of his/her immediate supervisor the time of his/her arrival, and he/she shall report to his/her classroom or place of duty at least thirty-five (35) minutes before the start of the official school day for students.
b. Itinerant service providers shall immediately upon their arrival at each school assigned, record in the school business office their time of arrival.
c. Service providers shall record in the school business office or in the office of their immediate supervisor the time of their departure at the end of the school day.
d. Service providers shall not be required to use time clocks.

*As stated in the WTU contract

SCHOOL BASED & ITINERANT DSI STAFF:

1. All sign-in/sign-out sheets must be signed by you on a daily basis.
2. All leave slips must be submitted thru PeopleSoft and approved by your Program Manager (annual, sick, compensatory time, overtime, administrative, etc…).
3. All annual leave must be approved prior to the leave period.
4. All administrative leave requests for seminars, conferences and official travel must be accompanied by appropriate documentation (registration, receipt, etc.).
5. All requests for leave for over two weeks must be approved by your Program Manager and the Director of Related Services.
6. Leave without pay must be APPROVED by the Deputy Chancellor for Special Education.
7. Staff should not plan to request leave during the two weeks prior to the start of the new school year. Emergencies will require APPROVAL by the Deputy Chancellor for Special

Education.

8. "Use or lose" leave must be exhausted prior to the use of annual leave.
9. All compensatory time or overtime must be approved by the Deputy Chancellor for Special Education prior to the work being performed and provide a copy to your supervisor.
10. 12 month employees (WTU and CSO providers) may not take extended leave during Extended School Year.

ENTERING TIME IN PEOPLESOFT

How do I enter my own time?

1. Log into the PeopleSoft online system.
    - Inside of DC Network: https://pshcm.dc.gov
    - Outside of DC Network: https://ess.dc.gov
    - Login: Your DCPS email address without @dc.gov (generally firstname.lastname)
    - Use the "Forgot Your Password?" link if you do not know your password.
2. Click on "Self Service" in the blue box on the left side of the page.
3. Click on "Report Time" under the Time Reporting heading.
4. Click on "Timesheet" under the Report Time heading.
5. Enter the appropriate number of hours for each day of the current week.
    - You may need to change the Date field if you are entering time late.
    - After changing the date, click "Refresh" to enter time for a previous time period.
6. Select a Time Reporting Code from drop down menu. The most frequently used codes are:
    - Regular Pay – REG
    - Annual Leave Taken – ALT
    - Sick Leave Taken – SLT
    - Holiday Pay – HOL
    - Administrative Closing Pay – ACP
    - Telework Situational – STTW (to be used for extended school-wide closures)
7. Click the "+" at the far right of the line if you will be entering more than one type of time.
    - Ex: 2 lines would be needed if you worked Monday-Thursday, but you were sick Friday.
    - Ex: 3 lines would be needed if the above were true except that Monday was a holiday.
8. Click "Submit."
    - Submitted time can be changed (prior to the end of the pay period) if needed.
    - Saved time cannot be approved. Please do not use the "Save for Later" button.
    - Only enter time for the current week, except prior to winter and spring breaks.

When do I need to enter my time?

All ET-11 and ET-15 Speech-Language Pathologists are required to enter time into People Soft Weekly (Thursday). Each SLP must submit all supporting documents via fax, email, route mail or hand deliver to their assigned Program Manager prior to taking leave.

How do I submit a leave request in PeopleSoft?

1. Log into the PeopleSoft online system.
2. Click on "Self Service" in the blue box on the left side of the page.
3. Click on the "Time Reporting" heading.
4. Click on "Absence Request" under the Report Time heading.
5. Populate all of the fields on the page (leave may only be taken in 1 hour increments).
6. Click "Submit." Do not use the "Save for Later" button.

You will receive an email once your leave is approved. Follow up with your manager directly if you do not receive this confirmation at least 48 hours prior to the start of your leave.

What if I need help?

Click here to view online tutorials on how to enter time and absence requests. For more information, refer to the Human Resources page of the DCPS website or call the PeopleSoft Helpdesk (202.727.8700).

Please check your leave balances prior to submitting requests for leave in PeopleSoft. Leave balance information can be obtained by logging into PeopleSoft.

In DCPS network: http://pshcm.dc.gov or Outside DCPS network: https://ess.dc.gov

ET- 15 (Refer to WTU Contract for detailed information)
G. LEAVE

Sick and Emergency Leave

a. For the purposes of accruing and using sick leave, a day of leave is defined as eight (8) hours, regardless of the tour of duty. For leave purposes, one-half of the tour of duty is calculated as four hours. Twelve (12) days (96 hours) of sick leave are posted at the beginning of each school year for ten (10) month service providers. Four (4) sick leave days may be used for general leave and one (1) additional sick leave day may be used for "personal business leave" during each school year. General leave and personal business leave shall not be cumulative. Unused sick leave shall be carried forward from year to year.

b. Fifteen days (15) days (120 hours) of sick leave are posted at the beginning of each school year for twelve (12) month teachers (ET 15/12). Three (3) sick leave days may be used for general leave and one (1) additional sick leave day may be used for "personal business leave" during each

school year. General leave and personal business leave shall not be cumulative. Unused sick leave shall be carried forward from year to year.

c. A service provider who becomes sick or disabled to the point that he/she is unable to do his/her job, or has a scheduled medical or dental appointment, shall be permitted to use his/her accumulated leave in accordance with the Rules of the Board. **Leave requests for medical or dental appointments must be made by the service provider to his/her immediate supervisor as soon as the appointment is known to the employee**. **If a service provider cannot report for work due to illness, he/she shall notify the supervisor or designee as soon as possible, but in no case later than the first fifteen (15) minutes of the service provider's workday.**

d. A service provider may be required to submit a doctor's certificate after three (3) or more consecutive days of absence due to illness, provided, however, that a service provider may be required to submit such a certificate in support of sick leave for any lesser period if the supervisor has reason to believe that the use of such leave has been abused.

e. In cases of emergencies, service providers may be required to submit appropriate documentation in support of such absences.

f. Service providers may be excused immediately from duties, with charge to leave, for pressing, urgent emergencies at any time upon oral explanation and notification to the supervisor or his/her designee. For the purpose of this Article, emergency shall be defined as any situation requiring immediate attention over which the employee has no control.

g. Leave (sick and emergency), not to exceed thirty (30) days may be advanced to permanent and probationary service providers in cases of personal serious disability, illness or an emergency, which requires the service provider's personal attention. Service providers in a temporary status may be advanced sick leave in amounts equal to anticipated sick leave accruals during their temporary appointments. A request for advanced leave must be submitted and approved in writing at least five (5) days prior to the absence.

h. A service provider may elect to return to the Board one half (1/2) of the sick leave days accrued but not taken during the current year at the current daily rate of pay. Un-purchased sick leave shall be credited each year to the service provider's sick leave balance and shall not be subject to the Sick Leave Buy-Back Plan.

i. An employee sick leave bank shall be operated under the guidelines approved by the Board and the Union.

j. An employee maternity/paternity leave bank may be established annually at the option of the Union. If established, it shall operate under the guidelines developed and approved by the Board and the Union.

k. One day of "individual professional development leave" shall be posted at the beginning of each school year for all bargaining unit members. Such leave shall be cumulative and unused "individual professional development leave" shall be carried over from year to year as part of the cumulative sick leave. The Chancellor and the President of the WTU shall mutually agree on the parameters associated with the use of "individual professional development leave".

2. General and Annual Leave

a. Twelve (12) month service providers (EG09) shall receive annual leave with pay for each calendar year, exclusive of Saturdays, Sundays and holidays as follows:

(a) Service providers with less than three (3) years service shall receive thirteen (13) days;
(b) Service providers with three (3) but less than fifteen (15) years of service shall receive twenty (20) days; and,
(c) Service providers with fifteen (15) or more years of service shall earn twenty-six (26) days.

b. A request for the use of general or annual leave (Application for Leave) shall be given to the supervisor or his/her designee at least one (1) day prior to the expected absence. The unavailability of the application form at the school shall not be a reason for denial of leave.

3. Funeral/Bereavement Leave

a. Four (4) additional days of leave will be granted without loss of pay and benefits for the death of an employee's or his/her spouse's/domestic partner's parent, legal guardian, child, sibling, or such persons designated in writing to the building supervisor prior to the beginning of each school year.

b. This does not preclude the use of accrued sick leave if additional days are needed for the purpose of bereavement or attending a funeral.

c. Funeral/Bereavement leave shall not be cumulative.

4. Administrative Leave

a. Administrative leave shall be granted to a teacher when it is necessary for the teacher, in a major hardship case, to use time during the school day to seek redress under the terms of this Agreement.

b. Service providers who are authorized by the Board to attend appropriate job-related technical, scientific and professional conferences, conventions, meetings, seminars, symposiums, approved

training courses, workshops and to visit industry and other schools during regular duty hours are considered to be in an administrative leave status.

c. Service providers shall be carried in a leave without loss of pay status when summoned to serve as a juror on a petit or grand panel, or to appear in court as a subpoenaed witness in their official capacity, or on behalf of federal, state, or municipal governments. The service provider shall furnish his/her supervisor with a copy of the summons within twenty-four (24) hours of his/her receipt of the summons. If a service provider is excused from jury duty for a day or a substantial portion thereof, he/she shall report to the place of his/her employment and perform the duties assigned for that day or portion thereof. Any pay received for service as a witness or juror, other than expenses, shall be handled in accordance with applicable policy or law.

d. When a service provider is injured in the performance of his/her duties, he/she shall be considered in a duty status during the time required for initial examination, emergency treatment, or treatment during duty hours.

e. A service provider shall be granted a reasonable amount of time to present appeals in connection with adverse actions, grievances and discrimination complaints.

f. Leave shall not be charged when schools are closed to service providers for emergency reasons.

g. Service providers who are injured on the job and are unable to work shall be entitled to compensation as provided for in Section 1-624.2 of the D.C. Code. Upon notification that a service provider has been hurt on the job, the building supervisor shall immediately notify the Office of Risk Management and submit all appropriate documentation in a timely manner. Copies of workmen's compensation forms shall be available at the work site.

5. Extended Leaves of Absence

a. Extended leaves of absence with or without pay for periods in excess of thirty (30) days and not to exceed two (2) years may be granted by the Board to permanent or probationary service providers. Among the reasons, but not limited to, for which such leaves of absence may be used are the following:

(1) Personal illness leave
(2) Family care leave
(3) Maternity leave
(4) Paternity leave
(5) Adoption leave
(6) Educational leave with pay
(7) Educational leave without pay
(8) Military service leave

b. A service provider who is granted an extended leave of absence for maternity/paternity purposes may elect to use her accrued sick leave at the time she begins the extended leave of absence from duty.

c. A service provider returning from maternity/paternity, adoption or educational leave shall have the right to return to his/her former or comparable position.

d. A service provider shall be permitted to return from maternity/paternity, adoption, or educational leave upon a thirty (30) day written notice of intent to return to work prior to the end of a semester. This shall not preclude a teacher from an earlier return at the discretion of the Board.

e. Upon proper application, permanent teachers may be granted a leave of absence without pay for one (1) school year to serve as a full time employee of the Union. A service provider granted such leave of absence shall retain all rights of reinstatement in accordance with the Rules of the Board.

6. Educational Leave With Pay

1. A permanent teacher may be granted a leave of absence with one-half (1/2) of his/her salary after six (6) continuous years of service in the Public Schools of the District of Columbia to pursue full-time graduate study in a program approved by the Board.

2. Such leave as granted in paragraph 1 above may be terminated at any time if the teacher fails to pursue in a satisfactory manner the purpose for which said leave of absence was granted.

7. Family and Medical Leave

Bargaining unit employees shall receive benefits as provided in the Family and Medical Leave Act of 1993, as amended, and as provided in the District of Columbia Family and Medical Leave Act of 1990.

ET-11 SPEECH-LANGUAGE PATHOLOGISTS - CSO (Refer to CSO contract agreement for detailed information.)

LEAVE

1. Annual

a. Service providers shall earn leave with pay in any one calendar year, exclusive of authorized leave for educational purposes and assignments and exclusive of Saturdays, Sundays and holidays as follows:

1. Less than three (3) years service, thirteen (13) days per year;
2. Three (3) years service, but less than fifteen (15) years service, twenty (20) days per year; or
3. Fifteen (15) or more years service twenty-six (26) days per year.

b. Officers may accumulate annual leave for later use up to a maximum of thirty (30) days.

c. Each supervisor in conjunction with the officer staff shall develop a tentative leave schedule for the use of annual leave, which shall be developed early in the leave year, which provides for vacations on a staggered basis throughout the year. On the basis of mutual agreement between employees and their supervisors, vacation periods should be scheduled in such a manner as to provide the least interruption to the work unit. These schedules may, of course, be revised from time to time. Employees should be given the opportunity for a planned period of extended vacation leave.

Annual leave may be used as the service provider chooses, provided that the leave has been requested by the related service provider and approved by the related service provider's immediate supervisor in advance of the utilization of the leave and in accordance with established leave policies.* However, if and when exigencies of the service provider's area(s) of responsibility occur, then the officer's immediate supervisor may rescind the approval of the leave request. In the event an officer's approved annual leave request is rescinded, the immediate supervisor should provide priority consideration to the service provider's future request for annul leave.

***PLEASE NOTE:** Guidelines indicate that "in advance" requires that you submit your request for leave at least three (3) days prior to the start date of your leave requested.]

d. Service providers may exceed the thirty (30) day accumulation of annual leave under the following conditions:

1. Administrative error where such error causes the loss of annual leave;
2. Exigencies of the public business when the leave was scheduled in advance and the exigencies caused the cancellation of the leave; or
3. Illness or injury when leave was scheduled in advance and cancelled because of illness

or injury.

The term "scheduled in advance" means before the start of the third bi-weekly pay period prior to the end of the leave year.

e. Restoration of Leave

1. The Board is responsible for notifying the membership of, and providing the required form(s) for, the process to be followed in the restoration of annual leave in accordance with the annual "use or lose" leave protocol.
2. The Board will provide the process for recording and utilization of restored annual leave to the membership and all responsible supervisors – in accordance with paragraph 6 below.
3. If the Board fails to properly notify officers of the process to be followed and the forms to fill out for the restoration of annual leave, the restored leave the service provider would have been entitled to shall not be subject to the "use or lose" leave protocol timeline and will be restored.

f. Requests to restore leave lost due to any of the three (3) conditions listed above should be submitted to the Department of Human Resources in writing and include the service provider's name and social security number, organizational code, amount of hours to be restored, reason(s) the scheduled leave could not be used and the date(s) the leave was scheduled for use, supported by documentation. Requests for restoration of leave must be submitted within thirty (30) days of the end of the leave year in which the leave was lost.

g. Upon separation from service, an officer shall receive a lump-sum payment, at the rate of salary on the effective date of separation, for accumulated or restored annual leave.

2. Sick Leave

a. Service providers shall earn thirteen (13) days sick leave, with pay, in any one calendar year.

b. Sick leave, which is not used during the year it is earned, shall accumulate and be available for use in accordance with Board Rules.

c. Upon arrival by the Board, an officer may use accumulated sick leave in addition to the maximum useable accumulation provide in 5 DCMR §1200.9 of the Board Rules.

d. Permanent or probationary service providers may be advanced up to thirty (30) days leave by the Chancellor. Every application for advances leave shall by supported by a certificate signed by a registered practicing physician or other licensed practitioner certifying that the service provider is unable to perform regular duties. Any advance leave is paid back. Sick leave may be advanced irrespective of whether the officer has annual

leave credit. If the employee voluntarily or involuntarily terminates their employment prior to the repayment of the advance sick leave, the employee will be required to repay, at their then current rate of pay, the amount remaining.

3. Court & Jury Leave

a. Service providers shall be entitled to a leave of absence with pay when they are required to report for jury duty or to appear in court as a subpoenaed witness, other than as a litigant, or to respond to an official subpoena from duty authorized government agencies. Service providers shall provide a copy of the documentation, in the form of the subpoena or jury duty notice, to the supervisors. Any pay received for service as a witness or juror, other than expenses, must be submitted to the D. C. Public Schools, Department of Human Resources.

b. If a service provider is excused from jury duty for a day or a substantial portion thereof the service provider shall report to their place of employment and perform the duties assigned for that day or portion thereof.

4. Family & Medical Leave (FMLA)

In accordance with D.C. Official Code §32-501, et seq., the Board acknowledges that an eligible employee who is employed for one year without a break in service except for regular holidays and worked at least 1,000 hours during a 12-month period shall be entitled to a total of 16 work weeks of family leave during any twenty-four (24) month period for:

a. The birth of a child of the employee:
b. The placement of a child with the employee for adoption or foster care;
c. The placement of a child with the employee for whom the employee permanently assumes and discharges parental responsibility; or
d. The care of a family member of the employee who has a serious health condition. D.C. Official Code §32-502(a).
e. Family member means:
    i. A person to whom the employee is related by blood, legal custody, or marriage;
    ii. A child who lives with an employee and for whom the employee permanently assumes and discharges parental responsibility; or
    iii. A person with whom the employee shares or has shared, within the last year, a mutual residence and with whom the employee maintains a committed relationship. D.C. Official Code §32-501 (4).

    An employee who is unable to perform the functions of the employee's position because of a serious health condition shall be entitled to medical leave for as long as the employee is unable to perform the functions, except that the medical leave

shall not exceed sixteen (16) work weeks during any twenty-four (24) month period. D.C. Official Code §32-503 (a).

The Board shall provide and implement Family and Medical Leave consistent with D.C. Law. The provision and implementation of Family and Medical Leave is based on D.C. Law.

5. Administrative Leave

a. Each service provider, upon request and approval, shall be allowed three (3) days of leave with pay per year for visits to schools, industry and participation in conferences, seminars and workshops which are beneficial to the school system subject to the educational program and/or the service provider's work assignments during the period of leave request. Such leave must be requested by the service provider fifteen (15) days in advance.

b. At the initial of the Board, leave with pay to attend conferences, workshops, conventions and seminars, which are beneficial to the school system, may be granted to the service provider.

6. Educational/Sabbatical Leave of Absence

a. Educational/Sabbatical leave for academic study/professional improvement may be granted at the Chancellor's discretion and approval for academic study, research or other purposes that will increase or further the officer's professional growth and development and will contribute to the improvement of the school system.

b. An outline of a planned program must be submitted with the application for leave, including what the officer intends to accomplish during the period of leave, how the leave would enhance the service provider's performance/career and benefit the school system, and a plan for monitoring progress during the term of leave. In addition, the service provider must obtain approval of the Chancellor or his/her designee who will monitor the plan, review progress reports submitted by the officer, and approve the documented completion of the approved program.

1. Standard: The total number of service providers granted sabbatical leave at the Chancellor's discretion in any leave year will not exceed one (1) percent of the total number of service providers.

2. Eligibility: A service provider becomes eligible for sabbatical leave, for a minimum period of a full semester, up to a maximum of one full year after five (5) consecutive years of employment with the District of Columbia Public Schools, excluding periods of Family and Medical leave, military or exchange leave. Eligibility is reestablished seven years after the first sabbatical leave is completed.

3. Salary Allowance: A service provider granted sabbatical leave shall receive a maximum of fifty (50) percent of his/her salary for the period of the sabbatical leave minus all required and/or elected deductions. Should the sabbatical leave be for participation in a program for which the officer is to receive remuneration, the total remuneration (DCPS salary and program assistance/compensation) shall not exceed the service provider's annual DCPS salary. In cases where the combined remuneration exceeds the service provider's annual DCPS salary, the service provider's DCPS salary shall be reduced accordingly.

Benefits during Sabbatical Leave

1. A service provider on sabbatical leave shall for all purposes be viewed as a full-time employee. The service provider's rights and privileges, length of service, and the right to receive salary increments as provided by the policies of the Board or this contract will be the same as if the service provider had remained in the position from which he/she took leave. However, annual or sick leave may not be used or earned while on sabbatical leave.

2. During the period of sabbatical leave, the officer's contributions to his/her retirement plan will be continued.

3. The service provider shall retain membership in the employee benefit plans, for which he/she shall be made for the period of leave; and the Board shall continue to make its contributions thereto.

Contractual Agreement for Sabbatical Leave

A service provider accepting sabbatical leave shall enter into a separate, written contract whereby he/she agrees to return to service in the District of Columbia Public Schools for a minimum two-year period immediately following the sabbatical leave. If the service provider fails to return and remain for the specified time, he/she shall be required to refund all monies paid to or for him/her or on his/her behalf by the Board, along with interest at the rate of six (6) cent per annum, prorated to account for any time served out of the two-year period. DCPS may deduct any amount owed from the Officer's termination pay upon agreement with the Officer.

Non-completion of program: If the service provider cannot complete the planned program for which sabbatical leave was granted, it is his/her responsibility to notify the Chancellor. The leave may then be rescinded by the Chancellor and the service provider is placed on the appropriate employment status. Salary allowances and benefits shall be adjusted accordingly. The service provider must repay any monies paid him/her or on his/her behalf for which he/she may be liable as a result of the change in leave status.

Satisfactory service as a probationary or permanent employee in the DC Public Schools shall be credited in determining eligibility for leaves of absence for educational purposes with or without pay.

7. Leave for Council Business

a. Service providers elected to full time Council positions may be granted a leave of absence without pay for a period of one (1) year. Service providers granted leave of absence shall retain all rights to reinstatement and shall continue to accrue seniority.

b. Service providers who are granted leave without pay for Council business may elect to receive retirement credit for such period of leave in accordance with the DC Official Code §38-2021.01 (a).

8. Return from Leave

A service provider returning from Family and Medical leave or educational/sabbatical leave of absence shall have the right to return to his/her former position or to an equivalent position and the same salary class. Excluding returns from Family and Medical leave, the returning service provider will be returned to his/her former or equivalent position if he/she has maintained appropriate/requisite certification/licensure and is considered to be in good standing at the time of scheduled return from leave.

9. Special Leave

Service providers required by the Chancellor to serve as administrators or supervisors of the regular summer school program during the entire period of the program shall be entitled to ten (10) days of special leave. The additional leave resulting from this provision must be used prior to the service provider's next administration of the regular summer school program. If the service provider has been denied requested utilization of earned Special Leave, due to exigencies of their position or responsibilities, prior to retirement, termination or non-reappointment, the service provider will receive a lump sum payment for the number of days not utilized at their rate of pay on the effective date of the payout.

10. Sick Leave Bank

A sick leave bank for service providers shall be established and operated under the guidelines approved by the Board and Council.

11. Funeral/Bereavement Leave

a. Four (4) additional days of leave without loss of pay and benefits will be granted annually for the occasion of the death of an employee's spouse/domestic partner, child, parent or sibling (whether adopted, natural, step, foster or in-law).

b. The employee may be required to submit to the immediate supervisor a written statement specifying the date of funeral.
c. This provision does not preclude the use of accrued sick leave if additional days are needed for the purpose of bereavement or attending a funeral.
d. Funeral/bereavement leave shall not be cumulative and if not used during the school year, will not be carried over into the subsequent school year.

12. Religious Accommodations Request

DCPS respects employees regardless of their religious affiliations. DCPS provides employees with religious accommodations if those accommodations do not cause an undue hardship for the agency. Examples of reasonable religious accommodations include, but are not limited to:

- Leave for religious observances;
- Flexible scheduling for religious observances;
- Voluntary shift substitutions or swaps;
- Permission to dress in appropriate religious clothing or practice certain grooming techniques; and
- Modifications to workplace polices or practices.

If a DCPS employed related service provider would like to receive a religious accommodation, they should contact their discipline program manager. Consultation with the program manager will include determining the type of accommodation needed, developing a make -up plan if needed and sending correspondence to the school principal and local education agency representative designee.

For additional information on religious accommodations, please refer to DCPS August 2017 Employee Rights and Responsibilities Policy.
https://dcps.dc.gov/publication/employee-rights-and-responsibilities-policy

13. **Note**

Any officer (i.e., service provider) other than principals and assistant principals, who is not authorized or assigned administrative functions shall be granted liberal leave when schools are closed for emergencies for students or teachers.

I. DEPARTMENTAL OFF-BOARDING PROCEDURES- Providers Who are Going on Extended/Maternity Leave , Resigning or Retiring

Below you will find a list of deliverables that are due to close-out your caseload prior to your transition and to assist with the continuity of services for your students upon your departure. These actions are required in order to leave DCPS and the Speech-Language department in "good-standing" and is part of your professional obligation (see Ethics section regarding abandonment). This is applicable to the following scenarios: 1) planned medical/family leave; 2.)

maternity leave; 3.) retirement; and/or 4.) resignation during the school year. Please review the below information and discuss with your assigned PM prior to your leave/departure.

- ☐ Weekly documentation through the agreed upon date of leave must be submitted into SEDS by COB (3:30 PM).
- ☐ Service tracker notes for all students must be finalized by COB (3:30 PM) on the last date of leave for all services rendered during the month.
- ☐ Submission of the Missed Session form to capture services missed between the beginning of school through the date of your leave/departure.
- ☐ Completion of information in SEDS for upcoming IEP meetings (Present Levels of Performance, Goals, Service Duration/frequency) for students on your current caseload for up to two weeks post the date of your intended leave/departure.
- ☐ A letter must be sent home to the parents of the students that you service to notify them of your departure/upcoming leave.
- ☐ Return all assessment and intervention materials and laptop that were loaned during the time of your hire. Please make arrangements with your assigned PM regarding the delivery/drop-off of these materials (This only applies to providers who are resigning or retiring).
- ☐ Completion and uploading into SEDS the assessment reports for students (along with their information in the PLAAF, speech and language goals, and recommendation for service amount)
- ☐ Most current therapy schedule and caseload roster information
- ☐ Submit formal letter of resignation to be submitted via the Quickbase link, which will be provided by your Program Manager
    - This must be done at least two or more weeks prior to resignation/retirement date from DCPS

J. DRESS EXPECTATIONS

It is the provider's responsibility to find out the dress code requirements for their assigned school site and to wear the appropriate attire. Providers must be in compliance with the dress code for the school. Cleanliness and professionalism are the primary considerations. The following is a non-exhaustive list of expectations:

a. All clothing should be clean, and neat. *Clothing should not contain any suggestive or offensive pictures or messages*.
b. Tops should be of opaque fabric (not see-through), fit appropriately, not too low cut, tight or loose, and long enough to remain tucked in with movement (i.e., no bare midriffs). Showing of cleavage is not appropriate. Tops should allow for rising of hands above head without exposing skin. T-shirts that convey a casual

appearance are not to be worn. For men, collared shirts and ties may be appropriate in many settings.

c. Pants should fit appropriately, loose enough to allow for mobility but not to present a safety hazard by getting caught in equipment.
d. Skirts or skorts may be worn, but should be no shorter than 2" above the knee and have no slits above the knee.
e. Piercing- other than ears- should not be visible while working with students. All tongue jewelry must be removed.

K. PERFORMANCE EVALUATIONS

Each RSP is evaluated twice per school year using IMPACT: The DCPS Effectiveness Assessment System for School-Based Personnel or IMPACT. The primary purpose of IMPACT is to help the employee become more effective in your work. Our commitment to continuous learning applies not only to our students but to the employee as well. IMPACT supports the employee's growth by:

- **Clarifying Expectations** - IMPACT outlines clear performance expectations for all school-based employees. Over the past year, we have worked to ensure that the performance metrics and supporting rubrics are clearer and more aligned to your specific responsibilities.

- **Providing Feedback** - Quality feedback is a key element of the improvement process. This is why, during each assessment cycle, you will have a conference to discuss your strengths as well as your growth areas. You can also view written comments about your performance by logging into your IMPACT account at http://impactdcps.dc.gov.

- **Facilitating Collaboration** - By providing a common language to discuss performance, IMPACT helps support the collaborative process. This is essential, as we know that communication and teamwork create the foundation for student success.

- **Driving Professional Development** - The information provided by IMPACT helps DCPS make strategic decisions about how to use our resources to best support you. We can also use this information to differentiate our support programs by cluster, school, grade, job type, or any other category.

- **Retaining Great People** - Having highly effective teachers and staff members in our schools helps everyone improve. By mentoring and by serving as informal role models, these individuals provide a concrete picture of excellence that motivates and inspires us all. IMPACT helps retain these individuals by providing significant recognition for outstanding performance.

All school-based SLPs are in Group 12A. There are four IMPACT components for the members of Group 12A. Those components include:

- Related Service Provider Standards (RSP)
- Assessment Timeliness (AT)
- Core Professionalism (CP)
- Individual Education Plan Timeliness (IEPT)

Please refer to your Group 12 IMPACT book for additional information. You may also contact the IMPACT office at (202) 719-6553 or impactdcps@dc.gov.

L. INCLEMENT WEATHER POLICY

As you know, inclement weather has the potential to impact our school schedule (delayed openings or school closings). As in the past, the decision made and announced will be one of the following:

Inclement Weather Options

- Option 1: All schools and district administrative offices are closed. Only essential personnel report to work.
- Option 2: Schools are closed. District administrative offices are open.
- Option 3: Schools open for students and teachers two hours late. District administrative offices open on time.
- Option 4: Schools and district administrative offices open two hours late.

Notification Options:

When poor weather requires changing school schedules, DCPS works closely with radio, TV and other news outlets to notify the community. During these situations, it is important that related service providers monitor one of the stations listed below or check this page. Look for updates (i.e. delayed openings or complete closures) on the radio and TV stations below. DCPS aims to work with stations to post closings by approximately 5:30 am.

- AM Radio
  WMAL (630), WOL (1450), Radio America, Spanish (1540), WTOP (1500)
- FM Radio
  WAMU (88.5), WTOP (103.5), WHUR (96.3)
- Television
  Channels 4, 5, 7, and 9 and Cable Channels 8, 16 and 28
- Website
  www.dc.gov/closures
  www.dcps.dc.gov
- Telephone

(202) 442-5885 or dial 311 for DC's Citywide Call Center

M. COMMUNICATIONS

DCPS E-mail
Each related service provider has a DC Government e-mail address (k12.dc.gov). This is our primary means of communication. Messages should be checked daily and returned promptly. Failure to receive notification of job-related information due to a lack of timely checking of one's e-mail is not an acceptable excuse for non-compliance to work responsibilities. Related service providers are required to use their k12.dc.gov email address – no other email address should be used.

When the service provider is out of the office, the "Out Of Office" reply option should be utilized. Your message should include a greeting, dates you will be out of the office, scheduled return date and contact information of your Program Manager during your absence.

Program Managers, Special Education Coordinators, Principals, teachers and parents often send email messages to related service providers. Please ensure the LEA has the correct email address to ensure proper communication.

Email communication is maintained by the District of Columbia's Office of the Chief of Technology Officer. The help desk number for email difficulties is (202) 442-5715.

Sample of E-mail Signatures

Jane Smith, M.A., CCC-SLP
Speech-Language Pathologist
Office of Teaching and Learning
Social Emotional Academic Development
Division of Specialized Instruction

District of Columbia Public Schools
E Jane.Smith@k12.dc.gov
T (202) 555-1111
F (202) 555-2222

Out of the Office Messages

When the provider is out of the office and unable to respond to his/her dc.gov email for extended periods, the provider is required to set up an auto-reply message for incoming emails that notifies senders of your plan for responding to their emails. Your message should include a greeting, dates you will be out of the office, scheduled return date and contact information during your absence.

Follow these steps to set up your out of the office message:

- Go to the DCPS web main page: http://dcps.dc.gov/DCPS
- Click on the "Employee Webmail Login" at the bottom of the page.
- Enter your user name and password in the Outlook Web Access window, and click on "log on"
- Click on "Options" on the left side of the page. This will take it to the "Out of Office Assistant" section
- Select "I am currently out of the office"
- Customize the following message and add it into the box of the "Out of Office Assistant" section
  - *Thank you for your email. I am out of the office from [DAY, DATE] to [DAY, DATE] and unable to respond at this time. If you need immediate assistance, please contact (Name school level staff as alternate contact.)*
  - *I look forward to responding to your email within 24 hours of my return.*
  - *Thanks.*
  - *Your Name and Title*
  - *School Name*
  - *School Address*
  - *T: Your telephone number*
  - *F: Your fax number*
  - *Email: Your k12.dc.gov email address*
- Click on "Save and Close"

CANVAS

This site will house information and forms related to policy and procedures. Related service providers will also be able to access template forms using this site.

Directly Hired Providers

- CANVAS can be accessed via the following web address: https://dcps.instructure.com

Contractual Staff (Login Information)

https://dcps.instructure.com/courses/2025/pages/instructional-practice-impact
Username: DCPS Contractor
Password: canvas22

Mailbox
Service providers are encouraged to check with school staff regarding correspondence. Route-Mail Service. A DCPS mail service is available for sending documents to DCPS work locations. Envelopes may be available at your school's main office. An area for all outgoing route mail is designated at each school and work location. Provide the sender's name and school address on the route mail envelope.

Route-Mail Service
A DCPS mail service is available for sending documents to DCPS work locations. Envelopes may be available at your school's main office. An area for all outgoing route mail is designated at each school and work location. Provide the sender's name and school address on the route mail envelope.

MS Office 365

- MS Teams – this is an online platform that is used across DCPS to hold teleconference meetings, access departmental and/or school-based information and to conduct online services during extended school closures
- MS SharePoint – this is an online application that is used to provide departmental information and to save information to folders to support service delivery
    - **SLP Monthly Notice**
        - SLPs will receive monthly departmental emails via the SharePoint application. It may include the following information and updates: SLP timeliness rates for assessments and Random Moment In Time Study timeliness, documentation percentages, tasks due for the week, reminders on upcoming important dates or events in OSI and DCPS.

ACCELIFY
RSPs will be able to review their caseload, assigned assessments, document Tier II interventions for RTI, 504 Plans, and service delivery and documentation. Accelify is accessible through quickbase by accessing the following website: https://dc.acceliplan.com/app/home . Providers should maintain confidentiality when viewing student level information with accessing this databass. Providers are required to sign and submit the DCPS Data System User security Pledge (See Appendix)

N. ACCELIFY PROVIDER MANAGEMENT TOOL

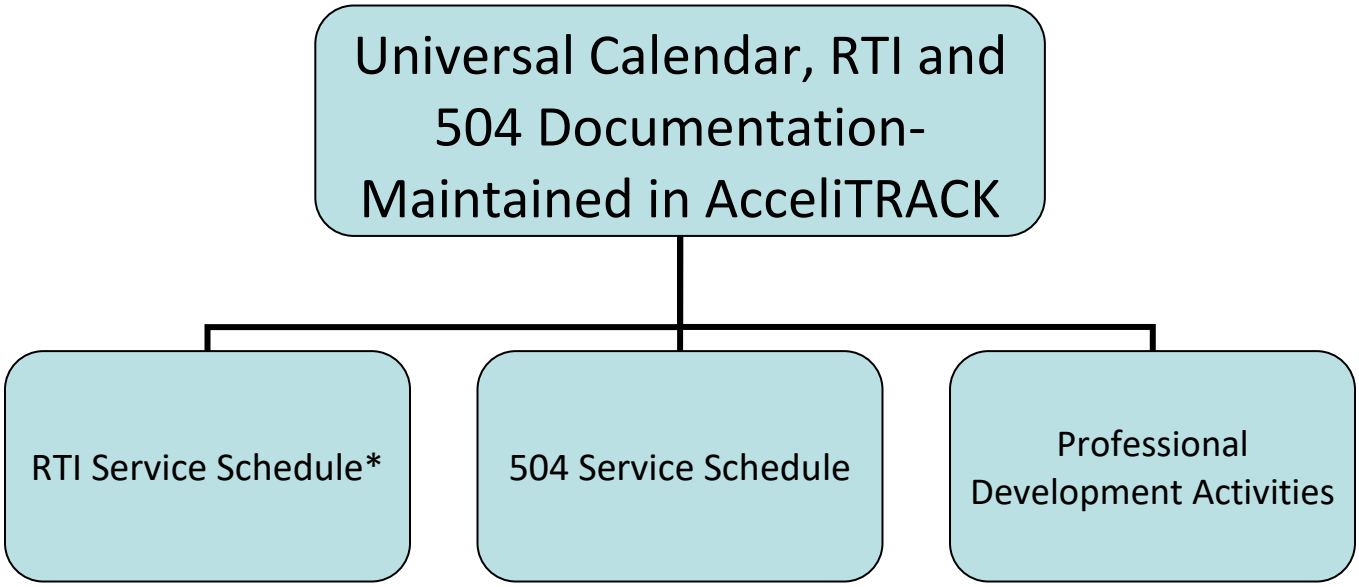
Beginning July 31, 2017, DCPS will replace the Provider Management Application (PMA) in QuickBase with a new web-based data system, Accelify. Accelify training is mandatory for all new and returning providers. After this date, access to the PMA for existing users will be restricted to view-only.

Accelify will replicate and/or enhance many of the functionalities performed by the PMA. The following will be the functionalities for the new tool:

- Monitor compliance of IEP, 504, RTI and equitable service delivery, documentation and timely assessment completion.
- Documentation of Response to Intervention(RTI) service delivery
- Documentation of 504 related service delivery
- Provide productivity and workload reports for provider activities (if applicable)
- Provide alerts for the status of professional licenses (OSSE Certification and DOH)
- Receive alerts for meeting requests for Non-Public Schools
- Documentation of provider-led and provider-attended training activities.

Below are changes in the provider expectations and workflow as it related to the new Accelify Provider Management Tool:

Accelify Documentation Requirements – DSI Providers



Universal Calendar (Based on Provider Scope of Work)

- Required for DSI RSPs assigned to central office teams (NPU, CIEP, ECAT, Bilingual)
- Create template and copy standing appointments and activities forward each week
- Record notes in activities and service lines by COB each Monday

RTI Service Schedule

RTI service lines must be created in RTI AcceliPLAN (following workflow events) to be added to provider caseload to drag and drop onto TRACK calendar.

- Providers should create a service line for students whom they are assigned in the Aspen RTI Plan.
- Providers should create a service line if you are meeting a general education student for more than 3 times for ongoing intervention (intermittent contacts with a student should be recorded in the "student activity" screen).

Note: RTI Plans and progress reporting of RTI plans and goals are documented in the Aspen-RTI Module.

504 Service Schedule

- Add "Create Service" in the TRACK Calendar by clicking onto the day/time of service. A 504 Service Detail screen will appear.
- Document the service log notes in corresponding fields
- Record delivery status

Professional Development Activities

- From the "Toolbox" (far left on screen in TRACK), click Training Manager
- Add a "Training Conducted" or "Training Attended" and complete required fields
- Upload sign in sheets, feedback forms, principal approval letter, (required for training conducted) and handouts using the "select file" button

Student and Non-Student Activities

Student Activities refer to actions in service of a student (ex: observation, crisis intervention)

My Activities refer to actions taken *not* related to a particular student (ex: duty, documentation of services, team meetings)

- Add "Create Student Activity" or "Create Activity" in the TRACK Calendar by clicking onto the day/time of service. An Activity Detail screen will appear.
- Document the GARP/contact note in corresponding fields
- Record delivery status
- *See "IEP Service Delivery Schedule" on page two regarding recording any activities for students with IEPs*

For How-To instructions of system functionality, browse knowledgebase articles at support.acceliplan.com.

Technical Support

Technical support for navigation of the system and access issues will be managed by Accelify and the tech support contact will provided in the Accelify user guide. Providers should not contact managers directly for Accelify technical support

O. TEST KITS/COMPUTERS

Assessment Test Materials are assigned to each provider on a permanent basis. Other instruments may be shared between speech language pathologists and infrequently used tests are available on a temporary loan basis. It is important to return loaned items promptly since other speech language pathologists may be waiting for them. Additionally, speech language pathologists are asked to inform your program manager of any problems found with these tests, e.g., missing or broken items.

Laptop Computers are assigned to all service providers for the purpose of scoring tests, writing reports and maintaining progress notes in the Special Education Data System (SEDS). Laptops are the responsibility of each service provider and should be appropriately maintained and secured at all times.

Laptop Computer Repairs Policy- For providers who are issued Macs, all repairs should be handled through your local Apple store. All computer technology issues should be directly referred to the DCPS IT Support department using one of the following options:

- Phone: 202-442-5715
- https://itremote.dc.gov
- http://dcforms.dc.gov/webform/it-servus-request-form

The DCPS IT support department will provide a ticket number for your technology request. Please retain of copy of this ticket number for your records. In the event your laptop or computer becomes inoperable, this information will be required.

Stolen Computer / Laptop

In the event your laptop or computer is stolen, please inform your school security officer and the DC Police Department (DCPD). You are required to file a report with the DCPD. If you are school based providers, please submit the police report to your school administration. For centrally funded staff, please submit the police report to your manager.

PLEASE NOTE: Testing equipment & testing materials are on loan for work purposes only. Therefore, upon your resignation, retirement, or termination your materials must be returned in good condition to the Program Managers prior to your separation date. Failure to return property will result in garnishing of wages.

SECTION III
Special Education Disability Classifications and Process

The Division of Specialized Instruction (DSI) Special Education Reference Guide contains IEP Process and related guidance on the implementation of the IEP Process as well as best practices for implementation of the IEP Process. This IEP Process Guide will help answer questions about referrals to special education, the eligibility process and IEP development and implementation processes. Additional policy guidance can be found contained within this guide that will help schools implement the regulatory requirements of IDEA and the DCMR. Please find a link to the Special Education Reference Guide below:

https://dcps.instructure.com/login/ldap

The presence of a disability is not sufficient to establish eligibility for special education. The disability must result in an educational deficit that requires specially designed instruction (i.e., special education). In order to qualify for services a student, due to his/her disability, must require special education and related services.

Eligibility for special education and related services is determined by documenting the existence of one or more of the following disabilities and its adverse effect on educational performance. Refer to the Office of the State Superintendent of Education's Chapter 30 policy for more detailed descriptions.

- Autism
- Traumatic Brain Injury
- Intellectually Disability
- Emotional Disturbance
- Specific Learning Disability
- Other Health Impairment
- Orthopedic Impairment
- Speech Language Impairment
- Hearing Impairments including Deaf / Hard of Hearing
- Visual Impairments including Blindness including Blind / Partially Signed
- Multiple Disability
- Developmental Delay

Autism Spectrum Disorders (AUT)

A developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age 3.
Common Associated characteristics:

- Exhibit a condition characterized by severe communication and other developmental and educational problems such as extreme withdrawal, self-stimulation, repetitive motoric behavior and inability to relate to others
- Diagnosed by a psychologist or physician as autistic

Traumatic Brain Injury (TBI)

The term TBI included open or close head injuries resulting in mild, moderate or severe impairments in one or more of the following areas:

- Cognition
- Language
- Memory
- Attention
- Reasoning
- Abstract thinking
- Judgment
- Problem solving
- Sensory, perceptual and motor abilities
- Psychosocial behavior
- Physical functions
- Information processing
- Speech

Intellectually Deficient (ID)

Consideration of a disability classification of ID requires review of the following:

- The ability of a person's brain to learn, think, solve problems, and make sense of the world (called IQ or intellectual functioning); and
- Whether the person has the skills he or she needs to live independently (called adaptive behavior or adaptive functioning).

Intellectual functioning is usually measured an IQ test. The average score is 100. Scores ranging from below 70 to 75 are within the intellectually deficient range. To measure adaptive behavior, professionals look at what a student can do in comparison to other student of his or her age. Certain skills are important to adaptive behavior. These are:

- Daily living skills, such as getting dressed, going to the bathroom, and feeding one's self;
- Communication skills, such as understanding what is said and being able to answer;
- Social skills with peers, family members, adults, and others.

Both IQ and adaptive behavior limitations are required in the definition and identification of ID.

Emotional Disturbance (ED)

Exhibit one or more of the following characteristics over a long period of time and to a marked degree that adversely affects educational performance:

- An inability to learn that cannot be explained by intellectual, sensory or health factors
- Have a history of difficulty in the educational setting in relating to adults and / or peers as reflected by a diminished capacity to learn, and the inability to comply with school rules due to a limited frustration tolerance level

Specific Learning Disability (SLD)

The student must exhibit a disorder in one or more of the basic psychological processes involved in understanding or in sign language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, speak or to do mathematical calculations.

Speech Language Impairment (SLI)

To be eligible for SLI, a student must:

- Exhibit a communication disorder, such as stuttering, impaired articulation, a language impairment or a voice impairment that adversely affects educational performance
- Be diagnosed by a speech language pathologist
- Be certified by the MDT as qualifying and needing special education services

NOTE

Speech and Language Only IEPs (SLP as a Primary and a Related Service)

Speech and language services can be provided either as a primary service or as a related service. A primary service consists of speech language services as the specialized instruction needed by a child with a disability of SLI to benefit from special education. When speech is the primary service, the student's disability classification must be SLI (Speech Language Impaired). **Occupational and Physical therapy services should not be automatically added to Speech and Language only IEPs.** If it is found that an additional disability is suspected, the IEP team should be consulted and additional assessments considered.

Hearing Impairments including Deafness / Hard of Hearing (HI)

To be eligible as a student with deafness, a student must meet the following criteria by an MDT:

- An assessment by an audiologist or otolaryngologist who determines that there is a bilateral impairment in excess of 71 dB and connected speech is not understood at any intensity level
- Communication must be augmented by signing, lip reading, cued speech and / or other methods

To be eligible as a student hard of hearing, a student must meet the following criteria by a MDT:

- An assessment by an audiologist or otolaryngologist who determines that the hearing loss is greater than 20dB
- Hearing acuity can be improved through amplification to maximize usage of residual hearing
- Evidence of both articulation and delayed language development associated with hearing loss

Visual Impairment (VI)

To be eligible as a student with blindness, a student must be certified by a MDT to:

- Exhibit a visual capacity of 20/200 or less in the better eye with the best correction or a peripheral field so contracted that the widest diameter of such field subtends an angular distance no greater than 20 degrees

To be eligible as a partially signed student, a student must be certified by a MDT to:

- Exhibit a visual acuity between 20 / 70 and 20 / 200 in the better eye with best correction or other dysfunctions or conditions that affect the vision

Orthopedic Impairment (OI)

To be eligible for special education as a student with orthopedic impairment, a student must:

- Exhibit a severe orthopedic impairment, including impairments caused by a congenital anomaly, disease or other causes that adversely affects educational performance
- Be diagnosed by a physician as orthopedically impaired

Other Health Impaired (OHI)

Other health impairment means having 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 such as asthma, attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, an sickle cell anemia; and adversely affects a student's educational performance.

Multiple Disabilities (MD)

Concurrent impairments (such mental retardation-blindness or mental retardation-orthopedic impairment), the combination of which causes such severe educational needs that they cannot be accommodated in special education programs solely for one of the impairments **MD does not include deaf-blindness**

Developmental Delay (DD)

To be eligible for special education as a student with a developmental delay, a student must:

- Be aged three to seven
- Experiencing development delays and measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:
  - Physical development
  - Cognitive development
  - Communication development
  - Social or emotional development
  - Adaptive development
- Be certified by the MDT as qualifying and needing special education services

Special Education Law

Individuals with Disabilities Education Improvement Act (2004)

On December 3, 2004, the Individuals with Disabilities Education Improvement Act of 2004 (IDEA 2004) was enacted into law as Public Law 108-446. The statutes, as passed by Congress and signed by the president, reauthorized and made significant changes to the Individuals with Disabilities Education Act of 1997 (IDEA 1997)

IDEA 2004 intended to held children with disabilities achieve high standards – by promoting accountability for results enhancing parental involvement, using proven practices and materials, and providing more flexibility and reducing paperwork burdens for teachers, local school districts and states. Enactment of the law provided an opportunity to consider improvements in the current regulations to strengthen the federal effort to ensure every child with a disability has available a free and appropriate public education that is of high quality and designed to achieve the high standards reflected in the Elementary and Secondary Act of 1965, as amended by the No Child Left Behind Act of 2001 (NCLB) and its implementing regulations.

The purpose of IDEA 2004 was to ensure that all children with disabilities have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs and prepare them for further education, employment and independent living

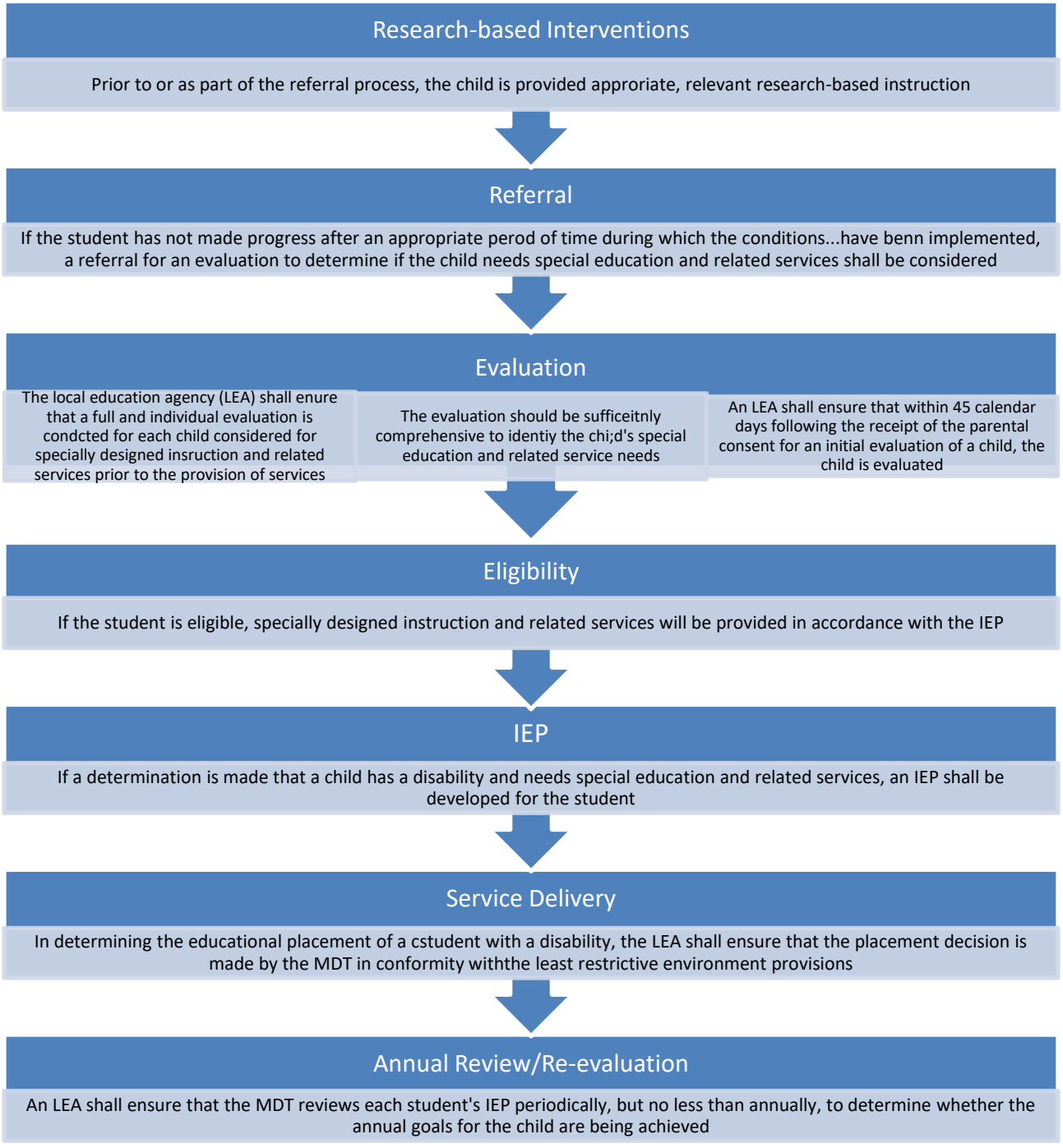
The Enhanced Special Education Service Act

The Enhanced Special Education Services Act of 2014 (DC Law 20-195; DC Official Code § 38-2614 and § 38–2561.02) made important updates to special education services in DC, including:

- **Secondary Transition**: Lowers the minimum age for the creation of secondary transition plans for students with disabilities from age 16 to 14, “beginning July 1, 2016, or upon funding, whichever occurs later.”

- **Initial Evaluation**: Requires LEAs to make reasonable efforts to obtain parental consent to evaluate the child within 30 days of referral, and then complete the evaluation and eligibility determination within 60 days of parental consent. This requirement of the law takes effect "beginning July 1, 2017, or upon funding, whichever occurs later."

The Special Education Process



SECTION IV
Assessment Referral Procedures

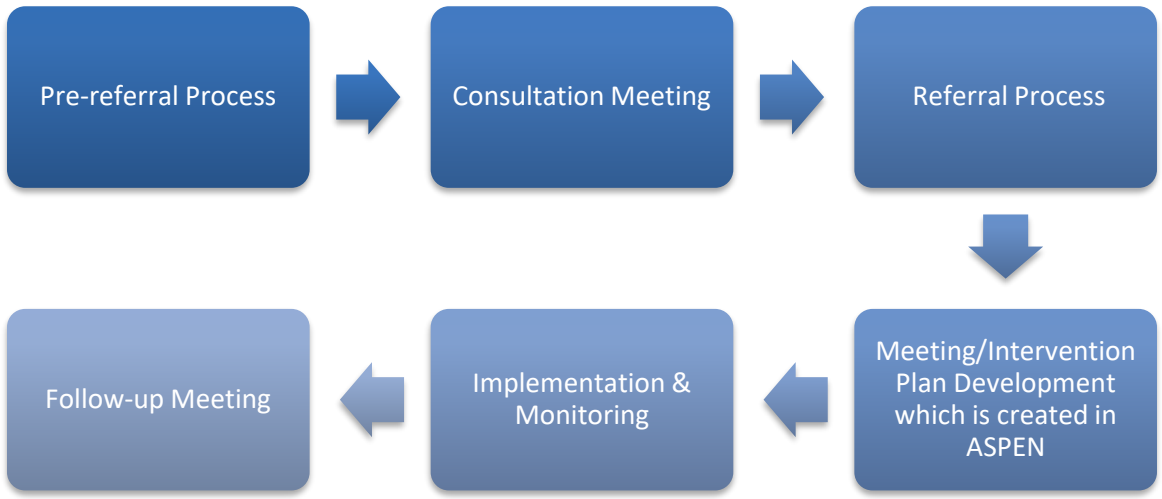
A. PRE-REFERRAL PROCESS (formerly SST)

The pre-referral process is a problem-solving methodology utilized by of school-based personnel to determine if a student needs accommodations/modifications, Response-to-Intervention (RTI), and/or as assessment to determine if a disability exists. Parents are encouraged to participate as an active member of the team. The RTI Coordinator organizes and facilitates *weekly meetings* to address the academic and/or behavioral needs of students. The team:

- collects and analyzes student data
- identifies student need(s)
- Identifies interventions matched to student need(s)
- creates a student intervention plan with desired success targets
- establishes fidelity and monitoring systems
- agrees on a home-school communication system
- schedules the six-week progress update meeting
- provides support to the teacher for plan implementation

Prior to a referral being submitted the educational team should meet on the student to determine what interventions will be implemented to assist in meeting the individual needs of the student.

<u>The Pre-referral Process</u>



This process is a vital part of the student referral process. Members of the RTI include three to five members. Examples of team members include an administrator, a counselor, a regular education teacher, a special education teacher, a school social worker, a parent, specialist or other central office persons, as appropriate. Speech Language Pathologists should serve as consultants to the team. The RTI pre-referral process should be implemented over approximately six weeks, to determine if the recommendations are successful. If the strategies are not successful the team can meet again to modify the strategies. Students should be referred to Special Education if a number of important decision criteria are met:

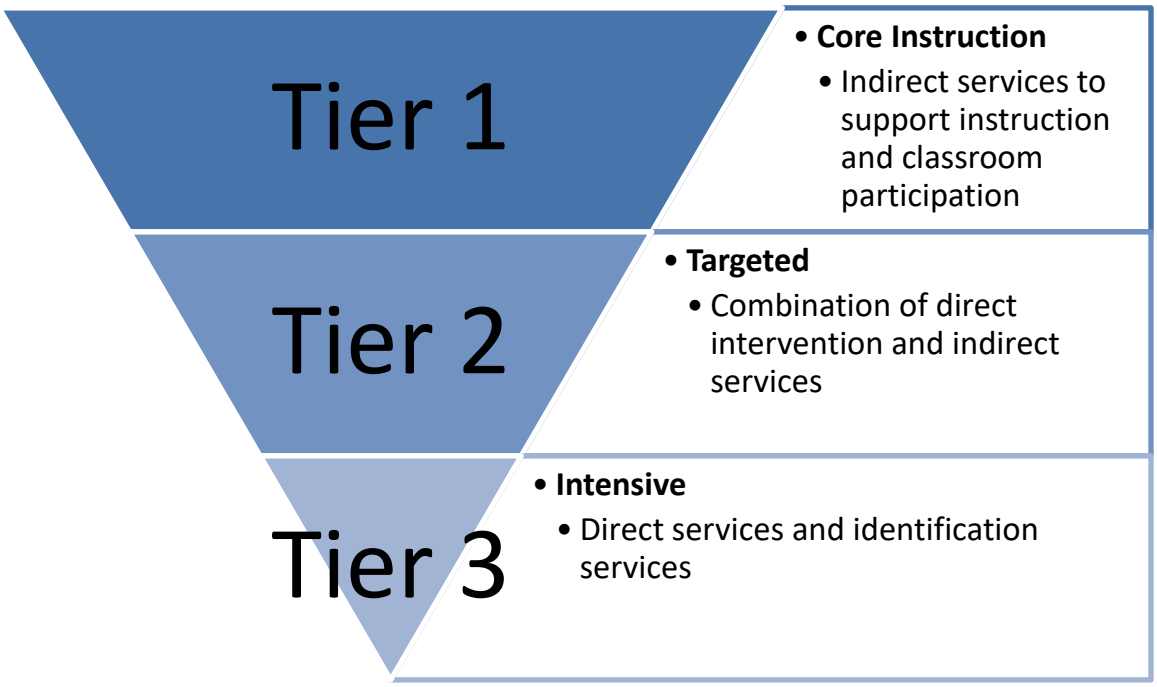
- Reasonable classroom interventions of sufficient duration have been carefully attempted, without success.
- The cause of the problem is suspected to be a disability that cannot be resolved without special education services.

Exceptions to the process include those students for whom RTI would delay obviously needed special education services. In these cases, the RTI process may occur concurrently during the special education referral/assessment process.

As a Speech Language Pathologist, you may be asked to consult on the pre-referral RTI team for certain students. As a member of the pre-referral team, you should provide strategies to the teacher and parent to address the identified communication concerns. In addition, tier 1 or 2 RTI interventions, strategies and techniques may be required by the Speech Pathologist. If the SST process is not successful in addressing the communication concerns, the student should be referred for a special education evaluation.

Effective SY 2017 – 2018, RSPs will be able to document pre-referral interventions in the Accelify, which is accessible through quickbase by accessing the following website: https://dc.acceliplan.com/app/home

B. Response to Therapy Intervention (RTi)



Role of Speech and Language Pathologists

The SLP's key roles in RTI are to provide intervention through general education for students not meeting expectations in speech and language skills and to use RTI data to assist with identification of speech and/or language disabilities. Prevention of communication disorders is one activity listed in the definition of speech-language pathology services in the Individuals with Disabilities Education Act**.** SLPs offer expertise in the language basis of literacy and learning, experience with collaborative approaches to instruction/intervention, and an understanding of the use of student outcomes data when making instructional decisions.

Role of the SLPs at each Tier Level

<u>At the universal tier 1 of RTI/MTSS, speech and language pathologists may:</u>

The SLP provides mostly indirect services to support quality instruction in the classroom and to participate in prevention activities. Direct services include expanded speech and language screening or providing support for struggling students through a variety of classroom activities that support oral language development. Indirect activities include completing student observations, helping the teacher make connection between oral language and literacy, and staff development to promote understanding of students' language learning needs

At the targeted tier 2 of RTI/MTSS, speech and language pathologists may:

The SLP provides a combination of direct intervention and indirect services. Direct services **include targeted group intervention** to support students' speech and language skills in small, same- ability groups. Indirect activities include completing student observations, and assisting with frequent progress monitoring of Tier 2 literacy intervention.

At the intensive tier 3 of RTI/MTSS, speech and language pathologists may:

The SLP provides mostly direct intervention and identification services. Direct services include intensive, individualized intervention to support students' speech and language skills. Indirect activities include helping to select research-based interventions, completing student observations, assisting with frequent progress monitoring, and **helping the team** make decisions regarding referral for special education evaluation.

SLPs can be a valuable resource as schools design and implement a variety of RTI models. The following functions are some of the ways in which SLPs can make unique contributions:

- Explain the role that language plays in curriculum, assessment, and instruction, as a basis for appropriate program design
- Explain the interconnection between spoken and written language
- Identify and analyze existing literature on scientifically based literacy assessment and intervention approaches
- Assist in the selection of screening measures
- Help identify systemic patterns of student need with respect to language skills
- Assist in the selection of scientifically based literacy intervention
- Plan for and conduct professional development on the language basis of literacy and learning
- Interpret a school's progress in meeting the intervention needs of its students

ANALYZING EXISTING DATA (AED)

The analyzing existing data step of the evaluation process should be completed to determine whether or not there is sufficient information to make an eligibility determination or if formal assessments are needed to make a determination. This review must be conducted by a group of individuals that include required members of an IEP Team.

- ☐ Review existing evaluation data
  - Information provided by parent
  - Classroom-based observations
  - Response to Intervention in the General Education setting
  - Information provided by teachers
  - Formal and informal assessments

- ☐ The IEP team should begin their review of the referral by analyzing as many of the following types of existing data as are available:
  - Attendance
  - Behavior or Incident reports
  - Classroom observations
  - Class work samples
  - Current grades
  - Discipline reports
  - Documentation of academic and behavior interventions
  - Evaluations and information provided by parents
  - Health records and medical reports
  - Report cards
  - Standardized test scores

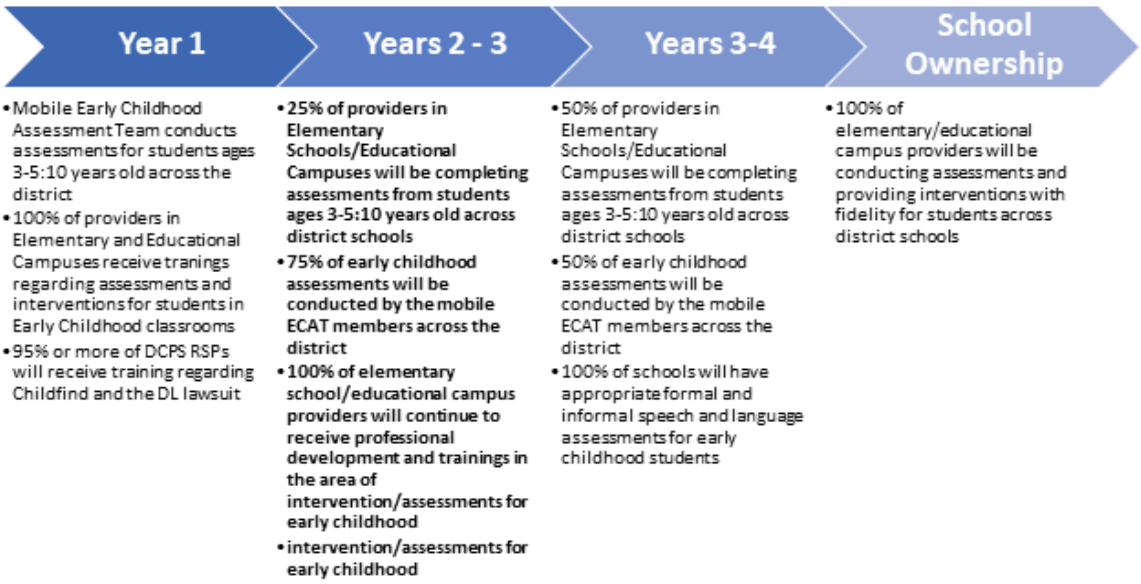
- ☐ Identify the data that is needed to be determined
  - Category of disability
  - Present level of performance
  - Special education and related services
  - Modifications to allow child to meet IEP goals and participation in general education
  - The student's progress

- ☐ Documentation of this review must include:
  - The team conclusions/decisions
  - The date the conclusions/decisions are finalized
  - The names of individuals participating in the review
  - Conclusion if additional assessments are needed

C. Early Childhood Assessments for DCPS Enrolled Students

Students enrolled in a DCPS school between the ages of 3 and 5 years, 10 months are assessed by the special education team at the local school. To support the DCPS schools, a district-wide multidisciplinary team, Early Childhood Assessment Team, will complete assessments for initial special education referrals for DCPS students between the ages of 3 and 5 years old 10 months. The assessment process should **not** be deferred to provide Response to intervention (RTI). Interventions should be provided simultaneously as a student is going through the assessment and eligibility process.

ECAT was designed as a temporary unit to help schools by providing assessment assistance, but also to build the capacity for local schools to inherit the work. ECAT will provide tiered support to schools which include assessment, training and support. The goal is to transition all the phases of PK child find to the local schools



The Collaborative Relationship between Providers in Schools and the Early Childhood Assessors (Early Stages and ECAT)

The assessments conducted by the DCPS mobile team play an integral part in the shaping of the students receiving therapy services within the schools. The early identification of students is intended to reduce future educational impact and adverse effects the student may experience throughout his/her educational career. In order to ensure that the needs of our students are adequately met, it is imperative that the Mobile Team RSPs and School-based RSPs collaborate as it relates to identification, recommendations, and determination of services and service delivery.

On many occasions, The DCPS mobile team requires input from the student's attending school teachers and/or related service providers. In those instances, school observation data will need to be provided to the mobile team by school based Related Service Providers for the evaluation process. Within 24 hours of the mobile team's assessment being completed, prior to the eligibility decision meeting, the appropriate mobile team's RSP will email the RSP at the school to complete the observation.

To ensure greater collaboration and that educational impact is captured, providers on the DCPS mobile team may do the following methods of contact with providers at elementary schools and educational campuses:

- Contact providers via email or phone to assist with conducting classroom observations and/or completion of observations forms.
- Share findings from assessment reports regarding students who are in their assigned schools.
- Provide recommendations and/or determinations of service delivery models/types and frequency.
- Notify the provider (when made aware or given the information in advance) regarding upcoming IEP meeting for students assessed by the mobile team, so the school-based provider may attend if their schedule allows.
- Share outcomes from the IEP meeting as it relates to service delivery recommendations and frequency.
- Discuss current service delivery interventions that are being implemented within the school setting for greater alignment when making recommendations/formulating goals.

Early Childhood Assessments for non-DCPS Enrolled Students

Non-DCPS enrolled students between the ages of 3 and 5 years, 10 months who are referred for an initial special education evaluation are assessed by the Early Stages team, not the special education team at the local school. Initial assessments for student's special education eligible 5 years, 11 months, are to be completed by the RSPs assigned to the

school. Initial assessments for special education eligible students younger than this age are also to be completed by Early Stages. This includes any bilingual assessments.

Students referred to the Early Stages Center receive a full assessment at the center located at Walker Jones Education Center or Minnesota Avenue Center.
Early Stages Contact Information: (202) 698-8037 www.earlystagesdc.org

The assessment process should **not** be deferred to provide Response to intervention (RTI). Interventions should be provided simultaneously as a student is going through the assessment and eligibility process at Early Stages.

Early Childhood assessments completed at Early Stages are a snapshot of the student's present level of performance during testing. This will impact the format and information incorporated in some of the assessment reports received from Early Stages. Assessments and progress monitoring for early childhood students should be ongoing after the assessment is completed.

Student's transitioning from IFSPs to IEPs

Per court order, student's transitioning from an IFSP to IEP may not be re-evaluated by Early Stages providers. RSPs at Early Stages are only able to complete a review. This is because when a student transfers from an IFSP to an IEP it takes into account, presumptive eligibility that the student still requires the service(s). Typically, hours on an IFSP are higher than an IEP secondary to the student not having any educational opportunities. Therefore, due to this process it may impact these student's IEPs as having greater hours than a typical IEP that has gone through the evaluation process.

Multidisciplinary Assessment Reports
In order to facilitate a greater streamlined process of trans disciplinary collaboration, some reports will incorporate the findings of all educational testing/observations within one report. Therefore, these assessment reports will indicate cumulative strengths/weaknesses across all disciplines.

Part C and Transition

Each discipline has its own perspective and definitions for the evaluation and assessment procedures used within their scope of practice. However, under Part C of IDEA 2004, the definitions of these procedures may differ from those used in other practice settings; therefore, providers must be well informed about the definitions under Part C.

Steps for a Smooth Transition

For all toddlers with an IFSP, the steps, at the time of the transition meeting, shall include provision of information; parent training and discussion of transition needs, as appropriate, regarding future placements; and plans for the transition to special education programs under Part B, to early education, or other appropriate services (34 CFR § 303.344(h); 17 CCR § 52112(c) and (d)). The transition IFSP must also include the procedures to prepare the toddler for changes in service delivery. Steps to help the toddler adjust to and function in a new setting, as well as a projected date are established for conducting a final review of the IFSP to document progress toward achieving early intervention outcomes by age three (17 CCR § 52112(c)(3)).
For toddlers who may be eligible for preschool services from the LEA under Part B (e.g., special education and related services), the transition must include the following steps:

- Obtain parental consent for exchange of information about the toddler with the LEA (e.g., progress reports, evaluation/assessments).
- Review IFSPs that have been developed and implemented and other relevant information.
- Identify the needed assessments to determine special education eligibility.
- A statement of the process necessary to ensure that the LEA receives the referral in a timely manner to ensure that assessments required are completed.
- That an IEP is implemented by the initiations and provision of related services by the toddler's third birthday.

This means that the referral must be received by the LEA no later than the time the toddler is two years nine months old, or before the LEA's break in school services if the toddler will become three years of age during a break in school services. DCPS has their own evaluation and assessment procedures to determine eligibility. The eligibility criteria reflect differences in the populations served, as well as the focus and purpose of the services that are needed, as a result of these evaluations and assessments. One of the key changes at the time of transition from early intervention services to Part B services is the shift in service delivery, primary focus, and purpose of services. Specifically, related services, under Part C of IDEA, may be required or primary early intervention services if the team determines that they are needed and they are specified on the IFSP. However, once the child becomes eligible for special education services, related services may be identified as a related service, which means that related services may be determined to be necessary for the child to benefit from his/her special educational program as a related service.

The Collaborative Relationship between Providers in Schools and Early Childhood Assessors

The assessments conducted at Early Stages plays an integral part in the shaping of the students receiving Speech-Language therapy services within the schools. The early identification of students is intended to reduce future educational impact and adverse effects the student may

experience throughout his/her educational career. In order to ensure that the needs of our students are adequately met, it is imperative that the Early Stages RSPs and School-based RSPs collaborate as it relates to identification, recommendations, and determination of services and service delivery.

To ensure greater collaboration that educational impact is captured providers at Early Stages may do the following methods of contact with providers at elementary schools and educational campuses:

- Contact providers via email or phone to assist with conducting classroom observations and/or completion of observations forms.
- Share findings from assessment reports regarding students who are in their assigned schools.
- Provide recommendations and/or determinations of service delivery models/types and frequency.
- Notify the provider (when made aware or given the information in advance) regarding upcoming IEP meeting for students assessed at Early Stages, so the school-based provider may attend if their schedule allows.
- Share outcomes from the IEP meeting as it relates to service delivery recommendations and frequency.
- Discuss current service delivery interventions that are being implemented within the school setting for greater alignment when making recommendations/formulating goals.

Determination of Settings for Interventions

When making the determination regarding the setting for the recommended service, the Early Stages clinician will seek the input of the school-based clinician in order to align current models of service deliveries being implemented. However, the student's overall progress and level of severity dictates the amount of service and the location. There may be occasions, when the Early Stages clinician might recommend that services may be provided in both the general education setting and outside the general education setting (this typically happens if a school has not yet been identified for the student and they are unable to contact the assigned school-based provider). Given those occasions the Early Stages clinician should input the following to into SEDS to reflect the setting of the delivery of service (as an example):

Service	Setting	Begin Date	End Date	Time Frequency
Speech-Language Therapy	Outside General Education Setting	2/27/2020	2/26/2020	60 min/month
Speech-Language Therapy	Inside General Education Setting	2/27/2020	2/26/2020	60 min/month

OR

Service	Setting	Begin Date	End Date	Time Frequency
Speech-Language Therapy	Outside General Education Setting	2/27/2020	6/20/2020	120 min/month
Speech-Language Therapy	Inside General Education Setting	6/21/2020	2/26/2020	60 min/month

Feeding Plans for Pre-K Students

If feeding and swallowing concerns are indicated at the time of eligibility, it is the responsibility of the Early Stages clinician to formulate a Feeding and Swallowing Plan and enter the required documentation (i.e., MBS report, doctor's order, etc…) per the "Feeding and Swallowing Guidelines". This is to ensure that upon the student enrolling into his/her school, there is a plan already formulated and ready to be implemented. Therefore, this reduces the possibility of the student not having his/her feeding plan available when starting at his/her school and the educational team not being aware of the needs of the student. The Early Stages clinician will utilize the most recent MBS (modified barium swallow) study results to assist with the formulation of this plan. Once a student identified as needing a "Feeding Plan", it is the responsibility of the school-based SLP to provide training the educational staff, conduct periodic monitoring, and modify the plan if necessary. If at the time of the eligibility, feeding and swallowing concerns are indicated, but the parents have not obtained a swallow study and/or do not have the results of a swallow study, the Early Stages provider should do the following:

- Work with the parents and educational team by providing the list of identified locations (see Feeding and Swallowing Guidelines)
- Provide education to the parent regarding the importance and need for obtaining an evaluation to determine their child's least restrictive diet so safety and hydration needs can be met once enrolled in the school
- Notify the receiving school's SLP to make them aware of the concern, so they are able to follow-up with the student upon enrollment

Early Learning Standards Info

The Early Learning Standards include indicators for infants, toddlers, two-year-olds, preschoolers (3s & 4s) and the exit expectations for children leaving pre-kindergarten and kindergarten. The standards provide parents and teachers with a sense of what children should know and be able to do at various ages and grade levels. The Early Learning Standards focus on the whole child and include a broad range of domains because young children's learning and development are interrelated and cross all domains of learning. The Early Learning Standards acknowledge the essential role of the teacher in intentionally guiding children's learning and development in a high-quality environment. The Early Learning Standards recognize that early childhood professionals are key decision-makers in the process of helping young children

develop and learn.
http://osse.dc.gov/sites/default/files/dc/sites/osse/publication/attachments/DC%20Early%20Learning%20Standards2013.pdf

D. Vision/Hearing Screening

Vision and hearing screenings are completed by school personnel (i.e., school nurse). If either screening is failed, appropriate measures must be taken (parent notified, audiological assessment obtained, glasses prescribed, requests for vision / hearing assessments etc.) in an attempt to correct the problem. If it is ascertained that a vision or hearing impairment cannot be corrected or has been corrected to the extent that it can be, this information should be included and incorporated into the assessment report. If in certain cases testing has to proceed following a failed hearing/vision screening, standardized assessment tools and scores cannot be reported. A qualitative assessment method would have to utilized in those cases and caution be indicated within the Validity section of the report.

Qualitative Assessment Reports for Students Who Have Failed Hearing/Vision Screenings
In order that assessment reports remained timely, the process of cancelling assessments secondary to failed hearing/vision screenings is no longer occurring at Early Stages. If a student fails a hearing/vision screening then he/she will receive still be evaluated through a qualitative assessment. Therefore, only informal measures will be used and there will be no reporting of standardized scores. Eligibility criteria will be based on the fact the student's deficit equate to >25% delay and/or a deficit of greater than 1 year chronological age.

In the event an audiological assessment is warranted, please complete the following steps:

- Have the LEA order the audiological assessment in the Special Education Data System (SEDS)
- Contact the Audiology department at (202) 698-8011

E. Central Auditory Processing Disorder Protocol

Students who are suspected of having Auditory Processing Disorders (APD), or who are diagnosed with APD, should be considered for special education services though the same process as any student suspected of having a disability. To qualify for special education and related services, the disorder must interfere with the student's ability to obtain reasonable benefit from regular education.

A Central Auditory Processing problem causes difficulty in understanding the meaning of incoming sounds. Sounds enter the auditory system but the brain is unable to interpret efficiently or at all the meaning of sounds… in an extreme case, meaningful sounds cannot be differentiated from non-meaningful sounds.

Referral Guidelines

The student must:

- Be at least seven (7) years or older.
- Have normal peripheral hearing acuity.
- Full Scale IQ score of 80 or above.
- Have a recent psycho-educational assessment (within the year).
- Have a recent speech and language assessment (current within one year, which must include a language battery (e.g. CELF-5) and phonological processing skills assessment (e.g. CTOPP-2).
- Have intelligible speech.
- Be able to follow directions.

The referral must:

1. Include the psychological, educational and speech-language assessment.
2. State clearly and in detail why the student is being referred for an APD evaluation.
3. List any diagnoses including ADD.
4. Indicate whether or not the student is taking medication for ADD. A student who is taking medication for ADD but has not taken it in the morning of APD, testing will be rescheduled.
5. Indicate which special classes the student attends and for how much of the day.
6. Indicate what modifications are being made for the student at present.
7. Include the Justification for Consideration of APD Assessment Evaluation (see Appendix).

The DCPS Audiologists as a team will determine if the APD assessment is appropriate. DCPS completes APD Assessments at the DCPS audiology center at Payne (where equipment resides).

Criteria used to identify an educationally significant APD

The student must meet the following two criteria in order to be identified as having an educationally significant APD:

- Scores that are below the age-corrected normal region (-2.0 standard deviations) on at least two different dimensions.
- Evidence of difficulty in the academic setting based on observation, multidisciplinary assessment and academic performance.

F. Speech and Language Assessment Referral

When a speech and language assessment is necessary, a referral for assessment will be initiated. Prior to making a referral for a speech and language assessment, the teacher or SST members should complete the DCPS Communication Abilities Rating Scale form. This information can assist the speech pathologist in completing the Analyzing Existing Data section in EasyIEP. Per the DCPS guidelines, initial and reassessments must be completed within 45 days of parental consent.

G. Assessments for Parentally Placed Students

District of Columbia Public Schools' (DCPS), Centralized IEP Support Unit (CIEP), is responsible for locating, identifying, and evaluating all parentally-placed, self-funded private and religious school children ages 5 years 11 months to 22 years old who have a disability or suspected disability. Children who have been parentally placed, and self-funded in a private or religious school will be evaluated to determine whether they are eligible for special education. If eligible, they may be offered equitable services. Staff will be placed on the CIEP teams and will be responsible for several groups of students. These Teams are responsible for all students who are parentally placed and self-funded, private and religious schools. The school served could be a:

- Day Care Center
- Private school
- Parochial school
- Charter school
- Non-Public School (regardless of student's home address)

If it is determined that the student is eligible for special education equitable services, an Individual Service Plan (ISP) is developed. The parent has the option of remaining in the private/religious school or enrolling their child full time into a DCPS school.

In the event the parent elects to remain with the private school option, DCPS will provide the related services from the ISP during the school day at the student's educational location.

If a parent reports to your school with an IEP for their non-attending student, refer the parent to the Central IEP team. Please contact Brigid Cafferty at (202) 442-5475 or dcps.childfind@dc.gov

Documenting
Documentation for students receiving equitable services is entered into SEDS. All providers must complete the required equitable services documentation and upload into SEDS by relabeling a miscellaneous cover sheet. See forms for equitable services in Appendix.

H. Bilingual Assessment Referrals and Services

School-based speech-language pathologists play an important role in determining appropriate identification, assessment, and academic placement of students with limited English proficiencies (Adler, 1991, ASHA, 1998f).

Speech and language pathologists must understand the first as well as the second language acquisition process. They must be familiar with current information available on the morphological, semantic, syntactic, pragmatic, and phonological development of children from a Non-English language background to be able to distinguish a communication difference from a communication disorder in bilingual children. ASHA's Office of Multicultural Affairs has compiled information on the phonemic systems for Arabic, Cantonese, English, Korean, Mandarin, Spanish

and Vietnamese languages on http://www.asha.org/practice/multicultural/Phono.htm.

Language Difference vs. Disorder

Language Difference- Expected variations in syntax, morphology, phonology, semantics, and pragmatics when an individual is acquiring another language. Decreased language skills may be result of experience rather than ability

Language Disorder-A disability affecting one's underlying ability to learn a language. In bilingual children, disorder should be present in both languages (to one extent or another).

The primary goal for most second language learners is to function as proficient learners in the classroom. Literacy skills will transfer from the first language (L1) to the developing second language (L2) if the student has learned the academic skills (reading, writing, organization of information) in the 'home' or first language. Most language learners experience a time when they acquire receptive language skills before they are able to use the language expressively. They listen but do not speak. This silent period parallels the stage in first language acquisition when the children are internalizing the vocabulary and rules of the new language. The students are making needed connections between the first language and their new language. Conversational proficiency is the ability to use language in face-to-face communication. It is important to remember that oral proficiency does not constitute second language proficiency. Oral proficiency is not sufficient for the increased language demands required for academic competence.

STAGES of SECOND LANGUAGE ACQUISITION (Hearne 2000)

STAGE I: Pre-Production (first 3 months of L2 exposure)
- Silent period
- Focusing on comprehension

STAGE II: Early Production (3-6 months of exposure)
- Focusing on comprehension
- Using 1-3 word phrases
- May be using formulaic expressions ('gimme five')

STAGE III: Speech Emergence (6 months-2 years of exposure)
- Increased comprehension
- Using simple sentences
- Expanding vocabulary
- Continued grammatical errors

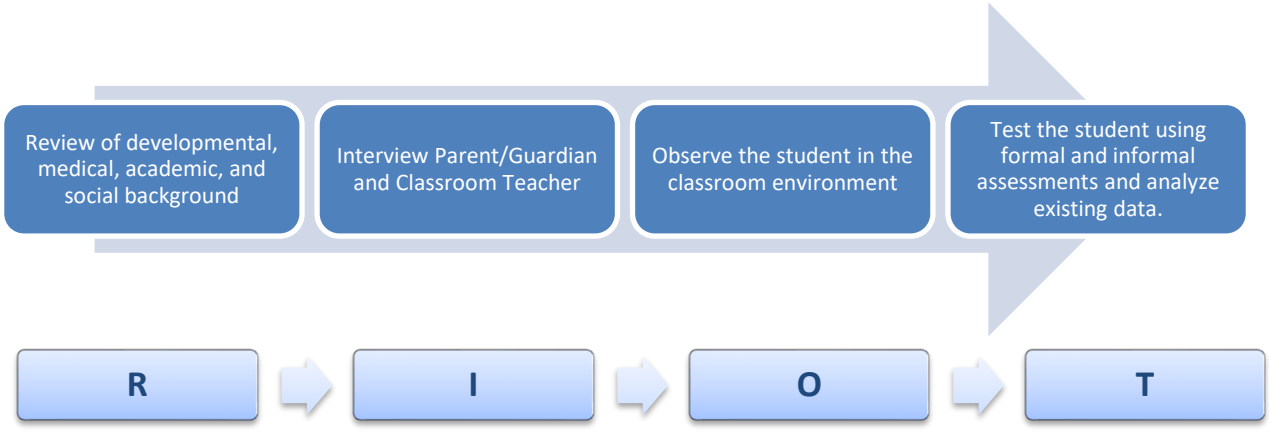
STAGE IV: Intermediate fluency (2-3 years of exposure)
- Improved comprehension
- Adequate face-to-face conversational skills
- More extensive vocabulary
- Few grammatical errors

Bilingual Assessment

Assessment includes measuring both social language and academic language abilities. Proficiency in social language may develop within the first 2-3 years of exposure to English, whereas it may take an additional 5-7 years for academic language proficiency to develop. Basic interpersonal communication skills (BICA) are the aspects of language associated with the basic communication fluency achieved by all normal native speakers of a language (social language). Cognitive academic linguistic proficiency (CALP), on the other hand, relates to aspects of language proficiency strongly associated with literacy and academic achievement (Cummins, 1981). Proficiency in cognitively demanding tasks such as: understanding academic lectures, telling and writing imaginary stories, using language to predict, reason, analyze, synthesize and evaluate, reading and writing (literacy skills).

The Process for Evaluating Bilingual Student

Four steps should be followed by the SLP to determine whether a student demonstrates a language disorder.



A. STEP ONE - RIOT

Follow the suggested guidelines of Review, Interview, Observe, Test, or RIOT, as described in greater detail in Langdon & Cheng, 2002, pp.83-86):

- Review various pieces of information such as school and medical records while learning about the student's cultural, social and family background.
- Interview family members/significant others, peers and teachers regarding their perceptions and the student's experiences and exposure to language(s), school and literacy events
- Observe the individual in as many contexts as possible including the classroom environment if the individual is a student, and determine if adequate teaching techniques are implemented to maximize learning in English and acquire academic skills.

- Keep in mind the difference between everyday uses of language (Basic Interpersonal Communication Skills or BICS) vs. language that needs to be used in a learning environment (Cognitive Academic Language Proficiency of CALP) (Cummins, 1981).
- Are there signs of language loss that seem to transcend normal limits?
- Test while taking into account that multiple sources of information should be considered such as authentic and dynamic assessment, analyze portfolios and gather data on how the student has progressed over time. Take into account the legal and ethical considerations listed above during this process.

B. STEP TWO - Red flags

Look for the following RED flags:

- The student has made slow progress in learning English and academics despite accommodations and special classroom interventions.
- The individual has a significant medical history that may have impaired speech and language development.
- Family reports impairment in the primary/native language.
- Teachers and parents report student is learning very differently from other siblings and/or students who have had similar linguistic background and learning opportunities.
- When the above areas have been considered and the student should be assessed, it is important to determine if assessment should be done in one or two languages

C. STEP THREE – Primary language testing

Determine whether to test or not test in the primary/dominant language:

- Legally under IDEA, the SLP must test in the student's primary language. In other settings, ASHA's guidelines should be followed: "{student's} who are proficient in their native language but not in English, assessment and intervention of speech and language disorders of limited English proficient speakers should be conducted in the {student's} primary language.
- For students who possess limited communicative competence in both language--speech and language should be assessed in both languages to determine language dominance."
- If the SLP is not proficient in the student's primary language, a trained interpreter will be essential for a valid assessment and accurate diagnosis.

D. STEP FOUR - Assessment process

- Assess each language during separate segments to assess performance in each language.
- Select appropriate assessment instruments and procedures. Both informal and formal procedures should be utilized.
- Informal assessment may include examining previous assessment data, family (patient, parent/caregiver) interview, review of educational and health history, language sampling and dynamic assessment.

- Formal procedures may include the use of standardized tests normed on the target population. SLPs should not use standardized tests unless normed on the same linguistic background as the individual being tested. A variety of standardized tests are available in Spanish with few instruments available in other languages.
- Modifications of tests may be necessary to gain maximum information. All instruments must be examined for relevancy to the referred individual.
- It must be recognized that translations of English tests have many limitations. They do not provide normative or developmental information and, if used at all, should be used cautiously, to gain general information about the individual's language and academic skills.
- In the event there are no language tests available in the individuals primary language, the SLP is encouraged to team with a speaker of the target language to help conduct a structured assessment and/or obtain a language sample.

Test Interpretation

When administering tests not normed on bilingual or limited-English-proficient students, utilize a disclaimer statement or provide additional information on student's performance. When presenting results, SLPs should report the use of trained interpreters, any test adaptations or modifications, the language and language order of testing, and specific standardized and alternative measures used along with test findings. Scores should never be reported for standardized or translated tests, unless they have been normed for that specific cultural group. Strengths and weaknesses should be described instead.

Eligibility for Speech Therapy for Bilingual Students

Eligibility for special education with speech-language impairment must be based on the presence of a speech-language impairment in L1, NOT the child's limited English proficiency. Care must be given to determine the cause of the communication skill deficits. At any point in the process of acquiring second language proficiency, a student may appear to have language delays or even language disorders as observed in the classroom. However, if the speech-language pathologist's analysis shows that English errors are due to interference caused by learning L2, a disorder would not be indicated, but rather a characteristic of second language acquisition.

A student is not eligible for Speech and Language Services if the answer is yes to either of the following:

- Cultural factors, economic or environmental disadvantage?
  - 34 CFR§300.30 (a)(3), DCMR 3006.4
- Limited English proficiency?
  - 34 CFR§300.306 (b)(1)(iii), DCMR 3006.6(a)

COMPARISON OF CHILDREN WITH LIMITED ENGLISH PROFICIENCY WITH /WITHOUT DISABILITIES

Characteristics	Child with Limited English Proficiency	Child with Limited English Proficiency with a disability
Communication Skills	Normal language learning potential. Communicative use of English is reduced and easily noted by native English speakers. English phonological errors common to culture. No fluency or voice impairment. Can be communicatively proficient to function in society.	May exhibit speech and language disorders in the areas of articulation (atypical phonology or prosody), voice, fluency, or receptive and expressive language; may not always achieve communicative competence in either first or second language. May exhibit communication behaviors that call attention to himself/herself in L1.
Language Skills	Skills are appropriate for age level prior to exposure to L2. The nonverbal communication skills are culturally appropriate for age level (e.g., eye contact, response to speaker, clarification of response, turn taking). Vocabulary deficit and word-finding difficulties in L2 only. Student may go through a silent period. Code switching common.	May have deficits in vocabulary and word finding, following directions, sentence formulation, and pragmatics in either L1 or L2. Atypical syntactic and morphological errors. Persistent errors in L2. Low mean length of utterance (MLU) in both languages. Difficulties in first language and English cannot be attributed to length of time in English-speaking schools. Stronger performance on tests assessing single word vocabulary than on tests assessing understanding of sentences or paragraphs.
Academic Functioning	Normal language learning potential. Apparent problems due to culturally determined learning style, different perceptual strategies, or lack of schooling in home country.	May observe limited progress in second language acquisition, difficulty retaining academic information, difficulty in schoolwork of home country, or difficulty in acquiring the first language.
Progress	Progress in home language is contingent upon adequacy and continuation of first language instruction. Academic progress in English should be steady, but will depend on the quality and quantity of English instruction.	May show less than expected progress in English acquisition and development of academic skills. May show a marked or extreme discrepancy between different areas (e.g. oral skills and writing skills) that cannot be attributed to lack of sufficient time or appropriate interventions.
Social Abilities	No social problems in L1. May have some social problems due to lack of familiarity with American customs, language, expected behaviors, etc. Student may experience social isolation and may be likely to be a follower rather than a leader in a group of English speakers.	May exhibit persistent social and behavioral problems that are in L1 and his/her native culture and not attributable to adjustment and acculturation.

Adapted from the Fairfax County, CLiDES Handbook Team (2003).

The Speech Pathologist's responsibilities related to a bilingual assessment may include:

- serving as a member of the interdisciplinary pre-referral team when there is concern about a limited-English proficient student's classroom performance
- seeking collaborative assistance from bilingual speech-language pathologists, qualified interpreters, ESL staff, and families to augment the speech-language pathologist's knowledge base (ASHA, 1998f)

- teaming with a trained interpreter/translator to gather additional background information, conduct the assessment, and report the results of assessment to the family (Langdon et al., 1994)
- compiling a history including immigration background and relevant personal life history such as a separation from family, trauma or exposure to war, the length of time the student has been engaged in learning English, and the type of instruction and informal learning opportunities (Cheng, 1991; Fradd, 1995)
- gathering information regarding continued language development in the native language and current use of first and second language
- providing a nonbiased assessment of communication function in both the first (native/home language) and second language of the student (Note: IDEA Section 612(a)(6)(B) requires assessment in "the child's native language or mode of communication unless it clearly is not feasible to do so."
- evaluating both social and academic language proficiency

If the MDT determines based on the results of the English Proficiency Test that they need to be assessed in their native language, the Special Education Coordinator will complete the Bilingual Assessment Justification Form. It is still necessary for all of the pre-referral steps, including intervention, to be completed prior to the submission of justification form**.** Please see the Bilingual Referral and Assessment Guide using the following Google documents link:

- https://sites.google.com/a/dc.gov/office-of-special-education-reference-guide/bilingual-assessments

In cases when a Bilingual Speech and Language Pathologist is not available in the requested language, the monolingual Speech and Language Pathologist is responsible for assessing the student with an interpreter.

How to use an Interpreter

Prepare the interpreter by using the BID process:

Briefing

- Establish Seating Arrangement;
- Provide overview of assessment purpose, session and activities;
- Review student behaviors and characteristics that may impact; Discuss plans in case the child is not cooperative;
- Discuss issues of confidentiality and it's boundaries;
- Provide protocols, interviews, language sample materials in advance so that the interpreter can become familiar with them;
- Discuss technical terms and vocabulary ahead of time so that the interpreter may ask questions to verify concepts;
- Review how to translate precisely-especially student errors and differences in sentence structure, style, grammar or imprecise vocabulary.
- Discuss cross-cultural perspectives. The interpreter may provide the SLP with pragmatic rules consistent with the student's background
- Explain that the interpreter will need to limit non-verbal cues, such as hand gestures or vocal variations that may impact assessment results
- Remind the interpreter to take notes on the student's responses

Interaction

- Develop an agenda for the assessment session and review it with the interpreter interaction
- Welcome student, introduce participants and establish rapport
- Inform the student of the role of the interpreter and the role of the SLP
- Speak directly to the student avoiding darting eyes between the interpreter and student
- Speak in short, concise sentences and allow time for the interpreter to translate everything precisely
- Pause frequently to allow the interpreter to translate information

- Avoid oversimplification of important explanations
- Avoid use of idioms and slang

Debriefing

- Review student responses
- Discuss any difficulties in the testing and interpretation process
- Examine the language sample. Discuss excerpts with transcription as necessary to illustrate critical elements of student's language usage

DSI Related Services Interpreter Request Process

The Division of Specialized Instruction (DSI) Related Services Interpreter Request process allows Related Services providers (RSPs) to formally request interpreter/translation services. Interpreter/translation services may be requested to support RSPs while conducting student evaluations, and assist parents participating in student meetings. All requests for interpreter/translation services require the RSP to submit an Interpreter Request Form. Requests can be made for the following services:

1. Interpretation/translation in the student's native language during evaluation
2. American Sign Language services
3. Translation of student assessments

All requests should be submitted within a minimum of four business days, prior to the date services are needed. Any incomplete request forms will not be processed.

The information below outlines the process to secure an interpreter for a bilingual assessment, pending the availability of a DCPS bilingual provider:

- LEA representative orders the assessment in SEDs and assigns the assessment to the school's assigned provider
- LEA representative/RSP completes the Interpreter Request form using the following link: https://docs.google.com/a/dc.gov/forms/d/e/1FAIpQLSfrK4PWymBSKfq_IjrthJKroe4LVbou44OjRcVqB8PBPTSQ3g/viewform
- The Related Services point of contact will identify a vendor to complete the interpreter services and provide confirmation of interpreter/translation services at least two days prior to the date of services
- Upon completion of interpreter services, the provider sends a follow-up email to DCPS.RelatedServices@dc.gov confirming the services requested were rendered with attached evaluation form (interpreter should provide form for the provider to complete at the time of service). All evaluation forms should be sent within 2 days of completed interpreter services.

If there are any inquiries or questions regarding the Interpreter Request process, please contact your assigned Program Manager For more information regarding the bilingual assessment referral guidelines in the Appendix section.

I. AUGMENTATIVE & ALTERNATIVE COMMUNICATION (AAC) AND ASSISTIVE TECHNOLOGY (AT) ASSESSMENT

Assistive Technology (AT) is an umbrella term for all services that directly help a student with a disability select, acquire, or use an AT device too access the curriculum. AT devices and services are used by students with IEPs or 504 plans to access the general or special education curriculum. There are three major categories of AT: AT for Access, AT for Communication, and AT for Learning. AT for communication, also known as Augmentative and Alternative Communication, provides supports for the communication needs of students with disabilities.

The Assistive Technology Process

Policy at a Glance

School-based teams, including IEP and 504 teams, are responsible for the consideration, provision, and implementation of assistive technology. The following section provides an overview of IDEA requirements for assistive technology, the DCPS assistive technology process for school-teams, and additional support provided by the DCPS assistive technology team. For more information and our complete policy guidebook and training modules please access the Assistive Technology Canvas page.

Assistive Technology

Assistive Technology (AT) is an umbrella term that includes any device, product, software, or system that increases, maintains, or improves the functional capabilities of individuals with disabilities (Assistive Technology Industry Association, 2017). In regard to students with disabilities, AT is used in schools to increase access to the learning curriculum or environment and includes low to high tech features and tools.

Assistive Technology Eligibility

All students with disabilities are eligible for assistive technology. Unlike traditional evaluations, AT evaluations **are not necessary** to determine if a student should access assistive technology and **are not required** during the initial eligibility or re-evaluation process. Rather, the assistive technology decision making process is a collaborative assessment process that occurs throughout the school-year.

The DCPS Assistive Technology Process

School-based teams should follow a collaborative process for assistive technology decision making. This systematic process is followed to assess a student's assistive technology needs. Each step of this aligns with IDEA guidance and best-practices for assistive technology. The FACTS mnemonic guides school-teams through each step of this AT process:

- Step 1- Find classroom tools and evidence-based practices to support the area of need.
    - School-based teams should implement evidence-based practices and integrate appropriate classroom accommodations and modifications based on the area of need. For students with speech and language deficits, these supports may include core vocabulary boards, picture symbols, and visual schedules. Please see our AAC Resource and Strategy Guide for low-tech and Tier 1 AAC supports or our AT Consideration Guide for available resources.
- Step 2- Analyze data to determine if these supports are effective.
    - The school-based team should collect and analyze data to determine if these strategies and supports increase student performance in the area need as well as access to the educational environment. This information should be documented within service trackers in addition to present levels of performance within the IEP.
- Step 3- Consider assistive technology at the annual IEP:
    - According to IDEA, school-based teams must consider assistive technology during the annual IEP to discuss student needs, abilities, the effectiveness of current tools, and determine if the student may benefit from additional supports. 504 students may also benefit from assistive technology accommodations. During this process, the school-based team uses the SETT framework to facilitate the discussion. Please see our section below, Assistive Technology Consideration, for more information.

- Step 4- Trial Assistive Technology Tools
    - If the SETT discussion determines that the student may benefit from additional supports, the IEP team should then trial specific tools to determine if this assistive technology increases the student's access to the curriculum or performance on IEP goals. Teams may obtain trial assistive technology supports by using available technology within the school (ex: laptops and one-to-one tablets), on loan on from the AT team (for specialized equipment), or by receiving a device trial directly from a vendor or the DC Assistive Technology Program.
- Step 5- Supplement to the IEP or 504
    - If data indicates this AT tool is effective in supporting student access to the curriculum, school-based teams should update the IEP or 504 plan. This update may include Services and Supplemental Aids section if the student requires a dedicated device, special considerations for assistive technology for additional Tier 1 AT supports, and relevant IEP goals and accommodations. Please see additional guidance for updating relevant section of the IEP on Canvas.

Provision of Additional AT Tools

School-based teams are responsible for ensuring that students have access to assistive technology supports as documented in the AT consideration, accommodations, goals, and supplemental aids section of the IEP, or required for trial. To ensure that students have access to the required supports, school-based teams are responsible for the following:

- Implementation of existing hardware (school laptops, tablets, one-to-one devices) to access district-available AT features.
    - Many assistive technology features are available district wide. If a student requires access to district-wide AT features (ex: text to speech, speech to text, word prediction), school-based teams should ensure that students have access to these features on the available school hardware. Please see our AAC Resource and Strategy Guide for low-tech and Tier 1 AAC supports or our AT Consideration Guide for available resources.
- Device loan from the Assistive Technology Department.
    - The assistive technology team may provide specialized equipment on loan to the school to meet the requirements of the student's IEP or as needed through device trials.
- Device loan from government AT loan facilities (ex: DC Assistive Technology Program) or vendors.
    - The DC Assistive Technology Program is a government funded AT loan and training program available to all DCPS staff, students, and residents. This program has a variety of specialized AT equipment available for loan. In addition, some vendors provide loaner equipment. Please contact the DC Assistive Technology Program or specific AT vendors for guidance on their loner program.
- Direct purchase of the assistive technology tool.
    - Schools may also purchase assistive technology supports, including adaptive and programmatic AT supports required for students to access the building. Please contact your Manager of Accountability for more information.

Assistive Technology Consideration

IEP teams are responsible for the consideration of assistive technology. Consideration is the process of determining the effectiveness of existing supports and if a student would benefit from additional low-to high tech assistive technology tools. During the annual IEP or 504 meeting, school-based teams use a systematic process, guided by the SETT framework , to collaboratively consider assistive technology. This framework helps teams thoughtfully consider the

components that impact the student's access to the curriculum and select appropriate AT tools. School-teams should summarize information from the SETT framework into a one paragraph response in the Special Considerations for Assistive Technology section of the 504 or IEP. To learn more about available assistive technology tools and view examples of the AT consideration section, please view the AT Consideration Guide, which provides potential assistive technology supports and best practices for implementation based on student need in addition to the inventory section of the AT Canvas page for potential AT tools.

Collaboration with the AT Team

Per IDEA, school-based teams are responsible for the assistive technology decision making process and provision of assistive technology supports. However, if the school-based team requires support during these processes, the team may collaborate with the central-based assistive technology team. Collaboration requests are submitted by LEA representatives in the AT Quickbase portal. For each request type, proof of consideration during the IEP process is required. The types of collaboration requests are discussed below.

Consultation

School-based teams may receive consultations from the central-based AT team to support in the collaborative assessment of a student's assistive technology needs. **Support from the AT team does not automatically yield a device**. The continuum of support provided by assistive technology team may also include a focus on using available technology and materials in the classroom. Prior to submitting a consultation request, teams must first consider assistive technology during the annual IEP using the SETT framework. A copy of this SETT framework worksheet is required during the consultation request process. During this process, the AT Team collaborates with the school-based to support with the identification of appropriate assistive technology tools for the area of concern.

This consultation process relies on existing data and information provided by the school-based team, including service trackers, present levels of performance, and information within the SETT framework worksheet. The process also includes mandatory SETT meeting with the school-based team to discuss concerns and brainstorm potential AT solutions and concludes with a written consultation report that provides a summary of the team's decision-making process, recommended assistive technology, and suggested implementation plan. Please see the Assistive Technology Roles and Responsibilities document for more information on the school-team and central based AT team for more information about roles and responsibilities during this process.

Implementation Support

Teams may also request implementation support from the AT team. Implementation support may consist of virtual and live trainings and support with developing an implementation plan. Teams may request implementation support for Tier 1 assistive technology tools, student owned communication devices, and loaner devices. Prior to receiving implementation support, the AT tool must be documented appropriately within the appropriate AT sections of the IEP. Teams must submit a completed SETT form at the time of request. In addition, on demand training resources are available on our Canvas and Streams pages.

Device Loans

The AT team may provide specialized loaner AT equipment based on documentation within the IEP. This loaner equipment may include trial and dedicated devices, as documented within the special considerations or services and

supplemental aids sections of the IEP. The AT team only provides loaner supports for specialized, student specific equipment and supports.

Assistive Technology Evaluations

Many students who require assistive technology do not need a formal evaluation. Identification of assistive technology during the FACTs process and/or consultation with the AT team may quickly match a student with the assistive technology required to access the educational environment. Formal assistive technology evaluations should only be conducted if additional data outside of school-based team consideration and AT team consultation is required for informed AT decision making.

Prior to requesting formal AT evaluations, school-teams must consider assistive technology and document this consideration in the AT consideration section of the IEP. Teams must then receive parental consent and request an AT evaluation in SEDS within 24 hours. Formal AT evaluations are a collaborative process that contain the same components as the consultation process, but with additional data collection points. Assistive technology evaluations are coordinated by the specialist but require input and data collection from members of the IEP and 504 teams. Please see Canvas for a complete overview of the AT evaluation process.

Independent Assistive Technology Evaluations

Families may obtain independent assistive technology evaluations, which provide recommendations AT for learning, communication, and access that may assist the student in accessing the educational environment. When independent assistive technology evaluations are conducted, the school-based team should request a copy of the assessment and upload the assessment to SEDS. The school-based team should then schedule a time to review these recommendations as an IEP or 504 team and agree upon the supports that are necessary for the student to access the educational environment. The team should then update the necessary sections of the IEP, including special considerations for assistive technology, IEP goals, or 504 accommodations. If the school-based team requires support in interpreting the results of an independent assistive technology assessment, then the school- team may contact the AT team for support.

Student Owned Assistive Technology

Students may use their personally owned assistive technology, such as communication devices, within the educational setting. Many of these devices correlate to independent assistive technology evaluations. Prior to implementing these supports in the classroom, the school-team must first review the results of the outside evaluation as a team and update the IEP. If the team determines that this support will be used within the classroom, teams should update the special considerations for assistive technology section of the IEP by listing the student owned device that will be used and discussing how this will be implemented within the classroom. The team should also update relevant IEP goals to incorporate this device as appropriate. Please see additional guidance for updating relevant section of the IEP on Canvas.

School-based teams may also determine that this student owned device will not be used within the educational setting, but the student requires comparable assistive technology in order to access the educational environment. School-teams who make this decision should follow the device provision steps listed above.

Contact and Additional Supports.

If you have additional questions, please contact DCPS.assistivetech@k12.dc.gov. In addition, you may access our complete AT Guidebook on our AT Canvas or SharePoint pages. Implementation and technical training modules are located on our AT Canvas Page and Microsoft Stream.

J. GOLD ASSESSMENT: EDUCATIONAL RELEVANCE AND IMPACT FOR EARLY CHILDHOOD STUDENTS

Early childhood classrooms in DCPS utilize a curriculum and assessment tool called Teaching Strategies GOLD. Teaching Strategies GOLD is an authentic observational assessment system for children from birth through kindergarten. It is designed to help teachers get to know their students well, what they know and can do, and their strengths, needs and interests.

The Teaching Strategies GOLD assessment system blends ongoing, authentic observational assessment for all areas of development and learning with intentional, focused, performance – assessment tasks for selected predictors of school success in the areas of literacy and numeracy. This seamless system for children is designed for use as part of meaningful everyday experiences in the classroom or program setting. It is inclusive of children with disabilities, children who are English-language or dual-language learners, and children who demonstrate competencies beyond typical developmental expectations. The assessment system may be used with any developmentally appropriate curriculum.

The GOLD links key developmental milestones with instruction in order to track student progress. Individual objectives correspond to the dimensions which include: (a) Social - Emotional; (b) Physical (c) Language; (d) Cognitive; (e) Literacy; (f) Mathematics; (g) Science and Technology; (h) Social Studies; (i) The Arts; and (j) English Language Acquisition.

The Teaching Strategies GOLD Language goals are as followings:

- Objective 8 - Listens to and understands increasing complex language
    - Comprehends language
    - Follow directions
- Objective 9 - Uses language to express thoughts and needs
    - Uses an expanding expressive vocabulary
    - Speaks clearly
    - Uses conventional grammar
    - Tells about another time or place
- Objective 10 - Uses appropriate conversational and other communication skills
    - Engages in conversations
    - Uses social rules of language

Early childhood SLPs can use the Teaching Strategies GOLD language goals to determine the educational relevance and impact of early childhood students with communication deficits. Here are the educational impact definitions for each Teaching Strategy Gold language goal.

Objective 8: Listens to and understand increasing complex language
A student with difficulty in this area will have deficits in vocabulary development, following directives in class, understanding the routine, interpreting what they hear and connecting it to curriculum task.

Objective 9: Uses language to express thoughts and needs
The student will have deficits using language to express feelings, thoughts, needs, making request, gaining information,

sharing ideas and stories which impact on telling simple stories with details, sequence details, tell elaborate stories that refer to other times and places and use intelligible speech 75% of the time.

Objective 10: Uses appropriate conversational and other communication skills.
The student with deficits in this area will have difficulty following social rules of communicating. They may not use socially polite language, speak so the listener can understand, take turns in a conversation across two or more exchanges and make appropriate comments. The student may not adhere to acceptable personal space, use appropriate eye contact, appropriately interact with peers, use appropriate gestures or fail to understand nonverbal social cues and respond appropriately. This skill must be addressed by the teacher, SLP, SW and / or Psychologist in the IEP goals.

Providers should utilize this data in conjunction with teacher input to determine if students are making academic progress based on their age and level of school exposure to specific skill to identify is an educational impact to warrant eligibility for special education services under the disability Developmental Delay or Speech or Language Impairment.

K. Untimely Assessment Guidelines

Per DCPS guidelines, initial and reassessments must be completed within 45 days of parental consent. There may be times where assessments cannot be completed within the allotted time at no fault of the provider. In those cases, please adhere to the Untimely Assessment Guidelines within the Due Diligence Guidelines developed in April 2017. Refer to Appendix for guidelines

SECTION V
Speech and Language Assessment Procedures

A. WHAT IS "ELIGIBILITY"?

Eligibility refers to the meeting of specific criteria for receiving special education and related services. A student may not receive special education and related services as defined in IDEA unless they have been determined to be eligible by the MDT. For a student to be considered eligible for special education and related services there must be documentation that the student meets the two-part test defined by IDEA.

B. WHAT IS THE SPECIAL EDUCATION ELIGIBILITY TIMELINE?

As a result of the Enhanced Special Education Services Amendment Act of 2014, beginning July 1, 2017, the *maximum amount of time allotted* for the evaluation and assessment period for students recommended for special education services will change (DC Code §38-2561.02 (a)).

- After receiving the student's referral for special education services, the LEA has 30 days to obtain parental consent for an evaluation.
    - A referral may be oral or written. Oral referrals must be documented by the LEA within 3 business days of receipt (DCMR 5-E3004).
    - The LEA must make reasonable efforts to obtain parental consent (DCMR 5-E3005). The LEA must make at least three attempts to communicate with a parent using three different modes of communication. Possible modes include correspondence by mail, by phone, or by conducting home visits. All communication attempts must be documented in the communications log in SEDS.
- After gaining parental consent, the LEA has 60 days *(adjusted from 120 days)* to conduct an evaluation and determine the student's eligibility.
- After conducting an evaluation and determining eligibility, the LEA has 30 days to develop the IEP (20 USC §1414(d); 34 CFR §300.320-326).

Timeline by Law:

Note: If parental consent is gained on Day 5, conducting an evaluation and determining eligibility must be completed by Day 65 (within 45 days). Since each phase has a specific amount of time allotted, the timetable for each phase begins immediately after the preceding phase is completed.

Time Allotted By Best Practices		
Step	**Best Practices**	**Required by Law**
Review Referral and Send Procedural Safeguards Manual and Referral Acknowledgement Letter to parent	3 days	≤ 30 days
Collect Student Information and Send Referral Meeting Invitation to parent	3 days	
Analyze Student Information	4 days	
If Assessment is NOT Needed: Hold Referral Meeting, **Obtain Parental Consent**, and Schedule Eligibility Meeting	5 days	
If Assessment IS Needed: Hold Referral Meeting, **Obtain Parental Consent**, Schedule Eligibility Meeting, and Order Assessment, Assigning Assessment to the Provider ***within 48 hours*** of Obtaining Parental Consent	10 days	
If Assessment IS NOT Needed: Prepare for Eligibility Meeting and Send Eligibility materials for discussion to parent ***at least 10 days in advance***	10 days	≤ 60 days
If Assessment IS Needed: Conduct Assessments, Prepare for Eligibility Meeting, and Send Eligibility materials for discussion to parent ***at least 10 days in advance*** **Note:** After the IEP Team orders an assessment, providers have 45 days to conduct it	45 days	
Hold Eligibility Meeting **PWN:** Send Eligibility Determination to parent **Note:** For initial IEPs, teams should be prepared to hold an IEP development meeting on the same day as the Eligibility meeting	10 days	
Develop IEP	30 days	**≤ 30 days**

C. WHY ARE WE REQUIRED TO USE SUCH A STRENUOUS PROCESS TO DETERMINE THE ELIGIBILITY OF A STUDENT?

There are two reasons for the process to determine if a student is eligible for special education. First and foremost, the process is designed to ensure that students who need special education actually get it! When a student is determined to be eligible for special education, the District basically guarantees that the student will have what they need to learn and benefit from education. Federal and state funds are set aside to guarantee the student receives appropriate services. Explicit instructions are provided for teachers and service providers to help them know how to facilitate student learning.

The second reason that a strenuous process exists is to prevent students from being labeled as disabled for arbitrary reasons such as poor teaching, cultural differences, racial bias, or socioeconomic disadvantage. This process ensures that general education teachers and other educators do not use special education as a dumping ground for students who might not be “perfect learners.”

In addition, the process for eligibility for Speech - Language services should be just as strenuous to avoid over-identification of students, and to ensure that appropriate services are delivered to the students who need them.

D. HOW IS EDUCATIONAL IMPACT DEFINED?

Adverse effect means the child’s progress is impeded by the disability to the extent that educational performance is significantly and consistently below the level of similar age peers. Adverse Effect must have been consistently present, across time and settings. Situational issues such as divorce or a death in the family – may cause temporary educational problems that should improve with time which means the educational problem is not due to a disability. The term “educational performance” includes academic areas and non-academic areas. Educational performance in non-academic areas can include reading, math, communication, etc.; progress in meeting goals for the general curriculum; and performance on state-wide and local assessments. Non-academic areas include daily living activities, behavior, mobility, mental health, etc.

While consideration of a student's eligibility for special education and related services should not be limited to a student's academic achievement, evidence of psychological difficulties, considered in isolation, will not itself establish a student's eligibly for classification as a student with an emotional disturbance. Moreover, as noted by the U.S. Department of Education's Office of Special Education Programs, "the term 'educational performance' as used in the IDEA and its implementing regulations is not limited to academic performance" and whether an impairment adversely affects educational performance "must be determined on a case-by-case basis, depending on the unique needs of a particular child and not based only on discrepancies in age or grade performance in academic subject areas" (Letter to Clarke, 48 IDELR 77).

The IEP Team’s determination of adverse effect is based on the results of assessments and/or data sources determined by the team to be necessary to validate the effect of the disability on educational performance. The following is a list of assessment(s) or data source(s) used to determine adverse effect:

1. Standard or percentile scores on nationally-normed, individually-administered achievement test(s); or for children ages 3 to 5, appropriate multi-domain nationally-normed test(s) or rating scale(s)
2. Standard or percentile scores on nationally-normed, group-administered achievement test(s), including nationally-normed, curriculum-based measures.
3. Any report prepared by the SST or presented by the parent/guardian that reflects academic or functional performance
4. Performance on comprehensive assessments based on a learning results, such as Common Core, or measurements of indicators within GOLD
5. Criterion-references assessment(s) of academic or functional performance
6. Student work products, language samples, or portfolios
7. Disciplinary evidence or rating scales based on systemic observations in more than one setting by professionals or parents/guardians.
8. Attendance patterns
9. Social or emotional deficits as observed by professionals or parents/guardians in multiple settings, on clinical rating scales or in clinical interviews.

In order to determine educational impact, the IEP team must consider the following questions:

- Is there a disability condition (i.e., a communication disorder)?
- Is there an adverse effect on educational performance (academic achievement and functional performance) resulting from the disability condition?
- If so, are specially designed instruction and/or related services and supports needed from the teacher and/or related service provider to help the student make progress in the general education curriculum?

The following is a list of some areas of educational performance (academic, functional and/or developmental) that are impacted by a variety of disabilities:

- Academic performance
- Communication functioning
- Social functioning
- Pragmatic (social) language
- Organizational Skills
- Group work skills
- Problem solving skills
- Emotion regulation
- Hygiene
- Behavior
- Attention challenges
- Daily living skills/adaptive behavior

E. WHO DETERMINES SPEECH-LANGUAGE THERAPY?

A qualified speech language pathologist with input from the members of the MDT determines if a student is eligible for Speech - Language therapy. The speech language pathologist and the MDT decides if a student is eligible for Speech - Language services using information collected from a multidisciplinary evaluation. This decision is made only after the provisions for pre-referral interventions, referral, and a multidisciplinary evaluation have been completed. A speech language pathologist who can interpret educational implications of evaluations must be an MDT member when evaluations are discussed.

F. WHAT IS THE PROCESS FOR DETERMINING ELIGIBILITY FOR SPEECH-LANGUAGE THERAPY UNDER IDEA?

Once the Speech - Language evaluation has been completed, the MDT convenes a meeting to review the data and determine if the student is eligible. The basic steps for determining if the student is eligible for Speech - Language services are as follows:

The speech language pathologist:

1. Carefully reviews and discusses each piece of data collected
2. Decides if there is sufficient data to determine if the student is eligible for an assessment
3. Applies the Speech - Language Eligibility Criteria Standards**
    - Mandatory Comprehensive Speech - Language Evaluation and report
    - Speech - Language Eligibility Criteria Standards checklist
4. If a student is determined eligible, a copy of the Speech – Language evaluation must be provided to parents no fewer than 10 business days before the scheduled eligibility meeting

G. HOW IS EDUCATIONAL IMPACT OF SPEECH-LANGUAGE DEFCITS DEFINED?

A communication disorder, such as stuttering, impaired articulation, language impairment or a voice impairment that adversely affects a child's educational performance. A student is eligible for speech-language pathology services through IDEA 2004 when s/he exhibits a speech impairment that has an adverse effect on educational performance to the degree that specially designed instruction or related services and supports are needed from the SLP to help the student make progress in the general education curriculum. Adverse effect on academic achievement – generally refers to a child's performance in academic areas such as reading or language arts, math, science, and history. The determination regarding whether there is an adverse effect resulting from the communication disorder on academic achievement requires an understanding of the general education curriculum and the language, speech, and communication demands on the student to make progress in academic activities (ASHA, 2007). Adverse effect on functional performance – generally refers to skills or activities that are not considered academic or related to a child's academic achievement and often used in the context of routine activities of everyday living (Federal Register, 71[156], p. 46661). The determination of whether there is an adverse effect resulting from the communication disorder on functional performance requires analysis of how "functional" the student's communication is outside of the classroom learning environment. When the communication disorder limits participation in interpersonal activities (e.g., social conversations, group discussions, peer interactions) or extracurricular and nonacademic activities (e.g., athletics, meals, recess, and clubs), an adverse effect on functional performance is present (ASHA, 2007).

H. HOW DOES SLI DIFFER FROM THE OTHER DISABILITY CLASSIFICIATIONS?

Of the thirteen IDEA classifications, SLI is the only one that can stand alone without specialized instruction. 34 CFR §300.8(a)(2); 34 CFR §300.39(a)(2) OSSE Non-Regulatory Guidance to the Related Services Policy Guidance, issued on June 23, 2010.

Per OSSE's Related Services Policy Guidance (June 2010):

- Special education services refers to specially designed instruction provided at no cost to the parent which meet the unique needs of a student with a disability.
- Related Services are services that are required to assist a student with a disability with benefiting from special education . Related services support special education services by directly or indirectly addressing an identified impairment resulting from a student's disability.
- The term specially designed instruction refers to the adaptation of content, methodology, or delivery of instruction as appropriate to meet the unique needs of a child with a disability. Specially designed instruction assists the student in accessing the general education curriculum, so that the student can meet the education standards that apply within the jurisdiction of the District.
- In the District of Columbia, related services that can be considered specially designed instruction under special education include: speech-language pathology, vocational education, travel training and instruction in physical education

1. Does the child meet the criteria associated with one of the disability categories established in the law (e.g., speech-language impairment)?
2. Does the child need special education and related services as a result of this disability?

The definition of speech-language impairment highlights the importance of considering the child's performance in school when making the decision about eligibility: "...speech-language impairment means a communication disorder, such as stuttering, impaired articulation, a language impairment, or a voice impairment, that adversely affects a child's educational performance" (34 C.F.R. Section 300.8(c)(11)).

I. SHOULD AGE OR GRADE EQUIVALIENT SCORES BE USED IN MAKING ELIGIBILITY DECISIONS?

Age-or-grade equivalent scores should not be used in making eligibility decisions. Equivalent scores reflect the median score of children in the normative sample at a given age or grade. They do not account for normal variation around the test mean, as do standard scores. The normal range of variability of children of the same age or grade as the child being evaluated might include scores as low or high as the median scores of other ages or grades. Grade-level equivalents may be mistakenly understood to have a relationship to curriculum content at that level. Furthermore, since the age or grade equivalent scale is not an equal interval scale, the significance of a delay at different ages is not the same. While seemingly easy to understand, equivalent scores are highly subject to misinterpretation and should not be used to determine whether a child has a significant deficit.

J. WHAT IS AN EDUCATIONAL MODEL OF SPEECH LANGUAGE PATHOLOGY?

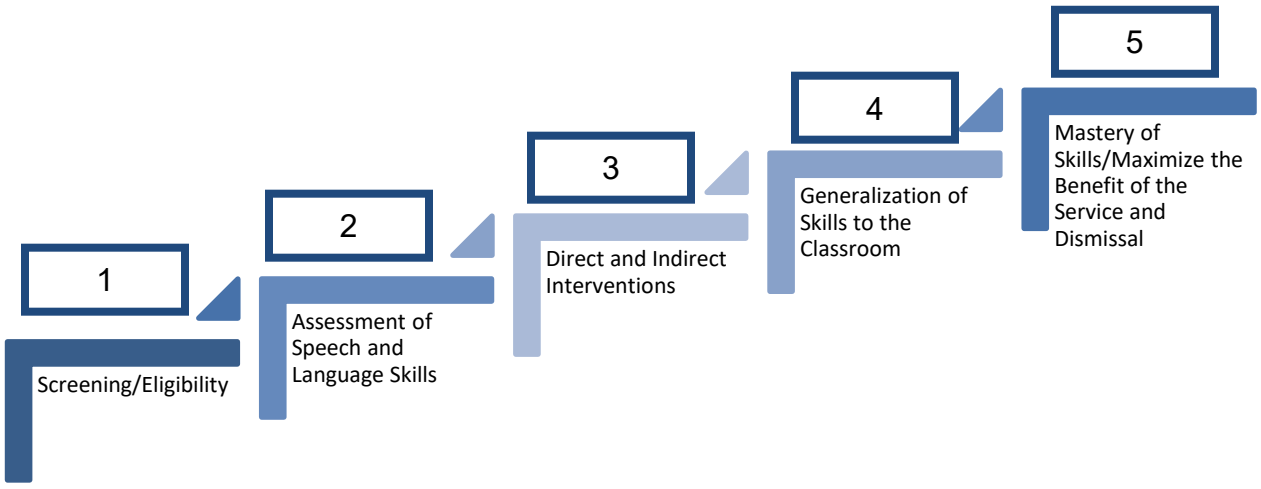
The educational model of speech language pathology provides evaluation and remediation of oral communication to students within the context of an overall educational profile. Recommendations for frequency and duration of services should align with the District's eligibility criteria and the mandate to support the student's educational program within the *least restrictive environment*. When making recommendations for eligibility, frequency, and duration of Speech - Language services, speech language pathologists should take into consideration the whole range of resources that are available within the educational setting. Many programs (early childhood, autism, hearing impaired, etc.) provide instruction in a language-rich environment using personnel that are trained in being primary facilitators of oral language within their classrooms. Our ultimate goal should be that the student generalizes oral communication skills to their least restrictive educational environment. Often, this is the classroom setting.

K. WHAT IS A COMPREHENSIVE SPEECH LANGUAGE EVALUATION?

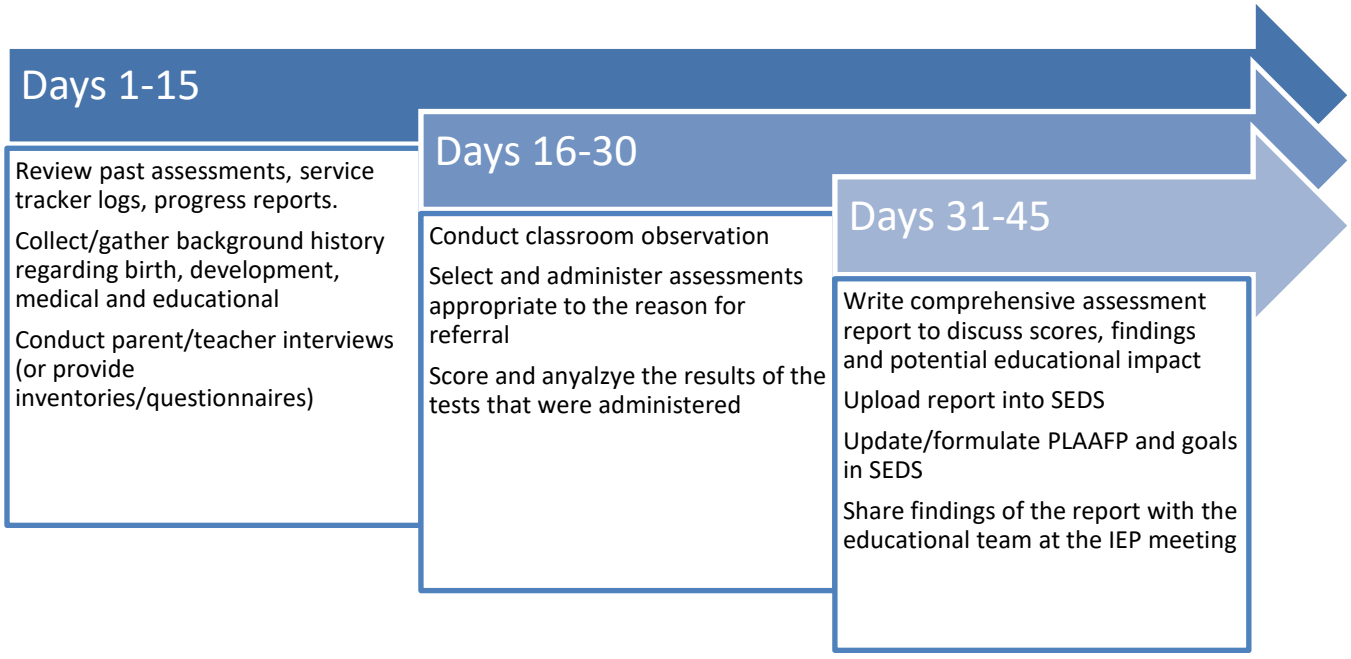
A Comprehensive Speech-Language Evaluation is an assessment of communication functioning to determine if there is a speech-language disorder affecting a student academically, social/emotionally, and/or vocationally. The mandatory areas that must be assessed in an initial or re-evaluation comprehensive evaluation are receptive/expressive language and vocabulary. If the area of concern is other than language and/or vocabulary, then you must administer a standardized test (for example; articulation, pragmatics, etc). This also applies when determining the continued eligibility of speech and language services for a student (dismissal from services).

***A comprehensive Speech - Language Evaluation includes a standardized measure of language and a standardized measure of vocabulary, unless the student is unable to participate in standardized assessment. If the suspected area of disability is articulation, fluency or pragmatic language, a standardized measure for those areas must be a part of the standard battery of assessment.**

L. WHAT IS THE SPEECH LANGUAGE SERVICE PROCESS?



M. HOW LONG IS THE ASSESSMENT TIMELINE FOR RELATED SERVICE PROVIDERS? WHAT ACTIONS SHOULD TAKE PLACE WITHIN THE TIMEFRAME?



N. WHAT IS THE ROLE OF RELATED SERVICE PROVIDERS FOR ASSESSMENTS?

In order to determine whether or not a student demonstrates a disability, his/her skills are assessed using formal and informal measures. Based on the results and with comparison to educational assessments, the information is utilized to determine if the student meets certain characteristics of the disability coding outlined by IDEA. Below you will find a list of the types of assessments completed by related service providers, which is used along with provided information from the educational team (teachers and special educators) to determine if a disability exists, the type of disability, and the overall educational impact of the disability within the academic setting as it relates to education, social-emotional, vocational, and transition.

Types of Assessments	Related Service Provider Responsible	Types of Information Gathered to Make Determinations Regarding Disabilities
Observation	Social Worker Psychologist Occupational Therapist Physical Therapist Speech-Language Pathologist	Observing behavior of a child in a natural setting is a required part of the evaluation process. A natural setting may include the classroom, playground, restroom, bus, or home. Observations should occur in places familiar to the child where her or she is comfortable and will have the opportunity to demonstrate typical behaviors. Observations add a critical dimension to the evaluation process, particularly when they are used in conjunction with objective tests, behavioral checklists, questionnaires, and interviews.
Language and Communication	Speech-Language Pathologist Audiologist	Measures the child's understanding of language and expression of language, pragmatic language skills, speech production (including articulation/phonology, phonation/voice, and fluency), oral motor development, and feeding/swallowing skills.
Adaptive Behavior	Occupational Therapist Physical Therapist Speech-Language Pathologist Psychologist Audiologist	The performance of developmentally appropriate daily activities required to meet personal needs and social responsibility. Areas of adaptive behavior o be assess include, self-help skills, play skills, learning styles, communication skills, motor skills, and social interaction/behavioral skills.

January 2003. Guide for Determining Eligibility and Special Education Programs and/or Services for Preschool Students with Disabilities. The New York State Education Department; Office of Vocational And Educational Services for Individuals with Disabilities. Albany, NY.

O. WHAT IS THE ROLE OF RELATED SERVICES?

Related services is defined by the United States *Individuals with Disabilities Education Act (IDEA)* 1997 as, "transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education..."[section 300.24(a)]. Students who need special education and specially designed instruction are eligible for related serves under *IDEA*. During the evaluation process the student is evaluated to first find out if the student has a disability, and secondly to determine what types of related services the student requires.

P. WHAT SPEECH-LANGUAGE ASSESSMENT TOOLS ARE AVAILABLE IN THE SPEECH DEPARTMENT LENDING LIBRARY?

Name of Assessment Tool	Age Range	S/L Domain Addressed	Brief Description of What the Assessment Measures
Arizona Articulation and Phonology Scale-Fourth Edition (Arizona-4)	Ages 18 mos-21;11 years	Articulation	Measure of articulation and phonology to help clinicians identify individuals in need of speech sound services. The individual names, repeats, or reads stimulus content and the examiner notes articulatory and phonological errors.
Auditory Skills Assessment (ASA)	Ages 3;6-6;11	Auditory skills	Three domains are examined: Speech Discrimination, Phonological Awareness, and Nonspeech Processing. The ASA assesses the ability to discriminate words in noise, repeat nonsense words accurately, perform early phonological awareness tasks of blending syllables and phonemes and recognizing rhymes, and discriminate between and perceive the sequence of nonverbal sounds.
Brown Attention-Deficit Disorder Scales	Ages 3;0-Adult	Executive Functioning	Screen for and explore the executive cognitive functioning associated with ADHD
Childhood Autism Rating Scale-Second Edition (CARS-2)	Ages 2 years and up	Autism	Rating scales used to identify children with autism and determine symptom severity through quantifiable ratings based on direct observation
Clinical Assessment of Articulation and Phonology-Second Edition (CAAP-2)	Ages 2;6-11;11	Articulation and Phonology	Norm-referenced measure of articulation and phonology. Standard scores in words, sentences, and phonology.
Clinical Evaluation of Language Fundamentals Preschool - Second Edition Spanish (CELF-P2 Sp)	Ages 3;0-6;11	Rec/Exp Language	Assesses general language ability in receptive language and expressive language skills.
Clinical Evaluation of Language Fundamentals-Fifth Edition (CELF-5)	Ages 5 -21 years	Rec/Exp Language	Sentence comprehension, following directions, word structure, sentence recall, sentence formulation, understanding spoken paragraphs, word definitions, semantic relationships, pragmatics
Clinical Evaluation of Language Fundamentals-Fifth Edition: Metalinguistics (CELF-5: Meta)	Ages 9;0-21;11	Pragmatics, Higher level language skills	Assessment includes five tests of higher-level language skills embedded in upper-grade curricula and critical to classroom success. Measure a student's ability to think about and use language to make inferences, manipulate conversational speech given a context, use words in multiple ways, and use language in a non-literal manner.
Clinical Evaluation of Language Fundamentals-Fourth Edition Spanish (CELF-4 Spanish)	Ages 5-8 & 9-21	Rec/Exp Language	Spanish version of the CELF-4 used to assess receptive and expressive language skills.

Name of Assessment Tool	Age Range	S/L Domain Addressed	Brief Description of What the Assessment Measures
Clinical Evaluation of Language Fundamentals-Preschool: Second Edition (CELF-P:2)	Ages 3;0-6;11	Rec/Exp Language	Assesses general language ability in receptive language and expressive language skills.
Comprehensive Assessment of Spoken Language-Second Edition (CASL-2)	Ages 3 -21 years	Rec/Exp Language	Receptive vocabulary, expressive vocabulary, idiomatic language, sentence expression, grammar, sentence comprehension, nonliteral language, meaning from context, inference, pragmatic language
Comprehensive Receptive and Expressive Vocabulary Test-Third Edition (CREVT-3)	Ages 5;0-89;11	Rec/Exp Vocabulary	Norm-referenced measure of receptive and expressive oral vocabulary.
Comprehensive Test of Phonological Processing-Second Edition (CTOPP-2)	Ages 4;0-24;11	Phonological Awareness	A norm-referenced test that measures phonological processing abilities related to reading. Areas assessed include phonological awareness, phonological memory, and rapid naming.
Conners-Third Edition	Ages 6;0-18;11	Attention	Assessment of attention-deficit/hyperactivity disorder (ADHD) and its most common comorbid problems and disorders in children and adolescents. It is a multi-informant assessment that takes into account home, social, and school settings, with rating forms for parents, teachers, and youth.
Developmental Assessment of Young Children-Second Edition (DAYC-2)	Birth-5;11	All domains	Norm-referenced measure of early childhood development examining domains of cognition, communication, social-emotional development, physical development, and adaptive behavior.
Diagnostic Evaluation of Language Variation Screening Test (DELV)	Ages 4;0-12;11	Rec/Exp Language	Screening test used to distinguish variations due to normal developmental language changes or to regional and cultural patterns of language difference from true markers of language disorder or delay. Useful for identifying at-risk students.
Differential Assessment of Autism and Other Developmental Disorders (DAADD) (out of print)	Ages 2;0-8;11	Autism and other DD disorders	The DAADD is used to identify childhood behaviors that can be used to discriminate among specific developmental disorders, such as autism, Rett's syndrome, Asperger's, etc. Areas assessed include language, pragmatic/social, sensory, motor, medical/physical, and behavior. Observation scale which determines the presence or absence of behaviors.
Early Functional Communication Profile (EFCP)	Ages 2;0-10;0	Language	Used to gather information on foundational communication skills in young children, pinpoints deficits in joint attention, social interaction, and communicative intent that neurotypical children develop prior to the emergence of verbal communication

Name of Assessment Tool	Age Range	S/L Domain Addressed	Brief Description of What the Assessment Measures
Early Language Milestone Scale-Second Edition (ELMS-2)	Birth-3 years	Rec/Exp Language	Assesses early language development skills through either a pass/fail option or a point scoring method.
Evaluating Acquired Skills in Communication-Third Edition (EASIC-3)	Ages 3mos-6;0 yrs	All domains	Assesses prelinguistic skills, semantics, syntax, morphology, and pragmatics for students functioning under the language and cognitive level of the average 6 year old. Developed for use with children having developmental disabilities and those on the autism spectrum. The assessment is also applicable to young children and to older children with moderate to severe cognitive and language disorders.
Expressive Language Test-Second Edition Normative Update (ELT-2 NU)	Ages 5;0-11;11	Expressive Language	A measure of expressive language focusing on sequencing, metalinguistics, grammar and syntax, and defining categories
Expressive One-Word Picture Vocabulary Test-Fourth Edition (EOWPVT-4)	Ages 2;0-85+	Expressive Vocabulary	Assesses the ability to name objects, actions, and concepts when presented with color illustrations.
Expressive One-Word Picture Vocabulary Test-Fourth Edition Spanish (EOWPVT-4 Spanish)	Ages 2;0-85+	Expressive Vocabulary	Spanish version of the EOWPVT-4 used to assess use of vocabulary
Expressive Vocabulary Test, Third Edition (EVT-3)	Ages 2;6-90+	Expressive Vocabulary	Assesses expressive vocabulary and word retrieval for children and adults; measures expressive vocabulary knowledge with two types of items, labeling and synonym.
Fluharty Preschool Speech and Language Screening Test-Second Edition (Fluharty-2)	Ages 3;0-6;11	Rec/Exp Language, Articulation	A screening test to identify those who need a more comprehensive diagnostic evaluation of communication skills. Standard scores and percentiles are obtained in articulation, receptive language ability, expressive language ability, and general language ability.
Functional Communication Profile-Revised (FCP-R)	Ages 3;0-Adult	Language	Used to gather information on eleven major skill categories of communication, including Sensory, Motor, Behavior, Attentiveness, Receptive Language, Expressive Language, Pragmatic/Social, Speech, Voice, Oral, and Fluency
Gilliam Asperger's Disorder Scale (GADS)	Ages 3;0-22	Asperger's Disorder	The GADS is a behavioral rating scale that helps identify persons who have Asperger's Disorder. The scale can be completed by parents and professionals at school and home. Standard scores and percentiles are provided.
Goldman-Fristoe Test of Articulation-Third Edition (GFTA-3)	Ages 2;0-21;11	Articulation	Assesses speech sound abilities in the area of articulation in children, adolescents, and young adults. Standard scores for speech sound abilities at both the word level and connected speech level.

Name of Assessment Tool	Age Range	S/L Domain Addressed	Brief Description of What the Assessment Measures
Goldman-Fristoe Test of Articulation-Third Edition Spanish (GFTA-3 Sp)	Ages 2;0-21;11	Articulation	Spanish version of the GFTA-3 Assesses speech sound abilities in the area of articulation in children, adolescents, and young adults. Standard scores for speech sound abilities at both the word level and connected speech level.
Gray Oral Reading Tests-Fifth Edition (GORT-5)	Ages 6;0-23;11	Oral Reading	Measures oral reading ability with results in oral reading rate, accuracy, fluency, and comprehension
Illinois Test of Psycholinguistic Abilities-Third Edition (ITPA-3)	Ages 5;0-12;11	Oral and written language	Contains 12 subtests which measure areas in listening, speaking, reading and writing. Three composites are obtained: General Language, Spoken Language, and Written Language. Subtests include vocabulary, morphology, syntax, rhyming, sequencing, decoding, and spelling.
Khan-Lewis Phonological Analysis-Third Edition (KLPA-3)	Ages 2;0-21;11	Phonological Processes	Norm-referenced, in depth analysis of phonological process usage for children, adolescents, and young adults. Designed as a companion tool to the GFTA-3.
Language Processing Test-Third Edition Elementary (LPT-3: E)	Ages 5;0-11;11	Language Processing/Rec	Measures the ability of the child to attach increasingly more meaning to information received to then formulate an expressive response. Subtests include labeling, stating functions, associations, categorization, similarities, differences, multiple meanings, and attributes
Lindamood Auditory Conceptualization Test-Third Edition (LAC-3)	Ages 5;0-18;11	Phonological Awareness	Measures an individual's ability to perceive and conceptualize speech sounds using a visual medium. Evaluates an individual's ability to distinguish and manipulate sounds.
Listening Comprehension Test-Second Edition (LCT-2)	Ages 6;0-11;11	Listening Comprehension	Diagnostic test of listening comprehension which measures strengths and weaknesses in specific listening comprehension skill areas related to classroom listening situations. Five subtests require students to pay attention to auditory stimuli, listen with purpose in mind, remember what they hear well enough to think about it, avoid being impulsive in giving answers, express answers verbally
Marshalla Oral Sensorimotor Test-MOST	Ages 4;0-7;11	Oral Motor	Criterion-referenced measure which assesses oral movement, oral-tactile sensitivity, facial and oral tone, as well as basic respiration, phonation, and resonation skills.
Montgomery Assessment of Vocabulary Acquisition (MAVA)	Ages 3;0-12;11	Rec/Exp Vocabulary	Norm-referenced measure of receptive and expressive oral vocabulary.

Name of Assessment Tool	Age Range	S/L Domain Addressed	Brief Description of What the Assessment Measures
Mullen Scales of Early Learning	Birth-68 months	Cognitive	Assesses abilities in visual, linguistic, and motor domains, and distinguishes between receptive and expressive processing.
Oral and Written Language Scales-Second Edition (OWLS-II)	Ages 3-21*	Oral language/Listening Comprehension, Reading Comprehension /Written Expression	*Measures oral language skills for ages 3-21 and written language skills for ages 5-21, tests full range of language skills from lexical/semantic, syntactic, supralinguistic, pragmatic, text structure, and writing conventions
Oral Passage Understanding Scale (OPUS)	Ages 5;0-21;11	Receptive Language	Assesses listening comprehension. A passage is read aloud to the examinee and answers questions about the passages.
Peabody Picture Vocabulary Test, Fifth Edition (PPVT-5)	Ages 2;6-90+	Receptive Vocabulary	Evaluates comprehension of the spoken word in Standard English and is a measure of the individual's achievement in acquiring vocabulary.
Phonological Awareness Test-Second Edition: Normative Update (PAT-2: NU)	Ages 5;0-9;11	Phonological Awareness	Measures phonological awareness, phoneme-grapheme correspondence, and phonemic decoding skills.
Pragmatic Language Observation Scale (PLOS)	Ages 8;0-17;11	Pragmatics	Standardized norm-referenced rating scale that assesses specific pragmatic language behaviors seen in instructional settings (e.g., pays attention to oral directions, retrieves words quickly, expresses thoughts clearly).
Pragmatic Language Skills Inventory (PLSI)	Ages 5;0-12;11	Pragmatics	Norm-referenced teacher-rating instrument that helps identify children who have pragmatic language disabilities. Examines pragmatic characteristics in areas of Classroom Interaction, Social Interaction, and Personal Interaction skills.
Preschool Language Scales-Fifth Edition (PLS-5)	Birth-7;11	Rec/Exp Language	Used to measure receptive and expressive language skills in the areas of attention, gesture, play, vocal development, social communication, vocabulary concepts, language structure, integrative language, and emergent literacy.
Preschool Language Scales-Fifth Edition Spanish (PLS-5 SP)	Ages Birth-7:11	Rec/Exp Language	Spanish version of the PLS-5 used to assess receptive and expressive language skills in the areas of attention, gesture, play, vocal development, social communication, vocabulary concepts, language structure, integrative language, and emergent literacy.
Receptive One-Word Picture Vocabulary Test-Fourth Edition (ROWPVT-4)	Ages 2;0-85+	Receptive Vocabulary	Assesses the ability to understand the meaning of words spoken without context.

Name of Assessment Tool	Age Range	S/L Domain Addressed	Brief Description of What the Assessment Measures
Receptive One-Word Picture Vocabulary Test-Fourth Edition-Spanish (ROWPVT-4 SP)	Ages 2;0-85+	Receptive Vocabulary	Spanish version of the ROWPVT-4 used to assess understanding of vocabulary.
Receptive-Expressive Emergent Language Test-Third Edition (REEL-3)	Birth-3 years	Rec/Exp Language	Designed to help you identify infants and toddlers who have language impairments or who have other disabilities that affect language development. Includes a vocabulary inventory form.
Rhode Island Test of Language Structure (RITLS) (out of print)	Ages 3-20	Syntax	To assess hearing impaired children's syntactic processing of sentences.
Ross Information Processing Assessment-Primary (RIPA-P)	Ages 5;0-12;11	Information Processing	Measures ability to processing information, use with children who have acquired or developmental brain dysfunction. Subtests include immediate memory, recent memory, recall of general information, spatial orientation, temporal orientation, organization, problem solving, and abstract reasoning.
Rossetti Infant-Toddler Language Scale	Ages 0-36 months	Rec/Exp Language	Criterion referenced instrument designed to assess the communication skills. The scale assesses preverbal and verbal areas of communication and interaction including: Interaction-Attachment, Pragmatics, Gesture, Play, Language Comprehension, and Language Expression. Behaviors may be observed or elicited or parent/caregiver report may be used.
Screening for Central Auditory Processing Difficulties	K-2nd grade**	Auditory processing skills	Used as a tool to identify children who may be AT RISK for central auditory processing disorder. Criterion referenced using a parent checklist, teacher checklist, and quick screening of the student.
Social Emotional Evaluation (SEE)	Ages 6;0-12;11	Pragmatics	Evaluates the social skills and higher-level language that students need to interact successfully in everyday situations at home, school, and in the community. The SEE presents typical social situations and common emotional reactions that students typically encounter. Ideal for identifying social emotional needs of students with autism spectrum disorders, emotional disorders, learning disabilities, or attention deficit disorders.
Social Language Development Test-Elementary Normative Update (SLDT-E NU)	Ages 6;0-11;11	Pragmatics	Norm-referenced test that yields results regarding the social language development of children with four subtests: Making Inferences, Interpersonal Negotiations, Multiple Interpretations, and Supporting Peers.

Name of Assessment Tool	Age Range	S/L Domain Addressed	Brief Description of What the Assessment Measures
Stuttering Prediction Instrument (SPI)	Ages 3;0-8;11	Dysfluency	Three assessment procedures include parent interview, observation and tape recording, and analysis of tape recording. Criterion-referenced, percentiles, and severity ratings
Stuttering Severity Instrument-Fourth Edition (SSI-4)	Ages 2;0-10+ (adult)	Dysfluency	Assesses the severity and improvement of an individual's stuttering habits, specifically the frequency, duration, physical concomitants, and naturalness of the individual's speech.
Test for Auditory Comprehension of Language-Fourth Edition (TACL-4)	Ages 3;0-12;11	Receptive Language	A measure of receptive auditory language; focuses on vocabulary and grammar
Test of Adolescent and Adult Language-Fourth Edition (TOAL-4)	Ages 12;0-24;11	Oral and written language	Measures communicative abilities in spoken and written language. Subtests include word opposites, word derivations, spoken analogies, word similarities, sentence combining, and orthographic usage.
Test of Aided Communication Symbol Performance (TASP)	Ages --Any age	Ability to use AAC	General goal of the test is to define four specific aspects of symbolic communication performance for single-meaning symbols. Areas assessed include symbol size and field number; grammatical encoding; categorization; and syntactic performance. Used to highlight strengths and weaknesses in ability to recognize, interpret, and use single-meaning symbols to communicate.
Test of Auditory Processing Skills-Third Edition (TAPS-3)^^	Ages 4;0-18;11	Auditory Processing	Assessment of auditory skills necessary for the development, use, and understanding of language commonly utilized in academic and everyday activities. Measures skills in the areas of auditory attention, basic phonological skills, auditory memory, auditory cohesion.
Test of Childhood Stuttering (TOCS)	Ages 4;0-12;11	Dysfluency	
Test of Early Communication and Emerging Language (TECEL)	2 weeks-24 mos	Early communication	Assesses the earliest communication behaviors and emerging language abilities
Test of Early Language Development-Fourth Edition (TELD-4)	Ages 3;0-7;11	Rec/Exp Language	Norm-referenced screening test that assesses oral language ability in children with two subtests, Receptive Language and Expressive Language.
Test of Early Reading Ability-Deaf or Hard of Hearing (TERA-D/HH)	Ages 3;0-14;0	Reading	Normed on students who are Deaf and Hard of Hearing, Used to measure early development of reading.
Test of Expressive Language (TEXL)	Ages 3;0-12;11	Expressive Language	Norm-referenced measure of expressive language skills. Companion test to the TACL-4). Subtests include Vocabulary, Grammatical Morphemes, and Elaborated Phrases and Sentences.

Name of Assessment Tool	Age Range	S/L Domain Addressed	Brief Description of What the Assessment Measures
Test of Language Development-Intermediate: Fourth Edition (TOLD-I:4)	Ages 8;0-17;11	Rec/Exp Language	Semantics, grammar, phonological, pragmatics
Test of Language Development-Primary: Fifth Edition (TOLD-P:5)	Ages 4;0-8;11	Rec/Exp Language	Semantics, grammar, phonological, pragmatics
Test of Narrative Language-Second Edition (TNL-2)	Ages 4;0-15;11	Narrative Language skills	Measures narrative language skills
Test of Nonverbal Intelligence-Fourth Edition (TONI-4)	Ages 6;0-89;11	General Intellectual Ability	Uses abstract reasoning and figural problem solving to estimate general intellectual ability.
Test of Pragmatic Language-Second Edition (TOPL-2)	Ages 6;0-18;11	Pragmatics	Assessment of pragmatic language ability utilizing narratives and story contexts that revolve around natural, everyday communicative and social interactions.
Test of Problem Solving-Second Edition Adolescent (TOPS-2 A)	Ages 12;0-17;11	Pragmatics	Diagnostic test of problem solving and critical thinking for adolescents. It is designed to assess a student's language-based critical thinking skills. The subtests assess a student's strengths and weaknesses in specific critical thinking skill areas related to situations in and outside of the academic setting.
Test of Problem Solving-Third Edition: Elementary Normative Update (TOPS-3:E NU)	Ages 6;0-12;11	Pragmatics	Diagnostic test of problem solving and critical thinking for elementary students. It assesses language-based critical thinking skills. The focus is on a student's linguistic ability to think and reason and is not primarily a test of pragmatic or social language skills.
Test of Semantic Skills-Intermediate: Normative Update (TOSS-I:NU)	Ages 9;0-13;0	Rec/Exp Language	A receptive and expressive language test which assesses semantic skills. Vocabulary is relevant to every day life and familiar.
Test of Word Finding in Discourse (TWFD)	Ages 6;6-12;11	Word Finding	Assessment of word-finding skills in discourse using a picture description/storytelling format for obtaining a child's narrative.
Test of Word Finding-Third Edition (TWF-3)	Ages 4;0-12;11	Word Finding	Standardized assessment of children's word finding skills.
Test of Written Language-Fourth Edition (TOWL-4)	Ages 9;0-17;11	Written Language	Measures written language skills with subtest scores obtained in vocabulary, spelling, style, logical sentences, sentence combining skills, contextual conventions, contextual language skills, and story construction

Name of Assessment Tool	Age Range	S/L Domain Addressed	Brief Description of What the Assessment Measures
Verbal Motor Production Assessment for Children (VMPAC) (out of print)	Ages 3;0-12;11	Oral Motor	A systematic assessment of the neuromotor integrity of the motor speech system. Can be used in determining whether or not a motor disruption is a dimension of a child's speech production disorder.
Vocabulary Assessment Scales-Expressive and -Receptive	Ages 2;6-95;11	Rec/Exp Vocabulary	Measures vocabulary and oral language development; used to evaluate an individual's understanding of words and the breadth of an individual's vocabulary.
Wiig Assessment of Basic Concepts (WABC)	Ages 2;0-11;11	Rec/Exp Vocabulary	Norm-referenced assessment designed to evaluate a child's understanding and use of basic word opposites and related concepts.
Wiig Assessment of Basic Concepts-Spanish Version (WABC)	Ages 2;0-11;11	Rec/Exp Vocabulary	Spanish version of the WABC. Norm-referenced assessment designed to evaluate a child's understanding and use of basic word opposites and related concepts.

Q. MANDATORY SPEECH/LANGUAGE REPORT ELEMENTS

1. DCPS Letterhead, Page numbers
2. Title:
    a. Initial S/L Evaluation; S/L Re-evaluation; S/L Classroom Observation; S/L Independent Assessment Review; S/L Data Review Evaluation
3. Identifying Information
    a. Student Name
    b. Date of Birth
    c. Student Identification Number
    d. Chronological Age
    e. Grade
    f. School (Home/Attending)
    g. Date of Evaluation
    h. Date of Report
    i. Examiner/Reviewer
4. Reason for Referral
5. History/Background/Record Review
6. Teacher and/or Parent Report
7. Classroom Observation
8. Behavioral Observations
9. Validity Statement
10. Assessment Protocol
11. Hearing
12. Oral Peripheral
13. Articulation
14. Voice
15. Fluency
16. Receptive Vocabulary
17. Expressive Vocabulary
18. Language
19. Pragmatics
20. Summary/Impressions
21. Recommendations
22. Signature
23. Title/Credentials
24. Date

Description of the Report Elements

Each section must include the mandatory elements with required information for each section. Each section must include a summary of the test results using quantitative and qualitative information/data. In addition, the report should describe the specific communication skills and the student's ability to access the curriculum /grade level material. As school based providers, the written report must discuss the student deficits and its educational impact based on the test results, observations, teacher reports, etc.

Here is a template sample of a speech language assessment report.

DISTRICT OF COLUMBIA PUBLIC SCHOOLS
Office of Specialized Instruction

TITLE OF REPORT

Name: Name of student
DOB: Date of Birth
SID#: student id number
CA: Chronological age
Examiner: Name and credentials

DOE: Date of Assessment
DOR: Date of Report/Review
Grade: The grade that the student is in
School: Name of Attending School
Teacher: Name of student's teacher

Reason for Referral

- This section must state that the assessment was ordered by the IEP team, as well as the type of assessment (i.e., initial, re-evaluation, etc…) and purpose (i.e. difficulty formulating sentences during classroom activities, etc…).
- In the case of an initial assessment, this section may also include the person who is making the referral.

History/Background/Record Review

- Pertinent birth, medical, and academic history and information from student file
- Previous Speech & Language Assessment results
- Progress on interventions (RTI or speech therapy IEP goals)
- When conducting a re-evaluation, this section must include information regarding previous therapy goals and progress made/performance
- When referring to previous assessments, state the date of report/assessment, name and credentials of the examiner, findings and level of severity

Teacher and/or Parent Interview

- Report information from the teacher and/or parent that are gathered from interviews, rating scales, or questionnaires to describe student's current level of functioning and support possible educational impact.

Classroom Observation

- Report information from observing the student engaged in a language-based activity within the classroom setting.
- Indicate the type of class/setting student was observed in along with their participation and engagement in the tasks.
- Be sure to address information as it pertains to attention, any observed generalization (or lack thereof) of speech-language skills (or alignment to goals for students who are being re-evaluated).

Behavioral Observations

- This section should include information regarding the student's behavior during the testing session. It may include statements regarding: activity level, distractibility, impulsivity, preservation, effort, cooperation, comprehension of test directions and separation from parent or classroom.
- This section may also include the number of testing sessions provided, participation level, and other pertinent information.

Validity Statement (can be placed after the Behavioral Observations section or before the Summary section of the assessment report) This section must answer the following three (3) questions:

1. Was the assessment procedure valid for the intended purpose?
2. Were the assessment procedures valid for the student to whom it was administered and the results are a valid report of the student's current functioning?
3. Were procedural modifications made when assessing the student to increase the validity of the results?

Assessment Protocol

- List of formal and informal assessment procedures used in completing the assessment

Student Name
Page 2

Hearing

- Information about hearing function and results of the last hearing screening/audiological assessment (indicate date conducted and by whom)

Oral Peripheral

- Information about the oral mechanisms, structures and its functions as it may/may not impact speech production and swallowing

Articulation/Phonology

- Formal and/or informal Information about articulation and speech production function and performance.
- Use IPA where appropriate (i.e., /p/), for sounds that do not have an available IPA symbol, place the sound between quotation marks, such as “ch”

Voice

- Formal and/or informal Information about vocal function including pitch, volume, and resonance

Fluency

- Formal and/or informal information about stuttering/cluttering

Receptive Vocabulary

- Formal and informal results from testing of out receptive vocabulary skills

Expressive Vocabulary

- Formal and informal results from testing about expressive vocabulary skills

Language

- Formal and informal results from testing about the student’s receptive and expressive language function and performance.
- Must report Core Language Scores.

Pragmatic Language

- Formal and informal information about social language skills.
- Provide information and examples of verbal and non-verbal communication interactions with peers and staff.

**** All formal and informal assessments for articulation/speech production, fluency, language (receptive, expressive and pragmatic) and vocabulary must include the following:**

- **Description of what the tests and subtests measured.**
- **Description of what the tasks was supposed to do to indicate the skill (i.e., point to pictures, formulate sentences using pictures, etc…).**
- **Report and the interpret of the standard/scaled scores for each test and subtest**
    - **All standardized tests must include standardized scores, unless the clinician is unable to establish a baseline/basal.**
        - **In those instances the provider must indicate that the test/subtest was attempted and describe (i.e., behaviors, etc…) that precluded the student from being able to complete the test tasks. Providers should not include raw scores in their reports.****
- **Indicate the student’s strengths and weaknesses as it pertains to the student’s performance on the tests and subtests.**
- **Manifestation statements for each test and subtest regarding how the student’s strength or weakness would manifest within the classroom setting.**

Student Name
Page 3

Summary

- Summary of formal and informal assessment information/findings.
- Information on the educational impact of the student's communication abilities must be discussed.
    - Impact statements must include a clear explanation including at least one specific example of how the disability impacts the student's achievement in the general education setting
    - If the results indicate that there are no S/L impairments, then the provider must indicate that there is no potential educational impact.
- For re-evaluation reports, there must be a comparison statement regarding the current findings of the assessment report with results/performance from previous assessment reports.

Recommendations

- Statements regarding eligibility and placement should defer to the MDT or IEP after all relevant data / assessments have been reviewed and discussed.
    - Do not use any references to whether the student qualifies/does not qualify OR make reference to the continuation/discontinuance of services OR service amount/frequency
- Strategies for teachers and parents to improve communication based on student needs
    - The strategies must align with areas of weaknesses identified in the report
    - If there were no areas of weaknesses, then the strategies should align with the referral concerns.

_____
Name, Credentials (highest degree obtained and Certificate of Clinical Competence)
Title (Speech-Language Pathologist, Speech Therapist)
ASHA #/DOH#

EXPLANATION OF VALIDITY STATEMENTS

When caution needs to be taken when interpreting the results of an assessment, which may impact the validity of the test administration:

- Special accommodations are provided, which are not permitted per the administration manual of the assessment
- Failed vision or hearing screening
- Medications were or were not taken that may/may not have impacted attention, focus, and/or behaviors
- Assessment was attempted, however based on the student's cognitive functioning and/or behaviors the assessment tool was not appropriate or did not accurately measure student's performance
- Child is bi-lingual and needed an interpreter when the assessment was administered
- Special seating needed
- The communication output of the student varied (i.e., the use of a AAC device or picture icons)

Examples of Validity Statements

Example 1: The evaluation procedures included the use of (standardized measures, informal assessment, observation in a variety of settings, and interviews of student, teachers and/or parents). All tests were administered in the student's primary language or through an interpreter, and were administered by qualified personnel in accordance with the instructions provided by the test publishers. Tests were selected to provide results that accurately reflect the student's aptitude, achievement, and which are not influenced by impaired sensory, manual, or communication skills. Except where otherwise noted, the results of this assessment are believed to be valid.

Example 2: The findings of this assessment should be reviewed with caution due to the student demonstrating non-compliance and work-refusal behaviors, therefore it may not be an accurate reflection of his speech and language abilities. Student required multiple redirection to tasks and additional repetition beyond that indicated in the assessment manual.

Example 3: The assessment procedures used throughout the testing sessions were valid for its intended purpose to assess the student's speech and language skills. Based on performance and observation, the procedures were valid and accurately reflected the student's current speech and language functioning. However, a French interpreter was used to read and translate the student's responses to increase the student's ability to comprehend information and answer questions to increase the validity of the results.

R. TWO TYPES OF ASSESSMENTS: QUANTITATIVE VERSUS QUALITATIVE

Quantitative Assessment Method:

A quantitative assessment includes methods that rely on numerical scores or ratings. A quantitative measurement uses values from an instrument based on a standardized system that intentionally limits data collection to a selected or predetermined set of possible responses. Quantitative assessment approaches work by the numbers, collecting, analyzing, interpreting, and charting results, trends, and norms. As such, this type of assessment in the educational setting allows for objective data and the ability to compare student performance across ages, grades, peers and oneself.

Qualitative Assessment Method:

A qualitative assessment gathers data that does not lend itself to quantitative methods but rather to interpretive criteria. Includes methods that rely on descriptions/ anecdotal information as opposed to numeric values. This type of assessment is more concerned with detailed descriptions of situations or performance; therefore it can be much more subjective but can also be much more valuable when analyzed by an expert. This tends to be the case because it

accounts for human behavior, emotions, needs, desires and routines, which naturally captures insight into the "why" not just the numerical outcome.

Quantitative Assessment Method	Qualitative Assessment Method:
• *Focuses more on numerical outcomes* • *Focuses on average performance, comparison with peers* • *More of an objective interpretation*	• *Focuses more on contextual data* • *Focuses more on individual performance and progress* • *Considers performance outcomes based on exposures with environmental filters* • *Subjective interpretation* • *More time consuming*

Rationale for Utilizing Qualitative Assessments

Standardized tests may not be easily administered according to the recommended procedures with certain populations (e.g., students who fail hearing screenings, students with severe cognitive or attention problems, students from culturally and linguistically diverse backgrounds, etc…) In some cases, modifications of these procedures may yield important descriptive information about conditions under which the student's performance improves or deteriorates. When tests are modified in any way, modification should be reported in the validity section of the assessment report and test norms cannot be applied, as they are no longer valid.

Qualitative assessments is a descriptive approach to assessing, which examines how a child uses his/her knowledge of linguistic structure and communication rules with different communication partners in a variety of settings at various times with various levels of support. Qualitative assessments provide a more realistic picture of how a student naturally uses his/her communication knowledge and abilities in everyday situations and the impact of speech-language deficits in those settings. A qualitative or informal assessment for speech and language skills should only be utilized when a norm-referenced, standardized assessment is not appropriate and/or to supplement the findings from a standardized assessment. For certain populations, such as students with severe disabilities or students who English proficiency is limited, unbiased assessments will require focusing on descriptive measures.

In an attempt to script the best possible learning profile of a student it is optimal that a combination of quantitative and qualitative assessments be conducted. This practice allows the professionals administering these assessments to drill down numerical outcomes and conduct cross analysis with all descriptions and anecdotal data.

Definition of Descriptive Measures for Qualitative Assessments

Below you will find terminology along with a corresponding description that are commonly found within comprehensive assessment reports. These terms are defined to assist providers with expectations and understanding the type of information that is included within reports.

- Record review (birth, developmental, medical, social, previous assessment data and educational histories)
- Direct Observation of the student within the natural environment/setting to elicit a representation of communicative function
- Parent/Teacher Interview (probing to determine level of demands within the communicative environment;
- Questionnaires and/or inventories that provide information regarding the student's communication abilities within the home and school settings, such as making request, length of MLU, joint attention, etc…(to be completed by the parent and/or teacher)

- Informal comprehension probes (responses to requests; following familiar and unfamiliar directions/routines; retelling of a story; responding to inferential questions)
- Language sampling identifies and analyzes the student's use of linguistic features in functional communication in terms of phonology, semantics, grammar, morphology and syntactical structures
- A criterion-referenced assessment which compare a student's performance on specific skills, grammatical structures or linguistic concepts to a previously determined performance level. The criterion is based on expectations of what the child should be able to do.
- Dynamic assessment places emphasis on a student's learning potential rather than test performance by capturing the potential change in a student's performance on a task in response to specific facilitation techniques (e.g., test-teach-retest; modifying the presentation of formal tests; and providing graded prompts, etc…)
- Play-based assessment uses free and structured play opportunities to observe and document the student's behavior as he/she interacts with toys and people.

Determination of Appropriateness for Qualitative Assessments

There are certain situations and scenarios where it is more appropriate to utilize a qualitative assessment instead of a standardized assessment. Typically, these are cases where the normed population for the standardized assessment tool is not aligned with the individual being testing or the administration of the assessment has to be modified. Reporting standardized scores for individual who do not meet the requirements and norms as outlined in the testing manual, would potentially invalidate the findings of the assessment report. Below you will find a list of common reasons when it would be inappropriate to use a standardized assessment, therefore a qualitative assessment should be used.

A qualitative (informal) assessment should be utilized in the following types of scenarios:

- When a student fails a hearing screening, but proceeds with speech and language testing
- When a student's behavior and/or attention impacts his/her ability to engage in the tasks of an assessment tool
- When a student is unable to achieve a basal score on the components of a standardized assessment
- When a standardized assessment tool has not been norm-referenced on the population that is being tested (i.e., student who speaks another language that the test was not normed on)
- When a student's cognitive abilities and/or limited verbalizations may impact the student's performance on a standardized assessment

Format for Qualitative Assessment Reports

Report format for qualitative assessments should adhere to the outlined DCPS format as per the SLP Guidebook and maintain the headings and content areas. Below outlines the procedures how to input information within certain sections of the report when utilizing qualitative assessments.

- Validity - This section should indicate why standardized tests were not used in the administration of the speech-language assessment. It should also indicate that the findings of the assessment should be interpreted with caution secondary to issues indicated in the scenarios outlined in the "Determination of Appropriateness for Qualitative Assessment" section of this document. These are some of situations where there could be potential invalidation of the findings within the assessment report.

- Hearing - This section must denote when the screening/assessment was attempted/administered along with the findings. If a future appointment has been scheduled and is known at the time when the report is written, it should be indicated. If a student failed a hearing screening, please indicate whether or not the child did/did not do the following: localize to sound (eye gaze, head turn, etc…), responded to his/her name when called, followed simple directions without repetition, and answered questions.
- Oral Peripheral – In this section of the report, if the student demonstrates difficulty engaging in and/or imitating the tasks, then it should be noted. However, informal observations noted throughout the testing session should be included. These would include things such as the following: tone; drooling noted; symmetry/asymmetry at rest and with movement, etc…
- Articulation- This section should indicate whether or not the student was able to imitate modeled sound production in words, if a standardized assessment is not administered. It should include an inventory of produced sounds that would be developmentally appropriate based on the student's age. It should also include a statement regarding the level on speech intelligibility for an unfamiliar listener. Also, if phonological processing errors are noted throughout the assessment, it should be noted in this section (include examples) and indicate if they are developmentally appropriate based on age. If the student has limited verbalizations, then indicate the vocalizations and approximations that were demonstrated by the student (CV, VC, CVCV) by providing a description of the repertoire used.
- Vocabulary - This section should provide a sampling of the types of objects/pictures/words that the student was able to identify and use during the testing session. This information would be gathered per the examiner's observations, performance on other tasks/tests, and parent/teacher interview.
- Language - This section of the report should in essence paint a picture of how the student comprehends and uses language across various contexts. This section should be descriptive regarding the types of responses observed when engaged in various tasks and play. Since qualitative assessments do not provide a score, the provider should note within the report in terms of skills expected at certain age/age ranges and/or denote the level of functioning in terms of age based on developmental norms. If a standardized assessment is used, such as the PLS-5, scores cannot be reported. However, the qualitative information can be utilized to provide a description of the student's performance in terms of receptive and expressive language skills.
- The "Recommendation" section needs to indicate the type of follow-up recommended if necessary following the administration of the assessment, such as suggestions for future assessments (this could be to gain additional information needed to make determinations). An example of this is to rule-in/rule-out a hearing impairment and the need for a re-evaluation following the outcome of the hearing assessment (i.e., recommend that the student's speech and language skills to be re-evaluated within three months of the hearing assessment scheduled on ….)

Eligibility Guidance for Qualitative Assessments

In terms of eligibility, a child is eligible for speech and language services when they demonstrate a delay of one year (12 months) of skills or greater or > 25% delay per developmental milestones in communication as noted on an informal assessment, which indicates a moderate deficit in the student's speech and language skills.

Below indicates the documentation that is required to support the decision for eligibility for speech and language services for the various areas of speech-language pathology. This information can also be found in the SLP Guidebook.

- Language: Formal testing is not appropriate. As an alternative method, a minimum of two informal measures were used to document the communication deficit. Describe the types of alternative assessment measures used and why formal testing is not appropriate
- Articulation: There is documentation that this deficit in articulation and/or phonology significantly affects the intelligibility of the student's oral communication. The student has consistent speech sound errors or disordered phonological processes that do not occur in typically developing students of similar ages or due dialectal differences. These errors persist beyond the age at which maturation alone might be expected to correct the deviation.
- Voice: The student demonstrates a vocal deficit resulting from pathological conditions of abnormal use of the vocal mechanism that interferes with communication. Medical information is necessary to rule out upper respiratory infection or allergies or to determine the contribution of vocal pathology to the voice symptoms.
- Fluency: The student demonstrates speaking behaviors characteristic of a fluency deficit. There is documentation of impaired fluency and a mild to severe rating on a standardized fluency measure. Disruptions in the normal flow of verbal expression frequently occur and are markedly noticeable, and are not readily controlled by the student.
- Pragmatics: Based on two informal measures, the student demonstrates deficits in communicating and understanding needs / interactions with others in various contexts.

When making determinations about disability classification and possible impairments reports must include caution statements based on documentation and appropriate recommendations for follow-up.
Final eligibility will be determined based on the triangulation of the observations/interviews, review and finding of informal assessments, team discussion, and potential educational impact.

S. INDEPENDENT ASSESSMENTS

There are times when an outside assessment is submitted to the public schools for consideration for the eligibility of a student with a suspected disability for the purpose of seeking placement in education programs or accessing services. A multidisciplinary (MDT) assessment team is required to review all relevant documentation and decide if data is sufficient and/or additional information is needed.

A DCPS Speech Language Pathologist must review all independent speech and language assessments. The reviewer must complete the DCPS Review of Independent Assessment checklist form. In addition to the completion of the form, a typed review of the report must be attached to the report. The review of an independent speech and language report must include the following components:

- Place on DCPS letterhead
- Title: Independent Assessment Review
- Student's identifying information
- Background information
- Teacher and/or parent interview
- Classroom Observation (required)
- Summary with educational impact statement (must encompass informal and formal assessments to determine eligibility, i.e., performance in the classroom, test findings and interpretation of scores, academic performance (grades, PARCC testing, benchmark testing, etc…)
- DCPS' recommendations
- Signature, Title and Credentials (electronic signatures are not accepted)

Independent assessments must meet DCPS' criteria of a comprehensive speech and language assessment per the DCPS Speech & Language Eligibility / Dismissal Criteria. There may be occasions where the administrations of additional test batteries are required (i.e., vocabulary batteries, a complete language battery, etc..). In those instances where a provider needs to complete additional testing in order for the student to have a comprehensive speech and language assessment, the provider must use the IEE review and title it "Additional Testing Completed".

In addition to completing a review of an independent speech and language assessment, the provider must complete the "Independent Assessment Review", which is found on Canvas (Portal → Teaching and Learning → Specialized Instruction → Related Services→ Speech-Language Pathology → Policy and Procedures → Independent Assessment Review).

T. TRIENNIAL ASSESSMENTS/ RE-EVALUATIONS

Students placed in special education must have their individualized educational programs re-evaluated every three years. The purpose of the triennial assessment is to determine:

- If the student is still eligible for services under IDEA
- Determine the student's present levels of academic achievement and functional needs
- Whether any additions or modifications to the special education services in a student's IEP are needed, such as a change in disability category.

After a thorough review of the information available regarding a student's present level of performance, the IEP team (including the parent) is responsible for making a decision as to if new assessments are needed to address the above bulleted questions. The Analyzing Existing Data section of SEDS must be completed by the team members for all areas of concern as part of the re-evaluation process. Using this data, the team can determine if assessments are warranted.

Speech and language assessments are not always necessary for re-assessments. The need for a formal assessment should be reviewed and discussed by the IEP team. Examples when a formal speech-language assessment is not warranted for a triennial assessment, include:

- Standardized testing would not provide any additional relevant information.
- The student has demonstrated little change in functional skills.
- There is sufficient anecdotal and informal assessment information to provide an accurate assessment of a student's needs and current levels of performance as documented in the Analyzing Existing Data section and under the Information Reviewed fax cover sheet.
- There is no change in eligibility or location of services.

If the decision is not to conduct new assessments, the parents must be informed of school decision, reasons for it, and their right to request new assessment.

- Informed parental consent should be sought with due diligence by the school before any new assessments take place. The school division may proceed with new assessment if the school can show that it has taken reasonable measures to obtain this consent and the parents have failed to respond. These attempts must be documented in SEDS.
- A triennial assessment must include new assessments if the parent requests it.
- A triennial assessment should include new assessments, if:
    1. Additional information is needed for continued placement and/or delivery of services.
    2. The IEP committee is considering a change of placement, disability, or eligibility.

3. The evaluator determines that the previous assessment(s) is outdated, erroneous or inconsistent.

If the decision is to conduct new assessments, a comprehensive speech and language evaluation must be conducted using a language and vocabulary battery. If formal language and vocabulary batteries are not appropriate, informal measures, checklists, observational ratings, or inventories should be completed due to student's difficulties with completing formal batteries.

U. ASSESSMENT DUE DILIGENCE

There are occasions when a student is frequently absent, truant and / or refuses to participate in an assessment session. In those cases, the April 2017 Untimely Assessments and Due Diligence Guidelines should apply. See Appendix for Guidelines.

V. ALTERNATIVE ASSESSMENT REPORT

The process for an **alternative assessment** should only be followed if **all** of the following conditions have been fulfilled

- You have made at least 3 documented attempts to assess the student, and the student was uncooperative or absent each time.
- You have been in communication with the school staff (Case Manager, Special Education Coordinator, or Administrator) about the case, and they have not been able to assist in making the student available for testing.
- You have spoken to the parent/guardian about the case OR you have confirmed the phone number for the parent/guardian and name/contact information of this individual with school staff, and you have left at least three voice messages (one after 5pm) for the parent and they were not returned.

This process should not be followed if:

- You have not tested the student because you were unable to keep a scheduled appointment for any reason
- You have not successfully scheduled an appointment because you are waiting to hear back from school staff

An **alternative assessment report** should include the following:

- An explicit explanation of why a complete battery of testing measures was not conducted
- A chronological reference to each act of due diligence conducted by the provider. This includes information you sent or provided to the parent/guardian in any format, explaining the scope of the testing you intended to conduct and requesting parental assistance make the student available for testing and to be present on the day of the evaluation. Include dates of phone calls and/or letters sent to caregiver for this purpose.
- Explain your interaction with the LEA, case manager, and school staff. Include reference to any communication that the LEA or school staff has made to the parent regarding this matter.
- Title your report as **"Speech and Language Data Review Evaluation".**

In the absence of new test data, your report should emphasize a robust summary of existing data based on records review and interviews with all school staff who interact with the student are available and parents/guardians. You should place emphasis on:

- Work samples or notes from the student's classroom teacher
- Teacher's concerns/observed difficulties as they pertain to academics affected by the areas of concern
- Accommodations and adaptations the classroom teacher has made to mitigate/remediate deficits, and results.
- Information on the student's cooperation towards the implementation of those accommodations and adaptations.

- Previous assessment reports
- Progress reports by related service providers (where relevant)
- Classroom observation (if possible)

Your report must state that you or another DCPS provider may complete the full range of initially recommended testing if upon review of this report by the IEP team both of the following statements is true:
1. The team (or parent) still believes there is not enough data available to make an eligibility determination; AND
2. There is reason to think that the factors that previously inhibited you from completing the testing will be ameliorated.

Closing Out an Assessment in SEDS
Upon completing an assessment, the report must be uploaded and closed out in SEDS. The following steps should be completed to enter and submit assessment results.

Entering Assessments Results:

- To enter results for a completed assessment, click the "Results" button in the appropriate assessment type column.
- You will be taken to a separate details page for the assessment type you selected.
- Enter the date assessment completed.
- If applicable, you may indicate which tools you used as part of the assessment by selecting from the drop down menu and clicking the "Add Assessment Tool" button.
- In the areas addressed by this assessment section, select the appropriate areas being considered for the student (ex. Communication).
- For each area selected, complete a statement of strengths and concerns identified by the results of the completed assessments.
    - TIP: The list of areas that appears is based upon what was selected on the Analyzing Existing Data page as an area where more information was needed.

Creating an Electronic Signature

- Using a Blank Sheet of paper – Sign your Signature to the sheet of paper
- Go to a copy/fax machine with scanning capabilities. Scan the document
- Enter the destination email (which should be your dc.gov email address)
- Once the scanned signature has been received in your email. Save it as a JPG or Picture file for later use (suggestion: save it as "ESignature" so you're able to find it for future uses)

Adding Your Signature to Assessment Reports (prior to uploading report into SEDS)

- Open your document or assessment in Microsoft Word
- Go to the signature line of the document
- Click Insert Picture
- Select the file containing your signature and Click Insert

Submitting Assessment Reports

- Click on Documents tab and scroll to the bottom of the page.
- Click on the Upload External Attachment(s)
- Click the button next to the document you want to associate a file with
- Scroll to the bottom of the page and browse to locate the document
- Click the Upload File Button

Emailing the Case Manager

- Click the "Email Case Manager" button to access the **Send Email** composition page.
- The *To* and *From* address fields are pre-populated based on the user information available in the system.
- The subject link will be "Assessment Completed".
- In the body of the email, the text will indicate the type of assessment (SLP) that has been completed, along with the *Date of Request, the Date Due and the Date Completed*.
- Add additional comments in the text field if applicable.
- Click the "Save & Continue" button to send the email and return to the previous page.

It is expected that all providers upload (only) their completed assessments into SEDS 45 days from the date of consent. Uploading into the summary section is no longer an acceptable format for submission. Timeliness will be determined from the initial upload date, which should correspond with the date entered. All reports that are late or are incomplete will be considered Untimely. Please be sure to document and contact your Program Manager if there are any barriers to completing assessments in a timely fashion.

Canceling Assessments in SEDS

Scenario One: Staff orders assessments and the correct provider was not at the table to say assessment was warranted. If provider doesn't agree assessment is needed.
Response: The RSP should call LEA Rep or SEC to cancel the assessment. No need for deletion. *Follow Up*

Scenario Two: School refuses to cancel assessment.
Response: Contact your PM to reach out to the school's SES

Deleting Assessment Reports Uploaded in SEDS

Scenario One: Assessment was uploaded for the wrong student by the provider.
Response: The provider should upload new assessment report with correct student's name and inform the upload. Provider should escalate to spedoda.dcps@dc.gov, to confirm correct student was uploaded and deletes the erroneous report.

Scenario Two: Team reviewed assessment at table, but parent wants to amend report – e.g. correct wrong information. Report is uploaded into SEDS.
Response: Help Desk will instruct the provider/user to upload new report and keeps the old one in there. The provider must title the report "Updated" and same name as other report.

Scenario Three : The provider states report was uploaded into SEDS but all the pages are not showing.
Response: Won't delete original upload, but provider can upload the full completed report again.

Scenario Four : None of the above.
Response: Contact ODA SEDS Help Desk staff.

Please refer to your SEDS manual for additional information located at the following website:

https://osse.pcgeducation.com/dcdcps

PROVIDING DOCUMENTS TO PARENTS BEFORE AND AFTER ELIGIBILITY/IEP MEETINGS
Changes to DCMR Special Education Legislation

- Providing documents to parents before and after Eligibility/IEP meetings
- Translation of post-meeting documents

D.C. Acts 20-486, 20-487, and 20-488) were signed into law as of March 10, 2015, amending certain parts of the DC Municipal Regulations (DCMR) and introducing new pieces of legislation that have direct implications on how we provide special education in the District.

***Process for Providing Documents Before Meetings*:**

1. At least ten (10) business days before scheduled meeting, **all documents** that will be discussed during that meeting **must be sent home to parents.**
2. Pre-Meeting Packet letter that explains the information should be sent with packet. Found on Ed Portal
3. After all documents have been provided to parents, **Pre-Meeting Checklist must be completed and faxed into SEDS.** Use "Miscellaneous Cover Sheet" and rename "Pre-Meeting Materials Checklist".
4. A **communications log entry** must be completed after providing parents with documents.

Documents to Provide Before an Eligibility Meeting

Before Eligibility meetings, the following materials must be provided to parents:

- Analyzing Existing Data Report
- Copies/ results of any formal or informal assessments and/or evaluations (educational, FBA, speech, psychological, etc.)
- Any other additional relevant documents that will be discussed at the meeting.
- If any of the IDEA required IEP team members will be unable to attend or participate by phone, a Mandatory IEP Meeting Excusal Form is also required.

Documents to Provide Before an IEP Meeting

Before IEP meetings, the following materials should be provided to parents:

- Draft IEP
- ESY Criteria Worksheet
- Post- secondary transition plans and any informal vocational assessments or surveys (for students 14 and older)
- LRE observation reports (if applicable
- Transportation forms (if applicable)

- Dedicated aide observation reports (if applicable)
- Any data/documents related to possible change of service hours
- Any other documents that will be discussed in the meeting.
- If any of the IDEA required IEP team members will be unable to attend or participate by phone, a Mandatory IEP Meeting Excusal Form is also required.

Process for Providing Documents After Meetings:

1. *Within 2 business days* after an Eligibility or an IEP meeting, the school must send the **finalized documents to parents.**
    - Finalized Eligibility or IEP
    - Signed Eligibility or IEP signature page
    - Eligibility or IEP PWN
2. *Communications log entry* must be completed after providing parents with documents.

Providing Documents to Parents-FAQs

What meetings are subject to these new requirements?

All Initial Eligibility, Initial IEP, Re-evaluation, and Annual IEP meetings

How should documents be sent to parents?

Documents must be mailed , sent home in backpack, or handed to parents.

Who is responsible for sending documents, uploading cover sheets and creating a communications log entries?

The case manager is responsible for sending documents, uploading cover sheet, and creating communications log entries.

SECTION VI
Speech & Language Eligibility, Therapy and Dismissal Procedures

A. SPEECH-LANGUAGE DISORDER DEFINITIONS

General Definition: A speech-language disorder/ deficit is a communication disorder, such as a deficit in language, fluency, articulation, or voice, which adversely affects a student's educational performance.

Oral Language Disorder – Impaired ability in verbal learning evidenced by disability in the acquisition, production, and/or comprehension of oral language. Deficits may be reflected in semantics, syntax, morphology, auditory integration, verbal reasoning and pragmatics.

- Morphology: problems in structuring words from smaller units of words
- Syntax: problems putting words together in phrases & sentences
- Semantics: problems in selecting words to represent intended meaning and combining words and sentences to represent intended meaning
- Auditory Integration: deficits in processing, assigning significance to, and interpreting spoken language
- Verbal Reasoning: deficits in using language to problem solve
- Pragmatics: deficits in the semantic aspect of language (the meaning of what is being said) and the pragmatics of language (using language appropriately in social situations).

Articulation/Phonological Disorder – Defective production of speech sounds that interfere with intelligibility of speech and listener perception. Types of sound production errors include: substitutions, omissions, distortions, and additions.

Fluency Disorder – Markedly noticeable disruptions in the normal flow of speech that are not readily controllable by the student. These disruptions may include repetitions, hesitations, prolongations, interjections, and associated secondary characteristics.

Voice Disorder – Chronic or persistent abnormality in pitch, loudness, or quality resulting from pathological conditions or abnormal use of the vocal mechanism that interferes with communication. Medical information is necessary to determine vocal pathology.

B. DETERMINING ELIGIBILITY FOR SPEECH-LANGUAGE SERVICES

The determination of speech and language services is not based solely on scores on standardized assessments. When making determinations regarding eligibility for services, SLPs must consider whether or not the deficit in the area of communication has a potential adverse impact within the academic setting, hence there is an educational impact. In order to determine if there is educational impact, assessment report findings, progress in therapy towards goals, and qualitative information (i.e., teacher/parent interview, classroom observation, review of grades/benchmarks, etc…) and academic performance should be considered and discussed with the educational team to determine if speech and language services are warranted. Whenever teams consider the impact of a disability, they must also consider the educational impact of that disability. SLPs should share information with their educational teams based on their clinical expertise based on assessment findings and data collection as it pertains to the student's speech-language severity (i.e., mild, moderate, severe, profound) and overall prognosis with making progress towards goals (need to indicate things that may impact/support progress, such as interfering behaviors, difficulty recalling/utilizing strategies, etc…). Below are questions that every MDT should consider when making any determination regarding if a student is eligible for

specialized instruction or related services. ***However, the presence of a speech-language impairment does not equal eligibility for speech-language services under IDEA.*** That decision is the sole purview of the eligibility committee, which considers the speech-language assessment information and other data.

WHAT IS THE PURPOSE OF SPEECH-LANGUAGE THERAPY?

The purpose of speech-language therapy is to remediate an identified communication disorder that has an adverse impact on the student's access to academic, social-emotional and vocational curriculum.

1	• Identification of children with speech or language impairments
2	• Diagnosis and appraisal of specific speech or language impairments
3	• Referral for medical or other professional attention necessary for the habilitation of speech or language impairments
4	• Provision of speech and language services for the habilitation or prevention of communicative impairments
5	• Counseling and guidance of parents, children, and teachers regarding speech and language impairments.

What Makes a Student Eligible for Speech and Language Services?

The presence of an impairment does not make the child eligible for services.

- The crux of an eligibility decision for special education is whether the impairment "adversely affects a child's educational performance."
- The determination of eligibility is made by an interdisciplinary team that includes the parents, based on an analysis of data from multiple sources.
- IDEA prohibits a single professional—an SLP, psychologist, or a physician, for example—from making the decision regarding eligibility.
- The evaluation reports completed by individual professionals should clearly identify the presence of communication deficit or disorder.

Questions to Consider and Share with their Educational Team When Determining Whether a Student is Eligible for Speech-Language Services

- Is the child's speech-language impairment the primary disability impacting the his/her ability to access the academic curriculum?
- Is there documented adverse affect per IDEA which would indicate educational impact within the classroom setting?

- What other disabilities does the child have that may potentially impact his/her language and communication skills (prognosis for improvement given intervention)?
- Did the student demonstrate behaviors, attention issues, etc… which may have impacted the validity of the administration of the assessment?
- When the speech and language assessment is reviewed along with the other educational/psychological tests were academic/cognitive concerns revealed?
- Has the student had any exposure to the classroom/language rich setting in order to gain adequate speech/language skills necessary to be functional within the classroom setting?
- Does the child meet the criteria outlined by DCPS to be considered to have a speech and language deficits that has an education impact?

Factors to Consider When Qualifying a Speech and Language Services

In order for the student to qualify under IDEA, **ALL** of the following factors must be ruled out:

- Is the communication developmentally appropriate?
  - If yes, the student is not speech and language impaired
- Is the communication deficit related primarily to the normal process of acquiring English as a second language?
  - If yes, the student is not speech and language impaired
- Is the communication deficit related primarily to dialectal differences?
  - If yes, the student is not speech and language impaired
- Is the relative contribution of behavioral factors greater than communication factors?
  - If yes, the student may not be speech and language impaired

IDEA Sec 300.306(b)- Special rule for eligibility determination. A child must not be determined to be a child with a disability under this part--

- (1) If the determinant factor for that determination is--
- (i) Lack of appropriate instruction in reading, including the essential components of reading instruction (as defined in section 1208(3) of the ESEA);

When utilizing the Eligibility for Speech and Language Therapy Guidance Document, providers are encouraged to use the document as a tool to assist with formulating their scripting when sharing information with their educational teams regarding the severity and prognosis of a suspecting speech-language deficit. This is not a tool to use/share with their educational team to justify if services are warranted or not. Remember the decision for eligibility and services is determined by the educational team with insight provided by the SLP, who has an expertise in the areas of speech and language skills. This guidance requires SLPs to review the following information to assist with making determinations for speech and language services:

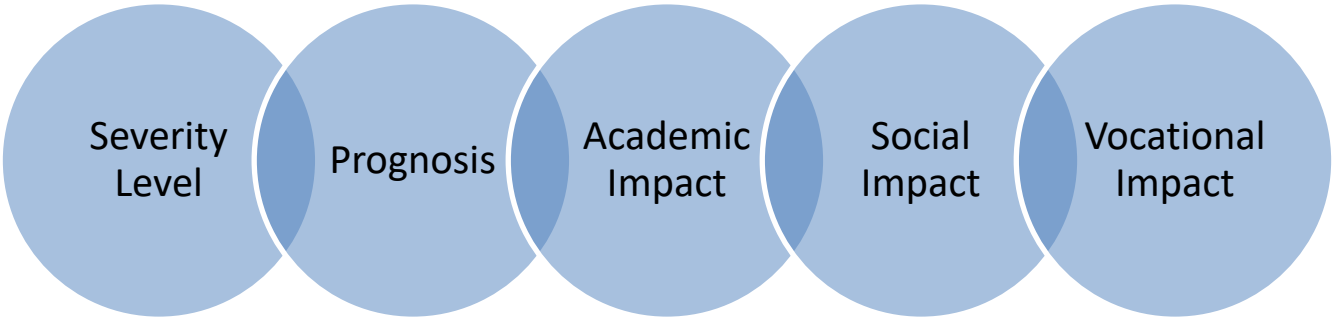
- ☐ Review of Standardized Assessment Scores (Qualitative Assessment Data when standardized tests are inappropriate)
  - Generally students who demonstrate moderate to severe deficits in the areas of language, speech production, fluency and voice will typically have greater educational impact in the classroom setting and outside the classroom
    - Indicate severity of speech-language deficits (if one exists) and the overall prognosis (include the factor considered to make this determination of prognosis)
- ☐ Review of Classroom Performance (PARCC test results, benchmarks, grades, etc…)
  - Generally students who demonstrate average scores and grades may have less educational impact in the classroom setting
- ☐ Input from the Classroom Teacher/Parent Regarding Student Performance

- Generally teachers are able to provide information regarding a student's performance with appropriate probing from the SLP, which will assist with determining if there is any potential educational impact as it pertains to communication

☐ Review of Data Collection and Work Samples (for re-evaluations)

- Generally if a student is making steady progress and/mastery towards goals on his/her IEP, then the potential for educational impact should decrease. Hence that student may not require speech and language services
- For students who are being re-evaluated, SLPs should always be able to share and describe the data collected from their therapy sessions to support/refute the need for services. In addition, it should be shared the level of prompting the student requires (i.e., independent → maximum assistance).

Factors to Consider When Determining Speech and Language Services



Educational Relevance of a Communication Disorder

<u>Academic Impact – ability to benefit from the curriculum</u>

- Below average grades
- Inability to complete language-based activities vs. non-language-based activities
- Inability to understand oral directions
- Grades below the student's ability level

<u>Social Impact – ability to interact with peers and adults</u>

- Peers tease student about communication problem
- Student demonstrates embarrassment and/or frustration regarding communication problem
- Student demonstrates difficulty interpreting communication intent

<u>Vocational Impact – ability to participate in work related activities</u>

- Inability to understand/follow oral directions
- Inappropriate response to coworker/supervisor comments
- Unable to answer/ask questions in a coherent/concise manner

Adverse Effect on Educational Performance

Speech or language impairment means a communication disorder that adversely affects a student's educational performance [300.8(c) (11)]. In developing each student's IEP, the IEP Team must consider the academic, developmental and functional needs of the student [300.324(a) (1)] The IEP must include a statement of the student's present level of academic achievement and functional performance [300.320(a)(1)].

Academic Achievement – generally refers to a student's performance in academic areas (reading or language, math, science, history).

No Adverse Effect	Temporary or Episodic Adverse Effect	Significant Adverse Effect
Student's communication disorder – such as stuttering, impaired articulation, language impairment, voice impairment – has no adverse effect on academic performance Student's communication skills are proportionate with overall functioning level and/or relative strength There is evidence that student is benefiting from special education program without speech-language therapy a related service	Data about the student's learning profile indicates that the student has a communication disorder and that any adverse effect on academic achievement is likely to be short term, temporary or episodic. Student's rate of learning, motivation, and responsiveness to intervention are positive indicators. Data indicates that the student's performance in the special education curriculum will likely require specially designed instruction from the SLP	There is a direct, noticeable relationship between the students communication disorder and performance/achievement The student's communication disorder contributes to academic struggle or below expected achievement in the special education program. The student's communication disorder interferes with academic achievement. The student needs speech-language therapy as a related service to benefit from special education.

Functional Performance – generally refers to skills or activities that are not academic or related to a student's academic achievement; often used in the context of routine activities of everyday living

No Adverse Effect	Temporary or Episodic Adverse Effect	Significant Adverse Effect
Student's communication disorder has no adverse effect on functional performance. Student's communication skills are proportionate with overall adaptive and functioning level and/or area of relative strength Student is benefitting from special education program without direct speech-language therapy as a related service	Data about the student's learning profile indicates that the student has a communication disorder and that any adverse effect on functional performance is likely to be short term, temporary or episodic. Students rate of learning, motivation, and responsiveness to intervention are positive indicators. Data indicates that the student's communication during activities of daily living will likely require specially designed instruction from the SLP.	Communication skills limit participation in self-care, interpersonal, and daily routines. The student has no functional communication, limited means of expression, or social/emotional adjustment is affected by the communication disorder. Communication patterns are noticeably disrupted and interfere with interaction and functional performance. The student's communication disorder is out of proportion with overall intellectual and adaptive functioning level.

Prognostic Levels Description

In keeping with standards for increased accountability, it is necessary to provide for each student a prognosis for improvement. The words traditionally used to describe prognosis, along with a brief description, are as follows:

Excellent - This prognostic statement indicates that the student has a high likelihood of improving significantly. All indicators are positive for significant improvement. This classification can be used for students who may require only a short period of therapy.

Good - Choosing this option indicates that the student can be expected to make reasonable progress toward improving functional communication. This statement may be qualified to state that the prognosis for achieving a limited set of goals is good. The person may have positive and negative influences on their likelihood to improve but a majority of the indicators are positive.

Fair - This term may be used for the student that has a similar number of both positive and negative prognostic indicators. The person may still be considered a candidate for therapy if the clinician determines that improvement is possible.

Poor - This term is used for the student who is not likely to demonstrate functional improvement from therapeutic intervention. This student has more negative than positive indices for improvement. This designation is used for the person who is not going to be enrolled in therapy or should be discontinued from therapy because he/she is not expected to continue to demonstrate progress. The clinician should provide the reason(s) for the poor prognosis.

Guarded - This term is used if prognosis presently appears "poor" but may improve significantly after medical intervention, fitting of appropriate amplification, or introduction of augmentative/alternative communication device.

Prognosis Withheld - In the case of a student requiring medical evaluation or intervention, state that "the prognosis is being withheld, pending medical consultation."

Severity Rating Scale

The purpose of this scale is to provide general guidelines for the severity ratings assigned to students. It is broadly divided into "Normal", "Mild", "Moderate", "Severe", and "Profound."; and within this range more specifically divided using a scale of 0 – 8. To determine severity, norm, criterion, and student-referenced measures should all be considered. For norm-referenced measures, consider age equivalency as well as standard scores and percentiles. The following should serve as a guide:

Normal

0 - No noticeable impairment in this area

1 - This classification can be used for the following types of students:

a) Proficiency in this area is technically within normal limits but is near the lower boundaries of what is considered normal. For a child, a recommendation may be to monitor and/or to follow-up with a consultation at some specified time in the future.
b) Someone who subjectively reports some effort in performing the skill but this difficulty is not evident to the listener.
c) Foreign dialect student whose dialect never or rarely interferes with intelligibility.

Mild: In general, a classification of either of the mild ratings indicates a disorder, which may be evident but does not significantly reduce the ability to be an effective communicator. In other words, there is a disorder but it does not interfere with everyday, functional communication. For a child, this classification would include those who are six to eight months below age expectancy in functional communication ability.

2 - Examples of the use of this classification include the following:

a) Disorder is noticeable to a trained listener, but may not be apparent to casual observer in a limited context.
b) Persons who have difficulty only in a few specific demanding situations.

3 - Examples of the use of this classification include the following:

a) Persons who have no or little difficulty with everyday, functional communication but may experience minor difficulty in several demanding situations such as high level, contextual conversation or in the presence of competing stimuli.
b) Persons who require some increased effort to communicate resulting in rarely noticed reduced facility of speech/language without significant decrease in ability to comprehend and/or express wants and thoughts.

Moderate: In general, this category represents the level in which a disorder of comprehension or expression becomes a definite impairment in communication. However, the skill level still enables the communicatively impaired person to effectively communicate in many structured and/or limited contexts. For a child, this level would be used to describe one who is eight to twelve months below age expectancy in functional communicative ability.

4 - Examples of the use of this classification include the following:

a) A person whose disorder is readily apparent to even the casual conversational partner. The impairment makes it somewhat more effortful to communicate with the communicatively impaired person.
b) A person who shares the burden of communication with the listener but the listener is still sometimes required to "fill in the blanks".

5 - Examples of the use of this classification include the following:

a) A person whose disorder is readily apparent. This person's conversation partner finds that it is effortful to communicate with the person, especially when not dealing with everyday topics or with unknown referent.
b) A child who is clearly below normal limits on a given communicative skill but retains enough functional ability in this area to get across basic wants and needs.
c) A communicatively-impaired person who shares the burden of communication with others at least half of the time. The conversational partner is often required to fill in gaps.

Severe: In general, this classification should be used to describe the student who often does not equally share the burden of communication with his/her partner. The person has limited ability to express basic wants and needs and is not usually able to participate in an actual conversation. The student's prognosis for developing any of these skills may range from poor to good. For the child, this level would be used to describe the child who is 12 months or more below age expectancy level for functional communication.

6 - Examples of this classification could include the following:

a) A person whose communication impairment interferes with all but the most elementary and routine conversational exchanges such as responding appropriately to "How are you?"

b) A person who can only be understood in limited contexts with referent known.

c) A child or adult with limited ability to express basic wants and needs. May be able to communicate some desires via simple verbal or non-verbal means.

7 - Examples of this classification could include the following:

a) A person whose communication impairment makes it difficult to communicate even with routine exchanges.

b) A person who has difficulty being understood even in limited contexts with referent known.

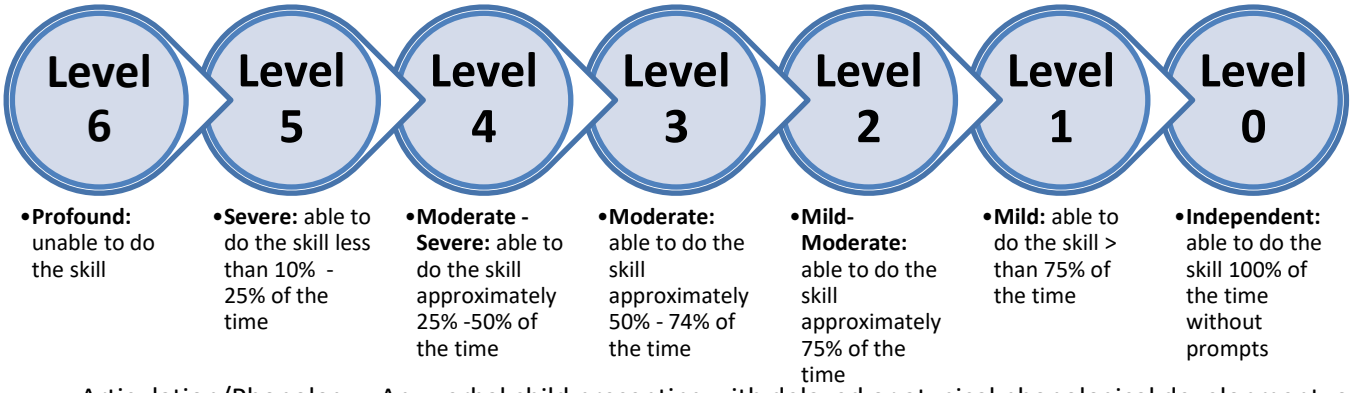
c) A child or adult with limited ability to express even the most basic of needs by any means.

Profound

8 - This category denotes no observable ability in functional communication.

Functional Communication Measures

The SLP utilizes the Functional Communication Measures to assess the student's level of dependence and severity from levels zero (0) to six (6) in the following speech-language domains (http://www.edu.gov.mb.ca/k12/specedu/slp/pdf/2.pdf):



- Articulation/Phonology - Any verbal child presenting with delayed or atypical phonological development, oral motor apraxia, or dysarthric speech secondary to congenital or acquired disorder. Speech sound production, phonological development, syllable structures, and overall intelligibility should be considered. All aspects of motor speech production (including articulation, respiration, resonance, prosody/rate, as well as timing, sequencing, and coordination of oral volitional movements) should be considered.
- Pragmatics - Any individual whose treatment plan specifically addresses pragmatic goals.
- Fluency/Rate/Rhythm - Any individual who presents with an atypical pattern of speech dysfluencies that interfere with communication. Rate, rhythm, and repetitions should be considered, as well as any secondary mannerisms or behaviors
- Language Comprehension - Any individual presenting with a receptive language delay/disorder and whose intervention plan recommends specific goals in the area of auditory language comprehension. Length and complexity, including syntactical, morphological, and semantic structures, phonological awareness, pragmatics, and metalinguistic skills presented for comprehension should be considered.
- Language Production - Any individual presenting with an expressive language delay/disorder and whose intervention plan recommends specific goals in the area of verbal language production. Length and complexity, including syntactical, morphological, pragmatic, and semantic structures of the communication should be considered, as well as any assistance needed for functional communication. Phonological awareness and metalinguistic skills should be considered.
- Voice Production - Any individual who presents with a functional or organic vocal deviation, which impacts on communication. Any individual exhibiting hypernasality secondary to velopharyngeal incompetence, or cleft palate should also be included. All aspects of vocal production including resonance, nasality, laryngeal quality, pitch, and loudness should be considered.
- Deaf and Hard of Hearing: Communication Strategies - Any individual who is being seen for aural habilitation/rehabilitation.

Benefits and Outcomes of Using Functional Communication Measure Levels

- Allows the SLP to provide consistent descriptions of the populations they serve.
- Demonstrates changes in communication status at the time of eligibility, throughout therapeutical interventions and dismissal.
- Provides the ability to benchmark and identifies progress towards goals.
- Assist with clinical decision-making process as it relates to determining most appropriate service delivery based on student's level of dependence and educational impact
- Provides consistency when describing student's performance, adverse effect of the speech-language disability and determination of the amount and type of service delivery

Eligibility for Speech and Language Therapy Guidance Document

FOR SLP USE ONLY

Page 1 of 2

Student Name:	**Student ID:**
Date of Birth:	**Date of IEP:**
Attending School:	**SLP:**

To determine eligibility for speech-language therapy services, the IEP team must document a communication deficit in at least one of the following areas on page one and *all* areas on page 2. A standardized language and vocabulary battery must be administered as a part of the assessment procedures. This documents is a GUIDANCE to be used by speech-language pathologists ONLY as they make a recommendation for speech-language services.

I. LANGUAGE (one box must be checked)

- ☐ The student scores at or below 1.50 standard deviations on a minimum of one standardized language assessment measure.

-OR-

- ☐ Formal testing is not appropriate. As an alternative method, a minimum of two informal measures were used to document the communication deficit. Describe the types of alternative assessment measures used and why formal testing is not appropriate:

II. ARTICULATION (all boxes must be checked)

- ☐ There is documentation of impaired articulation and/or phonology and a mild to severe rating on a standardized articulation/phonology measure that yields a severity rating.
- ☐ There is documentation that this deficit in articulation and/or phonology significantly affects the intelligibility of the student's oral communication.
- ☐ The student has consistent speech sound errors or disordered phonological processes that do not occur in typically developing students of similar ages or due dialectal differences. These errors persist beyond the age at which maturation alone might be expected to correct the deviation.

III. VOICE

- ☐ The student demonstrates a vocal deficit resulting from pathological conditions of abnormal use of the vocal mechanism that interferes with communication. Medical information is necessary to rule out upper respiratory infection or allergies or to determine the contribution of vocal pathology to the voice symptoms.

IV. FLUENCY

- ☐ The student demonstrates speaking behaviors characteristic of a fluency deficit. There is documentation of impaired fluency and a mild to severe rating on a standardized fluency measure. Disruptions in the normal flow of verbal expression frequently occur and are markedly noticeable, and are not readily controlled by the student.

V. PRAGMATICS (two boxes must be checked)

- ☐ The student scores at or below 1.50 standard deviations on one pragmatic measure (TOPL2, CASL-2 Pragmatic Judgment, PLSI, etc).
- ☐ The student did not meet criterion on the CELF5 Pragmatic Profile.
- ☐ Based on two informal measures, the student demonstrates deficits in communicating and understanding needs / interactions with others in various contexts.

Eligibility for Speech and Language Therapy Guidance Document

FOR SLP USE ONLY

ADVERSE EDUCATIONAL IMPACT

Must check both boxes below for eligibility for speech therapy services.

- ☐ There is documentation that the communication deficits affects oral communication in the student's academic environment and that this delay has an adverse affect on the student's educational performance, social and/or vocational development.

Method of Documentation

- ☐ Communication Samples
- ☐ Checklist
- ☐ Interview
- ☐ Observation
- ☐ Curriculum based assessments (e.g. portfolios, class tests)
- ☐ Other: _____

Explain the adverse affect:

- ☐ The student requires speech and language intervention to address oral language deficits that cannot reasonably be provided solely through his/her current educational setting. Accommodations and modifications that can be made in the student's regular education program do not, on their own, meet the communication needs of the student.

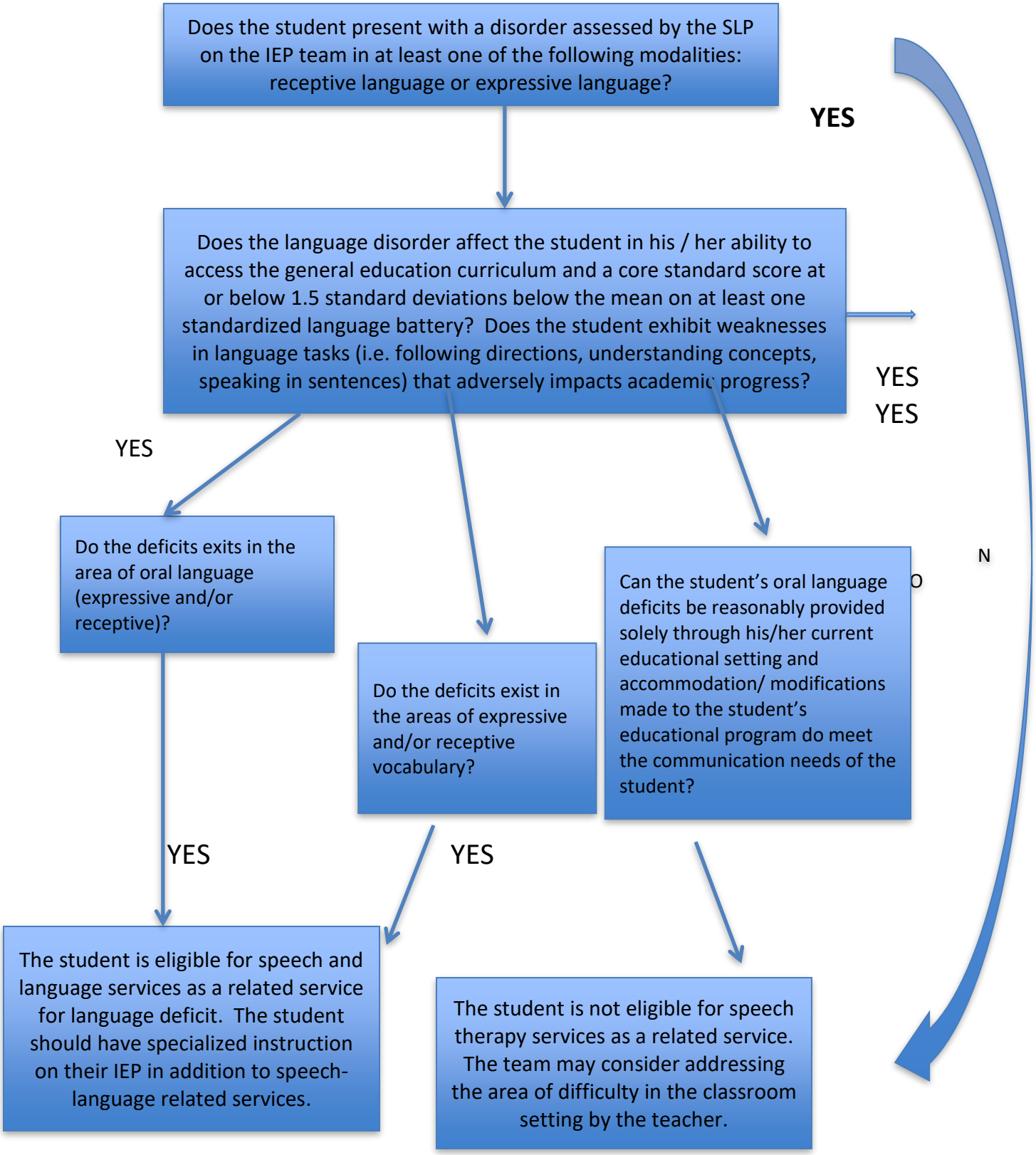
  Explain why:

EXCLUSIONS / RULING OUT OTHER FACTORS

In order for the child to qualify under IDEA, ALL of the following factors must be ruled out:

1) Is the communication developmentally appropriate? Yes or No
2) Is the communication deficit related primarily to the normal process of acquiring English as a second language? Yes or No
3) Is the communication deficit related primarily to dialectal differences? Yes or No
4) Is the relative contribution of behavioral factors greater than communication factors? Yes or No

SUMMARY OF FLOWCHART FOR IEP TEAM DISCUSSION: LANGUAGE DISORDERS



ENTRANCE FOR ARTICULATION DISORDERS

Eligibility Areas:

- **Sound Production – articulation or phonological processes**
- **Overall intelligibility**

Adverse Effect on Educational Performance:

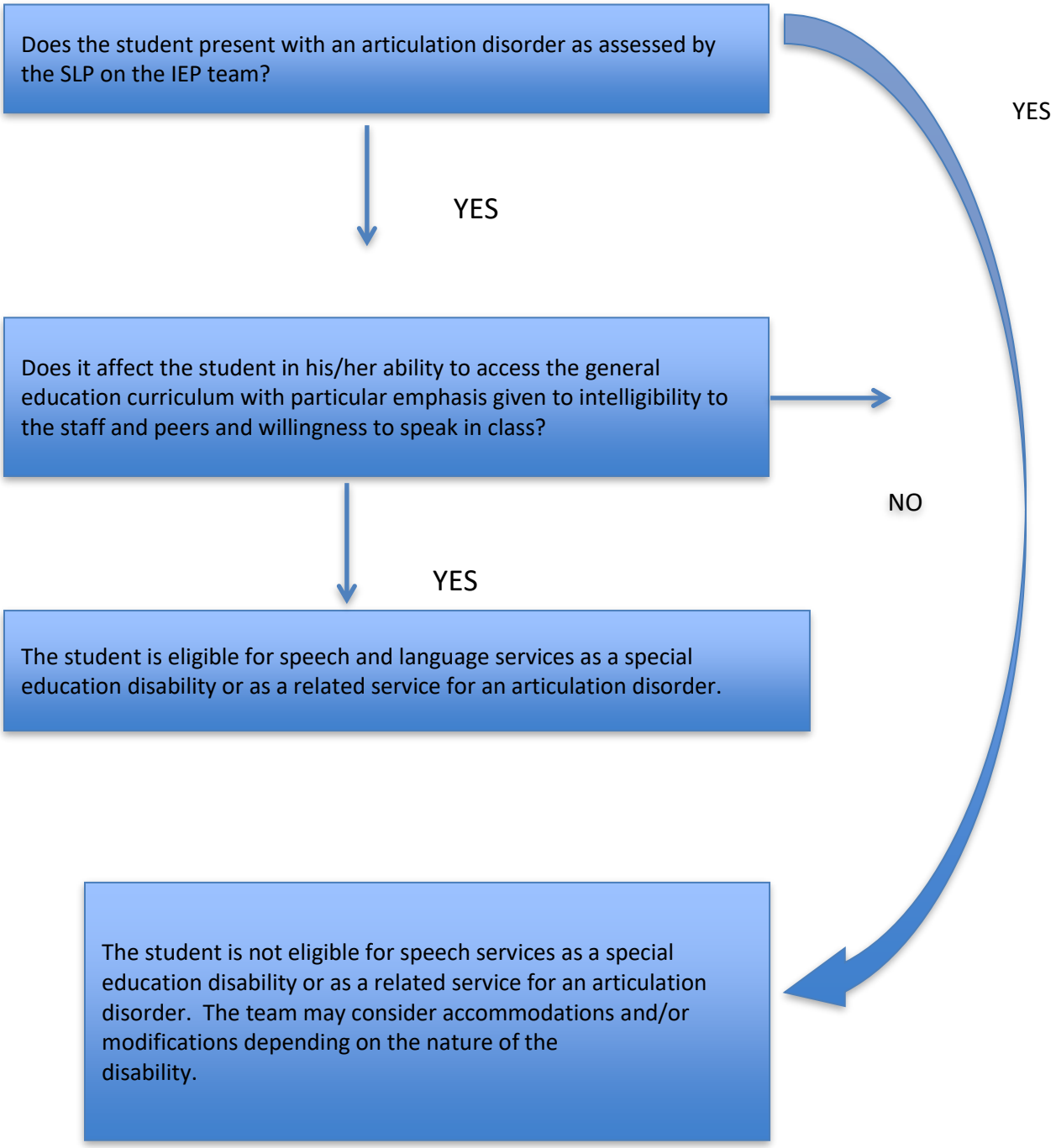
- **Oral participation**
- **Classroom listening**
- **Oral reading**
- **Content subjects**
- **Social emotional adjustment/ behavior**
- **Reaction of self, peers, teachers**

Assessment should reflect areas of concern and consider including the following when determining eligibility:

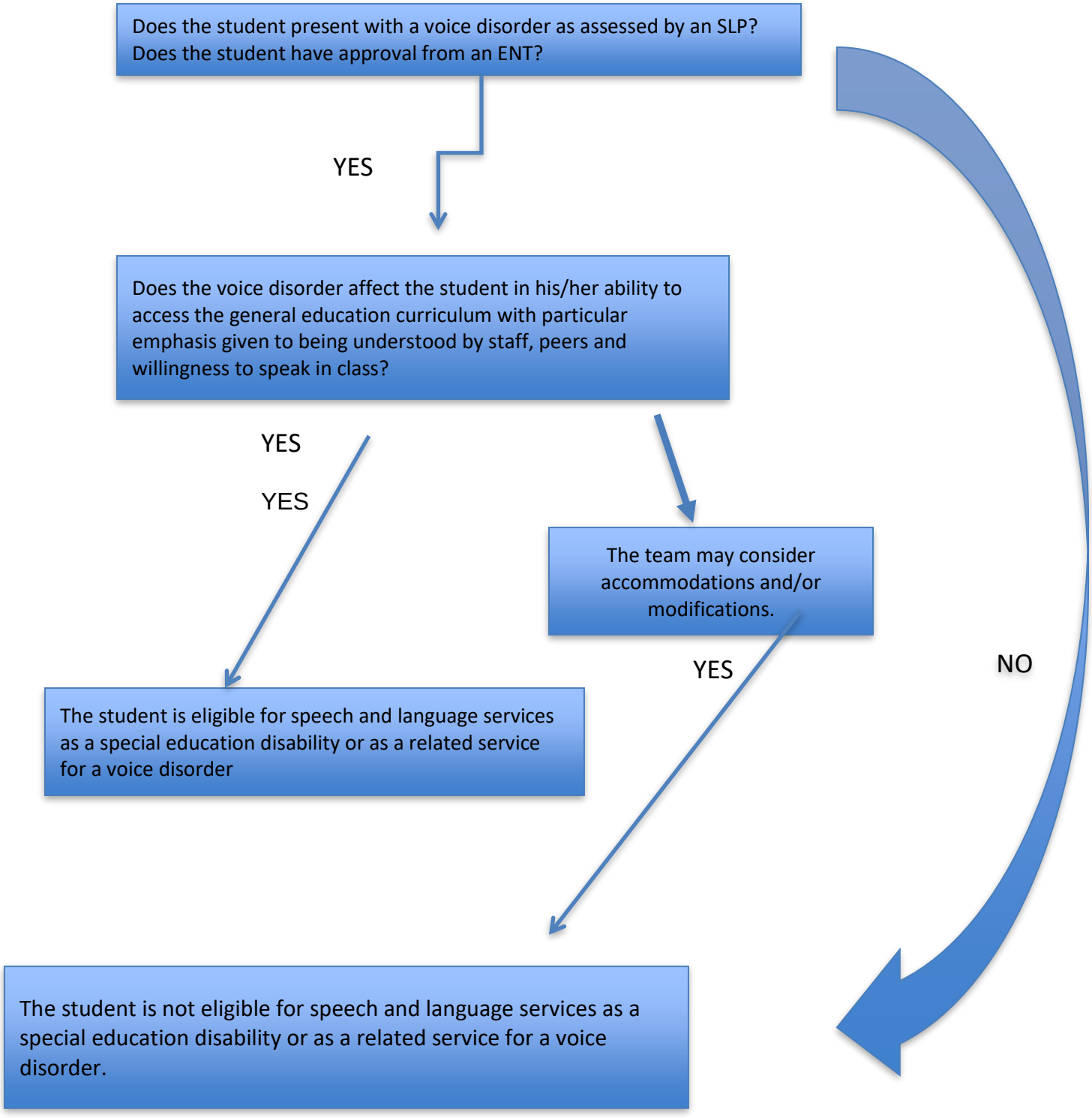
Phonology Area	**Impairment (yes or no)**	**Evidence**	**Adverse Effect on Educational Performance**
SOUND PRODUCTION			
Isolation			
Syllables			
Words			
Sentences			
Spontaneous Speech			
Oral Reading			
ARTICULATION PROCESSES			
Final consonant deletion			
Cluster Reduction			
Weak Syllable Deletion			
Glottal Replacement			
Labial Assimilation			
Alveolar Assimilation			
Velar Assimilation			
Prevocalic Voicing			
Final Consonant Devoicing			
Affrication			
Fronting			
Gliding of Fricatives			
Gliding of Liquids			
Vocalization			
Stopping			

Other			
Phonology Area	**Impairment (yes or no)**	**Evidence**	**Adverse Effect on Educational Performance**
STIMULABILITY			
Isolation			
Syllables			
Words			
Phrases			
Sentences			
OVERALL INTELLIGIBILITY			
Understanding of messages by familiar listeners			
By unfamiliar listeners			
Messages Understood in Context			
Messages Understood Out of Context			
Manner of Production Distracts from Content			
ORAL MECHANISM			
Structure			
Function			

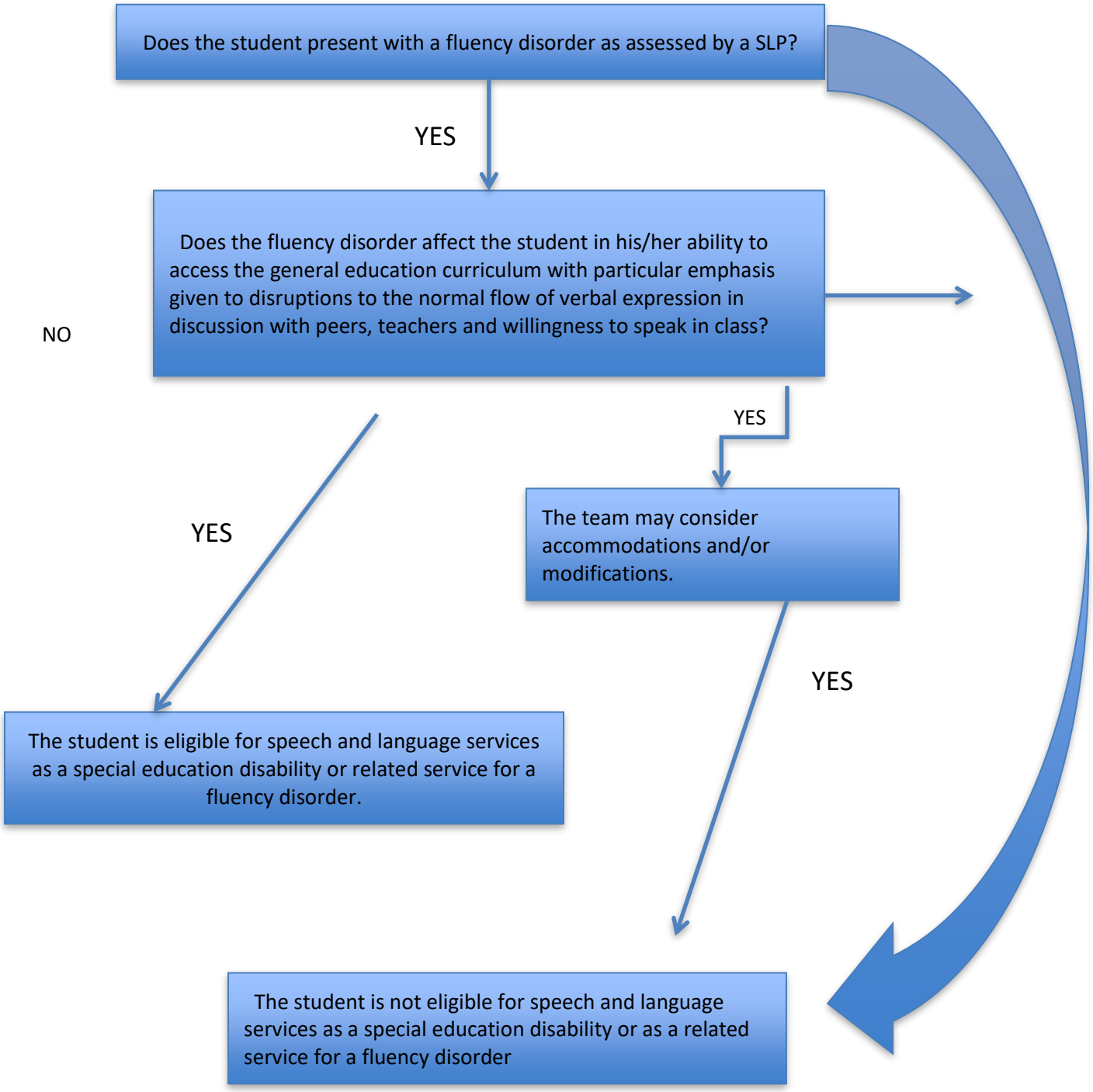
SUMMARY FLOWCHART FOR IEP TEAM DISCUSSION:
ARTICULATION DISORDERS



SUMMARY FLOWCHART FOR IEP DISCUSSION: VOICE DISORDERS



SUMMARY OF FLOWCHART OF IEP TEAM DISCUSSION: FLUENCY DISORDERS



C. PRAGMATIC LANGUAGE DISORDERS

Given the increasing in referrals of students on the autism spectrum within the district, this particular section focuses on pragmatic communication disorders. Pragmatic language difficulties frequently are a primary area of disability for children diagnosed with autism spectrum disorders. Pragmatic language skills are important for developing relationships with others, and for communicating with a range of interlocutors in a variety of contexts, including preschool and elementary school classrooms.

Pragmatics include:

1. The ability to use verbal labels to name objects, actions or attributes appropriately.
2. The ability to use language to request objects or information or to fulfill needs.
3. The ability to use language to relate previous incidents.
4. The ability to use language to relate original ideas.
5. The ability to use language to express emotions and moods.
6. Adherence to the basic rules of conversation, including imitating, turn taking, and staying on topic.
7. Adherence to the social rules of conversation such as maintenance of personal space, eye contact, posture and volume.
8. The ability to determine listener's reception and interpretations.
9. The ability to react to various speech settings appropriately.
10. The ability to understand and react appropriately to idioms, figures of speech, inferences and humor.

When one considers the complexity of the process listed above, it is understandable why a singular formal test would not accurately identify something as complex and context based as pragmatic problems. Pragmatics represents the whole act of communication and is not simply a sum of the parts.

The following methods may be used to assess pragmatic language deficits:

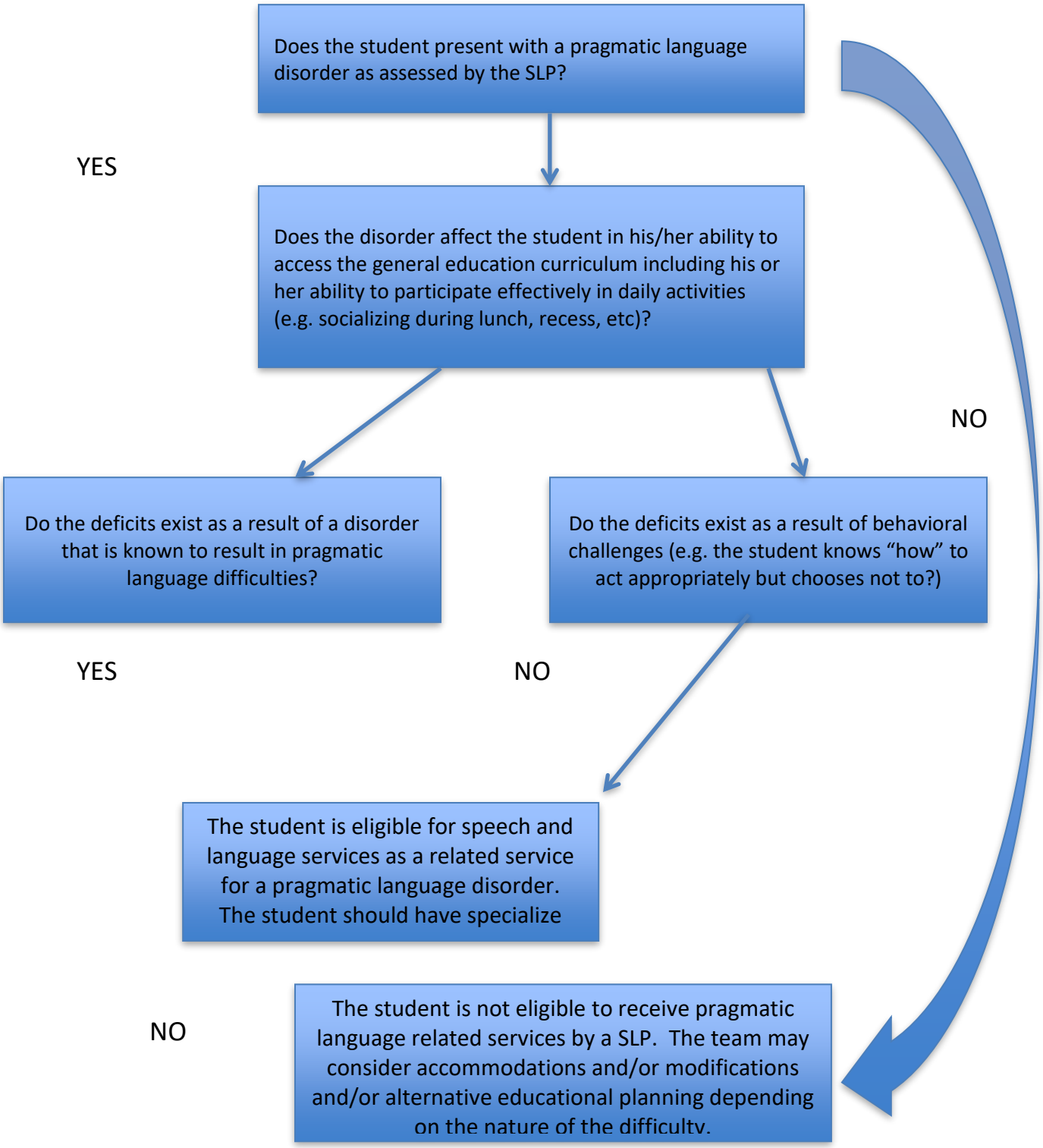
- Observe the student in various situations at school
- Interview people who are familiar with the student about what communication situations are challenging and identification of particular difficulties.
- Complete inventories or checklists that provide a criterion score (i.e. CELF-V)
- Administer the CASL-2 Pragmatic Judgment Subtest.
- Using informal situations to sample the person's ability to deal with specific communication challenges.

For an elementary school age student, this might translate into an observation in the classroom during group instruction and small group sessions, at recess, and in the lunchroom. Parents, teachers, aides and peers might contribute useful information during an interview or through a checklist. The student might be able to identify situations that represent a challenge by completing a checklist. Challenging situations could be embedded within the daily routine so that the student might demonstrate how he manages situations such as being overlooked as papers are passed out, someone teasing him, or needing to ask for assistance with a difficult task. This type of data is called qualitative data. This data collection method is used to analyze complex behaviors such as social interaction. Qualitative data can be as legitimate as quantitative data (test scores) for decision-making about programming needs if it has been collected in an appropriate manner.

NOTE: Pragmatic skills should not be addressed only by the SLP. It must be addressed by the teacher, SLP, SW and / or Psychologist and reflected in the IEP goals. This is best practice, as pragmatic language skills cannot be addressed in isolation as it fails to generalize across the academic setting without support from educational and other related

service staff. Since pragmatic language addresses the use of appropriate verbal and nonverbal communication across a multitude of social contexts and interactions, it cannot only be addressed by the SLP.

SUMMARY FLOWCHART FOR IEP TEAM DISCUSSION: PRAGMATIC LANGUAGE DISORDERS



D. LITERACY : ROLE OF THE SPEECH-LANGUAGE PATHOLOGIST

"Collaborative interventions featuring collective involvement of preschool and kindergarten teachers, SLPs, and parents to ensure timely development of key reading, precursors for all at-risk children is currently the gold standard for emergent literacy education and intervention."

Snow, C., Burns, M.S., & Griffin, P. (Eds.). (1998). *Preventing reading difficulties in young children.* Washington, DC: National Academy Press.

DCPS' position on the Speech-Language Pathologist's role and responsibilities in literacy: Phonemic awareness, reading comprehension, decoding, spelling, fluency and written expression are areas that are addressed under the educational assessment and are considered specialized instruction. The SLP has only a role in the identification and treatment of oral language disorders and not reading and written language.

Spoken language provides the foundation for the development of reading and writing. Spoken and written languages share a reciprocal relationship, building on each other to result in general language and literacy competence. Students who have problems with spoken language frequently experience difficulties learning to read and write and students with reading and writing problems often experience difficulties using language to communicate, think and learn. Research shows that students with communication disorders may perform at a poor or insufficient academic level, struggle with reading, and have difficulty understanding and expressing language. It will be the DCPS' Speech and Language Pathologist responsibility to address solely those concomitant oral language deficits, while the regular/special educator and/or reading specialist will address those academic deficits in reading and written expression.

Targeted Emergent Literacy (Pre-Literacy) Skills

- **Phonological Awareness (associating sounds with symbols and creating links to word recognition and decoding skills necessary for literacy).**
    - Discrimination (awareness of sounds in language)
    - Rhyming (awareness of words that sound alike)
    - Segmentation (awareness of that sentences can be broken down into words, syllables and sounds
- **Narrative and Literate Language (the process of storytelling and comprehension of story elements)**
    - Answering wh-questions
    - Recalling information and story details
    - Understanding cause-and-effect relationships
    - Following directions
    - Sequencing steps and event

National Reading Panel. (April 2000). Teaching children to read: An evidence-based assessment of the scientific research literature on reading and its implications for reading instruction (NIH Publication No. 00-4769). Washington, DC: U.S. Government Printing Office.

E. SPEECH AND LANGUAGE DISMISSAL GUIDELINES

The Speech-Language Pathologist MUST utilize the underlining criteria to terminate/discontinue Speech-Language Intervention Services

Re-evaluation of a student is required by IDEA Improvement Act of 2004 (C.F.R. 34 § 300.305) to determine that a child no longer has a disability. Re-evaluation must include current performance data and IEP progress data. Dismissal decisions must be individualized, based on developmental norms, progress data collected, assessment information and the current best practices. **In order to dismiss from speech-language services, the provider must complete a comprehensive assessment.**

The following steps should be followed when considering exiting a student from special education services for speech and/or language impairment

1	The criteria for exit from services for speech and language impairments should be discussed with the IEP team members at the beginning of intervention
2	The decision to dismiss is an hypothesis and should be assessed periodically
3	The decision to dismiss is based upon IEP team input (i.e., parent, teacher, etc…) initiated by the Speech-Language Pathologist or any other team member.
4	If progress is not observed over time changes must be made in the interventions/accommodations. If continued lack of progress is shown specific goals and intervention approaches must be re-examined. If additional progress is not observed, exit from special education may be warranted and considered.
5	If gains are general and are not related to intervention
6	If it can be determined that new skills would not greatly improve educationally-based speech and language skills of students with severely impaired communication or cognitive systems, and no specific special education goals remain
7	The student's current academic level, behavioral characteristics and impact o educational performance should be considered.

Exiting Factors and Rationale for Dismissal

Current Level of Performance

- Goals and objectives have been met.
- Maximum improvement and/or compensatory skills have been achieved
- Communication skills are commensurate with developmental expectations
- Successful use of augmentative or assistance communication device.

Behavioral Characteristics

- Limited carryover due to lack of physical, mental or emotional ability to self-monitor or generalize to other environments
- Poor attendance
- Lack of motivation
- Other disabilities or interfering behaviors inhibit progress
- Limited potential for change

Educational Impact

- Communication skills no longer adversely affect the student's education performance as seen by
- Communication skills no longer cause frustration or other social, personal, emotional difficulties.

Dismissal from Speech-Language Services may occur if:

- the student no longer has a speech-language deficit; OR
- although the student has a speech-language deficit, it no longer affects his/her academic performance, and accommodations and/or modifications can be provided to address communication needs; OR
- the student demonstrates a documented lack of measurable progress, triennial to triennial, with consistent speech – language services; OR
- the student has a documented history of refusal of services; OR
- the student's parent/guardian requests dismissal

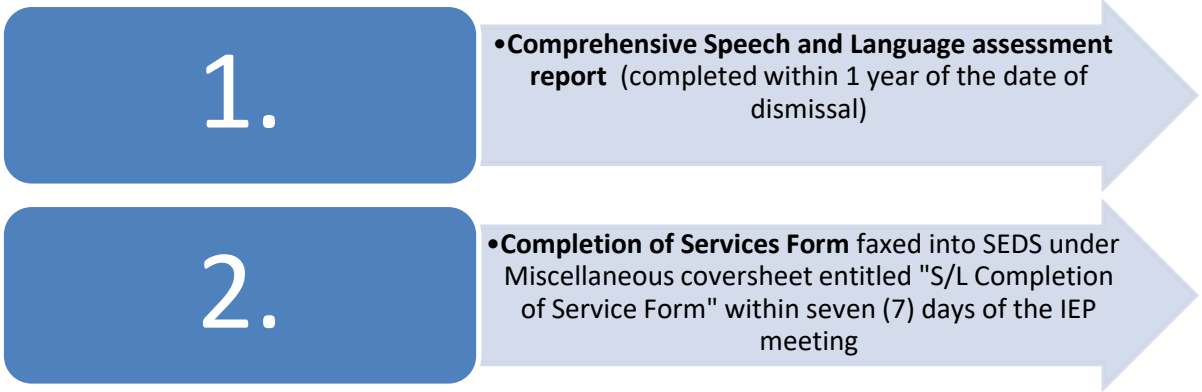
When students are not making progress as deemed by the Speech-Language Pathologist, the MDT/IEP team ***must***, according to IDEA Improvement Act of 2004 (C.F.R. 34 § 300.324 (c)), review the child's IEP to determine whether the annual goals for the child are appropriate. The IEP should be revised, as appropriate, to address any lack of progress toward the annual goal prior to consideration for dismissal. When a student demonstrates a documented lack of measurable progress, triennial to triennial, with consistent services, the provider must provide evidence to the MDT of supporting documentation (types of interventions provided, work samples, teacher interview, data collection, etc…) to support that the child has maximized the benefit of the services which may indicate dismissal.

Best practice for students who receive "Consult-Only" speech and language services, should be re-evaluated and dismissed after a full year of not receiving direct services. The rationale behind this practice assumes that during the consultation-only period of service the student's speech and language skills were being generalized across the academic setting and did not require direct services to access his/her curriculum. Therefore, the student should transition from consultation-only services and dismissed through a comprehensive speech-language assessment.

Once a student has been dismissed from services, the provider must fax the "Completion of Service" form into SEDS and label a miscellaneous coversheet as "S/L Completion of Service Form". The "Completion of Service" form requires the signature of the student's parent or the student if age of majority has been reached and the transfer of rights has been officially documented.

Please note that all service trackers for services provided to the student prior to the meeting must be entered and finalized in SEDS prior to the service being removed from the student's IEP.

Information that <u>Must</u> to be Uploaded into SEDS upon Dismissal from Services



Dismissal Through Eligibility/Triennial Evaluations

- Complete "Analyzing Existing Data" section in SEDS by including comprehensive information about student's performance and abilities
- Determine if formal assessments are warranted
    - If **YES** → complete assessments and make final determination based upon findings
    - If **NO** → include the supporting data used to determine why assessment is not warranted to determine continued eligibility in the AED
- Confirm with LEA and Case Manager that Speech and Language is NOT clicked for the "Eligibility Determination" portion .
- "Completion of Service" form is completed, parent signature has been obtained and faxed into SEDS along with the signature page (from IEP meeting)

Speech and Language Therapy Dismissal Guidance

FOR SLP USE ONLY

The IEP team must include a speech - language pathologist and information from the most recent comprehensive assessment when discussing dismissal from speech - language services. Providers should ensure that they utilize and present the following information to their educational teams when dismissing students: assessment findings and interpretation of scores; data collection from therapy sessions to support plateau/mastery; supporting information from classroom teacher regarding potential educational impact within the classroom setting.

Student Name:	**Student ID:**
Date of Birth:	**Date of IEP:**
Attending School:	**SLP:**

Section I: General Dismissal Criteria (Must Select One)

- ☐ The student no longer requires speech and language therapy. Documentation does not support a continued deficit that adversely affects oral communication in the student's academic environment, social and/or vocational development.
- ☐ Although the student has a speech-language deficit, it no longer affects his/her academic performance, and accommodations and/or modifications can be provided to address communication needs.
- ☐ The student demonstrates a documented lack of measurable progress, triennial to triennial, with consistent speech – language services.
- ☐ The student has a documented history of refusal of services. Due diligence procedures and documentation have been completed and are noted in SEDS (service tracker notes and communication log).
- ☐ The student's parent/guardian requests dismissal.

Section II: Specific Dismissal Criteria by language area.

AREA	Description
LANGUAGE (Must check one box)	☐ The student scores at or above 1.50 standard deviations on a minimum of one standardized language assessment measure. ☐ The student's score continues to fall at or below 1.5 standard deviations on the standardized measure but demonstrated improvements with IEP goals and improved performance on subtests addressed in intervention sessions.
ARTICULATION	☐ There is no documentation of impaired articulation and / or phonology as measured by a standardized assessment measure.
VOICE	☐ The student no longer demonstrates a vocal deficit.
FLUENCY	☐ The student no longer demonstrates speaking behaviors characteristic of a fluency deficit as measured by a standardized assessment. Disruptions in the normal flow of verbal expression do not frequently occur and are not markedly noticeable with respect to the student's connected speech pattern.
PRAGMACTICS (Must check one box)	☐ The student scores above 1.50 standard deviations on one pragmatic measure. ☐ The student met the criterion score on the CELF-5 Pragmatic Profile. ☐ The student continues to demonstrate deficits in communicating and understanding needs / interactions with others in various contexts but has demonstrated improvements with the IEP goals and implementing strategies.

SECTION VII
Speech & Language Intervention

A. RELATED SERVICE PROVIDER WEEKLY BUILDING AND INTERVENTION SCHEDULE

By the first day of school, Local Education Agency (LEA) must identify all students who require related services as per their IEP. This identification process includes:

- Type of service, Related Service Provider (RSP) assigned to the student
- Beginning date of service
- Intensity of service (e.g. one 60-minute session per week)

During the first two weeks of school, Related Service Providers must:

- Check with the LEA at each of their assigned schools to ensure they have all of the students on their caseload assigned to them in SEDS.
- If RSPs have difficulty engaging their LEA in this process, they should contact the OSSE SEDS (EasyIEP) Call Center (202) 719-6500 Monday – Friday, 7:30am – 6:00pm) for assistance in appropriately assigning students to their caseload and immediately notify their Program Manager via email. You can add students to your caseload using your EasyIEP access.
- Identify any students the RSP does not have the capacity to serve.
- Supply this information to their Program Manager immediately to ensure the Program Manager is aware of the capacity issue at that school.

Initiation of Services at the Beginning of the School Year

Providers will be notified of the initiation of the Speech and Language intervention start date during Pre-service Week. If services are not rendered that week, providers are required to make-up missed services for that week prior to the end of the 1st reporting period. Each service provider must complete and submit a copy of his or her schedule within one week after starting at the assigned school(s). Annually, the schedule need to be signed by the school principal is due to your PM via fax or email within the first two week of the beginning of school. If there are any changes to the schedule changes (i.e., addition of student, removal of students, changes in service times or locations) All submitted copies of the original schedule and updated schedules **must be signed be the principal at the assigned school(s)**. A copy of the schedule must be submitted to the program manager, special educational coordinator and principal.

Initiation of Services Throughout the School Year

Speech-Language IEP services for all students receiving an initial IEP, recently enrolling or recently transferred must be delivered within 14 calendar days of enrolling into the school. To ensure that providers are aware of new students who may be enrolling in their schools who require services, the RSP should check with their LEA Representative assigned to their school(s). Providers should document all attempts to provide and initiate speech and language services within SEDS.

Once a Part C to B transition student enrolls (ASPEN level 4) in a school, the principal and LEA Representative Designee are notified via email. This Quickbase email alert includes the student information, IEP services and reminds the LEA Representative Designee to add the respective school-based RSP in SEDS as the assigned provider.

RSPs will receive an email alert from Quickbase once a Part C to B transition student registers (APSEN level 5) in their school with their respective IEP related service. The email correspondence will include the deadline to deliver the services (direct and/or consultation). The school LEA Representative Designee will also be included on the correspondence.

I. Elements to Include When Creating Your Intervention Schedule

Your intervention schedule is the first line of defense in assisting you with workload and caseload management. The below elements are helpful in the event the provider has an unplanned leave of absence or if additional assistance is provided to help manage the caseload. Students are often grouped by age or area of deficit being addressed. If you ever need assistance with formulating your intervention schedule, please contact your Program Manager. Intervention schedules must contain the following information:

- All students listed on our caseload must appear on your schedule, including indirect/consultation services
    - First and Last Name
    - Type of Speech-Language Deficit Being Addressed (if multiple can be separated by hashmarks "/")
        - Articulation (A)
        - Language (L)
        - Consultation (C)
        - Fluency (F)
        - Voice (V)
            - Example: John Doe (A/L)
- Name of Clinician
- Name of School
- Contact telephone number for the School
- Make sure to include the following:
    - Time for IEP meetings
    - Time for assessments
    - Time for Case Management
    - Indirect/Consultative services
    - Time for collaboration and planning
    - Time for make-up sessions
    - Time for lunch
- Room # or location of where the service is provided (you may also indicate if you are proving classroom-based services by indicating teacher's name and classroom number).
    - Example: James Doe (L)
Jane Blank (L)
Ms. Nelson's Class (Rm. 202)

SLPs assigned to an assessment team must submit a weekly schedule to their assigned Program Manager.
If a related service provider varies their work location from what is recorded on the schedule, the principal and Program Manager must be notified. Refer to Appendix for a copy of the Related Service Provider Weekly Building Intervention/ Assessment Schedule.

II. Introductory Communication to Parents / Guardians from RSPs

Each Related Service provider is required to send an introductory letter to each parent / guardian of the students on his/her caseload no later than the Friday of the second week of employment. The correspondence should contain the following information:

- Your name
- Days assigned to School
- Day student is scheduled for Speech Therapy
- Your contact information (ex. Email or school phone number and extension)

Please refer to appendices for a template. The SLP must then document this action in the communications log of each student in SEDS.

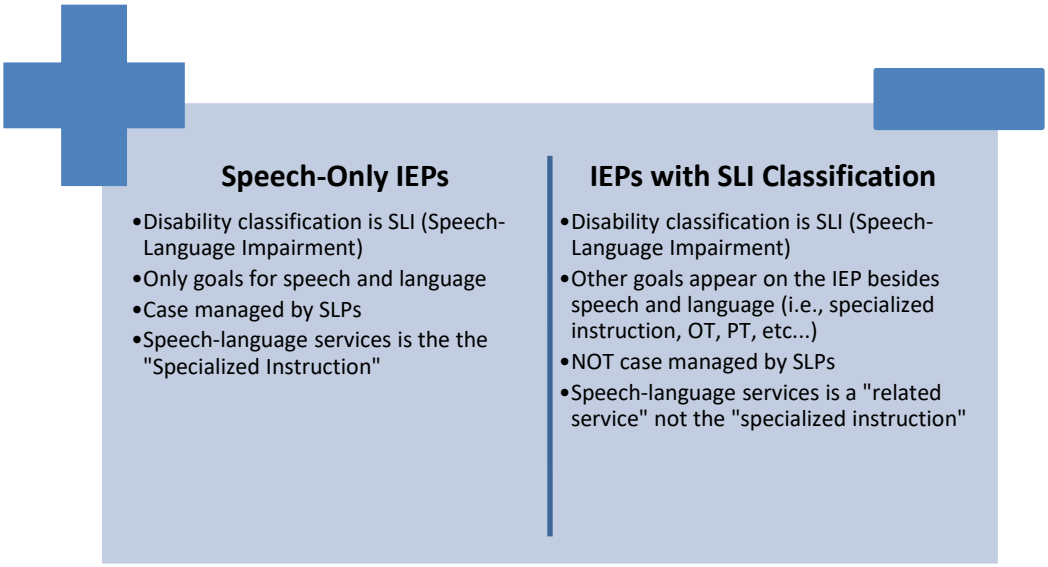
During the school year, students are added to the RSP caseload. Once a new student is added to an SLP's caseload, the RSP is required to send an introductory letter to the parent of the new student within two weeks.

B. IEPs with Only Speech and Language Goals

Speech and language services can be provided either as a primary service or as a related service. A primary service consists of speech language services as the specialized instruction needed by a child with a disability of SLI to benefit special education. When speech is the primary service, the student's disability classification must be SLI (Speech Language impaired). An IEP with the disability coding of SLI will fall into two categories: 1.) IEPs with only speech and language goals (to be case managed by providers); or 2.) IEPs with SLI classification that may also have specialized instruction and/or related services, which is not to be case managed by providers.

If a student is receiving special education services in the areas of reading, mathematics or written expression in the form of classroom instruction from a special education resource teacher or special education teacher, then speech and language services must be a related service. Special education instruction services would serve as the primary service. The disability classification can be SLI or any other IDEA disability classification. The primary disability should be the disability with the most significant impact on the student's ability to access the

curriculum.



Whether speech and language is a primary service or a related service does not depend on the severity of the disability. A comprehensive speech assessment must be completed in order for a student to be found eligible for speech language services, regardless of whether the speech therapy service is a primary service or a related service.

Per IDEA, you cannot have an IEP with speech consultation services only even for IEP's with a classification of SLI. An IEP with consultation must include either specialized instruction or a related service.

* Refer to March 2009 memo from Dr. Richard Nyankori in the Appendix

Below is the process outlined regarding the appropriateness of psychological assessments for initial and reevaluations for students considered or already classified for eligibility under SLI/speech only IEP:

Initial Evaluations

Psychologist will complete a psychological screener to determine whether a cognitive assessment is warranted. If warranted then a psychological evaluation assessing cognitive functioning will be conducted on students to ensure identification of any processing deficits or baseline functioning levels that may impact communication abilities, *when there are communication and/or language concerns identified. If the area of concern is only speech (i.e. articulation, stuttering, voice, apraxia, and dysarthria), then no Psychological evaluation is warranted.* ***Unless the speech issue is attributed to a traumatic life event that causes educational impact.***

Reevaluations

1. Psychologists will not conduct an automatic Data Evaluation Review Report.
2. SLPs will compile all necessary data to complete Analyzing Existing Data review
3. If the IEP team believes the disability classification may be inappropriate and that cognitive testing is needed to make a determination, a psychological assessment will be completed.

A psychological assessment will only be completed under conditions outlined in #1; it will not be completed for the sole rationale that a cognitive was not completed during the initial evaluation.

Please note, that if a student may no longer meets the qualifications of SLI and/or there is a concern that another disability may exist, it is important that the speech and language provider and school psychologist collaborate prior to the student's upcoming annual/re-evaluation meeting. The SLP along with the general/special education teacher are responsible for informing their school psychologist regarding concerns that are believed to be greater than a speech and language impairment. This notification needs to occur no less than six (6) weeks prior to the scheduled meeting, to allow the school psychologist adequate time to complete RTI in order to have the appropriate documentation to present to the team regarding the student's response to research-based interventions, the need for additional testing and/or to determine changing the student's disability classification.

C. Writing PLAAFP and Goals for IEP

Present Levels of Academic Achievement and Functional Performance (PLAAFP) (also referred to as PLOP)
The first main element of an IEP is a statement of the student's present levels of academic achievement and functional performance (PLAAFP). The purpose of the PLAAFP is to describe the problems that interfere with the student's progress in the general education classroom and with the general education curriculum. The PLAAFP is the foundation to develop the student's IEP and measure the student's short-term and long-term success. From the PLAAFP, the IEP team develops an IEP that identifies the student's appropriate goals, related services, supplementary aids and supports, accommodations, and placement. The IEP team should include goals as well as any necessary accommodations and/or modifications, related service, or supplementary aides and supports to address any identified area of weakness. Other educational needs of the student, not directly related to the academic curriculum, must also be addressed by the team, the SLP may need to address characteristics such as dysphasia where feeding and swallowing disorders impact the student's ability to participate in lunch time activities (CEC, 2000).

Academic Achievement	Functional Performance
• Reading • Written Language • Mathematics	• Physical, Health, Sensory Status • Emotional/Social/Behavioral • Communication difficulties • Vocational skills (ages 15 and older) • Daily life activities

Anyone who reads a student's PLAAFP should have a comprehensive understanding of the student's strengths and weaknesses. The PLAAFP should contain information on both the student's academic achievement and functional performance:

Data Sources
In order to draft a student's PLAAFP, the IEP team should consider data from a variety of sources. Data sources for the PLAAFP include:

- Most recent special education evaluation
- Student performance on DC-CAS/DC-CAS Alt
- Teacher reports
- Classroom observations
- Parental input
- Cumulative records: grades, attendance, retentions
- Discipline records

Three Components in Writing a PLAAPF Statement

Component 1 Present Levels of Academic Achievement and Functional Performance:	A description of the student's strengths and weaknesses using multiple sources of current data.
Component 2 Description of how the student's disability affects the student's **access** to the general education curriculum	Focus on the skill sets the student requires to access the general education curriculum, as well as functional performance, that impacts the student's ability to receive instruction in the general education setting.
Component 3 Description of how the student's disability affects the student's **progres**s in the general education curriculum	Describe how the disability affects the student's progress in the general curriculum. Identify the previous rate of academic/developmental growth and progress towards meeting grade- level standards/milestones. Convey the unique challenges or barriers that exist for the student as a result of the disability

Examples of Present Levels of Academic Achievement and Functional Performance

Example 1:
Todd, a fourth-grader, when given a first semester, second-grade-level passage currently reads 85 words per minute with 5 errors when assessed using curriculum-based measurement. According to district norms, Todd is reading in the 45th percentile rank for second-graders in the fall. There is approximately a two year gap in reading fluency between Todd and his typical peers in fourth-grade. He is not able to answer correctly comprehension questions for texts that he has read or those presented auditorially. Todd's narrative storytelling skills are not sufficiently developed to support fluid reading and comprehension of fourth-grade text.

Example 2:
Emily uses single words and a few two and three-word combinations to communicate her wants and needs at home and school. She initiates social interactions with her peers and labels objects in her environment. Children Emily's age typically use four to five word sentences to communicate. Emily's communication skills make it difficult for her to communicate with adults and peers and to share what she has learned. During a 20 minute play period with peers, Emily used 18 single word utterances (5 utterances also included a sign) and one two-word combination. When two-word combinations were modeled for Emily, she imitated only the last word of the phrase.

PLAAFP linked to Goals

PLAAFP are inherently linked to the development of annual goals because they serve as baseline data that describe how the student is currently performing academically and functionally. Therefore, PLAAFP should be used as the starting point in developing goals. For each area of weakness identified in the student's PLAAFP, the IEP team must develop

appropriate goals.

The present levels section provides insight into the relative strengths and needs of the student. Anyone who reads this section of the IEP should get a quick, yet comprehensive understanding of where the student is struggling and how to capitalize on the student's strengths. When writing the present levels section, teachers should have access to formal assessment results, and the classroom data – both quantitative and qualitative – that has been collected over the course of a year.

Goals entered into the Speech and Language section of the IEP in SEDS should only address the following areas of communication: speech production, language (receptive, expressive, pragmatic), voice and/or fluency. Goals pertaining to the following should NOT be entered in the Speech and Language section of the IEP in SEDS: written expression, reading comprehension, math calculation, occupational therapy, physical therapy, social/emotional/behavioral development. This is because Speech-Language Pathologists are only trained and certified to implement services as it relates to the area of expertise in the domains of communication (speech and language) as previously indicated.

Example 1:
Todd will increase ability to understand and respond to literature from curriculum a semester level as measured by curriculum testing.

Example 2:
Emily will use 2 word utterances and increase by 1 word observed during a structured play activity with 8 out of 10 opportunities.

IDEA (the Individuals with Disabilities Education Act) 2004 wants to ensure that children with disabilities have "access to the general education curriculum in the regular classroom, to the maximum extent possible, in order to (20 U.S.C Sec. 1400 (c) (5) (a) (i)) meet developmental goals, and to the maximum extent possible, the challenging expectations that have been established for all children; and (ii) be prepared to lead productive and independent adult lives, to the maximum extent possible."

DCPS requires goals written in a S.M.A.R.T. format.

S	Specific
M	Measurable
A	Use Action Words
R	Realistic and relevant
T	Time-limited

Specific goals and objectives "target areas of academic achievement and functional performance. They include clear descriptions of the knowledge and skills that will be taught and how the child's progress will be measured".

- Non specific example: Joey will improve articulation skills.
- Specific example: Joey will correctly produce /s/ phoneme in initial position 40 out of 50 words.

Measurable means that the goal can be measured by counting occurrences or by observation. "Measurable goals allow

parents and teachers to know how much progress the child has made since the performance was last measured. With measurable goals, you will know when the child reaches the goal".

- Non-measurable example: Jack will increase his fluency in class.
- Measurable Example: Jack will utilize easy onset with prompting in a structured classroom activity in increments of 10 minutes.

Action words - "IEP goals include three components that must be stated in measurable terms: direction of behavior (increase, decrease, maintain, etc.), area of need (i.e. reading, writing, social skills, transition, communication, etc.), and level of attainment (i.e. to age level, without assistance, etc.)"

- No use of action words example: Luke will give eye contact during conversational speech.
- Use of action words example: Luke will maintain eye contact with prompting during conversational speech in increments of 5 minutes

Realistic and Relevant goals and objectives "address the child's unique needs that result from the disability. SMART IEP goals are not based on district curricula, state or district tests, or other external standards".

- Unrealistic Realistic example: Evan will increase performance when following directions in class.
- Realistic and relevant example: Evan will follow three step unrelated directives in order without prompting, 8 out of 10 trials.

"Time-limited goals enable you to monitor progress at regular intervals"

- Not time-limited example: Rachel will improve her communication skills demonstrated by mastery of goals.
- Time-limited example: Rachel will increase her expressive vocabulary demonstrated by orally identifying 50 pictures from flashcards in 30 minutes then decreasing the time in 5 minutes intervals.

*Annual goals and objectives are required for students that are taking an alternative assessment (portfolio).

**** Goals are required for students receiving consultation services on their IEPs. This is necessary to indicate how the skills will be monitored and/or generalized across the academic setting to increase the student's overall independence . ****

Examples of Consultation Goals

Ex. 1 : Based on observations and/or report from educational staff, George will apply targeted compensatory speech intelligibility strategies (i.e., slow speech rate, over-articulate, etc…) engage in academic tasks across educational and social settings, to be monitored at least 2 times per reporting period.

Ex. 2: In order to ensure safe feeding strategies are being maintained, implementation of Susie's feeding plan will be monitored by observing her self-feed or being fed by educational staff at least 2 times per reporting period.

Ex. 3: Fluency-enhancing and stuttering modification strategies/techniques will be shared and reviewed with Joe's education team to increase his fluency within the classroom setting at least one time per month.

Ex. 4 : Articulation strategies and techniques will be shared and/or reviewed with Debbie's parents and/or outside treating therapist via email/phone/handouts to increase her speech production skills in the home and community at least 1 time per month.

3236 Reference: Parenting Special Needs Magazine, July/August Issue, Copyright [2009] by Parenting Special Needs LLC. www.parentingspecialneeds.org

COMMON CORE STATE STANDARDS (CCSS)

When formulating goals, providers should consider and incorporate standards from common core. This is important because it links the goals that are being addressed in therapy sessions to work students are doing in their classrooms within their academic curriculum. CCSS is organized by grade level across different academic content and context (i.e., speaking and listening, reading comprehension, written expression, etc…). The incorporation of CCSS in your goals and interventions will increase the generalization of speech and language skills and increase student's independence to make gains in the classroom.

Below are some links to assist providers with linking their goals to CCSS:

- CCSS DCPS Link
  - Elementary - http://dcps.dc.gov/page/elementary-school-academic-standards
  - Middle - http://dcps.dc.gov/page/middle-school-academic-standards
  - High - http://dcps.dc.gov/page/high-school-academic-standards
- Goal book Link
  - The sign in page is **https://goalbookapp.com/accounts/users/sign_in**
  - Here's a link to a recorded webinar for related service providers: https://goo.gl/3AiYUX

D. CONSULTATION (INDIRECT) SERVICES

Consultation is a service provided indirectly to the student consisting of regular review of student progress, student observation, accommodations and modifications or core material, developing and modeling of instructional practices through communication between the general education teacher, the special education teacher, parent and/or related service provider. Consultation is not the provision of direct speech and language services to a student. The focus of consultation is to ensure the generalization of the addressed speech and language goals are generalized across the academic setting and to assist the student with being independent of the skill outside of the therapy setting.

When documenting indirect services in SEDS, consultations should never be listed as a direct service in the service tracker notes, nor should the activity indicated in the note reflect that a direct service was delivered to the student. Students to be found eligible for speech and language services in an initial speech and language evaluation, should never receive "Consultation-Only" services on their IEPs.

Goals are required for students receiving consultation services on their IEPs. This is necessary to indicate how the skills will be monitored and/or generalized across the academic setting to increase the student's overall independence

Best practice for students who receive "Consult-Only" speech and language services, should be re-evaluated and dismissed after a full year of not receiving direct services. The rationale behind this practice assumes that during the consultation-only period of service the student's speech and language skills were being generalized across the academic setting and did not require direct services to access his/her curriculum. Therefore, the student should transition from consultation-only services and dismissed through a comprehensive speech-language assessment.

E. MONTHLY IEP SERVICES

Per a student's IEP, speech therapy services can be provided weekly, monthly or quarterly. Those mandated services must be provided in / out of the general education setting based on the setting designated on the IEP.

All IEP related services were written using a monthly frequency. While services are written in a monthly format, delivery throughout the month should reflect the student's need.

- Make monthly selection in SEDS.
- Benefits of monthly services:
  - Flexibility in providing services
  - Accommodating student and classroom needs
  - Increased opportunities to integrate services in the classroom or during school events
  - Allows rescheduling of sessions to accommodate provider unavailability
  - Scheduling options that can change to meet the student's needs
  - Increased opportunities to make up missed sessions

**** Service delivery implemented must match the frequency, duration and setting (inside general education setting or outside the general education setting) on the current IEP ****

F. Service Delivery Requirements

DSI's goal for all related service providers is to achieve 95% monthly documentation and a minimum of 85% service delivery rates each of student for each month. The IEP is a legally mandated document that includes the goals, specialized instruction, services and frequency / duration of the required for a student needed to access the curriculum. RSPs should provide IEP services in alignment with the IEP frequency and duration listed on each individual student's IEP. Provider's intervention schedules should include flexibility to accommodate the total prescription of services (i.e. weekly or monthly) on students' IEPs. Providers are encouraged to adapt service delivery models to ensure students receive their prescribed services.

- If the IEP related service is written weekly for 60 mins, the RSP should delivered 60 minutes of services each week in full. If there is a scheduled Monday holiday, the RSP should adjust their schedule to ensure the delivery of the IEP mandated time, 60 minutes per week in this example.

- If the IEP related service is written monthly for 120 mins, the RSP should deliver 120 minutes of services in full each month. If there is a scheduled February break, the RSP should adjust their schedule to ensure the delivery of the IEP mandated time, 120 minutes per month in this example.

For additional information on service delivery requirements, please refer to policies outlined by Office of State Superintendent of Education - https://osse.dc.gov/sites/default/files/dc/sites/osse/documents/Qlik%20Related%20Services%20Management%20Report%20Webinar%20Slides.pdf.

G. DOCUMENTATION

DSI's goal for all related service providers is to achieve a >95% monthly documentation and 80% service delivery rates each of their student's on their caseload each month.*

1. Progress Notes / Medicaid

Each intervention or consultation service listed on the IEP that is provided to a student must be documented in the Special Education Data System (SEDS) EasyIEP. This includes services to students with in the local schools, services parentally-placed students (formerly PRO), missed services, and home-hospital instruction program (HHIP).

Per OSSE guidelines, RSPs should not document services that are not included on the IEP. This includes consultation with parent or teacher, teacher or parent training, or information reported during an IEP meeting. To capture consultations, the RSP should enter the information (date, with whom, and type of contact) in the Communication section in SEDS. **Assessments and consultations should never be listed as a direct service in the service tracker notes.**

Each service tracker note must include the following information:

- Identification of the intervention activity / activities
- Description of the student's response to the intervention (quantitative and qualitative information)
  - Quantitative includes – accuracy percentage, number of trials/opportunities, etc…
  - Qualitative includes – level of prompting/dependence (i.e., moderate verbal prompts, tactile cues, hand-over-hand etc..), behaviors impacting/contributing to progress, etc….
- Explanation of the relevance of the activity to the IEP goal

DCPS, the Centers for Medicare and Medicaid (CMS), and the Office of the State Superintendent for Education (OSSE) have established a best practice service delivery documentation system. Related Service Providers should document the services they provide or attempt to provide pursuant to the IEP within the same school day those services were scheduled to occur.

Email your program manager if barriers exist for daily documentation of services. We recognize there may be challenges (e.g. incorporating time to collaborate with teachers and parents) that could prevent you from providing daily documentation 100% of the time. Therefore, DCPS has established a definitive due date for documenting services provided during a school week.

Definitive Due Date for Documenting Services: All services provided in a school week **must** be documented by **noon on the Monday of the following school week**. If school is closed on Monday then documentation is due by noon of the next school day. For example, 60 minutes of speech/language services provided on Friday from 2 to 3 p.m. should be documented by noon that upcoming Monday.

Refer to the Documenting Services Guidance memorandum dated November 2009 in the Appendix.

The website for EasyIEP is:

https://osse.pcgeducation.com/dcdcps

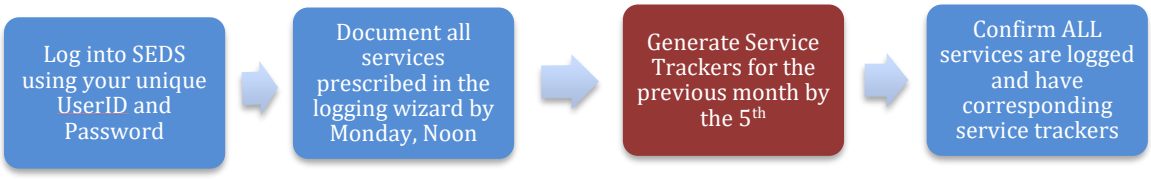
If you have questions about EasyIEP, please contact the call center at (202) 719-6500 or review the Related Service Provider Guide on the EasyIEP website. The SEDS Help Desk is moving to ODA effective August 1, 2013. Callers will hear three options when they dial the help desk (DC stars, SEDS, Blackman Jones). The new SEDS Help Desk email address is spedoda.dcps@dc.gov

Newly hired providers/contractors **must** register and complete SEDS

All documentation is completed using electronic signature. Service tracker notes must be generated or **finalized no later than the fifth (5th) of the following month**. For example, September notes must be generated or finalized by October 5th. If the fifth of the month falls on a weekend or holiday, the deadline moves to the next workday.

DCPS obtains Medicaid reimbursement for direct related services provided to students. The finalized service trackers are submitted monthly for reimbursement. A physical signature on the finalized service trackers is not required. By logging into SEDS, the provider understands and accepts that his electronic signature will be created with a unique combination of his/her network login username and secure password. The unique combination is necessary to ensure that only the provider has completed all documentation submitted into SEDS under this unique combination.

To document services per DSI guidelines, please adhere to the following steps:



1. Documenting Parentally Placed services (formerly PRO)
Documentation for students receiving equitable services is entered into SEDS. All providers must complete the required equitable services documentation and upload into SEDS by relabeling a miscellaneous cover sheet. See forms for equitable services in Appendix.

2. Documenting 504 Plans
The 504 Plan is created in ASPEN. The documentation for students receiving direct or indirect services via a 504 Plan should be entered into Accelify.

3. Documenting Missed Services

Refer to the Missed Related Service Sessions, Truancy and Due Diligence Guidelines dated April 2017 for additional information.

4. Documenting Make Up Services
Refer to the Missed Related Service Sessions, Truancy and Due Diligence Guidelines dated April 2017 for additional information.

5. Documentation of RTI Services

Documentation for students receiving tiers 1, 2 and/or 3 is entered into Accelify

6. Documentation for Winter and Spring Breaks

The RSP must document "Schools Closed" in SEDS for the dates that correspond with Winter and Spring Breaks. Please note that for the dates for breaks using the DCPS calendar.

7. Documentation of Make-Up Service Session Attempts

Refer to the Missed Related Service Sessions, Truancy and Due Diligence Guidelines dated April 2017 for additional information.

G. QUARTERLY IEP REPORT CARD DOCUMENTATION

Quarterly IEP report cards must be completed in EasyIEP for each student on the SLP's caseload. This IEP report must be printed and provided to the parent at the end of each advisory period. Please refer to the school calendar to obtain DCPS' report card due dates. SLPs who are case managers for "speech-only" students are required to finalize quarterly progress notes in SEDS each reporting period for the students on their case management caseload.

IEP report cards must include the following information:

- Current performance on all IEP goals. Indicate the student's specific progress on the goal. Do not use a general statement.
- Information on each goal must be noted on the IEP report card. Since goals are written to measurable, the update of progress toward the goal should also be reflected in the current level of performance of what was being measured (i.e, %ages, number of trials)
- Information regarding what might be impacting the student from making progress/mastering his/her goal (i.e., behavior, attendance, etc….)
- If an IEP goal was not addressed during the quarter, state that the goal was not addressed during the reporting period.
    - Remember, since goals are written to be specific and measurable, information in the students' IEP report card should be specific and measurable. For instance, for articulation goals, be sure to indicate the targeted sound, word position (initial, medial, final), level (isolation, words, sentences, phrases, or conversation) and level (no, minimal, moderate) of prompting required (independent, verbal prompt, tactile cue, modeling, etc…)

H. RANDOM MOMENT IN TIME STUDY (RMTS)

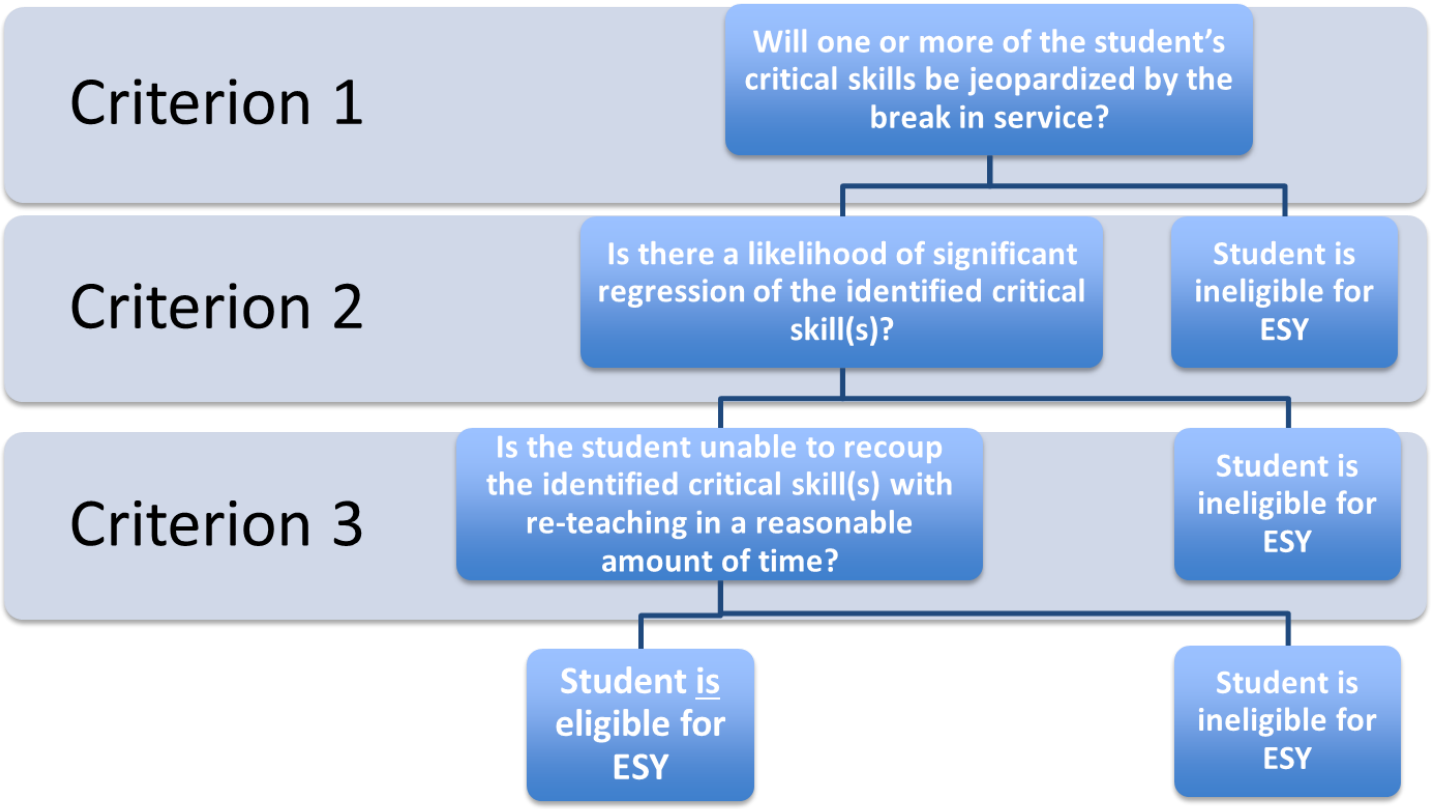
The Random Moment in Time Study is a mandatory study required by the federal Centers for Medicare & Medicaid Services (CMS) to evaluate how school-based staff spends their time providing special education services. These snapshots are required to support claims for Medicaid reimbursement of school-based health services, which ultimately generates revenue for DCPS for products and services for special education programs. As a related services provider your participation in this study is crucial to securing these funds; if the response rate drops below an average of 85% for all providers, DCPS is subject to financial penalties with regard to Medicaid reimbursement.

As a service provider you will be randomly assigned a "moment" five days in advance via email from dcps@pcgus.com. You will also receive four additional reminder emails (1 day before, 1 hour before, 1 day after and 2 days after) that your RMTS Coordinator will receive as well. It is essential that you regularly check your dc.gov email to ensure that you are aware that your moment is coming up. After your moment has arrived, log on to the website (https://easyrmts.pcgus.com/rmtsv2/) and candidly answer six simple questions. It should take no longer than five minutes to complete and you have a total of three business days to respond. If you have any questions about the Random Moment in Time Study you can contact DSI's Medicaid Analyst, Gloria Van Hook at Gloria.vanhook@k12.dc.gov,

I. EXTENDED SCHOOL YEAR (ESY) GUIDANCE AND CRITERIA

ESY services refer to IDEA Part B special education and/or related services that are provided to a student with a disability beyond the regularly scheduled school year. IDEA requires school districts to provide ESY services if a student needs these services to receive a Free and Appropriate Education (FAPE). Students with disabilities may lose skills which can impact their academic progress, as it may take significant time to relearn these skills. ESY is provided by districts to ensure that interruptions in the school schedule (ie. summer or prolonged school breaks) does not result in children with disabilities losing many basic skills.

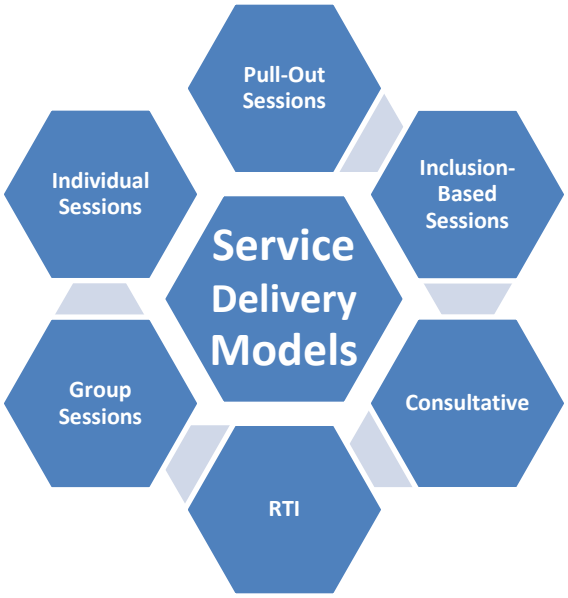
Eligibility for ESY should be addressed at every IEP meeting, and evidence of an individualized determination for every student, regardless of whether or not they are deemed eligible for ESY, should be documented via the SEA Criteria Worksheet and faxed into SEDS. Determination for ESY should be made between December 1st and April 1st to allow sufficient time to plan for summer services and give access to at least three months of current school year data to make sound, appropriate decisions. If a student's annual review is scheduled for a date before or after this time frame or if a student is deemed eligible for services after April 1, IEP teams can convene additional meetings to discuss the specific question of ESY and amend the IEP. The following eligibility criteria must be reviewed and determined in accordance with the guidelines established by the Office of the State Superintendent of Education (OSSE):



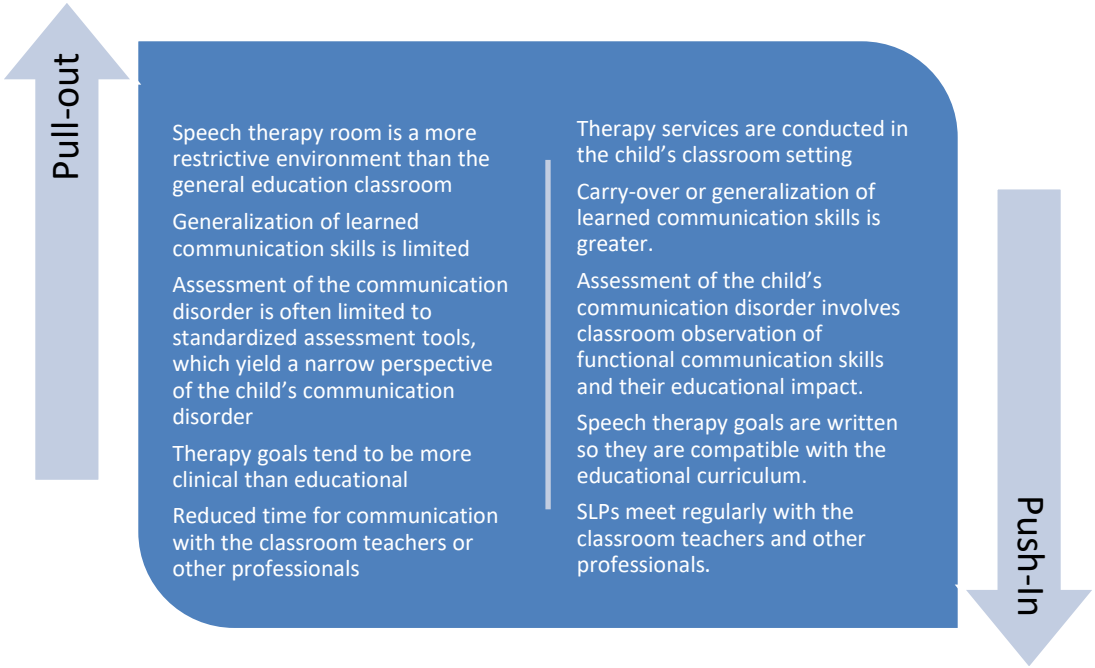
For additional information regarding ESY guidelines and criteria, please visit the CANVAS site at: https://dcps.instructure.com/courses/2025/pages/extended-school-year-esy-program

J. SERVICE DELIVERY MODELS

Speech and Language Services are provided to students using a variety of service delivery models to address communication skills across a wide context of the academic setting based on individualized needs. The type of service delivery model selected must reflect the student's individual level of severity and prognosis. Services should be provided on a continuum from most to least restrictive depending of the student's level of dependence. Providers should be mindful that the purpose of services is to assist the student with generalizing his/her skills to the classroom setting. These service delivery models can be implemented separately and/or in combination.



Traditional ("Pull-out" or "Outside of General Education Setting") vs. Inclusion ("Push-in" or "Inside General Education Setting") Models of Service Delivery



What is Inclusion?

- The American Speech-Language-Hearing Association (ASHA) defines inclusive practices as a type of intervention in which the unique needs of children with communication disorders are met in the least restrictive environment that involves utilizing the student's natural environment as an intervention context, framing services in a manner that integrates classroom context and curriculum activities, and collaborating with families, educators, and other personnel (ASHA, 1996).

Advantages to Inclusion-based Interventions

- Increased communication between the disciplines

- Improved knowledge about the relationship between language and academics
- Learning new techniques that support academic achievement
- Access to specialists and resources to help all children in the classroom
- Implementation of Educationally-relevant therapy
- Generalization of therapy & therapy materials (Textbooks, Class assignments, Workbooks)
- Staff members are able to determine where the student is struggling and collaborate to appropriately modify class assignments and tests.
- Provides strategies/techniques for better access/understanding of the curriculum
- Additional support within the classroom for the teacher and the students
- Exposes strategies and techniques regarding memory and organization for other students not on the speech/language caseload
- Clinician can provide feedback and/or suggestions regarding the classroom environment to increase engagement/participation

Inclusion ("Inside General Education Setting") of Services using the Co-Teaching Model

What Co-Teaching Is?

- Involves at least two credentialed professionals – indicating that co-teachers are peers having equivalent credentials
- Both professionals coordinate and deliver substantive instruction and have active roles
- Responding effectively to diverse needs students
- Instruction occurs in the same physical space

What Co-Teaching Is NOT?

- Doesn't involve a teacher and a classroom volunteer or paraprofessional
- Doesn't mean that two adults are merely present in a classroom at the same time
- Doesn't include separating or grouping students with special needs in one part of the classroom
- Doesn't include teaching teams that plan together and then group and instruct students in separate classrooms

Models of Inclusion – Service Delivery Options

1. Parallel Teaching

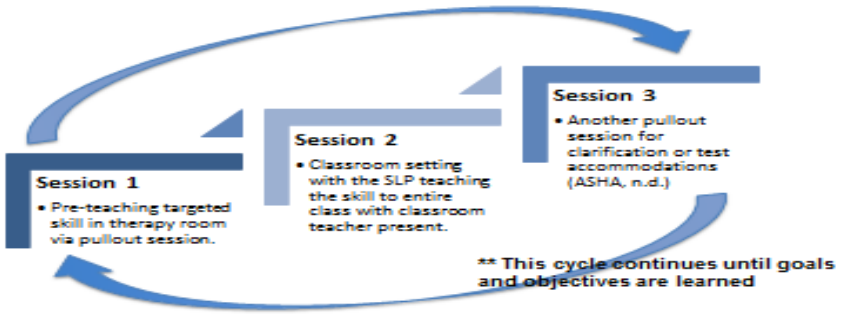
- This collaborative model divides the classroom in half and the SLP and the classroom teacher subsequently each instructs one half of the class on the same instructional material.
- The classroom teacher may use a standard format for instruction while the SLP may modify the lesson for the group so that the students will be able to master the material. The groups of students may change to accommodate individual strengths and weaknesses (Capilouto & Elksnin, 1994).

2. Complementary Teaching

- Role of the SLP in this model is a tutor, with the classroom teacher as primary instructor
- Classroom teacher presents the majority of the curriculum content & the SLP assists students with their work. The SLP floats around the room and intervenes when children encounter difficulty.
- The focus of the lesson may be on a related skill such as sequencing or paraphrasing the main idea of an assignment (ASHA, n.d.).

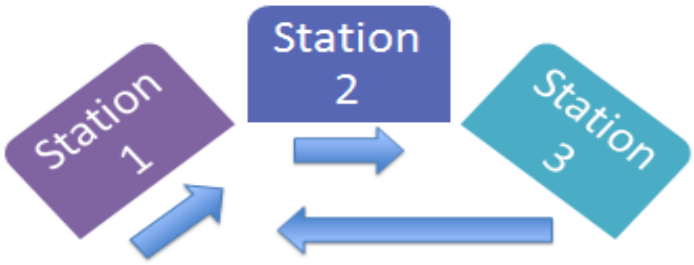
3. Supportive Teaching

- Combination of pullout services and direct teaching in the classroom setting.
- SLP teaches information related to the curriculum while also addressing IEP goals.



4. Station Teaching

- In this model the SLP and the classroom teacher divide the instructional content into two parts with each professional teaching one group of students.
- Once the instruction is completed, the two groups switch adults so that each group receives instruction from the classroom teacher and the SLP (Capilouto & Elksnin, 1994).



5. Consultation
   - The SLP works outside the classroom to analyze, adapt, modify, or create appropriate instructional materials.
   - Regular, ongoing classroom observations and meetings with teachers take place so as to assist the teacher with planning and monitoring student progress (ASHA, n.d.).

6. Team Teaching
   - The classroom teacher and the SLP, occupational therapist, physical therapist, or other professional teach a class or lesson together with each professional addressing his or her area of expertise.

- The classroom teacher may present the curriculum content while the SLP assists with a communication system. Similarly, the occupational therapist may work on handwriting while the physical therapist assists with positioning (ASHA, n.d.).

Interactions During Co-Teaching Using the Inclusion of Service Delivery Model

Lead Role

- Lecturing
- Giving instructions orally
- Checking for understanding with large heterogeneous group of students
- Circulating providing one-on-one support as needed
- Prepping half of the class for one side of a debate
- Facilitating a silent activity
- Re-teaching or pre-teaching with a small group
- Facilitating sustained silent reading
- Reading a test aloud to a group of students
- Creating basic lesson plans for standards, objectives, and content curriculum
- Facilitating stations or groups
- Explaining new concepts
- Considering modification needs

Support Role

- Modeling note-taking on the board/overhead.
- Writing down instructions on board.
- Checking for understanding with small heterogeneous group of students.
- Providing direct instruction to whole class.
- Prepping the other half of the class for the opposing side of the debate
- Circulating, checking for comprehension
- Monitoring large group as they work on practice materials
- Reading aloud quietly with a small group.
- Proctoring a test silently with a group of students
- Providing suggestions for notifications, accommodations, and activities for diverse learners
- Also facilitating stations or groups
- Conducting role playing or modeling concept.
- Considering enrichment opportunities.

What does the Lead and Support Roles Look Like in Various Inclusion-based Models?

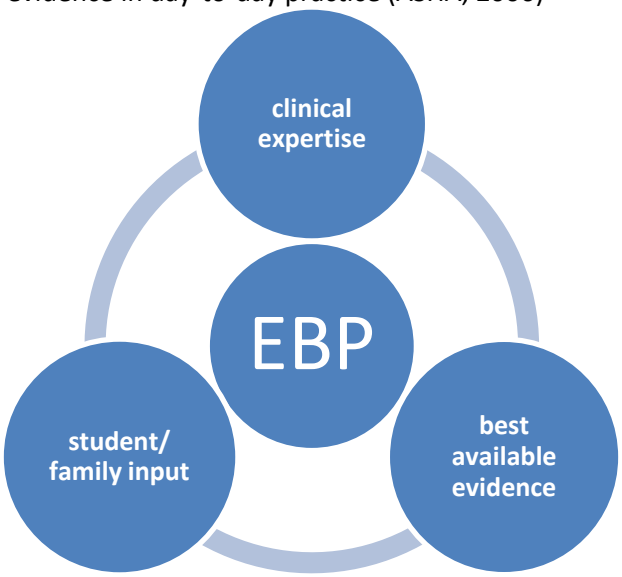
	Complementary Teaching	Station Teaching	Parallel Teaching
Design	***Lead Role*** • Models organization of content • Identifies skills and strategies needed for groups and individual students to complete tasks ***Support Role Assists*.**	***Lead and Support Roles*** • Segments the lesson content • Divide the number of stations that they are responsible for • Plan and organize their station activities with attention to possible group differences	***Lead and Support Roles*** • Collaboratively organize the lesson content • Identify strategies needed for groups and individual students • Divide the students into two groups
Communication	***Lead Role*** conducts formal teaching ***Support Role*** • Teaches components of lessons with small groups of individuals • Provides content to support lead teacher's lessons	***Lead and Support Roles*** segment learning to small groups or individual at the stations they design	***Lead and Support Roles*** • Independently deliver the lesson plan to each of these groups. • Facilitate learning in their group.
Benefits	Having two trained professionals to help individuals students after the lesson is presented	Facilitates small group learning and is responsive to individual needs	Helps to increase the likelihood of participation, publication, and sharing. Also, it allows more intensive work with small group

K. EVIDENCE-BASED PRACTICE

The term evidence-based practice refers to an approach in which current, high-quality research evidence is integrated with practitioner expertise and client preferences and values into the process of making clinical decision – ASHA Position Statement on Evidence Practice, 2005

Evidence-based practice I the conscious use of current best evidence in making decisions about how to treat individual clients. By integrating clinical expertise and experience, best available evidence, and student/family input, we can provide the best possible clinical service to each student. EBP is a continuous, dynamic integration of ever-evolving

clinical expertise and external evidence in day-to-day practice (ASHA, 2006)



How does EBP apply to school-based services (Moore-Brown, 2005)?

1. **Accountability:** SLPs must design IEPs that assist students in reaching the goals of the school. No Child Left Behind requires schools to shore improvement (i.e., adequate yearly progress). Therefore, it is critical that therapy methods offer the best possible clinical service to students. It is not enough to for therapy just because we have the materials on our shelf or because it is familiar to us.
2. **Due process:** In our obligation to students, we must select and use approached that have evidence behind them, yield good outcomes, and can be defended in a hearing or court.
3. **Student/clinician time:** Treatment approaches that yield favorable outcomes are the most efficient use of limited therapy time.
4. **Teacher/student satisfaction:** Our roe as partners with parents, teachers, and students is more critical with EBP. EBP clearly states the need for client/family input as we discuss treatment procedures and outcomes. In doing so parent, teacher, and student satisfaction will increase.
5. **Enhanced professionalism:** Treatment of communication disorders is complex, and requires thoughtful, informed professional consideration. It is critical to engage in current professional practices that demonstrate our commitment to our clients, our profession and DCPS.

The Evidence-based Process

1. Ask the answerable clinical question using PICO. The PICO approach helps ensure that the answers you get to your question are relevant to your situation.

- ***Population***
- ***Intervention***
- ***Comparison Intervention***
- ***Outcome***

Here's a case example to help illustrate the process.

Population – 7 year old boy with autism and social skill deficits
Intervention – teaching social skills in a group setting
Comparison Intervention – teaching social skills one-on-one
Outcome – effective use of social skills

The clinical question: "Is learning of social skills for a 7 year old boy with autism more effective in a group setting, one-on-one, or a combination of both?"

2. **Search for the best available evidence**. Your PICO question will help narrow your focus.

3. **Critically evaluate the evidence** that you find pertaining to your clinical question and to determining if it is appropriate and valid for our particular client and practice.

4. **Make a clinical decision with client/family input**. Share tour best evidence options with your client and his/her family. Explain the evidence for each particular intervention and the client/family weigh the pros and cons.

5. **Implement the course of action** by gathering data using the process to document the outcomes. Since EBP is a continuous process, this step brings you back to the beginning. It is critical to revisit the clinical question and/or continually seek the best evidence available to reinforce what you're doing is the best practice

Intervention Documentation and Data

After the evidence has been evaluated and the intervention has been selected and implemented, it is necessary to document the intervention and gather data. This data will be used to document student progress and is vital for the next step of evaluating outcomes. Data must be gathered throughout the process to determine whether the intervention is effective. Additional information on documentation and data collection is provided in the following link: www.ttaconline.org

Evaluate Outcomes

Professionals cannot claim to use EBP if they do not evaluate intervention outcomes. During this critical phase, the SLP reviews documentation and data collected to determine if the student is making progress. At a minimum, SLPs should use data and documentation of efforts to evaluate outcomes during naturally occurring points in the educational cycle such as the annual IEP and progress reporting periods.

Questions to Regarding the EBPs that are Selected for Implementation in Speech-Language Interventions

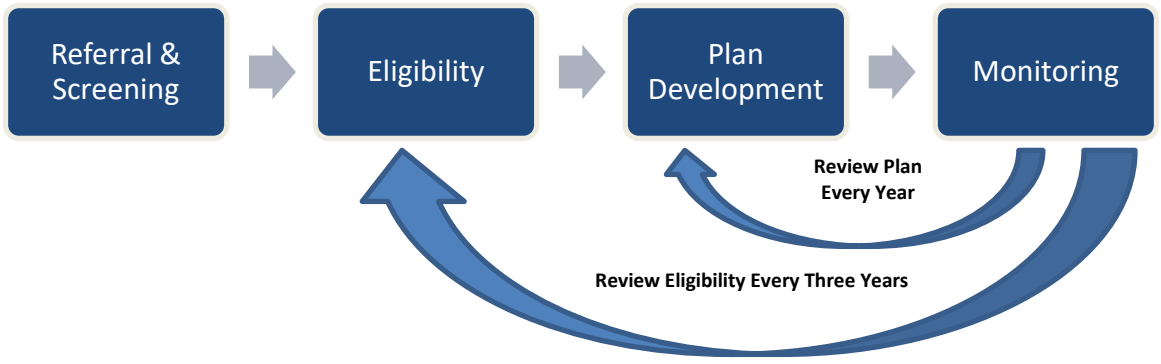
- What are the stated uses of the procedure, product or program?

- To which client/patient population does it apply? Is there documented evidence that it is valid for use with a specified population?
- To which other populations does it claim to generalize?
- Are outcomes clearly stated?
- Are there alternative interventions that are less restrictive, better researches, or perhaps more effective or efficient?
- Is the intervention with the existing skill set of practitioners or do they need prior training and consultation?
- How will the intervention be evaluated if you decide to implement?
- Has the intervention been shown to produce outcomes like the ones intended?
- Are there publications about this procedure, product, or program? Is the information published in a peer-reviewed professional journal? Is promotional material (e.g. brochures, training manuals, newsletters, popular press) the only published source of information?
- Is there peer-reviewed research (or information) that supports or contradicts the stated outcomes or benefits?

L. 504 PLAN SERVICES

It is the intent of the district to ensure that students who are disabled within the definition of Section 504 of the Rehabilitation Act of 1973 are identified, assessed, and provided with appropriate educational services. Under this policy, a student with a disability is one who (a) has a physical or mental impairment that substantially limits one or more major life activities, (b) has a record of such impairment, or (c) is regarded as having such an impairment. Students may be disabled under Section 504 even though they do not require services pursuant to the Individuals with Disabilities Education Act (IDEA). Due process rights of students with disabilities and their parents under Section 504 will be enforced.

The Section 504 Process in DCPS



What are the eligibility requirements for Section 504 accommodations?
For a student to be eligible for accommodations under Section 504, s/he must have a physical or mental impairment that "substantially limits one or more major life activities," as determined by the "504 team." Important terms are defined as follows:
• *Physical or mental impairment* can be any physiological condition that affects a body system, such as the respiratory, musculoskeletal, or neurological systems; any mental or psychological disorders, such as emotional or mental illness and intellectual disabilities; or specific learning disabilities. The definition does not limit the impairments that can qualify a student for Section 504 services.

• *Major life activities* means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. Again, this list does not limit what kind of activities can qualify a student as having a disability.
• *Substantially limits* means that the impairment results in considerable impairment with a permanent or long-term impact. A substantial impairment prevents or severely restricts a person from performing major life activities. Determining whether a child has a substantial impairment is based on a child's disability without any assistive measures other than ordinary eyeglasses or contact lenses. Eligibility will be reviewed at least annually.

Students who meet the eligibility guidelines will have a 504 Plan developed for use in school. The Plan specifies the nature of the impairment, the major life activity affected by the impairment, accommodations necessary to provide access based on the student's needs, and the person(s) responsible for implementing the accommodations. Parents are encouraged to participate in development of the plan. A case manager will be assigned to notify teachers about the accommodations and monitor implementation.

- Accommodations should be specific to the individual student and should not include accommodations typically provided to general education students.
- Accommodations should be specific to the individual student's physical or mental impairment in terms of the substantial limitation to the major life activity.
- Accommodations must be documented in writing

Role of the SLP within the 504 Process

The Speech-Language Pathologist will participate as a member of the 504 Team, if there are expressed concerns in the initial referral related to one or more of the following domains of speech-language pathology: receptive language, expressive language, fluency, speech productions (i.e., articulation, phonological processing disorder, apraxia, dysarthria, etc…), voice, swallowing, and/or pragmatic language. The Speech-Language Pathologist plays an integral role as it relates to determining the educational impact of one of the aforementioned domains within the classroom setting, social interaction with peers and staff and future access to developing vocational skills. The attendance of the Speech-Language Pathologist is important to discuss and interpret assessment finding conducted within or outside of DCPS. If the student is found eligible, then the Speech-Language Pathologist will assist with developing 504 plan accommodations as it relates to the student's communication skills.

Methodologies Used to Determine if a Student Qualifies for a 504 Plan

- Review of existing data and referral concerns
- Complete Screening
- Conducting classroom observation(s)
- Parent/Teacher Interview
- Formal Assessment of Speech-Language Skills (if testing is ordered)
- Gathering other supporting data to support/dismiss the need for a 504 Plan
    - Report Cards
    - Performance on classroom-based and/or state-wide testing
    - Work Samples
    - Data Collection (if student has been receiving RTI)

If a student qualifies for services under the 504 Plan the SLP will do the following:

- Provide accommodations/modifications to the classroom and/or special education teacher
- Provide direct, indirect and/or consultative services
- Conduct ongoing periodic monitoring of progress and/or concerns with the educational team to ensure accommodations/modifications are being implemented

- Collect data regarding performance given strategies
- Document communication with educational team and outside resources
- Participate in the 504 meetings to provide relevant information and updates
- Students with speech therapy services on a 504 plan will receive intervention services from the DSI Speech Language Pathologist.

If you have any questions regarding the 504 Process, you may contact the identified 504 Coordinator at your school or the 504 Specialist at DCPS.504@dc.gov

M. MISSED RELATED SERVICES GUIDELINES

Refer to the Appendix for the Missed Related Service Sessions, Truancy and Due Diligence Guidelines dated April 2017 for additional information.

N. Non-Attending Students - Parentally Placed Students (formerly known as Private or Religious Students) -

District of Columbia Public Schools' (DCPS) Centralized IEP Support Unit (CIEP), is responsible for locating, identifying, and evaluating all parentally-placed, self-funded private and religious school children ages 5 years 10 months through 21 years old who have a disability or suspected disability. DCPS is the Local Education Agency (LEA) for all students attending private schools, even if those children are not residents of DC. Children who have been parentally-placed and self-funded in a private or religious school will be evaluated to determine whether they are eligible for special education. If eligible, they may be offered equitable services. Staff will be placed on the CIEP team and will be responsible for all students who are parentally-placed and self-funded at private and religious schools. The school served could be a:

- Day Care Center
- Private school
- Parochial school
- Non-Public School

If it is determined that the student is eligible for special education, parents who are DC residents have the option of receiving an IEP and enrolling their child full time into a DCPS school to access a Free and Appropriate Public Education (FAPE). If the parent elects to remain in the private school and the student qualifies for equitable services, an ISP (Individual Service Plan) is developed. Parents who are not DC residents may obtain an ISP for their child, if the child qualifies for equitable services. DCPS provides equitable services from the ISP during the school day in the student's private educational setting.

dcps.childfind@dc.gov
(202) 442-5475

O. Non Attending Students HeadStart Students

DCPS has a memorandum of agreement with the DC Head Start program to provide specialized instruction and related services to Head Start students with an IEP. During SY 16-17, the Head Start students received related services at the DCPS closest to their Head Start center. For SY 17-18, the memorandum requires that the services and specialized instruction at the student's Head Start center.

The program will assign providers to provide the IEP services. At the Head Start sites. The following is the current list of Head Start locations:

- Bright Beginnings
  - 128 M Street NW
- Rosemount Center
  - 2000 Rosemount Ave NW
- Educare
  - 640 Anacostia Ave NE
- Appletree
  - 2017 Savannah Terrace SE
- Appletree
  - 2011 Savannah Street SE

P. DEPENDENT CHARTER SCHOOLS

The District of Columbia Public Schools (DCPS) has one dependent charter school - St. Coletta of Greater Washington. St. Coletta of Greater Washington serves children and adults with intellectual disabilities and supports their families.
http://www.stcoletta.org/

Q. PROJECT SEARCH

The High School Transition Program, Project Search, is a one-year internship program for students with disabilities, in their last year of high school. It is targeted for students whose goal is competitive employment. The program takes place in a business setting where total immersion in the workplace facilitates the teaching and learning process through continuous feedback and acquisition of employability and competitive work skills. Students participate in three internships to explore a variety of career paths. The students work with their team and Rehabilitation Services Administration throughout the school year. The goal of the program is competitive employment for each DCPS student intern.

Today, Project SEARCH has become an international program and model of success that provides people with disabilities with the training necessary to gain marketable skills that will enable them to secure competitive employment. There are two Project SEARCH programs, which are located at the following federal agencies: U.S. Department of Education and U. S. Department of Labor.

R. HOME-HOSPITAL INSTRUCTION PROGRAM (HHIP)

Students who are unable to attend school secondary to medical issues, continue to receive instruction and related services through the home-hospital instruction program. An assigned SLP goes into the home or hospital setting to deliver speech-language services per the student's IEP.

S. YSC SERVICE-PROVIDER DOCUMENATION AND MONITORING PROCESS

I. Background and Overview:

The documentation of all related services provided to students attending Youth Services Center (YSC) is required by District of Columbia Public Schools, (DCPS), the Office of the State Superintendent for Education (OSSE), the *Blackman-Jones* Consent Decree, and the *Jerry M*. Consent Decree. In accordance with applicable federal and state requirements, documentation of related services is analyzed and monitored by the Division of Specialized Instruction (DSI) to ensure services are delivered as set forth in the students' individualized education programs (IEPs). The lack of service documentation confirms services have not been provided and/or a potential interruption of services has occurred. Accordingly, related Service Providers must document all services delivered, or attempts to deliver services, pursuant to

the student's IEP.

II. Process/Procedure:

Step	*Action*	*Description*
1	**Dedicated Service Delivery Time**	YSC must provide all related service providers with 3-4 hours of dedicated time for service delivery daily. YSC must provide a minimum of 1 hour daily to document services. Full-time providers will create an intervention and testing schedule and provider to administration and teachers.
2	**Notification of students with related services**	- DYRS notifies YSC registrars immediately of new students.
3	**Recording of Service**	All related service providers will document their services, or attempt to render services, on the YSC service logs. The related service provider will note the type, of service, the duration of service, and whether the service is a make-up session. The related service provider will also note if the student is unavailable or refuses services and the reason therefore. Documentation of services rendered or attempted service delivery will be contemporaneous with the delivery or attempted delivery of those services. Providers must document school closure on the YSC service logs including extended breaks such as winter and spring break.
4	**District-Wide SEDS Access**	All related service providers assigned to YSC will be granted district-wide SEDS access. If a provider cannot log for a student, the provider should email dcps.relatedservices@dc.gov to request SEDS access to the student.
5	**Service Trackers are Placed in Student Files**	All related service providers will provide the YSC service logs to YSC administrative staff upon completion of the service. YSC staff will place each service log in the student's folder within 24 hours of service delivery or attempted delivery.
6	**All Files are in SEDS**	Related service providers will services provided during the week into the SEDS caseload logging wizard copy by Monday at 12:00 of the following week.
7	**SEDS-Generated Service Trackers**	Related service providers will finalize SEDS-generated service logs by the last day of each month. If the student transfers from YSC before the end of the month, the provider will finalize any outstanding SEDS service logs once notified of the transfer.
8	**File Auditing**	DCPS and DYRS will conduct regular audits of students' paper and SEDS files to ensure that all related services were appropriately provided and documents. These audits will take place on the 2nd and 4th Mondays, with that audit data submitted to the Related Services Supervisors. The audit will include: review of sample of YSC files for each discipline and SEDS analysis of documentation, delivery and missed services for the current month. YSC file audit and SEDS audit will be completed by RS Analyst. Results will be given to the RS supervisors to follow up with the providers. Related Service Providers will have until Wednesday of that week to complete outstanding documentation.
9	**Exit from YSC**	LEA representative will print student history page from SEDS to add to the file.

T. Crisis Intervention Procedures

Crisis intervention is offered through a partnership between the District of Columbia Public Schools and the Department of Mental Health to respond in times of emergency at local schools. Responding to crises requires an "all hands on deck" approach by utilizing local school counseling staff as first responders, and provides additional support through Office of Specialized Instruction's social workers and school psychologists.

At times, speech language pathologists assigned to the building may be requested to assist the school crisis team, school administration, staff and / or students during a crisis. Please refer to the DCPS Crisis Management Materials.

Responding to School Crisis

The focus of crisis response is to address distress in students and in the school community.
The three (3) categories of crises are:

1. ***Safety***
   - The student has been victimized by abuse or neglect (self report, injury, abandonment at school)
   - A student absconds from the school

2. ***Behavioral Health***
   - The student exhibits symptoms of emotional disturbance relative to his/her mental health status (suicidal ideation, homicidal ideation, psychosis)
   - Death of a current or former student or staff member
   - Critical threat or event

3. ***Criminal Acts***
   - The student exhibits behavior that is not mental health related such as assault, theft or willful destruction of property.

Crisis Protocols

All crisis response protocols are under the direction of the School Principal.

Safety

- CFSA (202-671-7233) must be contacted. All school personnel are mandated reporters.
- Abscondence requires that the school contact the parent(s), Office of School Security and MPD.

Behavioral Health

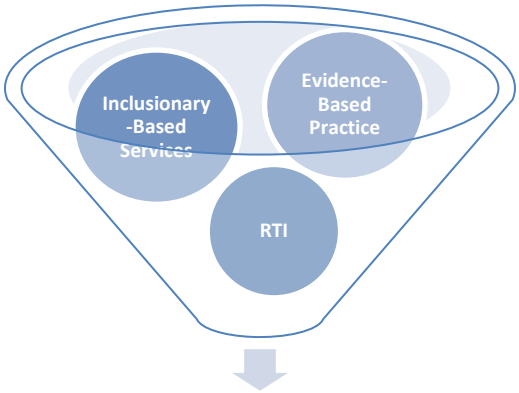
- School based mental health providers assess, de-escalate and develop a crisis plan.
- For school-wide crises, the Principal should consult with the School Crisis Team in addition to the Central Crisis Team Coordinator and the Central Office Security Coordinator.
- If the initial interventions are insufficient due to the severity of the symptoms a call is placed to:
  - ChAMPS (202-481-1450) for students ages 3 to 18
  - DBH Access Helpline (1-888-793-4397) for students ages 19 and older

Criminal Acts

When schools determine that actions meet criteria for criminal behavior, the school administration contacts the Office of School Security and MPD.

Please refer to the Emergency Response Plan and Management Guide located in each school's administrative office, for comprehensive instruction. Contact the Central Crisis Team at crisis.cct@dc.gov

SECTION VIII
Training And Support



Professional Development for 2020-2021

A. Related Service Provider Training Goal

- The RSD will implement trainings that promote high standards and "best practices" according to processes and procedures that support continuous quality improvement efforts and ensure compliance with court mandates, federal, local and discipline specific national organizations. As illustrated in IMPACT and the discipline specific procedural reference guides, which is allied to enhanced performance, increased collaboration and improved educational outcomes for students.
- The RSD will develop training programs that are evidenced-based, empirically driven and results-focused. These initiatives will be implemented through strategic planning aimed to identify effective strategies for improving the performance of related service provider in ways that enhance the quality of service delivery, mastery of student's goals for exiting services, quality assessments, appropriate educational planning, academic achievement, secondary transition outcomes as well as functional skills that improve educational outcomes of students with disabilities.

B. SLP Training Goals

- To utilize best practice in assessment and intervention for low incidence population to improve student performance and carryover into the classroom and home setting.
- To increase collaboration with teachers, parents and other related service providers to improve student performance in the school and home settings.
- To increase the utilization of various service delivery models to meet the needs of the student for academic success.

C. Mandatory Professional Development and Meetings

Professional Development trainings are provided to Related Services Providers to assist with augmenting their assessment and intervention skills, clinical decision-making and utilization of best practices to improve the provision of quality services in their schools. Therefore, attendance to Professional Development trainings is MANDATORY. Providers are notified regarding the dates for the upcoming trainings for the school year in August during Pre-service week.

Program Managers reserve the right to request a doctor's note when calling out and able to document as unexcused. If you have a conflict or pre-arranged obligation you must notify your Program Manager two months in advance.

Online Meeting links for half day Professional Development trainings will be emailed to providers and shared via the SLP Monthly and Outlook Calendar Invites. Times will be indicated in invitations.

Half-day Professional Development Dates are scheduled for the following dates:

August 25, 2020
August 27, 2020
November 6, 2020
January 29, 2021
April 12, 2021

D. Optional Trainings

DCPS and the SLP Department offer several free Professional Learning Unit (PLU) trainings after the workday. These trainings include cohort meetings, workshops, webinars, case conferences, peer reviews, and lecture sessions. The SLP department offerings will be sent via email in the SLP weekly. All interested employees and contractors must register using SchoolNet.

The training course calendar and registration are available by accessing DCPS' SchoolNet website at https://dcps.schoolnet.com. If you have difficulties accessing the SchoolNet website, please contact the help desk at 866-MY-SN-HELP (866-697-6435) or helpdesk@schoolnet.com.

E. University Partnerships

The SLP Department has established clinical externships with several universities in the DC Metropolitan Area and beyond. The department is continuously seeking ASHA Certified Speech Pathologists to serve as extern clinical supervisors for fall, spring and fall semesters for SLP graduate students. If you are interested in serving as a clinical supervisor for a semester, please inform your assigned Program Manager.

In addition, undergraduate SLP students in the area are looking for observation hours in the school based setting. The observation hours are required for their undergraduate coursework and towards ASHA certification. The department is seeking volunteers to allow undergraduate SLP students to observe assessment and intervention sessions. If you are willing to allow a student to observe your sessions, please inform your assigned Program Manager.

F. Mentoring

The mentoring program is established to assist those persons new to the District of Columbia Public School System, the Speech and Language Pathology (SLP) profession, and/or those who are new to the school setting. The purpose of the program is to pair new SLP professionals with experienced SLP pprofessionals to provide support. The experienced SLP will serve as a resource and reference for the new employee and will provide helpful hints and pertinent information about their assigned school and the SLP department. The mentoring pairs will be established no later than the first 2 weeks of school. The mentoring pair will then schedule meeting dates to cover specific agenda items that meet the needs of the new employee.

SECTION IX
Glossary Of Terms

A. Abbreviations

APE	Adapted Physical Education
AUD	Audiologists
BIP	Behavioral Intervention Plan
DCMR	District of Columbia Municipal Regulations
DCPS	District of Columbia Public Schools
DHS	Department of Human Services
DOB	Date of Birth
ED	Emotionally Disturbed
ESL	English as a Second Language
ESY	Extended School Year
FAPE	Free Appropriate Public Education
FBA	Functional Behavioral Assessment
HI	Hearing Impairment
HOD	Hearing Office Determination
ID	Intellectual Disability (Also known as Mental Retardation MR)
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Program
IFSP	Individualized Family Service Plan
ISP	Individualized Service Plan
LD	Learning Disability
LEA	Local Education Agency

LEP	Limited English Proficiency
LRE	Least Restrictive Environment
MD	Multiple Disabilities
MDT	Multidisciplinary Team
OHI	Other Health Impairment
DSI	Division of Specialized Instruction
OSSE	Office of the State Superintendent of Education
OT	Occupational Therapy
PT	Physical Therapy
SA	Settlement Agreement
SEA	State Education Agency
SLD	Specific Learning Disability
SLI	Speech Language Impairment
SLP	Speech Language Pathologist
SSI	Supplemental Security Income
SW	Social Worker
TBI	Traumatic Brain Injury
VI	Visual Impairment
VIS	Visiting Instruction Services

B. Key Terms

The key terms outlined below have specific meanings assigned by IDEA (34 C.F.R §300.34, and/or DCMR 5-3001. This is not an exhaustive list of the developmental, corrective and supportive services that an individual child with disabilities may require. However, all related services must be required to assist a child with disabilities to benefit from special education. To provide clarity on the various types of related services, the individual definitions are provided below.

- Audiology. Audiology services include (i) the identification of children with hearing loss, (ii) determination of the range, nature, and degree of hearing loss, including referral for medical or other professional attention for the habilitation of hearing, (iii) provision of habilitative activities, such as language habilitation, auditory training, speech reading (lip-reading), hearing assessment, and speech conservation, (iv) creation and administration of programs for prevention of hearing loss, (v) counseling and guidance of children, parents, and teachers regarding hearing loss; and (vi) determination of children's needs for group and individual amplification, selecting and fitting an appropriate aid, and evaluating the effectiveness of amplification.

- Counseling. Counseling services means services provided by qualified social worker, psychologist, guidance counselors, or other qualified personnel.

- Early identification and assessment of disabilities in children. Early identification and assessment means the implementation of a formal plan for identifying a disability as early as possible in a child's life.

- Interpreting services. When used with respect to children who are deaf or hard of hearing, this includes (i) oral transliteration services, cued language transliteration services, sign language transliteration and interpreting services, and transcription services, such as communication access real-time translation (CART), C-Print, and TypeWell and (ii) special interpreting services for children who are deaf-blind.

- Medical services. This service is for diagnostic or assessment purposes provided by a licensed physician to determine a child's medically related disability that results in the child's need for special
- Occupational therapy. Occupational therapy means services provided by a qualified occupational therapist and (ii) include (a) improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation, (b) improving ability to perform tasks for independent functioning if functions are impaired or lost, and (c) preventing, through early intervention, initial or further impairment or loss of function.
- Orientation and mobility. Orientation and mobility services means services: (i) provided to blind or visually impaired children by qualified personnel to enable those students to attain systematic orientation to and safe movement within their environments in school, home, and community, and (ii) includes teaching children the following, as appropriate: (a) spatial and environmental concepts and use of information received by the senses (such as sound, temperature and vibrations) to establish, maintain, or regain orientation and line of travel (e.g., using sound at a traffic light to cross the street), (b) to use the long cane or a service animal to supplement visual travel skills or as a tool for safely negotiating the environment for children with no available travel vision, (c) to understand and use remaining vision and distance low vision aids, and (d) other concepts, techniques, and tools.

- Parent counseling and training. Includes (i) assisting parents in understanding the special needs of their child, (ii) providing parents with information about child development, and (iii) helping parents to acquire the necessary skills that will allow them to support the implementation of their child's IEP or IFSP.

- Physical therapy. Physical therapy means services provided by a qualified physical therapist.

- Psychological. Psychological services includes (i) administering psychological and educational tests, and other assessment procedures, (ii) interpreting assessment results, (iii) obtaining, integrating, and interpreting information about child behavior and conditions relating to learning, (iv) consulting with other staff members in planning school programs to meet the special educational needs of children as indicated by psychological tests, interviews, direct observation, and behavioral assessments, (v) planning and managing a program of psychological services, including psychological counseling for children and parents, and (vi) assisting in developing positive behavioral
  intervention strategies. .

- Recreation. This service includes (i) assessment of leisure function, (ii) therapeutic recreation services, (iii) recreation programs in schools and community agencies, and (iv) leisure education.

- Rehabilitation counseling. Rehabilitation services means services provided by qualified personnel in individual or group sessions that focus specifically on career development, employment preparation, achieving independence, and integration in the workplace and community of a student with a disability.[1]

- School health and school nurse. These health services that are designed to enable a child with a disability to receive FAPE as described in the child's IEP. School nurse services are services provided by a qualified school nurse. School health services are services that may be provided by either a qualified school nurse or other qualified person.
  .
- Social work. Social work in schools including (i) preparing a social or developmental history on a child with a disability, (ii) group and individual counseling with the child and family, (iii) working in partnership with parents and others on those problems in a child's living situation (home, school, and community) that affect the child's adjustment in school, (iv) mobilizing school and community resources to enable the child to learn as effectively as possible in his or her educational program, and (v) assisting in developing positive behavioral intervention strategies.

- Speech-language pathology Services. Speech-language services include (i) identification of children with speech or language impairments, (ii) diagnosis and appraisal of specific speech or language impairments, (iii) referral for medical or other professional attention necessary for the habilitation of speech or language impairments, (iv) provision of speech and language services for the habilitation or prevention of communicative impairments, and (v) counseling and guidance of parents, children, and teachers regarding speech and language impairments.

- Transportation. Transportation includes (i) travel to and from school and between schools, (ii) travel in and around school buildings, and (iii) specialized equipment (such as special or adapted buses, lifts, and ramps), if required to provide special transportation for a child with a disability.

SECTION X
APPENDIX

DISTRICT OF COLUMBIA PUBLIC SCHOOLS
Office of Specialized Instruction

Home/Hospital Instruction Program Service Log for Related Services

Student Name: _____ Student DOB: _____
Student ID#: _____ Student's Home School: _____
Related Service: _____

Date	Time		Total # of Hours	Parent Signature
	In	Out		

Name of Provider: _____
Signature of Provider: _____
Date: _____

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

COMPLETION OF SERVICES FORM

STUDENT: _____ **DATE:** _____
ADDRESS: _____ **SCHOOL:**_____
Street# Street Name Apartment # **ADDRESS:** _____
_____ _____
City State Zip Code **TELEPHONE:** _____
TELEPHONE: _____
ID#: _____ **DOB:** _____ **GRADE:** _____

A multidisciplinary team meeting is required in order to determine whether a student has completed special education and related services identified on the IEP, including the consideration of information from the evaluation (for which you provided consent) in the area(s) to be considered. Complete the sections below identifying the services.

COMPLETION OF SERVICES(S) (Check all service that are being considered)

SERVICE	Goals/ Obj. Completed	Results of Evaluation	Date
☐ Speech-Language Therapy	☐Y ☐N		
☐ Orientation & Mobility	☐Y ☐N		
☐ Occupational Therapy	☐Y ☐N		
☐ Physical Therapy	☐Y ☐N		
☐ Counseling	☐Y ☐N		
☐ Adaptive PE	☐Y ☐N		
☐ Audiology	☐Y ☐N		
☐ Transportation	☐Y ☐N		
☐ Other (specify)	☐Y ☐N		
☐ Specialized Instruction	☐Y ☐N		
	☐Y ☐N		
	☐Y ☐N		
	☐Y ☐N		

REASON FOR COMPLETION OF SERVICES:
☐ Graduated ☐ Completed Services ☐Aged Out ☐Transferred Out of District ☐ Dropped Out
☐ Other: _____

☐ I agree with the proposed termination of the special education and related service(s) identified above.
☐ I have been provided with my procedural safeguards and questions answered. I understand that my consent is voluntary, and that I have the right to appeal the decision of the multidisciplinary team (MDT).

Signature: _____ Date: _____
Parent/Eligible Student
(Student if age of majority has been reached and the transfer of rights has been officially documented)

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Related Service Provider Weekly Building Intervention/Assessment Schedule
School Year 2020-2021

Discipline: **Employee:**

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
	School: Contact#:	School: Contact#:	School: Contact#:	School: Contact#:	School: Contact#:
A.M.					
8:00					
8:30					
9:00					
9:30					
10:00					
10:30					
11:00					
11:30					
P.M.					
12:30					
1:00					
1:30					
2:00					
2:30					
3:00					
3:30					
4:00 (ET 11)					

Principal Signature _____

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

SAMPLE INTRODUCTION PARENT LETTER

Dear Parent,

Welcome to School Year _____ ! I am excited about the opportunity to work with your child as their Speech Language Pathologist.

My goal in speech and language therapy is to improve your child's communication skills so he / she can be successful in the classroom. Therapy is provided using a combination of direct therapy with the child and collaboration with the teacher.

As the parent, you also serve as a crucial partner in the success of the child. At times, I will send home strategies or speech homework activities through your child. Please implement the strategies at home and complete the speech homework. If you should have any questions about any of the activities sent home, please don't hesitate to contact me.

I am assigned to _____ school on _____, _____, and _____. You can reach me by phone at the school on my assigned days or via email at _____.

Once again, welcome to a new School Year. Let's work together to make this a productive school year for your child.

Sincerely,

Name, Credentials
DCPS
Speech-Language Pathologist

Observation Form

Name: _____ School: _____

Student ID: _____ D.O.B. _____ Age: _____ Grade: _____

The purpose of this observation is to provide information regarding this student's performance in the school setting and behaviors in the area(s) of concern. Observe the student, complete this form and email to the Early Stages requestor. Attach additional sheet if necessary.

Date of Observation:	Start Time of Observation:	End time of Observation:
Setting of Observation:		
Describe the lesson/activities occurring during the observation session (e.g., lesson, discussion, independent seatwork, small group work) and the observed student level of participation and engagement. Include any special supports or conditions during this observation (e.g., student seated away from group, uses interpreter, etc.):		
Identify any instructional strategies and/or behavior supports used during the activity/instruction: ☐wait time ☐repetition ☐visual supports ☐graphic organizers ☐rephrasing ☐manipulatives ☐positive reinforcement ☐re-direction ☐teacher ☐other_____		
Describe the student's reaction to instructional strategy(ies) and/or the behavior supports provided:		
Describe the student's behavior during the observation session:		
Describe the student's academic, social, emotional and/or behavioral functioning during the observation session:		
Summary of additional comments or concerns:		

_____ _____

Print Name and Signature of Person Completing Observation

Job Title

JUSTIFICATION FOR CONSIDERATION OF AUDITORY PROCESSING DISORDER(APD) ASSESSMENT EVALUATION

Audiology Department – (202) 299-3810

Send this completed form to the Audiologist assigned to your school (See list of "Schools by Audiologist" and "Audiologist Contact Information Sheet") Please submit all of the following information by typing the information in via computer. Do NOT hand-write.

STUDENT INFORMATION

Student's name	
DOB	
Student ID	
Teacher	
Teacher contact info (e-mail/phone)	
Parent/Guardian	
Parent/Guardian contact info (e-mail/phone)	
Name of person making referral	
Referral contact info (email/phone)	
Submission date	

Please submit the following information. A full statement of guidelines is found on page 3 of this document: Please type an X in the box. Do NOT hand-write.

	Student is 7 years of age or older
	Verification that the student is a proficient English speaker.
	Verification that the student has normal hearing. Requires audiological evaluation within the past year. This may be done by an outside audiologist or may be requested of a DCPS audiologist.
	Submission of Psychological Evaluation within the last year documenting Full Scale IQ of 80 or better Submit review of report by DCPS Educational Psychologist if the evaluation was done by an outside source.
	Submission of Speech Language Evaluation within the last year documenting language proficiency, processing status, and speech intelligibility Submit review of report by DCPS Speech-Language Pathologist if the evaluation was done by an outside source.
	Include front page of IEP, hours of service and accommodations if applicable.
	Attach a brief statement of reason for referral.
	Attach a list of any additional diagnoses including ADD/ADHD, ASD, LD, ED, etc..

Student's name	
DOB	
Student ID	

TYPICAL BEHAVIORS OF CHILDREN AT RISK FOR AUDITORY PROCESSING DISORDER

Reference: Scale of Auditory Behaviors (SAB) (Conlin, 2003; Schow et al., 2006; Shiffman, 1999; Simpson, 1981; Summers, 2003).

Please rate the following behaviors by placing the appropriate number in the box. Do NOT hand-write.
1- Frequent
2- Often
3- Sometimes
4- Seldom
5- Never

	Difficulty hearing or understanding in background noise.
	Misunderstands, especially with rapid or muffled speech.
	Difficulty following oral instructions.
	Difficulty in discriminating and identifying speech sounds.
	Inconsistent responses to auditory information.
	Poor listening skills.
	Asks for things to be repeated.
	Easily distracted.
	Learning or academic difficulties.
	Short attention span.
	Daydreams, inattentive.
	Disorganized.

STATEMENT OF APD EVALUATION GUIDELINES

When referring for an APD Evaluation, the following guidelines must be met:

1. Be at least 7 years of age or older. An age criterion is important because it reflects the developmental component of the higher auditory pathways and resulting developmental abilities of the child. It is also important to meet the age requirement due to the need to match the child to appropriately age-normed tests.
2. List any diagnoses including ADD/ADHD, LD, and Autism Spectrum Disorder (ASD). Indicate whether or not the student is taking medication for ADD. A student who is taking medication for ADD but has not taken it the morning of APD testing will be re-scheduled.
3. Indicate which special classes the student attends and for how much of the day. Indicate what modifications are currently being made for the student.
4. Have normal peripheral hearing acuity (Note: Normal hearing must be documented by an Audiologist prior to considering APD testing). Testing in the presence of a hearing loss is generally inappropriate when attempting to diagnose an Auditory Processing Disorder. In the case of a hearing loss, APD testing will need to be considered on an individual basis.
5. Be able to cooperate with the APD test protocol. Testing requires extended period of attention.
6. The student is English proficient. APD assessments are normed on native English speakers.
7. Have a recent psychological evaluation (within a year). Performance is affected by cognitive ability. All APD tests are normed on individuals with average (normal) intelligence. Any child assessed must have normal cognitive function so results can be compared to age mates. The student's Full-Scale IQ must be 80 or higher (Note: Individual subtest scores are not an adequate criterion). Exceptions will be considered on an individual basis.
8. Have a recent speech and language assessment (within a year), specifically looking at processing skills. (CELF or equivalent evaluation of language; CTOPP or equivalent evaluation of phonological processing). In addition, the student must have intelligible speech.

OTHER CONSIDERATIONS

For all students in a special education program, re-evaluation is required every three years. If the student has a diagnosed APD, a re-evaluation may be a part of that formal process. The re-evaluation process will be identical to the procedure used in the initial evaluation. If the student is using a FM system, the re-evaluation will include assessing the benefit of the equipment.

DISTRICT OF COLUMBIA PUBLIC SCHOOLS
AUDIOLOGY
Payne Elementary School
(202) 299-3810

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Communication Abilities Rating Scale

Student: _____ **Date:** _____

Teacher: _____ **Grade:** _____

SLP: _____ **Return By:** _____

Please complete the Communication Abilities Rating Scale by identifying how often the following behaviors are observed.

1-Always *2- Sometimes* *3-Never*

Articulation

1.	Imitates sounds correctly in words.	1	2	3
2.	Enjoys speaking in front of the class.	1	2	3
3.	Is understood when the topic is known.	1	2	3
4.	Is understood when the topic is unknown.			
5.	Is able to sound-out unfamiliar words when reading aloud in class.	1	2	3
6.	Is able to spell words correctly.	1	2	3

Fluency

1.	Willingly speaks in class.	1	2	3
2.	Speaks with little or no frustration.	1	2	3
3.	Uses more speech than gestures to communicate.	1	2	3
4.	Speaks without noticeable tension/effort.	1	2	3

Understanding Language

1.	Follows spoken or written directions.	1	2	3
2.	Remembers things people say.	1	2	3
3.	Attends to oral class discussions.	1	2	3
4.	Understands content vocabulary and word meanings.	1	2	3
5.	Retains/recalls content information.	1	2	3
6.	Understands new ideas.	1	2	3

Using Language

1.	Explains ideas and thoughts clearly in logical order.	1	2	3
2.	Uses compound/complex sentences.	1	2	3
3.	Retells stories or events in the right order.	1	2	3
4.	Answers questions appropriately.	1	2	3
5.	Responds to questions in a timely manner.	1	2	3
6.	Asks questions appropriately.	1	2	3
7.	Asks for assistance when needed.	1	2	3
8.	Uses vocabulary or concept terms correctly.	1	2	3

Voice

1.	Speaks loud enough to be heard in class.	1	2	3
2.	Does not avoid speaking in class.	1	2	3
3.	Does not clear his/her voice or cough excessively.	1	2	3
4.	Does not lose his/her voice during the day.	1	2	3
5.	Does not use a voice quality that distracts from what he/she is saying.	1	2	3

Pragmatics

1.	Makes or responds to greetings to or from others.	1	2	3
1.	Begins /ends conversations appropriately.	1	2	3
2.	Observes turn-taking rules in the classroom or in social interactions.	1	2	3
3.	Maintains eye contact during conversation.	1	2	3
4.	Asks for/responds to requests for clarification during conversation.	1	2	3

Academic Performance

Is the student below grade level in any subject? Y/N

If yes, in what area(s)? _____

Comments:

_____

Infant/Toddler Communication Screening Careprovider Report: Birth to Three

Student's Name: _____ Date Completed: _____

Completed by: _____ Relationship to student: _____

Please answer the following questions about how your child communicate. Feel free to give examples.

1. How does your child usually communicate? (Check as many as applicable)

	Understands words of others		Makes sounds (e.g., /e/ as in eat, /a/ as in way)
	Follows simple instructions		Speaks single words
	Looks at people, object of interest		Gestures combined with sounds
	Cries or whines		Uses his/her own language/jargon
	Babbles during play		Putting 2-3 words together
	Gestures (pointing to objects, tugging for attention)		Uses short phrases
	Speaks in complete sentences		

2. How has your child's communication changed over the past few months? Provide examples.

_____

_____

	How Does Your Child …	Give Example
3	Attract your attention when you are busy?	
4	Let you know that he/she does not want something that you are offering?	
5	Let you know he/she want something out of reach?	
6	Let you know he/she needs help (i.e., opening a container or getting a toy)	
7	Greet someone entering or leaving the room?	
8	Play social games with you or ask you to play games (i.e., "peek-a-boo")	
9	Get you to look at something that he/she wants you to notice?	
10	Let you know that he/she is mad or frustrated, happy or sad?	
11	Comment on or describe an object or activity?	
12	Tell you something he/she has done or seen?	

13. What happens if you can't figure out what your child is asking for? What does your child do? What do you do?

_____

_____

Page 2 – Infant/Toddler Communication Screening Careprovider Report

14. How often does your child try to get your attention? (Check One)

	Seldom – 1 time a day

	Sometimes – 3-4 times a day
	Frequently – 10 or more times a day
	Very Frequently – During every interaction

15 (a) What words and directions does your child understand? Please list the names of common objects, toys, people or pets your child knows. If you are not sure your child understands the names of objects, toys, ask him/her to "show" or "touch" the item.

15(b) Please list directions your child can complete. If you are not sure, take objects familiar to the child and tell him/her to follow certain directions. Be sure the instructions involve actions you know he/she can do (For example, "Get diaper", "Give me the car", or "Put the doll in her bed")

Your Direction	**What did your child do?**

16. How does your child ask questions? Examples:

_____
_____

17. Please check the gestures your child uses

	Reaches up (to request to be picked up)		Waves (to greet)
	Extends arm (to show an action)		Points (to objects to indicate interest)
	Lead adult/you to desired object		Nods or shakes head (to agree or protest)
	Extends object (to give)		Open hand, palm up (to request)

18. Does your child combine two or more words in phrases? (e.g., more cookie, car bye-bye, etc…) Examples

_____
_____

19. Please list below THREE of your child's longest and best sentences or phrases:

a. _____
b. _____
c. _____

20. List words that your child uses SPONTANEOUSLY, without being prompted or cued

_____
_____
_____

Birth to Three Program – UAP – 2601 Gabriel Parsons, KS 67357 9316) 421-6550 Ex. 1859

Items have bee compiled from the following resources:
Rescotla, L. (1989). The language development survey: A screening ool for delayed language in toddlers. Journal of Speech and Hearing Disorders, 54 587-599.
Wetherby, A. & Prizant, B. (1990). CSBS Caregiver Questionnaire. San Antonio, TX: Special Press, Inc
MacDonald, J & Hoesmeier, D. (978). Environmental Language Intervention Program. Columbus, OH: Charles Merrill

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

MAKE-UP MISSED SERVICES PLAN

Student		Student ID Number	
Date of Birth		School	
Discipline		Provider Name	
Date		Signature	

Instructions:

(1) Follow DCPS guidelines regarding Due Diligence Missed Related Service Guidelines
(2) Notify the student's parent and teacher of missed sessions and make-up plan and document in Communications Log in SEDS
(3) Work with teachers to determine best times for providing make-up services
(4) Submit a copy of this form into SEDS and to assigned Program Manager or Clinical Specialist by the end of the quarter

Reason for Missed Service	Options for Making-Up Services
Select:	***Select:***
T1 – Provider unavailable due to student/district/building meetings	1. Add time before or after the student's scheduled session
T2 – Provider – illness; personal; professional development	2. Add a session another day
T3 – Not provide to cover school	3. Incorporate the student into other students' sessions
	4. Integrate service into classroom activities
	5. Schedule before/after school if permissible by the district

Dates of missed sessions	Amount of time missed (in minutes)	Reason	Option selected for make-up services	Dates services will be made up	Estimated completion date	Make up plan confirmed with teacher and parent	Date make-up was completed and documented

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

DSI RELATED SERVICES
RESPONDING TO PROVIDER VACANCIES
Process for covering service delivery due to RSP resignation or extended leave (more than 2 weeks)

AUDIOLOGY, OCCUPATIONAL THERAPY, PHYSICAL THERAPY & SPEECH-LANGUAGE PATHOLOGY

Action Item	Due Date	Responsible Person
Notification of resignation or extended leave is provided to the DSI Program Manager	Immediately	DSI RSP or Vendor
DSI Program Manager provides notification of resignation or extended leave to the Principal, LEA RD and Accountability Manager.	Immediately	DSI Program Manager
Review schedules, caseloads, and outstanding assessments of existing discipline providers. Based on availability and capacity, designate one or more providers to cover the gap.	Within one (1) week of RSP notification	DSI Program Manager
If there is no availability or additional capacity, solicit help from vendors to recruit for a contractual provider. **based on available contract funding*	Within one (1) week of RSP notification	DSI Program Manager
Provide a status update to the Principal, LEA RD and Accountability Manager. Request LEA RD to inform parents of affected students about the that the staffing gap and current status of securing a replacement.	Within one (1) week of RSP notification	DSI Program Manager School LEA RD
Provide a status update to the Principal, LEA RD and Accountability Manager.	Weekly	DSI Program Manager
If services are delayed for more than 3 weeks, LEA RD notifies affected families in writing the expected positioning of a new provider and how make-up services will occur. LEA RD documents the written communication in the SEDS communication log for each student. DSI Program Manager will supply the parent letter for the LEA RD.	During week 3 of staffing gap	DSI Program Manager School LEA RD
Once replacement provider (temporary or permanent) is identified, inform Principal, LEA RD and Accountability Manager. LEA RD informs affected families in writing of the replacement's start date. LEA RD documents the written communication in the SEDS communication log for each student.	Before the start of the replacement provider	DSI Program Manager School LEA RD

DSI Program Manager will supply the parent letter for the LEA RD.		
Replacement provider sends an introduction letter to the parents with information. Language includes provider will develop and provide a make-up plan for their student within 2 to 4 weeks.	At the start of second week of work	Replacement DSI RSP
Replacement provider contacts each parent via email to provide a copy of the make -up plan. Provider documents the written communication in the SEDS communication log for each student. Provider uploads a copy of the plan into SEDS. Once the make-up hours are completed, the provider updates the plan with the completion date and uploads into SEDS	Within 2 to 4 weeks of the parent introduction letter.	Replacement DSI RSP

DOCUMENTATION REQUIREMENTS DURING STAFFING GAP

Documentation Type	**Action and Owner**
Weekly and monthly service logs	No logs entered into SEDS
Quarterly Progress Reports	LEA RD or case manager includes information on the staffing gap and plan. DSI Program Manager will provide sample language. *"During this progress reporting period, the Division of Specialized Instruction (DSI) experienced an interruption in the provision of OT/PT/SLP services at your child's school. OT/PT/SLP services have been missed from 12/16/2019 to the present. Once a replacement OTPT/SLP is secured, the OT/PT/SLP will resume serving your child's IEP goals, as well as make up the missed services before the end of the SY."*
Communication with Parents (email, phone, mail)	All notifications to the parent regarding the staffing gap and/or plan must be document in the student's communication log in SEDS.
IEP Meetings (AED, Annual, Eligibility)	Ten days prior to the IEP meeting, the LEA RD requests coverage for the meeting by providing the date, time, student name, and meeting purpose. Five days prior to the IEP meeting, the DSI Program Manager will inform the LEA RD of assigned provider for the IEP meeting.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Deputy Director

MEMORANDUM

TO: Richard Nyankori
Deputy Chancellor, Office of Special Education
District of Columbia Public Schools

FROM: John McCarthy
Deputy Director
Department of Health Care Finance

DATE: August 9, 2010

SUBJECT: Electronic Signature for Medicaid-Reimbursable Related Services

This memorandum is in response to DCPS' request regarding the allowable use of e-signatures for documenting Medicaid services. DHCF understands that DCPS is undergoing a system-wide initiative to capture and maintain all special education related information electronically. This includes service encounter tracker forms, which contain the related services provided to students, progress notes, the provider's "wet signature", and other required Medicaid documentation.

In 2008, the District implemented the Special Education Database System (SEDS), which is a web-based system designed to manage all special education services to include Medicaid reimbursable related services. SEDS also contains the service encounter tracker form to track and document Medicaid reimbursable services. DHCF participated in a walk-through of the SEDS system in June 2010. DHCF understands that the SEDS system includes the following components:

- Mandatory SEDS training for all authorized special education providers to gain access to system;
- Unique user name and encrypted password to identify user;
- System entry with unique user name and password for authentication; and
- Date and time stamp entries and attestation to being the approved provider.

DHCF reviewed the above components and SEDS has the necessary safeguards for secure access to and documentation of Medicaid reimbursable services by authorized and authenticated users. Based on the information above, DHCF will accept electronic signatures by providers in lieu of physical signatures for Medicaid-reimbursable related services. This is contingent on the

825 North Capitol Street, N.E., Washington, D.C. 20002 (202) 442-5988 Fax (202) 442-4790

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

TO: Related Service Providers and Special Education Coordinators

FROM: Dr. Richard Nyankori
Deputy Chancellor for the Office of Special Education

DATE: March 4, 2009

SUBJECT: Speech-Language Services New Guidelines

There has been some confusion regarding the proper procedures for handling IEPs that contain only speech and language services. Official guidance from OSSE will be forthcoming, in the interim DCPS has established the following guidelines.

- An IEP with only speech and language services is acceptable and will remain in place. If the IEP is current, continue serving the student. No changes need be made until the next review meeting.

- At the next review meeting discuss the student's progress and any educational impact. Determine if there are current assessments that can be used to evaluate educational impact. If not, MDT members including the speech and language pathologist, psychologist, and teacher must decide which assessments are needed to determine educational impact and continued eligibility. If there is no educational impact, the team must recommend dismissal from special education.

- For initial referrals, proceed with the usual intake process to identify the appropriate assessments to determine the student's eligibility for services.

- If it is determined that there is an educational impact and speech language services are the only services needed to address that impact, an IEP with only speech and language can be drafted. There is no need to include specialized instruction in these instances as speech and language will be viewed as a form of specialized instruction for students with an IDEA classification of SLI. However, when entering in Easy IEP, specialized instruction should be entered as zero hours and the speech-language service documentation should be completed under related services.

Please carefully follow these steps to ensure that all our students are properly served. Thank you for your continued support and cooperation. If you have questions or need further clarification, please contact your supervisor or the SEDS help desk at (202) 719-6500.

Thank you,

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

DOCUMENTING SERVICES GUIDANCE MEMO

TO: All DCPS Employees and Contracted Related Service Providers

FROM: Dr. Richard Nyankori, Deputy Chancellor of Special Education
Dr. Erica Fener, Program Director of Related Services

DATE: November 13, 2009

SUBJECT: Establishment of Caseload Management and IEP Service Documentation Guidelines

Caseload Management for Related Service Providers
By the first day of school, Local Education Agency (LEA) must identify all students who require related services as per their IEP. This identification process includes:

- Type of service, Related Service Provider (RSP) assigned to the student
- Beginning date of service
- Intensity of service (e.g. one 60-minute session per week)

During the first two weeks of school, Related Service Providers must:

- Check with the LEA at each of their assigned schools to ensure they have all of the students on their caseload assigned to them in SEDS. If RSPs have difficulty engaging their SEC in this process, they should contact the OSSE SEDS (EasyIEP) Call Center (202-719-6500 Monday – Friday, 7:30am – 6:00pm) for assistance in appropriately assigning students to their caseload and immediately notify their Program Manager via email.
- Identify any students the RSP does not have the capacity to serve.
- Supply this information to their Program Manager immediately to ensure the Program Manager is aware of the capacity issue at that school.

IEP Service Documentation for Related Service Providers
DCPS, the Centers for Medicare and Medicaid (CMS), and the Office of the State Superintendent for Education (OSSE) have established a best practice service delivery documentation system. Related Service Providers should document the services they provide or attempt to provide pursuant to the IEP within the same school day those services were scheduled to occur. Email your program manager if barriers exist for daily documentation of services. We recognize there may be challenges (e.g. incorporating time to collaborate with teachers and parents) that could prevent you from providing daily documentation 100% of the time. Therefore, DCPS has established a definitive due date for documenting services provided during a school week.

Definitive Due Date for Documenting Services: All services provided in a school week **must** be documented by **noon on the Monday of the following school week**. If school is closed on Monday then documentation is due by noon of the next school day. For example, 60 minutes of speech/language services provided on Friday from 2 to 3 p.m. should be documented by noon that upcoming Monday.

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

MEMORANDUM

To: Related Services Providers
Program Managers and Clinical Specialists
From: Dr. Nathaniel Beers, Chief of the Office of Specialized Instruction
Cc.: Phuong Van, Medicaid Analyst, Office of Specialized Instruction
Re.: National Provider Identification Number
Date: February 19, 2014

Welcome to the District of Columbia Public Schools' (DCPS) Office of Specialized Instruction Inclusive Programming Division. Your commitment and dedication to helping our students reach their maximum potential is much appreciated.

The purpose of this memo is to inform you of an important step in ensuring your good standing as a Related Services Provider (RSP). A mandated service provider regulation passed on April 12, 2012, through the Affordable Care Act (rule 42 CFR Parts 424 and 431), requires all providers of medical services to obtain a National Provider Identifier (NPI) within one week of their employment start date. The NPI acts as a unique provider identifier for Medicaid claims submitted to the Medicaid Agency, and is necessary to the operations of both Medicaid and Related Services.

In order to properly conduct Medicaid claiming and to remain a provider employed in any capacity, all providers rendering services on behalf of DCPS must obtain their NPI number. Providers may verify their existing NPI number or obtain an NPI number online at https://nppes.cms.hhs.gov/NPPES. After securing an NPI within seven days of employment, please provide the number to your assigned Program Manager or Clinical Specialist.

Please review the attached National Provider Identifier FAQs and directions. For any other questions concerning your NPI number or any difficulties experienced while attempting to obtain your NPI number, please notify your assigned Program Manager or Clinical Specialist and contact the NPI Enumerator.

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

MEMORANDUM

TO: Related Services and Early Stages Program Managers

Cc: Dr. Art Fields, Senior Director of Related Services

Deitra Bryant Mallory, Director Related Services Quality

Regina Grimmett, Director Related Services Operations

Sean Compagnucci, Executive Director Early Stages

FROM: Dr. Nathaniel Beers, Chief, Office of Specialized Instruction

RE: National Provider Identifier Requirement for Providers Employed or Contracted with DCPS

As a result of the Affordable Care Act, the Centers for Medicare and Medicaid (CMS) issued a final rule (42 CFR Parts 424 and 431) on April 12, 2012 requiring all providers of medical services to obtain a National Provider Identifier (NPI). The NPI acts as a unique provider identifier for Medicaid claims submitted to the Medicaid Agency. In order to properly conduct Medicaid claiming, all providers rendering services on behalf of the District of Columbia Public Schools must obtain their NPI number.

Providers may verify their existing NPI or obtain an NPI for the first time online at https://nppes.cms.hhs.gov/NPPES

Frequently Asked Questions (FAQ's):

1. What is an NPI?
An NPI is a 10-digit number used by Medicaid to uniquely identify providers.

2. Why is the NPI required?
In order to properly submit Medicaid claims for special education services rendered, individual provider NPI's must be included in claims.

3. Why is this required now and not in past?
The Affordable Care Act (ACA) reinforced the 1996 HIPAA requirement that certain providers obtain an NPI, making the NPI requirement universal. The Centers for Medicare and Medicaid Services issued a final rule (42 CFR Parts 424 and 431) requiring all providers of medical services to obtain an NPI. As a result, states must provide the individual NPI when claiming.

4. If I'm providing services as part of my private practice, will this affect my ability to collect Medicaid?
As long as a provider is not submitting claims for services rendered on behalf of DCPS, then there should be no effect on a provider's ability to claim outside of these services.

5. Who is liable if DCPS is the Medicaid claimant?
Liability will be shifted away from providers, because DCPS conducts Medicaid claiming on behalf of providers and providers have no part in claiming themselves.

6. Will this be an annual requirement or just one time?
Obtaining an NPI is a one-time requirement.

7. When do I need to obtain an NPI/enroll with DC Medicaid?
DCPS requires providers to obtain an NPI within 7 days of employment. Please provide your NPI number to your discipline Program Manager.

8. What's the process to obtain an NPI?
Providers must access the National Plan and Provider Enumeration System (NPPES) at https://nppes.cms.hhs.gov/NPPES
Time to complete is an estimated 20 minutes. Required credentialing and identifying information is listed on the website.

9. Does it cost anything?
There is no cost to obtaining an NPI.

Any questions or concerns?

Contact:

Gloria VanHook
Medicaid Analyst, OSI Eligibility and Enrollment Specialist, OSI
Email: gloria.vanhook@dc.gov
Desk: (202) 7276196

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

TO: Related Services Providers

Cc: Dr. Art Fields, Senior Director Related Services
Deitra Bryant Mallory, Director Related Services Quality
Regina Grimmett, Director Related Services Operations
Sean Compagnucci, Executive Director Early Stages

FROM: Medicaid Team, Office of Specialized Instruction

RE: Directions to Apply for a National Provider Identifier

All providers rendering services on behalf of DCPS must obtain a National Provider Identifier (NPI). Individuals are eligible to receive one NPI regardless of the number of specialties practiced. Please follow the steps below if you never received an Entity Type 1 NPI.

Contact the NPI Enumerator (helpdesk) at 1-800-465-3203 or customerservice@npienumerator.com for questions about the application.

Open the hyperlink https://nppes.cms.hhs.gov/NPPES

Section 1:

- Select Entity Type 1: "An individual who renders health care"
- Is the individual a sole proprietor? Select No

Section 2:
Complete 1-19.

Section 3:
3-A and B: Input DCPS address for *Business Address* and *Business Practice Location*.

1200 First St NE, 9th Floor
Washington, DC 20002

3-C. Fill out if applicable

3-D. Provider Taxonomy Code

1. Click **Add Taxonomy**
2. Select **Provider Type Code**, click **Next**
3. Select **Taxonomy Code Area**, **Highlight** the appropriate code
4. Click **Save** and then click **Next**

The table below provides some Taxonomy Codes. For a complete list, please visit http://www.wpc-edi.com/reference/ and click on *Health Care Provider Taxonomy Code*.

Classification	Provider Type Code	Taxonomy Code
Audiology	23	231H00000X
Occupational Therapy	22	225X00000X
Occupational Therapy Assistant	22	224Z00000X
Physical Therapy	22	225100000X
Physical Therapy Assistant	22	225200000X
School Psychologist	10	103TS0200X
Clinical Psychologist	10	103TC0700X
Speech Language Pathologist	23	235Z00000X
School Social Work	10	1041S0200X
Clinical Social Work	10	1041C0700X

Section 4: Certification Statement.

Section 5: Provide your contact information.

****NPI information can be updated online. ****

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

DCPS Data System User Security Pledge - Accelify

I will have access to confidential student data provided by the District of Columbia Public Schools (DCPS) via the Accelify system. I understand that access to this confidential data carries with it the responsibility to maintain the confidentiality of such data in a secure fashion, including the duty to guard against any unauthorized use and unauthorized access.

To treat information as confidential means not to divulge it to or cause it to be accessible by any unauthorized person. To secure confidential data means to take all necessary precautions to prevent unauthorized persons from accessing such data.

I agree to fulfill my responsibility under this security pledge as follows:

1. I agree not to permit unauthorized access to these sensitive data, either electronically or in hard copy.

2. I agree to notify DCPS if there is a breach of data confidentiality as outlined in this pledge.

3. I agree to follow all DCPS policies and procedures governing the confidentiality and security of DCPS data in any form, either electronic or in hard copy.

4. I agree that I will not access, release or share confidential data except as necessary to complete my project duties or role responsibilities.

5. I agree that I will use all reasonable means to protect the security of confidential data in my control, and to prevent it from being accessed or released, except as permitted by law.

6. I agree that when my affiliation/employment with DCPS ends, I will not take any confidential data with me and I will not reveal any confidential data I had access to as a result of my role/responsibilities.

7. I agree to report unauthorized use or disclosure of confidential data, or security issues impacting the proper safeguard of confidential data to DCPS immediately.

I understand that disclosing confidential data directly, or allowing unauthorized access to such data, or failing to adequately secure data may subject me to criminal prosecution and/or civil recovery and may violate the code of research ethics, District of Columbia laws and DCPS rules and regulations.

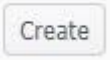
☐ I agree to the terms and conditions of use. E-Signature_____

Accelify – Provider's Licenses

Uploading Licensures: **DC DOH License**

Providers should maintain an updated copy of their DC Government Department of Health license in Accelify.

Adding/Editing a License

- From the home screen, go to the AcceliTrack drop-down, and select Administrative Tools then License Manager.
- From the License Manager, select the icon.
- To create a new License, click  and fill out all required fields on the Provider Certificate Details form and click .
- To upload a license, click , select the desired file, and then click .
- Edit your licenses by clicking the icon.
- Delete your license by clicking the icon.
- Note: You can also access the License Manager from the Toolbox tab in the Administrative Tools section.

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

March 2014

Guidelines for Speech Only IEP Case Management

Final Version

DCPS maintains discretion to revise, amend, or revoke this guidance at any time.

Definition of Speech Only IEPs **3**

How to Identify Number of Speech Only IEPs at My School **3**

Case Management of Speech Only IEPs **4**

What is not included in Speech Only Caseloads **5**

Maximum Caseload for SLPs **5**

Point of Contacts **6**

Definition of Speech Only IEPs

A speech-only IEP contains only goals and direct services in the area of speech-language pathology. A speech-only IEP does not contain any other related service(s) or specialized instruction.

How to Identify the Number of Speech Only IEPs at my School

There two (2) recommended ways to identify Speech Only IEP cases at your respective school. The Speech Only IEPs can be found either through SEDS or the Provider Management Application 2.0 (PMA). Below illustrates access to both databases to retrieve the information.

SEDS EASY IEP Access:

Identifying Speech-Language Only IEPs in SEDS:

1. Click on the *Students* tab located on the navigation pane of the home screen.
2. Select *Advanced Student Search* as the student search option located towards the bottom of the page.
3. Select *Special Ed* as the Status located in the middle of the page.
4. Select *Speech or Language Impairment* as the Disabilities located in the middle of the page.
5. Select *Speech-Language Pathology* as the Related Services located towards the bottom of the page.

NOTE: The results will identify **POTENTIAL** students with a Speech-Language Only IEP. Specific items must be present on the students IEP in order to qualify.

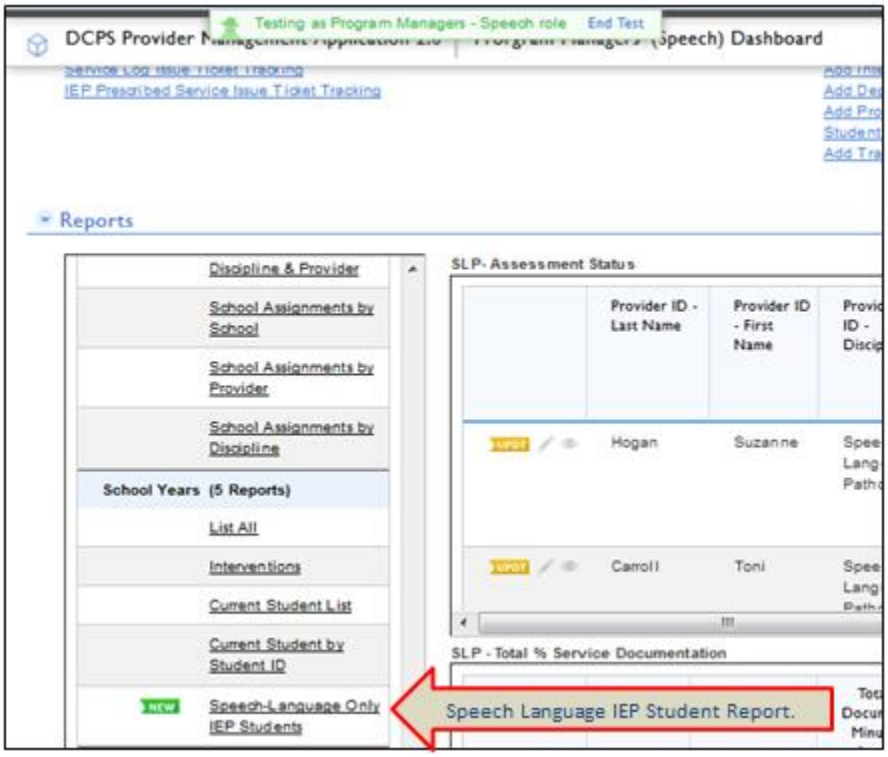
Qualifications for Speech-Language Only IEP that must be present

1. The disability classification can only be Speech or Language Impairment (SLI).
2. All related, consultative and extended school year services can only be Speech-Language Pathology.
3. If Special Education Services are present on the IEP, then the amount of time can only be zero (0).
4. All qualifications must be present on the student's IEP, in order to be assigned a speech-language pathologist as the case manager in SEDS.

Provider Management Application (PMA) Access:

- Log onto the PMA.
- Scroll down to section called "Reports" located on the left-hand side of the screen and find tab called "School Years."
- Under "School Years" find and enter section called "Speech-Language Only IEP Students."

This report lists all students that have a speech and language only IEP at each school. Within this report, it will indicate the students school and the IEP/Eligibility due date.


Testing as Program Managers - Speech role
End Test
DCPS Provider
(Speech) Dashboard
IEP Prescribed Service Issue Ticket Tracking
Reports
Discipline & Provider
School Assignments by School
School Assignments by Provider
School Assignments by Discipline
School Years (5 Reports)
List All
Interventions
Current Student List
Current Student by Student ID
NEW
Speech-Language Only IEP Students
SLP- Assessment Status
Provider ID - Last Name
Provider ID - First Name
Hogan
Suzanne
Carroll
Toni
SLP - Total % Service Documentation
Speech Language IEP Student Report.

Case Management of Speech Only IEPs

As a case manager, the Speech-Language Pathologist (SLP) is responsible for ensuring that students with speech-only IEPs have appropriately written Individual Education Plans (IEPs) and that they follow the District of Columbia Public Schools Policy and Procedure for compliance.

Responsibilities of Speech-only IEP Case Managers:

Responsibilities	Required Duties to Fulfill Responsibilities as a Case Manager
Parent Communication	• Scheduling meetings and sending Letter of Invitations
Assessments: Reevaluations	• Order and finalize all assessments in SEDs • Input all assessment results in SEDs
IEP Development	• Prepare draft IEP • Prepare all documents for IEP meeting • Enter all data/information into SEDs • Finalize the IEP
IEP implementation	• Ensure all students on caseload receive proper accommodations and modifications • Implement the IEP • Ensures the team signs the IEP and faxes the IEP into SEDs
Monitoring	• Progress monitoring • Develop and enter quarterly progress reports into SEDs

What is not included in Speech Only IEP Caseloads

Speech Only IEP case managers are not responsible for managing initial IEPs or initial eligibility. This responsibility remains that of the LEA Representative or case manager.

Maximum Caseloads for SLPs

Per the Washington Teachers' Union (WTU) bargaining unit agreement, case managers' caseloads are not to exceed fifteen (15) cases. In the incidence when caseloads do exceed fifteen (15) cases the case manager must be offered the administrative premium payment. As caseloads fluctuate, please refer to this stipulation and equalize caseloads amongst case managers as appropriate. Speech Only IEP case managers in excess of fifteen (15) at any school require that the SLP agree to receive administrative premium to manage those

cases, or that they be assigned to another case manager. The administrative premium funds are the responsibility of the school.

Points of Contact

- Gabriana Dennis, M.A., CCC-SLP
  Program Manager, Speech – Language Pathology & Audiology
  (202)
  GaBriana.Dennis@k12.dc.gov

- Darla Kimbrough, M.S., CCC-SLP
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DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

2014-2015 School Year

Swallowing and Feeding Guidelines for Speech-Language Pathologists

Version 3.0

It is DCPS' position that all students should utilize appropriate feeding and swallowing procedures while eating and remain adequately nourished and hydrated in order to access educational programs and participate fully. It is DCPS' position that the focus should be to maintain a student's current diet prescribed by a physician's order, which has been determined to be the safest and meets that student's nutritional and hydration needs.

According to ASHA's Guidelines for Speech-Language Pathologist providing swallowing and feeding services in schools (2007) addressing swallowing and feeding disorders is educationally relevant and part of the school system's responsibility for the following reasons:

- Students must be safe while eating in school. This includes providing appropriate personnel, food, and procedures to minimize risks of choking and for aspiration during oral feedings
- Students must be adequately nourished and hydrated so that they can attend to and fully access the school curriculum
- Students must be healthy (e.g. free from aspiration pneumonia or other illnesses related to malnutrition or dehydration) to maximize their attention at school.
- Students must develop skills for eating efficiently during meals and snack times so that they can complete these activities with their peers safely and in a timely manner.

Typically dysphagia is an accompanying disorder related to neurological and/or structural issues that impeded normal swallowing functions. Swallowing and feeding disorders are characterized by difficulty tolerating food and liquid, managing saliva, and taking oral medications which may be exemplified by choking and aspiration, oral-motor and sensory impairments, inappropriate behaviors during eating activities, refusal to eat, and restricted variety of accepted food and liquid. Students with swallowing and feeding disorders may present with difficulty affecting motor planning, postural and oral-pharyngeal motor abilities, sensory processing, respiration and digestion.

To facilitate consistency in service delivery, DCPS has developed Feeding and Swallowing Guidelines. DCPS's position is to ensure that the student is able to maintain adequate nutrition and hydration so that the student can access the educational curriculum. Due to the medical complexity of dysphagia, the possibility of silent aspiration, and the risk of potential harm to the student, parents requesting diet modifications, including oral trials will be referred to a medically based Speech-Language Pathologist or Swallowing/Feeding Clinic. **The school based SLP is not responsible for implementing oral trials, or changing diet consistencies or textures (i.e., mechanically ground/chopped, puree, nectar thick liquids, honey thickened liquids, etc…) this can only be done by a medically based Speech-Language Pathologist or Swallowing/Feeding Clinic under the orders of a physician.**

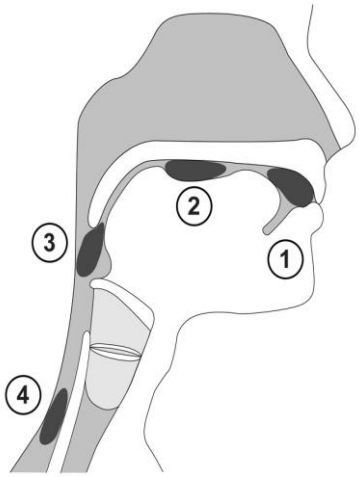
Part B of IDEA, concerning children from 3 through 21 years of age, describes disabilities that are governed by provision of the act and its accompanying regulations. A feeding and swallowing disorder is not of the disability categories listed in IDEA; however, such a disorder may coexist in children who are identified as having one or more of the listed disabilities, including autism, developmental delay, intellectual disability, multiple disabilities, orthopedic or other health impairments, and traumatic brain injury. Because a feeding or swallowing disorder is not a primary disability, feeding and swallowing services are included under related services when they are needed to support a child's special education instruction. In the case where a child may require modification of their diet (chopped, ground and/or puree food) or liquids (nectar-thick, honey-thick and/or pudding-thick) the child may require Assistive Technology via supplementary aids and services (i.e., adapted eating utensils, blender, thickeners, etc…). IDEA defines supplementary aids and services as 'aids,

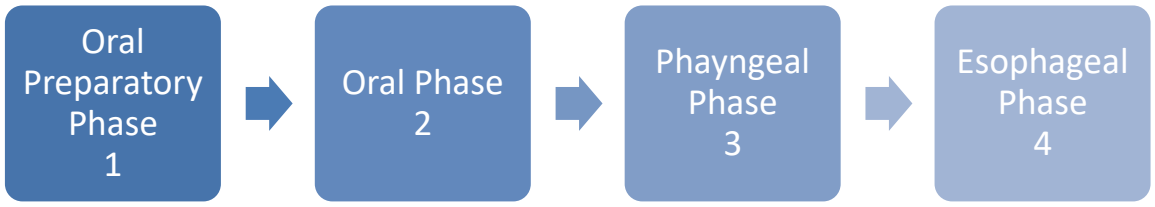
services, and other supports that are provided in regular education classes or other education-related settings to enable children with disabilities to be educated with nondisabled children to the maximum extent appropriate [IDEA Sec. 601]. These could include both direct (e.g., specific skill instruction) and indirect (e.g., monitoring by a paraprofessional) feeding and swallowing services and special equipment necessary to support dietary modifications, as well as access to food items. (CT State Department of Education)

504 Plans generally include accommodations necessary to facilitate access to school programs. For children with feeding and swallowing handicaps, these accommodations are likely to take the form of modified food, utensils and physical arrangements for feeding or eating. A child who is initially served under Section 504 may require referral to special education later on; conversely a child exiting special education may become eligible for services under Section 504. (CT State Department of Education)

4 Stages of the Swallow

The swallow is divided into 4 phases which encompass specific actions with the manipulation and transition of the food bolus: oral preparatory, oral, pharyngeal, and esophageal (Arvedson and Brodsky, 2002; Logemann, 1998; Swigert, 1998)





Oral Preparatory Phase	Food is introduced into the mouth(requiring adequate lip closure) where it is manipulated by the tongue, teeth and cheeks to break down the food and organize it into a bolus.
Oral Phase	Begins when the bolus enters the oral cavity and is mixed with saliva during mastication to allow formation of a cohesive bolus. The tongue lifts the bolus toward the hard palate, and moves it to the back of the mouth with a wave-like (peristaltic) squeeze for propelling the bolus into the pharynx.
Pharyngeal Phase	The second stage of the swallow is entered as the bolus is propelled toward the oropharynx, where the swallow reflex is triggered. Soft palate elevation during this stage prevents foods and liquids from entering the nasopharynx. The hyoid bone and larynx are pulled upward and anteriorally and the vocal folds midline. The epiglottis, a cartilage flap, closes, thereby protecting food from entering the airway. The posterior tongue base propels the food through the pharynx with the assistance of the peristalic wave contraction of the posterior pharyngeal wall
Esophageal Phase	As the food is passed through the pharynx to the esophagus, the upper esophageal sphincter relaxes, allowing the food to pass through into the esophagus. Peristaltic wave contractions continue to propel the food toward the stomach. The lower esophageal sphincter, located at the juncture of the esophagus and stomach, opens to allow entry of the food into the stomach. This sphincter then closes, preventing reflux. Esophageal conditions affecting swallowing may include gastroesophageal reflux, achalasia, and esophageal strictures, among many others.

Signs and Symptoms of Dysphagia

Recognizing signs and symptoms of dysphagia is critical for identifying children with evaluation an intervention needs in this area. The following signs and symptoms of swallowing disorders are among the most common (sources include Logemann in Homer et al., 200; Newman, 2000; and Nicolosi et al., 2004):

- Poor upper body control or posture
- Unusual head or neck posture
- Frequent refusal to eat or drink
- Irritability or behavioral problems during eating
- Difficulty placing or keeping food in the mouth (anterior spillage)
- Oral hypersensitivity or hyposensitivity
- Difficulty controlling saliva in the mouth or significant drooling, especially after eating
- Difficulty controlling food in the mouth or excessive mouth movement during chewing and swallowing
- Difficulty starting to swallow
- Needing to swallow a few times to get food down
- Repeated drinking while or immediately after chewing or swallowing
- Food left on tongue (residuals) or pocketed on the side of the mouth after swallowing
- Coughing before/during/after eating or drinking
- Frequent gagging or spitting or vomiting during or after eating or drinking
- Watery eyes (tearing) during or after eating or drinking
- Extended feeding periods (longer than 30-40 minutes)
- Frequent bouts of pneumonia or other chronic respiratory problems
- Gurgly voice quality or breath sounds, especially after eating or drinking

Oral Phase Dysphagia Symptoms	***Pharyngeal Phase Dysphagia Symptoms***

Difficulty with bolus management	Coughing/choking while eating
Inability to manage oral secretions (drooling)	Wet vocal quality
Food residue along the tongue/palate or food retained in cheeks after swallowing	History of frequent upper respiratory tract infections or pneumonia
Difficulty chewing food	Complaints of food "sticking" in throat
Loss of food from mouth while eating	Spiking high-grade temperature or consistently running a low-grade temperature
	Increased respirations with oral intake
	Throat clearing during meals
	Pain during the swallow
	Leakage of liquids through the nose while eating
	Repetitive Swallows

Texture Modifications to Foods and Liquids

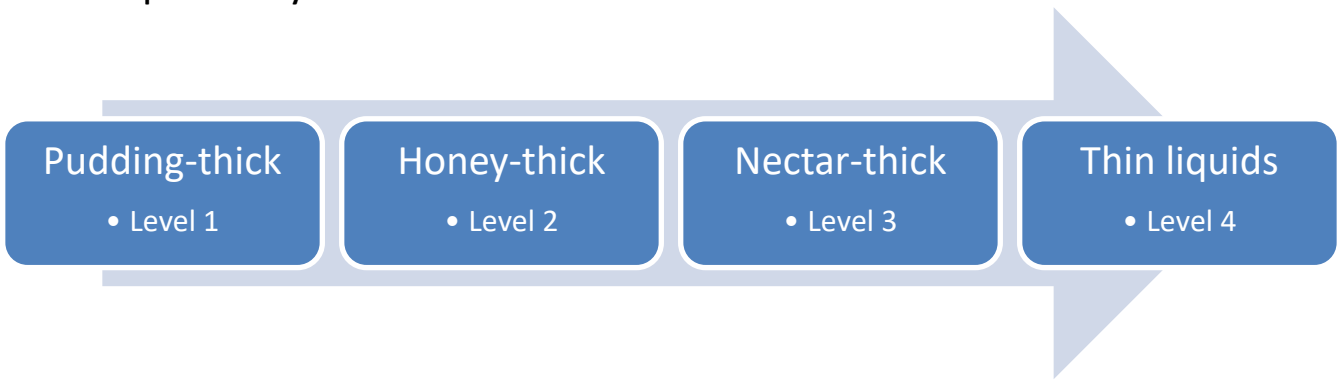
"When the oral phase is characterized by incoordination and delay, the child's potential for aspiration and choking is greater with thin liquids than with thickened liquids and thick semisolid foods. The thicker textures provide greater sensory information and do not tend to fall back in the oral cavity as quickly as thinner textures… In contrast… children with reduced pharyngeal motility and persistent residue after a swallow are most likely to aspirate on paste-consistency foods, because these firmer, sticky food are harder to clear from the pharynx with subsequent swallows. Children also may experience considerable irritation and discomfort, which can lead to food refusal and behavioral problems related to feeding" (Arvedson and Brodsky, 2002, pp 443-444). To avoid the potential dangers associated with feeding children with inappropriate textured food, clear communication among all parties regarding diet terminology and manner of preparation is essential. For safety reasons, clear descriptors of texture and multiple examples of allowable food choices must be insisted upon and this information must be clearly communicated to those responsible for food preparation and feeding. Food texture should not be changed arbitrarily. SLPs in the schools cannot modify food textures. **Food textures and consistencies can only be changed via a physician's orders and/or following the results of the most current findings on a swallow study (MBS).**

Among the children for whom texture/consistency modifications are indicated are those who:

- Have poor muscle control and have trouble chewing, forming a bolus or keeping food in their mouths;
- Are aspirating on thin consistencies;
- Are born with oral structure that have irregular sizes and shapes or deformities;
- Cannot open their mouths wide enough to eat because of joint problems, arthritis, or injury;
- Are transitioning from non-oral to oral feeding an therefore lack oral-motor experience with normal food consistency and have possible emotional resistance to the entry of food in to the oral cavity. (Connecticut State Department of Education)

Food Levels/Consistencies

Levels of Liquid Viscosity



Feeding and Swallowing Levels

Non-Oral Feeding- Nothing By Mouth: MUST HAVE MBS and GI Consult
In some students, dysphagia is so severe that the student should not or cannot swallow anything. A tube may be surgically inserted directly into the stomach (gastrostomy), through the nose (nasogastric), or through the mouth (orogastric) to provide hydration, feeding, and administration of medication. A qualified individual, usually a nurse and /or trained teacher, can give liquid or semi liquid foods directly through the tube. The physician prescribes the amount of food.

These students must have a Modified Barium Swallow study on file with the school nurse. The results of the study indicated a pharyngeal phased dysphagia even with modified consistency to puree and thicken liquids. Student is at great risk of aspiration and his/her nutrition/hydration is maintained via g-tube feeding. These students will NOT receive feeding/swallowing services via DCPS. These students should be referred for medically based speech-language therapy services to address the student's dysphagia. The student is maintaining adequate nutrition and hydration via non-oral means; therefore, he/she is able to access the educational program and participate fully.

Modified Consistencies- Oral Feeders: MUST HAVE MBS/GI Consult
The aspiration risk can be reduced for some students by altering the consistency or texture of the food, which is determined by the medical-based SLP in collaboration with the student's physician. These students may be receiving supplemental non-oral feedings to maintain nutrition/hydration and weight gain, such as a PEG or G-tube. The results of the MBS indicate a pharyngeal phase dysphagia requiring a modified consistency such as pureed or thickened liquids which results in reducing aspiration risks and increasing swallowing. These students will not receive feeding/swallowing services via DCPS that address the modification of diet consistencies or oral trials to upgrade diet consistencies. These students must be at a school with fulltime nursing staff. However

they can receive speech and language therapy that address oral motor exercises and non-nutritive stimulation to assist with the strengthening and/or coordination of the oral motor structures necessary for swallowing/feeding (i.e., using chewy tube to increase strength and/or assist with the rotary chew, lip closure and strengthening exercises to decrease drooling and anterior spillage, etc…). The students will need a feeding plan at their school, which includes a physician's order for a modified consistency and current Modified Barium Swallow Study. Parents can provide the physician's order or provide consent to the school SLP to obtain a physician's order regarding the modified consistency to the school. The speech-language pathologist acts a liaison between the school nurse and classroom teacher to ensure implementation of the physician's order. These students should have a feeding plan that includes: aspiration precautions, compensatory strategies (if required), MBS study and results from recent GI consult; emergency plan, seating and positioning needs, any feeding (sensory) prep needs, and any special equipment needed.

Oral Phase Dysphagia / Food Aversion:

These students may or may not have a Modified Barium Swallow study. The results indicate a normal pharyngeal phase with normal consistencies and thin liquids. All of the student's nutrition and hydration needs are met via oral feedings. These students have difficulty with anterior-posterior propulsion, bolus formation and clearing the oral cavity. These issues should be addressed in their feeding plan. These students' feeding plans should include: aspiration precautions, compensatory strategies (if required), MBS study (if available); choking protocol, seating and positioning needs, any feeding (sensory) prep needs, and any special equipment needed.

School-based Swallowing and Feeding Team

The school-based swallowing and feeding team consist of members who service in the school system, as well as medical practitioners outside the schools. The school-based team consists of core members who are primarily responsible for decisions regarding dysphagia. The core team typically consists of the following:

- Speech-Language Pathologist (who often services as the dysphagia case manager)
- Parent/Guardian
- Nurse
- Classroom Teacher
- Occupational Therapist (OT)
- Physical Therapist (PT)
- School Administrator

It may also include the following team members

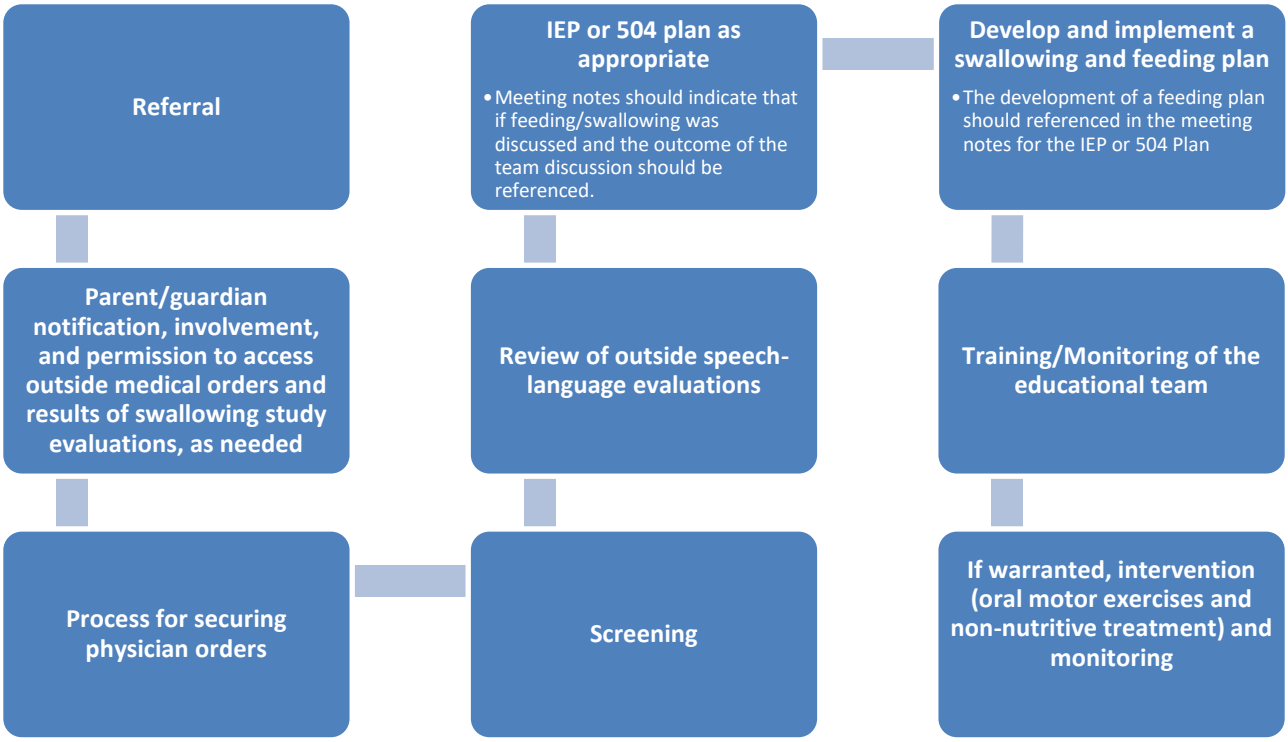
- School Psychologist
- Social Worker
- Cafeteria Personnel

Medical professionals outside the school system may include the following:

- Physicians (e.g., pediatrician, gastroenterologist, neurologist, ENT, radiologist, etc…)
- Speech-Language Pathologist
- Nurse
- Dietitian/Nutritionist
- Psychologist
- Occupational Therapist
- Physical Therapist

Process for Developing and Implementing the Swallowing/Feeding Plans and Interventions for Students

The following represents the process to be followed with developing and implementing swallowing/feeding plans and interventions for students to ensure that proper medical information is provided, which will be necessary for training the educational staff regarding safe swallowing to reduce/prevent signs and symptoms of aspiration.



Swallowing Referral Procedures

In some cases, a student may demonstrate symptoms of feeding and / or swallowing difficulties. In these cases, the IEP or 504 Plan team may wish to recommend that family seek a swallow study for the student. The following steps should be followed:

1. Designated team member contact family. This may include the nurse, teacher or speech pathologist.
2. Team provides information about the purpose of swallow study for the student (to determine the least restrictive diet in order to increase safety when swallowing and to decrease the risks of signs/symptoms associated with aspiration)
3. Parent contacts physician for a prescription for a swallow study and make appointment. If the parent encounters difficulty following their initiation of the request, than members of the educational team will provide assistance and/guidance on how to obtain the necessary information (Medical Based Resources are included within this guidance to refer parents).

However, parents must make the team aware of the barriers encountered, in order for the team to provide the appropriate type of assistance and guidance.

4. Parent informs school of pending appointment.
5. Parent provides copy of swallow study results / report
6. Team reviews swallow student results and recommendations
7. Team meets with family to discuss
8. Develop a feeding and swallowing plan if needed. Please see Appendix for plan.

Adapted Devices/Equipment for Feeding and Swallowing

This role is to be primarily addressed by the Occupational Therapist (OT) and Assistive Technology provider

- Does the student require a blender (to puree or chop food per the doctor's order) and/or thickener (to thicken the consistency of liquids per the doctor's order)?
    - If yes, the school is responsible for providing these items. It should be indicated in the AT section of the IEP and/or notated within the 504 Plan. This information should also be incorporated in the Swallowing/Feeding Plan
- Does the student require adapted eating utensils to address intake of food, increase independence for feeding and/or to assist with facilitating feeding?
    - If yes, the type of equipment needed should be indicated in the AT section of the IEP and/or notated within the 504 Plan. This information should also be incorporated in the Swallowing/Feeding Plan
- Does the student demonstrate postural concerns, which may require adaptation to the seating/wheelchair (to maintain proper positioning and body control during feeding to increase safety and reduce risks of aspiration)?
    - If yes, identify the type of seating modifications needed, which may/may not need to be indicated in the AT section of the IEP and/or notate within the 504 Plan. This information should also be incorporated in the Swallowing/Feeding Plan

The School-based Speech-Language Pathologist's Role and Responsibilities

- Develop a Feeding Plan (see appendix) to provide to educational staff
- Provide training to the educational staff (i.e., teacher, paraprofessional, etc…) regarding safe feeding and posturing.
- Fax Feeding Plan into SEDS under the miscellaneous coversheet labeled "Feeding Plan"
- Conduct periodic monitoring of education staff feeding student to ensure safe feeding and posturing is being maintained
- Contact treating physician to obtain a medical order indicating diet consistency and/or modifications
    - Fax medical order into SEDS using a miscellaneous coversheet, labeled as "Doctor's Order <date>"
- Contact/Communicate with medical-based SLP regarding report and results from the most recent swallowing study (MBS, FEES, etc…)
    - Most recent swallow studies must be faxed into SEDS using a miscellaneous coversheet entitled "Swallow Study Result <date>"
- Document training of educational staff regarding the feeding plan and how it should be implemented by the educational team.

- Use the Staff Development Verification Form and fax into SEDS using a miscellaneous coversheet entitled "Feeding/Swallowing Plan Training Attendance Sheet" (This form can be located on the Educator Portal in the Related Services Section under the IMPACT heading).
- Maintain indirect service/consultation logs in SEDS regarding training, monitoring, communication with medical or outside resources within the service tracker notes and/or the Communication Log
- Participate in 504 Plan or IEP meeting, if applicable

Components of the Feeding Plan

Safe feeding requires consideration of many factors that precede, occur during and follow the actual act of feeding and swallowing. The following components should be addressed:

- Environment in which the child is to be fed;
- Positioning during feeding;
- Equipment for food preparation and feeding (in collaboration with the AT team and/or cafeteria staff
- Diet content (including food and liquids), quality and texture as prescribed by doctor's order
- Feeding techniques
- Precautions, including emergency procedures as discussed and develop with student's nurse
- Training plans for personnel implementing the plan, including verification that it has taken place as scheduled (per the 504 Plan or IEP)
- Monitoring safety, progress and effectiveness of the plan and revising it accordingly;
- Process for communicating with families and the child's medical team

Direct Therapy Strategies for Feeding and Swallowing

There are strategies that are designed to directly affect swallow function through the student's practicing "active exercise" (Logemann, 2000, p. 52). Therefore, if it is determined that the student may require oral motor exercises to increase coordination and strengthening of oral musculature to assist with swallowing, the provide may utilize clinical judgment regarding if the student could benefit from goals to address this skill within the 504 Plan or IEP. It should be reiterate that all oral motor exercises are non-nutritive.

- Oral Motor Exercises
  Exercises to increase the range of motion, strength, or endurance of the muscles related to feeding and swallowing have frequently been included in feeding and swallowing intervention. Their purpose has been to improve bolus preparation and control for efficient passage into the pharynx and to protect the airway from aspiration. The major focus of these exercises has been increasing tongue tip elevation, improving jaw control, decreasing tongue thrust and developing lip closure. (Klein and Delaney, 1998; Swigert, 1998; Evans Morris and Dunn Klein, 2000)

- Swallowing Maneuvers
  These strategies "are taught to the student to change the timing or strength of selected movements during the oropharyngeal swallow. These require direction-following skills (comprehension skills in order to learn and retain), but may be taught to students as a game (Logemann, 2000, p. 53). Below outlines the four swallowing maneuvers described by Logemann (2000)
  - Supraglottic swallow (closes the true vocal folds before and during swallow)
  - Super-supraglottic swallow (Close entrance to airway at the level of the false vocal fold)
  - Mendelsohn maneuver (change laryngeal motion an cricopharyngeal opening)
  - Effortful swallow (improve pressure generated by tongue an base of tongue to help clear bolus)

If you have questions or concerns regarding swallowing concerns for a student on your caseload, please seek out assistance from your Program Manager to provide you guidance and support. There are several feeding programs within the metro area that address feeding aversion and modification of diet consistencies that parents can access if concerns arise:

Medical Based Resources

Kennedy Krieger Institute
Feeding Disorders Clinic
707 North Broadway
Baltimore, MD 21205
888-554-2080
www.kennedykrieger.org

Mt. Washington Pediatric Hospital
Feeding Program
1708 West Rogers Ave
Baltimore, MD 21209
410-578-8600
www.mwph.org

Children's National Medical Center
Feeding Disorders Clinic
111 Michigan Ave, NW
Washington, DC 20010
202-476-3032
www.studentrensnational.org

Key Terms

Aspiration Pneumonia - a lung infection caused by pulmonary aspiration

Pulmonary Aspiration - the entry of secretions or foreign material into the trachea and lungs

Modified Barium Swallow Study - using a swallowed contrast material which can be seen using X-rays, the physician is able to see all structures involved in swallowing (from the oral cavity to the esophagus) on a video screen while the test is taking place. Used to evaluate the swallowing process for people who are having problems speaking or swallowing food without aspirating it into the windpipe (a variation of the upper gastrointestinal series).

Anterior posterior propulsion – manipulation of the tongue and oral structures to propel food from the front to back of oral cavity

Bolus formation - During mastication and swallowing, food is cut into smaller pieces and softened by saliva and becomes bolus, then swallowed.

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DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Feeding and Swallowing Plan Form

Date _____

Student _____**Teacher**_____

Allergies _____

Equipment

Dish _____ Utensil _____
Cup _____ Straw _____

Need for help? Circle one

Independent Assisted Dependent
Explain _____
_____

Consistency. Circle.

Solid Food:	Pureed	Ground	Chopped	Mashed	Bite Size ____
Liquids:	No liquids	Thin liquids	Thickened liquids (Circle consistency)		
Consistency:	Nectar	Honey	Pudding		

Tube Fed

Fed Rate _____Flush Rate _____
Circle one below.
Tube fed / nothing orally Tube and oral fed Amount fed orally _____
Pleasure feeding Yes or No Amount _____

Procedures

Amount of food per bite _____
Food placement _____
Wait time _____
Behavior Techniques _____
Student's communication or signals during feeding _____
_____ Keep in upright position _____ minutes after meal
_____ Encourage student to cough to clear throat
_____ Offer a drink after _____ bites
Comments_____
_____

Positioning

Sitting Posture _____
Chair / seating device _____
Head position / support _____
Trunk control / support _____
Other _____

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

April 2017

Missed Related Services and Untimely Assessment Guidelines

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I. Executive Summary

A. Introduction

The District of Columbia Public Schools (DCPS) provides related services as illustrated in student's Individualized Education Plan (IEP) in accordance with federal and local law. DCPS seeks to provide consistent service delivery to meet the needs of its students and legal obligations. For this reason, **related service providers** (RSPs) must provide consistent service delivery to help students function with greater independence. Related service providers are also responsible for creating supporting documentation and acting to ensure student access to needed services. When delivery of a service is impeded, the RSP is responsible for documenting due diligence consistent with these guidelines. This document delivers the procedures necessary when a student or provider misses service session. It also deliver the guidance for the procedures to follow for untimely assessments. Bolded terms will be defined in the glossary at the end of the document. For further information regarding these guidelines, please direct your question to Division of Specialized Instruction (dcps.relatedservices@dc.gov).

B. Purpose

The purpose of this document is to provide guidance to related service providers (RSPs) regarding required actions for missed service sessions and untimely assessment. DCPS is required to ensure all students with disabilities receive free appropriate public education (FAPE) consistent with their individualized education program (IEP).[2] These guidelines clarify the roles and obligations of RSPs, identify when and by when missed related service sessions must be made up, and explain how to document missed, make-up, and attempted make-up service sessions.

Truancy is an agency-wide problem in DC Public Schools. **Truancy** is the unexcused absence from school by a minor (5-17 years of age), either with or without parental knowledge, approval, or consent. Since regular school attendance is critical to academic success, chronic truancy must be addressed[3]. Absences impact the number of instructional hours that a student receives and may result in failing grades, disengagement from the school environment, and ultimately, increase the likelihood of students dropping out of school. Since truant students often miss related service sessions, RSPs are uniquely situated to assist in increasing attendance and reducing truancy for special education students.

These guidelines address due diligence for service delivery to truant students and instruct RSPs on how to support truancy prevention. This document also provide necessary information for monitoring student engagement through service delivery, engaging parents in problem solving, and adhering to district reporting requirements for student attendance. RSP providers in every discipline should adhere to these guidelines and all other specialized instruction policies.

[2] See OSEP Response Letter Guidance (Mar.8 2016) available at http://www.asha.org/uploadedFiles/advocacy/federal/idea/OSEPResponseLetterGuidance.pdf (*interpreting* 34 CFR §300.101).
[3] 61 DCR 222

II. Missed Related Service Sessions Scenarios and Due Diligence Procedures

A. Provider Unavailable

1. Provider not available for schedule service session(s) (e.g., sick leave, annual leave, attending an IEP meeting, professional development)

When a service session(s) is missed because the provider is unavailable to deliver the service, DCPS has the following two options:

a) The RSP will schedule a make-up service session for the missed service session(s) during the quarter in which the missed service session(s) occurred. If the missed service session(s) occurred during the last week of the quarter, it must be made up within the first week of the following quarter. This policy ensures that all relevant information will be provided in the quarterly progress report. In most cases, this is the option that should be utilized. If the RSP cannot make up the session(s) by the following quarter, he/she must notify the program manager.

b) When the RSP absolutely cannot make up the session(s), and notifies the program manager, the program manager must assign a substitute provider to make up the missed service session(s) during the quarter in which the missed service session(s) occurred or develop an alternative option with the RSP and LEA. If the missed service session(s) occurred during the last week of the quarter, it must be made up within the first week of the following quarter.

B. Student Unavailable

1. Student in school, but not able to attend session

a) Student Attendance at School-Related Activities (e.g., field trip, assemblies): If a service session is missed because of student attendance at a school-related activity the RSP must:

- Consider the impact of the missed service session on the child's progress and performance and determine next steps to ensure the provision of FAPE. Determine whether missed session must be made up according to the following criteria:
    - If the missed service session due to the student's unavailability has caused a negative impact on the student's progress or performance, the missed session must be made up.
    - If the missed service session due to the student's unavailability has not caused a negative impact on the student's progress or performance, the missed session does not need to be made up.
- Document this determination in the **Service Log** in SEDS for that missed service session due to student unavailability and state the reason for the student's unavailability.

b) Student Refuses to Participate or Attend (e.g., verbal refusal, student is unable to be located)
When a student misses 3 service sessions because the **student refuses to participate or attend**:

- The RSP must
    - Document each missed service session;
    - Contact the teacher, attendance coordinator, and parent/guardian to determine the reason for the student's absence;
    - Document contacts, attempted contacts, and outcomes in the SEDS communication log;
    - Inform the Special Education Coordinator (SEC) via email that the student was absent or refused to participate and that the information has been documented.
    - Notify the LEA or case manager via email within 24 hours of the last missed service session. This notification prompts an **IEP meeting**. The LEA or case manager must

convene the IEP meeting within 15 school days of the 3rd missed service session to consider the impact of the missed session on the student's progress and performance and determine how to ensure the continued provision of a **free and appropriate public education (FAPE)**. Student attendance records should be reviewed at the meeting when making the determination.

- The SEC must:
  - Contact the parent/guardian at least three times using multiple modalities (e.g., written, phone, email, and visit). One contact must be written correspondence sent by certified mail with a return receipt;
  - Notify the related service provider via email when the attempts to contact the parent are made; and
  - Document contacts with parent/guardian, attempted contacts, and outcomes in the SEDS communication log.

The parent/guardian can agree in writing that the attendance of certain IEP Team members is not necessary for this meeting depending on the member's area of curriculum or related services. In this case an *IEP Team Member Excusal Form* must be completed in SEDS. **However, the RSP for the service sessions in question must be in attendance and cannot be excused from this meeting.** If the parent/guardian cannot physically attend the IEP meeting an alternative means of participation may be used (e.g., individual or conference telephone calls).

The SEC will send a letter by certified mail with a return receipt to the parent/guardian within five business days of the IEP meeting if the parent/guardian does not want to attend the IEP meeting or fails to respond to the *IEP Meeting Invitation/Notice*.

The parent's/guardian's signature must be obtained on the IEP and/or the Prior Written Notice (PWN) before the delivery of services can be modified. The LEA or case manager is responsible for obtaining the parent's/guardian's signature on the amended IEP within 5 days of a telephone conference.

While there is no requirement to make up missed service sessions due to student absence or refusal to participate, DCPS seeks to ensure that related services are delivered despite the reason for missed service sessions. Therefore, the IEP team should consider alternative service delivery options or a change in services when a student's absence or refusal is significantly impacting service implementation as outlined above. Examples of alternative service delivery options include: service delivery in the classroom, a consultation delivery model, or transition out of the current service type and replacement with different services (e.g., exit from speech/language services and increase research-based reading intervention). Appropriate alternative service delivery does not include inclusionary delivery of services (e.g., RSP attends assembly with student as part of his/her service session).

C. Multiple Student Absences/Truancy and Suspension

1. Student absent from school and scheduled service sessions

a) Truancy with or without approval, parental knowledge, or consent) The District of Columbia Compulsory School Attendance Law 8-247[4] and DC Municipal Regulations Title V Ch. 21[5] govern mandatory school attendance and the ways schools must respond when students are truant. The Compulsory School

[4] D.C. Law 8-247, § 2(a), 38 DCR 376, D.C. Law 20-17, § 303(a), 60 DCR 9839
[5] 5-A DCMR § 2103

Attendance Law states that parents/guardians who fail to have their children attend school are subject to the following:

- Truancy charges may be filed against the parent or student;
- Neglect charges may be filed against the parent;
- The parents may be fined or jailed;
- School-aged students may be picked up by law enforcement officers during school hours for suspected truancy;
- Students may be referred to Court Diversion and other community based interventions; and
- Parents and students may be assigned community service and placed under court supervision/probation.

2. When a student misses a related services session because of an excused or unexcused student absence the RSP must:

a) Speak with the teacher and Attendance Counselor / Attendance Designee to determine reason for the student's absence;

b) Check ASPEN to provide information regarding the student's absence;

c) Contact the student's parent, make a home phone call ***(if the absence is excused, there is no need to contact the student's parent)****;*

d) Document the contact with the student's guardian in the SEDS **Communication Log**;

e) Document each missed session in an entry the Service Log in SEDS (see examples below);

- "Attempted to provide (state related service), however (name of student) is absent per report of classroom teacher (name teacher). Per ASPEN the student's absence is excused/unexcused."
- You may also add information received following phone call with parent/guardian. For example "Per telephone conversation with parent (name the parent/guardian), (student's name) is absent from local school because (state the provided excuse)"; and

f) Notify the LEA or case manager via email within 24 hours of the missed service session.

3. When a student misses five (5) related service sessions because of unexcused student absences the RSP must:

a) Contact the student's parent or guardian by making a home phone call;

b) Inform the teacher, Attendance Counselor / Attendance Designee to determine what staff has already done to address attendance concerns;

c) Inform the LEA/Case Manager of the absences and attempts to contact the student's parent or guardian; and

d) Document the attempts to service the student and contact the student's guardian in the SEDS Communication Log **and** in the Service Log.

4. Per DCPS' Attendance Intervention Protocol, after five (5) unexcused absences:

a) The Attendance Counselor / Attendance Designee will mail an Unexcused Absences ASPEN letter to the student's home requesting an attendance conference;

b) Student is referred to the Student Support Team (SST);

c) Student, parent or guardian and appropriate school officials develop Student Attendance Support Plan to connect the family to in-school or community resources and city agencies, and to make recommendations for next steps;
d) Follow up within 10-days to track student's progress on next steps identified in attendance conference. The SST Team will follow up with programs/resources identified for support during attendance conference to determine if student/family is participating; and
e) A home visit must be conducted by the SST Team if parent is not responsive to meeting request.

The Attendance Counselor / Attendance Designee or SST chair will request RSP attendance in the SST meeting. RSPs should be prepared to contribute to the development of the Student Attendance Support Plan. A decision to reduce or remove a related service from a student's IEP due to truancy should not be made without consideration from the MDT to determine whether the student's non-attendance of service sessions is a manifestation of his/her disability. Refer to the *DCPS Attendance Intervention Protocol* provided below for the detailed protocol.

E. Student Suspension from School

1. Suspensions lasting ten (10) days or less

IDEA allows school administrators to apply short-term disciplinary removals of students with disabilities and students suspected of having disabilities for up to ten consecutive school days or ten accumulated school days throughout the course of the school year.

If a service session is missed due to a short-term disciplinary removal from school the RSP must:

a) Consider impact of the missed service session(s) on the child's progress and performance and determine next steps to ensure the provision of FAPE. Determine whether missed session must be made up according to the following criteria:
    - If the missed service session due to short-term suspension has caused a negative impact on the student's progress or performance, the missed session must be made up.
    - If the missed service session due to short-term suspension has not caused a negative impact on the student's progress or performance, the missed session does not need to be made up.
b) Document this consideration in the Service Log for the missed service session(s).

2. Suspensions beyond ten (10) consecutive or accumulated school days

Any additional removal beyond ten consecutive school days or ten accumulated school days constitutes a change in placement for the student. Under these circumstances, the IEP team must meet to determine:

a) The setting for the Individual Alternative Educational Setting (IAES);
b) The services that will be provided to the student at the IAES in order for the student to meet the student's IEP goals;
c) If additional services are necessary to ensure the misbehavior does not continue into the IAES; and
d) How the student will continue to participate in the general education curriculum.

On the 11th day of a student's removal from school, educational services must begin at the IAES. The IDEA's procedural safeguards require that all students with disabilities who have been suspended or expelled from school still must receive a free and appropriate education, which includes services provided to the student at the IAES in order for the student to meet his or her IEP goals. RSPs must provide services in the IAES regardless of whether the incident leading to suspension was a manifestation of the student's disability.

E. Administrative Circumstances

1. Student Withdrawn from ASPEN but showing in SEDS

If the school registrar has completed the steps to withdraw a student from ASPEN but the student is still showing in SEDS, the RSP must:

a) Document the missed service session (see *Procedures for Documentation*); and

b) Document as "student unavailable".

- The Service Log entry must include:
- Date student was withdrawn in ASPEN;
- Reason for withdrawal (noted in ASPEN); and
- Attending school if known.

c) Continue to document the missed services until the student is no longer showing in SEDS.

F. School Closure: School closed for holiday or emergency.

When school is not in session due to a scheduled holiday, delayed opening, or complete closure due to poor weather there is no requirement to make up the missed service session(s).

A. Missed Service Sessions

1. SEDS Service Log Procedures

For all missed service sessions, the RSP must complete the SEDS Service Log as follows:

a) Include detailed information to identify the missed service section and the student's progress:
   - Date of missed service session;
   - Service type (e.g., student absent, student unavailable, provider unavailable, school closure);
   - Duration of service scheduled (service duration must be documented even if a student is absent; if the student receives only partial service, document the altered duration.);
   - Group size; and
   - "Progress Report" (e.g., just introduced, mastered, no progress, not introduced, progressing, regressing).

b) Complete the "Comments" box in the SEDS Service Log:
   - Document why the service session was missed (e.g., student unavailable, student absent, provider unavailable, school closure); and
   - List action taken to ensure service delivery (e.g., contacted the parent/guardian, talked with the teacher, contacted the student).

2. Documenting Missed Services if Student is Unavailable

As mentioned above, in certain cases of "student unavailable," consider and document the impact of the missed session on the child's progress and performance. If the missed session has impacted the student's progress or performance, indicate that services will be made up and include the make-up plan dates. If the missed session has not impacted the student's progress or performance, please indicate and provide supporting data.

B. Make-Up Service Sessions

1. SEDS Service Log

a) The RSP must log all delivered or attempted make-up service sessions in the SEDS Service Log as follows:
   - Include detailed information to identify the missed service section and the student's progress:
   - Date and time of make-up service provided;
   - Service type (e.g., student absent, student unavailable, provider unavailable, school closure);
   - Duration of the service provided (if the student receives only partial service, document the altered duration);
   - Group size;
   - "Progress Report" (e.g., just introduced, mastered, no progress, not introduced, progressing, regressing).

b) Complete the "Comments" box in the SEDS Service Log:
   - Describe the session (i.e. "MAKE UP SERVICE SESSION for Missed Session on XX/XX/XXXX";
   - Record progress note standards for service sessions delivered; and

- List action taken to ensure service delivery (e.g., notified the parent/guardian of the make-up service session dates(s)).

C. Make-Up Service Session Attempts

1. SEDS Procedures for Session Attempts

The RSP is required to attempt to make up a service session three times. All attempts at make-up service sessions should be documented in SEDS as follows:

a) Any failed attempt prior to the third scheduled make-up session should be logged in the SEDS Communication Log, including:
   - Attempted date and time of service session; and
   - Which attempt it was (e.g., first, second, third, etc.).

b) Upon the third failed attempt the scheduled missed make-up service session should be logged in the SEDS Service Log indicating:
   - Attempted date and time of service session;
   - Service type (e.g., student absent, student unavailable, provider unavailable, school closure);
   - Which attempt it was (e.g., first, second, third);
   - Duration of service attempted (number of minutes or zero minutes);
   - Group size; and
   - "Progress Report" (e.g., just introduced, mastered, no progress, not introduced, progressing, regressing).

c) When documenting the third failed attempt, complete the "Comments" box in the SEDS Service Log:
   - Describe the session (i.e. "MAKE UP SERVICE SESSION for Missed Session on XX/XX/XXXX"); and
   - List action taken to ensure service delivery (e.g., contacted parent/guardian, talked with the teacher, contacted the student.

d) After three attempts have been made and documented in an effort to make up the missed service session(s) and DCPS has exercised due diligence, attempts to implement a make-up session for the missed session(s) can be discontinued.

IV. Untimely Assessments Scenarios and Due Diligence Procedures

The purpose of these Guidelines is to provide guidance when assessments are not conducted in a timely manner due to the student's absence, truancy, or refusal to participate or attend, lack of or withdrawal of parental consent for evaluation/reevaluation, or incomplete assessment.

A. Student Unavailable

1. Parent/Guardian Consent is Granted but the Student is Frequently Absent, Truant, and/or Refuses to Participate or Attend

When 2-3 attempts to assess are unsuccessful because the student is absent, truant and/or refuses to participate or attend:

a) The Related Service Provider (RSP) assigned to complete the assessment must:
   - Contact the teacher, attendance coordinator, and parent/guardian to determine the reason for the student's absence;
   - Document the reason for the student's absence for each time a scheduled assessment is missed;
   - Reschedule the assessment with the parent/guardian and document the agreed upon session in the SEDS communication log; and
   - Document contacts, attempted contacts, and outcomes in the SEDS communication log;
   - Inform the Special Education Coordinator (SEC) via email that the student was absent or refused to participate and that the information has been documented.

b) The SEC must:
   - Contact the parent/guardian at least three times using multiple modalities (e.g., written communication via letter, phone call, and email message when available). One contact must be written correspondence sent by certified mail with a return receipt;
   - Notify the related service provider via email when the attempts to contact the parent are made; and
   - Document contacts with parent/guardian, attempted contacts, and outcomes in the SEDS communication log.

c) The IEP Team must convene within 15 school days of the second failed attempt to assess. The Team will:
   - Review the student's attendance history since consent was obtained;
   - Consider the reason(s) for the student's absence, truancy, and/or refusal to participate or attend; and
   - Determine if an alternate assessment or schedule for the assessment may be warranted. Refer to discipline program guidebooks for the required elements of the alternative assessment report.

The parent/guardian and DCPS can agree in writing that the attendance of certain IEP Team members is not necessary for this meeting depending on the member's area of curriculum or related services; allowing a partial team to meet to address this particular situation. **However, the related service provider assigned to that assessment MUST be in attendance.** If the parent/guardian cannot physically attend the IEP meeting, an alternative means of participation may be used such as teleconference or virtual communication tools such as Skype.

The SEC will send a letter by certified mail with a return receipt to the parent/guardian within five business days of the IEP meeting if the parent/guardian does not want to attend the IEP meeting or fails to respond to the *IEP Meeting Invitation/Notice*.

2. No Parent/Guardian Consent for Initial Evaluation

If the parent/guardian fails to respond to the *Parent/Guardian Consent to Initial Evaluation/Reevaluation* within 15 school days the SEC must:

a) Contact the parent/guardian at least three times using multiple modalities (e.g., letter, phone, email when information is available). Importantly, RSP shall not if contact information is wrong or unavailable in the communication log after each attempt to access parent/guardian contact information. One contact must be written correspondence sent by certified mail with a return receipt;
b) Document contacts, attempted contacts, and outcomes in the SEDS communication log;
c) Send a Prior Written Notice (PWN) by certified mail with a return receipt to the parent/guardian indicating that the special education process has stopped. At this point, DCPS is no longer obligated to pursue consent or conduct assessments; and
d) Contact the cluster supervisor via email if he/she feels it is necessary to pursue the consent to evaluate. DCPS may elect to proceed to mediation and/or a due process hearing in order to override the lack of consent for assessment.

Appendices

Connect-Ed calls to absent students occurs daily ONLY when absence is recorded the same day as absence*

# OF ABSENCES	SCHOOL ACTION	DISTRICT ACTION	LEGAL ACTION
10 (Unexcused) Student becomes "chronically truant"	***Elementary and middle schools and educational centers (ages 5 – 13):*** a. If attendance interventions have been executed and documented in STARS,; ➢ AC/AD will complete CFSA educational neglect referral form and email to CFSA.EdNeglect@dc.gov and include Attendance Specialist on email b. Document referral in STARS adhoc field ***High school students (ages 14 and up):*** c. AC/AD refers student to SST for follow-up. SST meets to review student's progress and revise the Student Attendance Support Plan d. SST will notify administrators of **all** students reaching 10 unexcused absences	a. OYE will monitor CFSA referral compliance rate b. OYE will notify MPD & OSSE of all students with 10+ unexcused absences	✔
15 (Unexcused)	a. If all interventions have been executed and documented in DC STARS, AC/AD, in conjunction with their attendance specialist, will refer student/family to court in conjunction with Attendance Specialist **(students ages 5-17 only)** b. Document submission to OYE in STARS adhoc field	a. OYE will approve and send court referral to OAG/CSS b. OYE will monitor court referral compliance rate	✔
16+ (Unexcused)	a. Continue to monitor student's progress and modify Student Support Plan		
20* (Unexcused Consecutive)	b. AC/AD mails letter to student's home to notify parent/guardian that the student is eligible to be withdrawn from school ➢ School must have executed all the above interventions before withdrawal	a. Attendance Specialists will review list of students that have been withdrawn and will refer dropped students to Student Placement Team	✔

Additional Instructions for MPD Drop-offs

1. Student goes to designated office to sign in
2. AC/AD documents time of entry in adhoc MPD field in STARS
3. AC/AD contacts student's parent/guardian to inform them of MPD pick up
   a. Print and send STARS MPD Pick Up letter requesting a meeting within 5 days of pick up
4. AC/AD convenes **Attendance Conference** with parent/guardian to develop Student Support Plan

b. If parent is non-responsive to meeting request, student is referred to SST

1

Communication Log

Tab in in SEDS where all communications with parents should be documented in detail. Log entries should include date, mode of outreach (i.e. phone call, e-mail), summary of communication, and parent response.

FAPE (Free Appropriate Public Education)

Public education special education and related services that a) are provided at public expense, under public supervision and direction, and without charge; b) meet the standards of the SEA, including the requirements of this part; c) include an appropriate preschool, elementary school, or secondary school education in the State involved; and d) are provided in conformity with an individualized education program (IEP)" (34 CFR 300.17).

IEP Meeting

A written statement for each child with a disability that is developed, reviewed, and revised in a meeting that includes a) a statement of the child's present level of academic achievement and functional performance; b) a statement of measurable annual goals, including academic and functional goals; c) a description of how the child's progress toward meeting the annual goals will be measured; d) a statement of the special education and related services and supplementary aids and services to be provided to the child and a statement of the program modifications or supports or school personnel that will be provided to the child; e) a statement of any individual appropriate accommodations that are necessary to measure the academic achievement and functional performance of the child on assessments; and f) the projected date for the beginning of the services and modifications and the anticipated frequency, location, and duration of those services and modifications.

Related Service Providers (RSPs)

Related Service Providers (RSPs) provide wrap-around services for students. These positions include speech-language pathologists, social workers, school psychologists, and school counselors, etc.

Service Log

Tool in SEDS where all services (including those provided, missed, attempted, and made-up) should be documented in detail. Log entries should include date, duration of session, and summary of session.

Truancy

The unexcused absence from school by a minor (5-17 years of age), either with or without parental knowledge, approval, or consent.

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

School Year 2020-2021

Bilingual Assessment Referral Guidelines

SY 2020-21

Introduction

The Individuals with Disabilities Education Act (IDEA) regulations require assessments and other evaluation materials to be provided and administered in the student's native language or other mode of communication.

This set of guidelines is intended to help the Local Education Agency (LEAs) and case managers meet these requirements and provide appropriate assessments to inform the evaluation of students who are not native speakers of English.

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Definitions

English as a Second Language (ESL) - A model of instruction for students whose native language is other than English

English Language Learner (ELL) - linguistically and culturally diverse student who has an overall English Language Proficiency level of 1-4 on the ACCESS for ELLs test

ACCESS for ELLs - An assessment anchored in the WIDA English Language Proficiency Standards to help educators, parents and students better understand a student's development of English language proficiency on an annual basis (see page 4 of this guidebook)

Bilingual Assessment Team - The Student Support Division: Office of Improvement and Supports maintains a team of fully itinerant bilingual related service providers in different disciplines (Psychology, Social Work and Speech-Language Pathology) to conduct assessments of ELLs in DCPS local schools, public charter schools for whom DCPS is LEA, and DCPS tuition-grant students in non-public schools. These providers present the results of their reports at MDT meetings and assist the IEP team in developing or modifying IEPs for the students they assess

Language Acquisition Division (LAD) - Division, formerly known as the Office of Bilingual Education, that provides translation and interpretation services to central offices and local schools to enable parents of other language backgrounds to fully participate in the education of their children

Local Education Agency (LEA) Representative - The point of contact for all special education matters at a DCPS school. LEAs and IEP case managers are responsible for identifying children who may have a disability and for organizing all meetings related to special education. At some DCPS schools, a child's teacher serves as his or her IEP case manager

Multidisciplinary Disciplinary Team (MDT) - A group of persons whose responsibility it is to evaluate the abilities and needs, based on presenting data, of a child referred for evaluation and to determine whether or not the child meets the eligibility criteria

Multi-Tiered System of Supports (MTSS) – An integrated, prevention-based model of educating students that uses data and problem-solving to connect and integrate all the academic, behavior and social emotional instruction

Student Support Division: Office of Improvement and Supports - Works with schools to ensure that students with disabilities have the services and support needed to achieve success

What is the ACCESS for ELLs test?

The Assessing Comprehension and Communication in English State to State (ACCESS for ELLs) test places students in English language proficiency levels 1 to 5.

DCPS provides services to students scoring levels 1 to 4 and exits students from support programs when they reach level 5.

If a student's composite ACCESS score is less than 5 (i.e. 4.9 or below), they are eligible to be evaluated by a bilingual provider. The LEA may follow the process outlined in this document to proceed with a bilingual referral.

See the chart below for an explanation of the five scoring levels. It is expected that at level 5 students are ready to meet state academic standards with minimal language support services. ACCESS for ELLs measures language across the four domains: listening, speaking, reading and writing. It also measures across the following content areas: social studies; social and instructional English; math; science and language arts.

Level	Category	Description
1	Entering	Knows and uses minimal social English and minimal academic language with visual and graphic support
2	Beginning	Knows and uses some social English and generic academic language with visual and graphic support
3	Developing	Knows and uses social English and some specific academic language with visual and graphic support
4	Expanding	Knows and uses social English and some technical and academic language
5	Bridging	Knows and uses social English and academic language working with modified grade level material

For additional information, visit http://www.wida.us/assessment/access/

Assessment of bilingual students

As with any student, the MTSS/RTI team must review all existing data (e.g. school-based assessments, academic interventions and length of supports documenting limited growth) before determining that additional assessments are necessary to make an eligibility determination. The MTSS/RTI team is responsible for establishing that hearing and vision screenings are current (within 1 calendar year). It is important to remember that hearing and vision are exclusionary factors and therefore, the absence of this information could impact the eligibility for special education services.

Once the intervention process for the student has been completed and if it has been determined by the Multidisciplinary Team (MDT) that a student requires bilingual assessments (based on the results of the WIDA ACCESS or other English proficiency test), one of two processes will be followed. If the student is Spanish-speaking, the assessment should be assigned to the Bilingual Coordinator and it will be completed by a DCPS bilingual provider. For all other languages, refer to Requesting an Interpreter section below.

For bilingual Spanish assessment, all the pre-referral steps, including interventions, must be completed prior to the referral package being forwarded to the Bilingual Coordinator. Additionally, WIDA ACCESS scores must be obtained prior to referring to the Bilingual Coordinator. If the WIDA scores are **not** secured prior to signing consent, the assessment will be the responsibility of the local School Psychologists and an interpreter will assist with completing the assessment.

The current DCPS Bilingual Providers consist of Spanish speaking Social Workers, School Psychologists, and Speech Pathologists. IDEA 2004 requires that assessments and other evaluation materials be administered in the language 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 so provide or administer."

If the school/parent or any significant stakeholder suspects that a student is having difficulty working to their potential (ruling out external factors) and there is documented impact on the student's educational performance, the MTSS/RTI team can refer the student for further investigation.

The DCPS local schools conduct Multidisciplinary Team (MDT) meetings to analyze existing data which assists in determining if additional evaluations are needed and whether the student will require a bilingual assessment. If the student in question displays behaviors that may impact learning, please include a detailed description of the behaviors in the Emotional, Social, and Behavioral Development Section of the AED.

The determination will include but is not limited to the results on the WIDA ACCESS or other English proficiency test which are used to determine if the student is an English Language

Assessment of bilingual students (cont'd)

Learner (ELL) and in need of a bilingual assessments. English Language Learner students are given the WIDA ACCESS test every spring to determine their current English proficiency levels.

If the WIDA ACCESS or other English proficiency tests results are not available, the student can be referred to the Language Acquisition Division (LAD), which is currently housed at Emery Building, 1720 First St, NW, (202) 671-0755 to have the assessments completed. The English proficiency scores, along with the various other

data points indicated below, will assist in determining the student's dominant language to be spoken during the evaluation.

When determining if a student is to be assessed in English or another language, consideration of the number of years of academic instruction in English and the native language of the student are important. Students who have lived in the United States for 7 years or fewer, receive ESL services, and are non-native speakers of English should be considered for bilingual assessment.

Related Service Providers or specialists working with the student may recommend a bilingual assessment based on quantitative and qualitative data. Parents or parent advocates may also request a bilingual assessment with supporting documentation.

Once it is determined that the referred student requires a Spanish bilingual assessment, the local school is to order and assign the assessment(s), complete a Request for Bilingual Assessment Packet, **with attachments**, and upload the information in SEDS. This action is expected to take place within 24 hours of parental consent. Referral Packets will be reviewed to establish the completion of all stipulated documentation. **NOTE: The school-based service provider (school psychologist/social worker/speech-language pathologist) is required to sign the Bilingual Justification Form in order to make a referral packet complete.**

Once the Spanish Bilingual referral is received, it will be assigned within 48 hours to the designated provider(s) by the Bilingual Discipline Program Coordinator. The Bilingual Discipline Program Coordinator SEDS accounts are as follows:

Psychology = Bilingual Psychology Program Coordinator
Social Work = Bilingual Social Work Program Coordinator
Speech-Language Pathology =Bilingual Speech Program Coordinator

NOTE: The data will be reviewed by the bilingual provider to ensure that it is an appropriate referral. If not, it is subject to being reassigned to the school-based team.

Assessment of bilingual students (cont'd)

NOTE: The bilingual team does not include Audiologists, Occupational Therapists, or Physical Therapists. If there is an assessment need for one of these areas, the assessment should be assigned to the school-based provider and the provider should request an interpreter to complete the assessments. Refer to the section below labeled "requesting an interpreter for assessments."

If you have questions, please contact the discipline program managers listed in the points of contact section below.

IN SUMMARY: If the team has decided additional assessments are necessary, the student should always be referred for *bilingual assessment* if any of the following are true:

The student currently receives ESL services or

The student's composite ACCESS score is less than 5 or

The student has lived in the United States for 7 years or less or

The student is 7 years old or younger and a non-native speaker of English

In cases of extenuating circumstances, the MDT team (including the parent) can refer an ELL student for bilingual assessment even if none of the above criterion is met. **Each bilingual referral that does not meet one of the aforementioned criteria is subject to review by the Student Support Division: Office of Improvement and Supports.**

How to refer a student for Spanish bilingual assessment

The LEA Representative or case manager should request Spanish bilingual assessments as follows:

1. Locate the students ACCESS scores **prior** to obtaining signed parental consent.	For assistance, contact Margaret Miller (Margaret.Miller@k12.dc.gov) in the Language Acquisition Division (202) 868-6502 to request a copy for your school's files. **ACCESS scores must be obtained prior to the parent's signing consent**
2. Order a Bilingual Social History **when the parent's preferred language is Spanish**	It is preferred that social history is completed before any requests are made for a Functional Behavior Assessment (FBA). A bilingual social worker must complete Bilingual Social History in the case of an: ● initial evaluation ● major changes in the family ● social emotional or behavioral concerns ● traumatic incidents, i.e. physical, sexual abuse, etc.
3. Collect and evaluate appropriate data points	Consult the **Bilingual Checklist** in the handbook
4. Complete the *Bilingual Assessment Justification Form* (page 16-17)	*Upload to SEDS as Miscellaneous Doc*: ● Bilingual Assessment Justification form ● ACCESS scores ● Bilingual Checklist with required documents attached
5. Complete the "Additional Assessment" component in SEDS (Easy IEP) under the Eligibility section	Complete this component just as you would for any initial or re-evaluation assessment.
6. Assign each assessment. - "**Bilingual Psychology Program Coordinator**" - **"Bilingual Social Work Program Coordinator**" - "**Bilingual Speech Program Coordinator**" - **Other disciplines = assign to the school-based provider and RSP requests an interpreter**	Be certain to check the box that indicates "Send email to provider." If the assessment has not been reassigned within 2 business days, email ramonia.rich@k12.dc.gov to ensure that referral was received.

Assigning bilingual assessments

Within 48 hours of receiving the complete bilingual assessment request, the Bilingual Program Coordinator will:

1. The Bilingual Program Coordinator assigns the assessment to a member of the city-wide bilingual assessment team.
2. If the school-based provider is bilingual, the Bilingual Program Coordinator will reassign the case to the school-based provider.
3. If the bilingual team is at capacity, the Bilingual Program Coordinator will reassign the case to the school-based provider and the evaluation will be conducted with an interpreter.

*Please note that cases requested more than 48 hours after the parent consent may impact the timeliness of the assessment.

****Please note, this is a separate process from ordering a bilingual assessment****

An interpreter may be necessary to facilitate the bilingual assessment of ELL students. An interpreter may also be necessary to facilitate review meetings or other MDT meetings with non-English speaking parents. **Scheduling an interpreter for testing or meeting is the responsibility of the LEA Representative.**

There are two options to consider regarding interpreting **for meetings**:

Option 1	***Option 2***
A bilingual teacher (i.e. an ESL teacher) at the school who is fluent in the student's native language may serve as an interpreter.	■ Call the Language Line at 1-800-367-9559 ■ Agency Client ID **511049** ■ Access Code **701001**

Note: Meetings may be interpreted using the Language Line provided by the District of Columbia Office of Human Rights. However, this line ***may not*** be used for assessments.

NOTE: The bilingual service provider(s) are not interpreters.
Requesting an Interpreter for Assessments

In-Person Interpreter Request Process for RSP Assessments
The Interpreter Request process allows Related Services providers (RSPs) to formally request interpreter services. Interpreter services may be requested to support RSPs while conducting student evaluations when the student's primary language is not covered by the DCPS Bilingual Team or the bilingual team does not

have capacity. All requests for interpreter/translation services require the RSP to submit the request by completing a OneDrive form.

Here is the Interpreter Request form: Interpreter Request form

- All requests should be submitted within a minimum of five business days prior to the date services are needed. Any incomplete request forms will not be processed.

- The following languages are currently under contract. Note: Requests for other languages will take longer.

    - Spanish
    - Vietnamese
    - Chinese
    - Amharic
    - French

- A vendor will be assigned to complete the interpreter services and provide a confirmation email of interpreter/translation services at least two (2) days prior to the date of services to the school-based RSP.

- The interpreter will provide an evaluation form to be given to the related service provider at the time of service.

- Upon completion of interpreter services, the provider sends a follow-up email to Brigid Cafferty (brigid.cafferty@k12.dc.gov) confirming the services requested were rendered with the evaluation form attached. All information should be submitted within 2 days of completed interpreter services.

- If there are any inquiries or questions regarding the Interpreter Request process, please contact the Division of Specialized Instruction (DSI) POC, Brigid Cafferty (brigid.cafferty@k12.dc.gov).

- If interpretation services are no longer needed, the RSP must notify Brigid Cafferty via email 48 hours in advance. If the services are not cancelled in advance, DCPS is still fiscally responsible for vendor payment.

For more information regarding the bilingual assessment referral guidelines for SY 19-20, please access the Bilingual Assessment Referral Guidelines.

Frequently Asked Questions

When should a student receive a bilingual educational assessment?
For initial Spanish bilingual assessments, the psychologist or speech-language pathologist from the Bilingual Assessment Team assigned to each case will be completing all pertinent testing (e.g. cognitive, adaptive, articulation, language) including the educational. For re-evaluations, a bilingual educational assessment is only required if the student has received Spanish language instruction for at least 3 years and if it is suspected that there is a discrepancy between academic skills in both languages. If there is a special education teacher at the school who are also fluent in the student's native language, and the school has bilingual educational assessment materials, the special education teacher should complete the assessments. This course of action should be noted on the Bilingual Assessment Justification Form.

Should the bilingual provider present his/her report at the review meeting?
Yes, this is best practice. It is imperative that you include the bilingual assessor when scheduling the review MDT meeting.

Will the bilingual provider deliver general language interpretation at the review meeting?
No, the LEA representative should use the language line.

What school-based staff may interpret during assessments or at IEP meetings?
The MDT meeting may utilize teachers fluent in the student's native language to interpret. Any school-based staff the team decides to use to interpret for an assessment or at a meeting should be individuals who could otherwise have access to the student's file and be considered members of the MDT.

School support staff, such as secretaries, custodians, and cafeteria support should not be used as interpreters.

Community members or family members may interpret if the parent agrees to consider them as a consultative member of the IEP team. Remember, information discussed at MDT meetings or in the process of special education assessments is private.

What if the student is enrolled in a private/religious school?
The student's case manager should follow the same process as any other case manager to refer the student for a bilingual assessment.

What if the student is between 3 years (3.0) and 5 years 10 months (5.10) of age?
If the evaluation is an initial evaluation, then the student will be evaluated by the Early Childhood Assessment Team (ECAT). Refer to ECAT guidelines to make referrals. Reevaluations are to be completed in the school where the student is enrolled.

Does this process apply for deaf or hearing-impaired students fluent in American Sign Language?
If an assessment is needed for a student with a primary language of ASL, the interpreter request form should be completed by the related service provider.

How can I request a sign-language interpreter for a parent?

If the team requires a sign-language interpreter for a parent of a hearing-impaired student at a meeting, the LEA representative should fax the Request for Sign Language Interpreter Form to the DC Office of Disability Rights. Please note that requests should be received by ODR at least 5 business days for processing. Contact Haydn.Demas@dc.gov at (202) 442-4692 or (202)724-
5055.

How long should the team wait before referring a student new to the country (aka "newcomer") to be assessed for Special Education eligibility?

Cases involving students new to the country can be complex. Best practice is to allow a student to be in the country for at least a year and have remediation through MTSS/RTI. However, if you feel the case is unique and may need to be referred sooner, please consult with a member of the bilingual assessment team prior to initiating the referral process

Points of contact

Related Service Provider: Program Managers

Name	Discipline	Email	Phone	Fax
Darla Kimbrough, Program Manager	Speech-Language Pathology	darla.kimbrough@k12.dc.gov	(202) 281-8516	(202) 442-4368
Dr. Ramonia Rich, Program Manager	Psychology	Ramonia.rich@k12. dc.gov	(202) 369-2886	(202) 654-6150
Tamara Dukes, Program Manager	Social Work	Tamara.dukes@k12.dc.gov	(202) 907-8056	(202) 654-6153

Bilingual Consultation Contacts

Please contact a member of the city-wide bilingual assessment team for specific questions about bilingual cases. ***DO NOT*** assign assessments directly to the psychologists; *please follow the Bilingual Referral process found in this guidebook.*

City-Wide Team

Name	Role	Email	Phone
Isora Cruz-Cardona	Psychologist	Isora.cruz-cardona@k12.dc.gov	(202) 276-9802
Maura Garibay	Social Worker	Maura.garibay@k12.dc.gov	(202) 534-2740
Dr. Sonia Pilot	Psychologist	Sonia.pilot@k12.dc.gov	(202) 281-0183
Susanne Leslie	Psychologist	Susanne.leslie@k12.dc.gov	(202) 607-4694
Patricia Porro	Psychologist/ECAT	Patricia.Porro@k12.dc.gov	(202) 422-5410
Amaris Anglero	SLP/ECAT	Amaris.Anglero@k12.dc.gov	(202) 590-6697

School Based Bilingual Providers

Name	Role	School	Email
Ana Frontera	SLP	Bancroft ES	ana.frontera@k12.dc.gov
Guillermo Cintron	Social Worker	Bancroft ES	guillermo.cintron@k12.dc.gov
Elizabeth Castillo	Social Worker	Brightwood EC	elizabeth.castillo@k12.dc.gov
Kairo Vivas	Social Worker	Brightwood EC	kairo.vivas@k12.dc.gov
Fernando Rengifo-Caicedo	SLP	Brightwood EC	Fernando.rengifo-caicedo@k12.dc.gov
Ayo Olagbegi	SLP	Bruce Monroe ES	Ayo.Olagbegi@k12.dc.gov
Mayra Figueroa Clark	Social Worker	Bruce Monroe ES	mayra.figueroa-clark@k12.dc.gov
Diana Mata	Social Worker	Bruce Monroe ES	diana.mata@k12.dc.gov
Karina Rivas	Psychologist	Bruce Monroe ES	karina.rivas@k12.dc.gov
Katherine Zamore	Psychologist	Cardozo International Academy	katherine.zamore@k12.dc.gov
Mary Trumbore	Social Worker	Cardozo International Academy	maryanne.trumbore@k12dc.gov
Jennifer Vargas	Social Worker	Cardozo International Academy	jennifer.vargas@k12.dc.gov
Reinarldo Rodriguez	SLP	Cardozo International Academy	Reinaldo.rodriguez@k12.dc.gov

Makeda Greene	Psychologist	CHEC	makeda.greene@k12.dc.gov
Maria Gomez	Social Worker	CHEC	maria.gomez@k12.dc.gov
Paula Crivelli-Diamond	Social Worker	CHEC	paula.crivelli-diamond@k12.dc.gov
Reinaldo Rodriguez	SLP	CHEC	Reinaldo.rodriguez@k12.dc.gov
Carmen Suazo	Social Worker	Dorothy Height ES	carmen.suazo@k12.dc.gov
Robert Soriano	Psychologist	Marie-Reed ES	robert.soriano@k12.dc.gov
Letecia Manoel	Social Worker	Marie-Reed ES	letecia.manoel@k12.dc.gov
Rachel Friedlander	Social Worker	McFarland MS	rachel.friedlander@k12.dc.gov
Eduardo Del Valle	Psychologist	Powell ES	eduardo.delvalle@k12.dc.gov
Andres Nunez	Psychologist	Oyster Adams Bilingual EC (Oyster Campus)	andres.nunez@k12.dc.gov
Maria Martinez	Psychologists	Oyster Adams Bilingual EC (Adams Campus)	maria.martinez@k12.dc.gov
Melissa Shaw	Social Worker	Oyster Adams Bilingual EC	melissa.shaw@k12.dc.gov
Molly Hepner	SLP	Oyster Adams Bilingual EC	Molly.hepner@k12.dc.gov
Gisele Perez Hanson	Social Worker	Truesdell EC	gisele.hanson@k12.dc.gov
Jason Kling	Social Worker	Truesdell EC	jason.kling@k12.dc.gov
Jennifer Cardenas	Psychologist	Tubman ES	jennifer.cardenas@k12.dc.gov
April Norris	SLP	Tubman ES	April.Norris@k12.dc.gov
Valerie Bargas-Carroll	SLP	Tubman ES	Valerie.barges@k12.dc.gov
Margaret DeAngelis	Social Worker	Webb-Wheatley EC	margaret.deangelis@k12.dc.gov

Language Acquisition Division (LAD)

Name	Questions about	Email	Phone/Fax
Main Office	General Inquiries	LAD Coordinator	(202) 671-0750/2667
Vicki De'Javier	Interpreter	vicki.de-javier@k12.dc.gov	(202) 671-0755
Margaret Miller	Data/Records	Margaret.miller@k12.dc.gov	(202) 671-0750
Elba Garcia	Director	Elba.garcia@k12.dc.gov	(202) 671-0750
Leidy Navarro	Intake Manager	Leidy.Navarro@k12.dc.gov	(202) 671-0750
Ivy Chaine	Document Translation	Ivy.Chaine@k12.dc.gov	(202) 868-6504

Bilingual Assessment Justification Form

Providers from the Bilingual Assessment Team or interpreters will be assigned **only after both steps below are completed** by the LEA representative or case manager.

Step One: This completed form and a copy of the student's ACCESS scores and/or any other English language proficiency documentation are uploaded into SEDS under miscellaneous cover sheet (document section) for that particular student.

Step Two: Each required assessment is ordered in Easy IEP and assigned to Bilingual "DISCIPLINE" Program Coordinator within 24 hours of the parental consent date**. Click "email provider."**

NOTE: All referrals to the bilingual team are subject to review. Cases with incomplete data or those that are deemed inappropriate may be reassigned to the school-based team.

Information requested below about the student to be assessed must be complete and accurate.

Student's Name

Student DCPS ID#

Date of Birth Attending

School Native Language

Dominant Language

LEA Representative or case manager

Justification for Bilingual Assessment (check all that apply)

- ○ Student currently receives ESL services
- ○ Student's composite ACCESS score is lower than 5
- ○ Student has lived in the United States for fewer than 7 years
- ○ Student is younger than 7 and not a native speaker of English
- ○ None of the above, an explanation must accompany this form for review by the OSI

Note: If school-based staff will complete one or more bilingual assessments, must attach explanation.

BILINGUAL CHECKLIST

DATE: _____

NAME OF REQUESTER: _____ TITLE: _____

SCHOOL/LOCATION: _____ CONTACT PHONE #: _____

NAME OF STUDENT: _____ STUDENT ID#: _____

NAME OF PARENT/GUARDIAN: _____

DOCUMENTATION REQUIRED:

☐ PARENT/TEACHER & MTSS/RTI MEETING NOTES
☐ SPECIAL EDUCATION MEETING/MDT NOTES
☐ ACCESS LEVEL
☐ DOCUMENTATION OF ESL SERVICES (location, frequency, duration and type of instruction)
☐ HEARING/VISION
☐ MTSS/RTI: ☐ READING ☐ MATH ☐ WRITTEN LANGUAGE
☐ MTSS/RTI SOCIAL EMOTIONAL/BEHAVIOR (*FOR SOCIAL HISTORY)*

ADDITIONAL QUESTIONS

☐	PREVIOUS EDUCATION	**Y**	**N**	# YEARS OF PREVIOUS SCHOOLING: _____
☐	NEWCOMER (>2YEAR)	**Y**	**N**	# YEARS LIVED IN US: _____
☐	SOCIAL HISTORY	**Y**	**N**	
☐	REJOINING FAMILY IN US?	**Y**	**N**	

SERVICE LOCATION: PHONE (DIRECT LINE/CELL):

DAY OF CONTACT NAME: PHONE (DIRECT LINE/CELL):

_____
SIGNATURE OF SCHOOL BASED PSYCHOLOGIST

UPLOAD THIS FORM THIS FORM INTO SEDS WITH THE BILINGUAL ASSESSMENT JUSTIFICATION FORM.

APPROVED: ☐ **YES** ☐ **NO** DATE: _____

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

July 2012

Clinical Supervision of Graduate Students Guidelines

Version 1.0

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Purpose

This guidebook for clinical supervision of a graduate student is a comprehensive guide and reference point for providing career guidance through clinical supervision for speech-language graduate student clinicians. As a graduate student supervisor, the role of mentoring should be approached as a continual effort that encompasses a critical set of clinical skills and interpersonal attributes that enable an ability to develop and instill specific attitudes, values and practice habits in mentees in administering clinical support services. During clinical supervision, it is the responsibility of the supervisor to practice clinical teaching in adherence to the highest standards of integrity in establishing a mentoring relationship conducive to influencing clinical practices in developing and strengthening core competencies of graduate student clinicians.

In reviewing the contents of this guidebook, this document seeks to incorporate the fundamental standards observed by ASHA for SLP supervisors in administering clinical supervision over graduate student clinicians. In observing these standards, this document reviews core competencies, considerations and challenges that should be acknowledged by the supervisor in facilitating a gainful clinical supervisory relationship with the supervisee that provides mentoring guidance and enrichment through practical clinical experiences.

ASHA Position Statement

The position statement *Clinical Supervision in Speech-Language Pathology and Audiology* was approved in 1985. This current position statement updates that document with respect to the profession of speech-language pathology. Although the principles of supervision are common to both professions, this position statement addresses only speech-language pathology because of differences in pre-service education and practice between the two professions.

It is the position of the American Speech-Language-Hearing Association that clinical supervision (also called clinical teaching or clinical education) is a distinct area of practice in speech-language pathology and that it is an essential component in the education of students and the continual professional growth of speech-language pathologists. The supervisory process consists of a variety of activities and behaviors specific to the needs, competencies, and expectations of the supervisor and supervisee, and the requirements of the practice setting. The highly complex nature of supervision makes it critically important that supervisors obtain education in the supervisory process. Engaging in ongoing self-analysis and self-evaluation to facilitate the continuous development of supervisory skills and behaviors is fundamental to this process. Effective supervision facilitates the development of clinical competence in supervisees at all levels of practice, from students to certified clinicians. Clinical supervision is a collaborative process with shared responsibility for many of the activities involved in the supervisory experience. The supervisory relationship should be based on a foundation of mutual respect and effective interpersonal communication. Clinical supervisors have an obligation to fulfill the legal requirements and ethical responsibilities associated with state, national, and professional standards for supervision.

Reasons to Supervise

There are several reasons for a speech-language provider to serve as a mentor in fostering the professional development of a graduate student. As the mentoring experience should encompass a mutually beneficial learning experience for both the supervisor and supervisee, the mentor plays an integral role in influencing graduate students through observation and evaluation of clinical practices and offering relevant feedback and guidance to improve performance.

Through the reinforcement of best practices, the supervisor is a vital resource for providing guidance and ongoing dialogue that contributes towards improving confidence for independent decision-making and critical thinking for complex client management issues. As shown below, there are 10 compelling reasons to supervise a graduate student:

1. Develop and recruit future employees.
2. Stay current—learn what students are learning.
3. Share your expertise with future SLPs.
4. Establish a relationship with university programs.
5. Teach future SLPs to advocate for SLP services.
6. Introduce students to interdisciplinary teaming.
7. Feel good about giving back to the profession.
8. Develop your mentoring and supervisory skills.
9. Enhance your clinical skills by teaching someone else.
10. Leave a legacy.

As summarized above, these are diverse and substantive reasons on the value gained from a supervisory experience that entails clinical teaching and guidance. The role of a mentor is to gently guide the new clinician by offering knowledge, insight, perspective, or wisdom (Shea, 1997). Through continual interaction with the supervisee, a collaborative process emerges with a shared responsibility between the clinical supervisor and the supervisee. In turn, the undertaking of a supervisory role entails a committed effort to participate in the development of the supervisee as it pertains to improving areas of knowledge gaps and meeting clinical expectations in fulfilling core competencies.

Benefits for Graduate Students

The benefit gained from graduate students through mentorship includes a solid foundation for practical experience in administering clinical practices, treatment strategies and diagnostic procedures under the guidance of a seasoned professional. This role enables the supervisee guidance in developing an understanding of the profession through a supervisory relationship that is

conducive to fostering critical-thinking skills in evaluating and assisting clinical services. In addition, the supervisory relationship entails an active engagement of ideas in developing clinical skills through a variety of cases involving implementation of services and client management skills. The below reasons illustrate the benefit gained by graduate students from mentoring:

1. Access to a support system during critical stages of college and career development.
2. Clear understanding and enhancement of academic and career development plans.
3. Ability to develop mentoring relationships in industries where mentoring is not readily available.
4. Enhanced understanding of the importance of mentors.
5. Exposure to diverse perspectives and experiences.
6. Direct access to power resources within the professions of audiology; speech-language pathology; and speech, language, and hearing science.
7. Identification of skill gaps before leaving school.
8. Greater knowledge of career success factors.
9. A lasting career network.
10. Insider perspective on navigating their chosen career.

As a mentor, there are several reasons to participate in the supervisory process in facilitating the development of a graduate student in acquiring the core skills and competencies needed to be successful in the field. As a supervisor, the development of a colleagueship with a supervisee contributes toward the advancement of the profession in enhancing the quality of clinicians performing SLP services. The supervisor can impart knowledge on past experiences, which serves to expose the supervisee to diverse clinical cases, therapeutic treatment strategies and diagnostic procedures to enhance the supervisee's content knowledge and understanding of clinical practices.

Guidance

ASHA-certified individuals who supervise students should possess or seek training in supervisory practice and provide supervision only in practice areas for which they possess the appropriate knowledge and skills. The supervisor must oversee the clinical activities and make or approve all clinical decisions to ensure that the welfare of the client is protected. The supervisor should inform the client or the client's family about the supervisory relationship and the qualifications of the student supervisee.

The supervisor must provide no less than the level of supervision that is outlined in the current certification standards and increase supervision if needed based on the student's knowledge, experience, and competence. The supervisor should document the amount of direct and indirect supervision provided, and design and implement procedures that will protect client confidentiality for services provided by students under supervision.

ASHA members and certificate holders engaged in the preparation, placement, and supervision of student clinicians must make reasonable efforts to ensure that direct practicum supervision is provided by professionals holding the appropriate CCC. They must inform students who engage in student practica for teacher licensing, or other clinical practica under a non-ASHA-certified supervisor that these experiences cannot be applied to ASHA certification. ASHA-certified personnel cannot sign for clinical practicum experiences that were actually supervised by non-ASHA-certified individuals. It is unethical for certificate holders to approve or sign for clinical hours for which they did not provide supervision.

Essential skills and core competencies

There are essential skills and core competencies that are expected of clinical supervisors in having the capacity and ability to properly facilitate the clinical supervisory process. Mentors should recognize that they lead by example, and will be responsible for various aspects of the student's clinical experience. In turn, mentors will address all accountability, including documentation; reimbursement; confidentiality; licensure and certification requirements; local, state, and national standards and regulations; and preferred practice patterns.

As role models, mentors should be conscientious of their daily presentation, including attire and hygiene. As a professional, it should be implicitly and explicitly communicated through professionalism and daily work habits that the supervisor takes the mentorship role seriously. Although friendly interaction should be encouraged as a means to develop rapport with the supervisee, it is important that boundaries are set and a level of mutual respect is established in commanding authority from the supervisee. In communicating with the supervisee, it is imperative that the supervisor follows established protocol regarding clinical practices and doesn't deviate from standards to ensure consistency regarding expectations.

A mentor must not rely solely on his superior clinical knowledge and expertise in this process, but also must understand the role that one's individual and unique personality plays in mentoring. Mentors need to have knowledge of strategies that foster self-evaluation while recognizing and accommodating various personality types and learning styles. In turn, mentors should have skills that assist the supervisee in describing and measuring his/her own progress (ASHA, 2008b). As a supervisor, the opportunity arises for self-reflection and an in-depth examination of one's own teaching style and practice habits, including one's own individual strength's and weaknesses. Effective clinical teaching should include self-analysis, self-evaluation, and problem-solving skills (ASHA, 1985). This self-acknowledgement plays an integral part in the supervisor's awareness of how supervision is administered and how to enhance the supervisory experience to benefit the supervisee.

Code of Ethics

ASHA-certified individuals who supervise students cannot delegate the responsibility for clinical decision-making and management to the student. The legal and ethical responsibility for persons served remains with the certified individual. However, the student can, as part of the educational process, make client management recommendations and decisions pending review and approval by the supervisor. Further, the supervisor must inform the client or client's family of the qualifications and credentials of the student supervisee involved in the provision of clinical services.

All supervised clinical activities provided by the student must fall within the scope of practice for the specific profession to count toward the student's certification. The supervisor must achieve and maintain competency in supervisory practice as well as in the disability areas for which supervision is provided. The amount of supervision provided by the ASHA-certified supervisor must be commensurate with the student's knowledge, experience, and competence to ensure that the welfare of the client is protected. The supervisor must also ensure that the student supervisee maintains confidentiality of client information and documents client records in an accurate and timely manner.

Discrepancies may exist among state requirements for supervision required for teacher certification in speech-language pathology and audiology, state licensure in the professions of speech-language pathology and/or audiology, and ASHA certification standards. In states where credential requirements or state licensure requirements differ from ASHA certification standards, supervised clinical experiences (including student practica for teacher licensing) will count toward or may be applied toward ASHA certification (CCC) requirements only if those practicum hours have been supervised by ASHA-certified personnel.

ASHA's 13 tasks of supervision

The below tasks illustrate the directives encompassed within a supervisory relationship in maintaining an effective relationship that will contribute towards the development of the

supervisee in attaining and refining skills needed to administer SLP services. As a mentor, it is paramount that these tasks are fulfilled and reinforced throughout the duration of the supervisory process to establish expectations for the supervisee and to facilitate the professional development of the supervisee in promoting independent decision-making. The 13 tasks of supervision are as follows:

1. Establishing and maintaining an effective working relationship with the supervisee
2. Assisting the supervisee in developing clinical goals and objectives
3. Assisting the supervisee in developing and refining assessment skills
4. Assisting the supervisee in developing and refining clinical management skills
5. Demonstrating for and participating with the supervisee in the clinical process
6. Assisting the supervisee in observing and analyzing assessment and treatment sessions.
7. Assisting the supervisee in the development and maintenance of clinical supervisory records.
8. Interacting with the supervisee in planning, executing and analyzing supervisor conferences.
9. Assisting the supervisee in evaluation of clinical performance
10. Assisting the supervisee in developing skills of verbal reporting, writing and editing.
11. Sharing information regarding ethical, legal, regulatory, and reimbursement aspects of professional practice.
12. Modeling and facilitating professional conduct.
13. Demonstrating research skills in the clinical or supervisory process.

In completing the tasks, the supervisor should be fully engaged in the clinical process in monitoring and evaluating the clinical performance of the graduate student during their development. Under such supervision, this would include an acute involvement in the supervisee's development, guiding the ethical, regulatory, legal and clinical aspects of treatment in managing supervisee conduct. It is important for the supervisor to convey interest in the supervisory process, monitoring performance in recognizing the supervisee's clinical strengths and weaknesses. In turn, the supervisor should disclose feedback and constructive criticism as appropriate to enhance the supervisee's professional growth.

All certified SLPs have received supervision during their student practicum and clinical fellowship; however, this by itself does not ensure competence as a supervisor. Furthermore, achieving clinical competence does not imply that one has the special skills required to be an effective supervisor. ASHA does not have specific requirements for coursework or credentials to serve as a supervisor; however, some states or settings may require coursework and/or years of experience to serve as a supervisor. Knowledge and skills may be developed in a variety of ways: participating in courses or workshops on supervision, engaging in self-study, participating in Division 11 (Administration and Supervision), and gaining mentored experiences under the guidance of an experienced clinical educator.

Supervisory Requirements

The below requirements are expectations held to all supervisors in managing professional and clinical expectations of graduate students participating in externships with DCPS Related Services Speech-Language program. The following requirements enable the supervisor to understand the scope of the role and responsibilities in managing the student, as well as guidance in facilitating a relationship conducive to supporting the student in fulfilling core requirements in meeting clinical competency expectations:

1.) Site supervisors will inform the student of any pre-requisite site requirements such as background check and/or immunizations. The supervisor will familiarize the student with the facility's physical layout, orient the student to the institution's policies, make staff introductions as appropriate, and provide verbal and/or written expectations regarding student's time on site and performance requirements.

2.) Site supervisors will help to ensure that the student acquires needed direct client contact hours and will sign off clinical clock hour logs and on-site hour logs on a regular basis.

3.) Site supervisor will provide an appropriate amount of supervision to meet the student's level of knowledge, experience, and competence and will be on-site for the entire session.

4.) Site supervisor will provide supervision sufficient to ensure the welfare of the client or pupil.

5.) Site supervisor will provide direct supervision defined, according to ASHA Standards, as real time supervision that must never be less than 25% of the student's total contact with each patient, client or pupil in therapy and 50% of each diagnostic evaluation. This direct contact must take place throughout the practicum. Direct supervision is defined as on-site observation or closed circuit TV monitoring of the student clinician. In addition to the required direct supervision, supervisors may use a variety of other techniques to obtain knowledge of the student's clinical work, such as conferences, audio-and videotape recordings, written reports, staffing and discussions with other persons who have participated in the student's clinical training.

6.) Supervisor will provide written and verbal feedback on therapy and diagnostic sessions, lesson plans, data, and reports submitted by the student clinicians. The supervisor is responsible for conveying clinical requirements to the student and conveying information on the student's specific areas of strength and weakness in a constructive manner. The student will appreciate and benefit from feedback regarding performance and goal-setting.

Supervision Styles

Supervisors who maintain a “direct-active” style of supervision as described by J. L. Anderson are less likely to address the mentoring aspect of supervision. The “direct-active” style focuses mainly on growth in performance rather than on the personal growth of the supervisee. “Collaborative” or “consultative” styles, as described by J. L. Anderson, better facilitate the ability to address the mentoring aspect of supervision.

In this regard, mentoring includes supervision that empowers the student by monitoring professional development in a manner that includes a focus on the personal growth of the supervisee. This would entail 1) in-depth collaboration around reinforcing best practices, 2) providing clarity in areas of ambiguity or uncertainty regarding decision-making, 3) promoting the graduate student to think critically in administering treatment strategies in managing nuanced issues; 4) continually providing input & feedback regarding client assessments and course of treatment for intervention, and 5) assisting in the development of time management and planning skills for patient/client management. In facilitating a mentoring relationship with the supervisee, a dual relationship should emerge in which the supervisee can seek guidance, counseling and advice in a manner that maintains the professional integrity of the supervisor-supervisee relationship, however, yields to enable interpersonal communication that seeks to foster the personal development of the supervisee.

A variety of strategies have proven effective in explicitly defining supervisor expectations for performance and criteria for evaluation, and for enhancing objectivity. These include: a contract-based system, competency-based goal setting and evaluation, and interactive and joint involvement in the analysis and assessment of clinical performance.

Communication that is open, candid and respectful between the supervisor and student is crucial. Supervisors must provide maximum support for the student, which often means allowing the student to initially observe the supervisor providing services, moving to co-assessment or co-treatment, and continuing to delegate more responsibility only when the student has demonstrated the necessary competencies. New clinical experiences offer new challenges and require more intense supervision/direction by the supervisor.

The supervisor and supervisee should share in the planning, observation, and objective analysis of data from the observation as it relates to understanding the clinical and supervisory learning processes This partnership reportedly leads to a more analytical, problem-solving and ultimately self-supervising supervisee. In turn, there is a mutual responsibility that is shared for the professional growth and development of the supervisee.

Jean Anderson's Model Of Continuum Supervision

Jean Anderson's continuum of supervision serves as an example model platform for graduate student supervisors to utilize in planning stages of clinical supervision. Widely recognized and distinguished as a primary model for clinical supervision, each stage describes a gradual decrease in the amount and type of involvement by the supervisor with a corresponding increase in amount and type of involvement on the part of the supervisee (Anderson, 1988). This model promotes professional growth for supervisor, as each stage of supervision allows adjustment to the knowledge, needs and skills of the supervisee.

1. **Evaluation-feedback stage**:

- The supervisor is dominant and directive in working with the supervisee.
- The supervisee benefits (and appreciates) specific input and feedback for each client assigned for intervention or diagnosis.
- The supervisor serves as "the lead" in planning for the needs of the clients with whom the supervisee is working.
- The supervisory feedback is considered to be "direct-active" in that the supervisor controls and the supervisee follows direction.
- The marginal student, the student who evidences difficulty in planning, critical thinking, time management, and/or other areas of the therapy process may remain in the evaluation-feedback stage for an extended period of time.
- Typically, this is a more comfortable start for the supervisee; however it is the hope that the student will move through this stage of development relatively quickly. Be aware that for many supervisees, the direct-active supervisor is the easiest to work with for most, movement on the continuum to the transitional stage is anticipated.

2. The **transitional stage**: Some of the responsibility for case and client management shifts to the supervisee.

- This process is seamless and allows the supervisee the opportunity to begin participating in the planning, implementing, and analyzing the course of treatment for patients/clients. The transition to independence can create anxiety for the supervisee and the supervisor.
- The supervisee is anxious relative to the increased responsibility and planning required for the patient/client.
- The supervisor may feel anxious relative to "giving up control" for the patient and family. In addition to the new clinical student, a supervisee who is working with a new clinical population will generally begin in the evaluation-feedback stage. The supervisor needs to be sensitive to any signs of unusual stress exhibited by the supervisee.
- In this transition stage, the supervisor provides input and feedback; however the tone of the supervisory relationship becomes more of a joint project between the supervisor and the supervisee.

- The supervisee may be able to become more independent when working with clients having some disorder types sooner than with other disorder types (e.g., the supervisee may work effectively in setting short and long term goals with children with phonological disorders but may have difficulty establishing reasonable goals for children with autism). The desired outcome of the transitional stage is that the supervisee begins to demonstrate clinical and professional skills with some degree of independence.
- It is expected that the supervisee will become more participatory in all aspects of client management and will begin to self-analyze clinical behavior. It is possible that with certain skills (i.e. session planning) the supervisee may require little direction from the supervisor. However, the same supervisee may consistently evidence difficulty at communicating at an appropriate language level with clients/patients. In this case, the supervisor can provide collegial mentoring providing additional ideas or reinforcement as the graduate student establishes short-term goals for sessions, selects materials, etc.
- The supervisor may need to be directive in supervisory style when working with the same student in "scripting" information to be provided for the family emphasizing appropriate vocabulary choices, definition of professional terminology, etc.

3. The **self-supervision stage**: It is the goal for each supervisee to move to the self-supervision stage. When the student reaches this stage of the continuum, the supervisor serves in a consultative role with the supervisee.

    - The supervisee grows in clinical independence.
    - The supervisee is better able to plan and implement therapy with less direct supervisory input.
    - The supervisor begins to serve in a more collaborative role and feedback at this stage mirrors the change in the supervisory role. The supervisor listens and supports the supervisee in problem solving.
    - The supervisee is responsible for the primary management of the caseload.

Significantly, Anderson notes that the continuum is not time-bound. This means that there is no set period of time that a supervisee should achieve a particular skill. The continuum is designed to support the supervisee in the development and self-recognition of clinical and professional strengths as well as the development and self-recognition of those areas requiring additional development of skill.

Supervisor Tips

The below tips are helpful in planning a supervisory mentoring experience that is transparent and supportive of the supervisee in seeking to meet successful clinical outcomes. As each supervisee is unique in learning style, level of competency, personality and understanding of relevant content knowledge, the supervisor plays an integral part in guiding the student's initial clinical experiences in the profession, as well as upholding morale in dealing with the varying cases and challenges encompassed in performing clinical services. In turn, the tips shown below are helpful in outlining the framework of ideas in planning your mentorship experience:

- Complete any necessary paperwork attesting to your professional credentials (ASHA certification, state licensure, and/or state teacher certification) as this may be necessary for the graduate student to document their supervised clinical experiences when they make application for their own professional credentials.
- Clarify expectations about the amount of time the student will spend at your site (e.g, 3 or 5 days a week, number of hours, number of weeks).
- Contact the university placement coordinator to ask questions about communication between you and the university program once the graduate student is placed, including:
    - Type and frequency of contact;
    - Number of site visits by university coordinator;
    - Systems for addressing any problems;
    - Benchmarks and assessment for student progress

Educational considerations prior to graduate student placement:

- Find out what types of clinical experiences the graduate student has acquired.
- Determine the type of evaluation of the graduate student's performance that the university requires (frequency and format).
- Consider how you plan to assess and teach clinical skills.
- Determine how you will assign cases and manage your caseload accordingly.
- Determine graduate student assessment measures.

Educational considerations after graduate student placement:

When working with the graduate student, consider the following:

- Set up regular times for conferences.

- Encourage the graduate student to be an active participant in establishing mutually agreed upon educational goals for the placement, which take into consideration the student's level of experience and the nature of the clinical opportunities available at the site.
- Clearly state your expectations for the graduate student over the course of the practicum-hours, responsibilities (clients, assigned projects or readings), and facility policies -- and how the student will be evaluated.
- Be cognizant of the graduate student's learning style and how they respond to feedback.
- Avoid attempting to expose the graduate student to every type of patient and disorder. Periodically revisit the goals for placement and student learning objectives.
- Maintain communication with the university regarding the student's progress.

As a first-time supervisor, appropriate planning is integral in ensuring an effective supervisory experience in shaping the attitudes, behaviors and performance of the supervisee. In turn, much attention should be particularly focused on the supervisee's learning style and their level of competency to determine effective strategies to aid in the student's development. It is imperative from the onset of the mentorship that clear expectations and goals are established, as the supervisor should look to define the path in which the student's experiences and gradual development enable for expectations to be met.

Tips for Clinical Remediation

Occasionally as student or supervisor will encounter and/or perceive a problem in the supervisory relationship. If such matters are left unresolved, this may adverse impact the integrity of the relationship and undermine the supervisory experience. If a supervisor and/or graduate student perceives a problem that exists, a sequence of procedures should be followed to attempt to resolve the problem:

- Discuss the problem together. Usually simple misunderstandings can be resolved by discussion. The university coordinator should be informed regarding any issues, as this person can play a key role in seeking to resolve the problem.
- If the graduate student is having difficulties in clinic practicum, s/he may require a Remediation Plan. The remediation plan is a written document that captures the difficulties being experience, the objectives that need to be met, and the supports available for the student to meet goals and clinical expectations. The plan may focus on one or multiple aspects of work, and may also address a broad area of concerns. It can include professional expectations, clinical competencies, self-evaluation skills, interpersonal communication difficulties, etc.
- If the student is unsuccessful in completing the requirements of the remediation plan, the student will be withdrawn from the practicum experience. If the student is successful in completion of the remediation plan, decisions regarding upcoming placement should be made by the University Coordinator.

Frequently Asked Questions

Are there requirements to supervise student clinicians?

Yes. Supervisors should have established competency in any area of practice in which the supervisor or student may engage (e.g., supervisors without experience and competency working with pediatric populations should not supervise a student who is working with a child). The Issues in Ethics Statement on Supervision of Student Clinicians includes further discussion of this issue.

To meet ASHA's Standards for the Certificate of Clinical Competence (CCC), student clinicians must be supervised by an individual who holds the CCC in the appropriate area of practice (see Standard IV-E of speech-language pathology standards). University programs also may require the supervisor to hold the necessary state credential to practice in their setting, i.e. license and/or teacher certification.

Is there a requirement about the number of years one needs to be ASHA-certified before supervising a graduate student?

No. However, the supervisor should have acquired sufficient knowledge and experience to mentor a student and provide appropriate clinical education. Obtaining knowledge and skills related to principles of student assessment and pedagogy of clinical education is encouraged

Is there special "training" you need?

As with any area of practice, SLPs who are clinical educators should have established competency in supervision. There are a number of ways one can establish and maintain competency in this area. ASHA's position statement on clinical supervision outlines the competencies needed and training options.

How do I find an academic program that will send me student clinicians to supervise?

A list of graduate programs in speech-language pathology is available on ASHA's Web site. You can speak with the department chair, graduate program director, or clinic director for further information.

How much of the practicum has to be directly supervised?

According to Standard IV-E of the SLP Certification Handbook:

"Direct supervision must be in real time and must never be less than 25% of the student's total contact with each client/patient and must take place periodically throughout the practicum. These are minimum requirements that should be adjusted upward if the student's level of knowledge, experience, and competence warrants."

The implementation language further states that "The amount of supervision must be appropriate to the student's level of knowledge, experience, and competence. Supervision must be sufficient to ensure the welfare of the client/patient."

Also see the ASHA document, Quality Indicators for Professional Service Programs in Audiology and Speech-

Language Pathology, which includes information about supervision.

In addition, facilities, payers, and other regulatory agencies may have requirements regarding supervising student clinicians that may impact the amount of supervision provided.

Can I supervise more than one student at a time?

Yes. Supervisors often find that they are called upon to supervise more than one student at a time. There is no language within the standards that specifies the number of students that can be supervised by one person.

Do I have to be on-site when the student is on-site? Is it okay to have other SLPs on-site?

As noted in the question above, the amount of direct supervision provided must be appropriate to the student's needs and ensure the welfare of the client. If the primary supervisor cannot be on site, another clinician may supervise the student, if needed. It is important to note that all persons who take on supervisory responsibilities must hold the appropriate CCC in the professional area in which the clinical hours are being obtained in order for the graduate student clinician to apply those supervised clinical hours towards their own CCC application.

To learn more about payer requirements for reimbursement of services provided by student clinicians and how this may influence the issue of on-site supervision in health care settings, see the first question in the Health care section below.

Am I liable for the treatment provided by the student under my supervision?

As a supervisor, you are responsible for any actions taken by the student while under your supervision. You should ensure that the amount of supervision provided is appropriate to the needs of the client/patient and for the graduate student's experience and skill.

Do I have to co-sign all notes, such as treatment plans and IEPs, written by the student? Can anyone else sign the student's notes?

The supervisor of record for the case would be expected to sign all treatment documentation, in accordance with the facility's policies.

How many minutes are in a clinical practicum hour?

The Council For Clinical Certification defines one (1) clinical practicum hour as equal to 60 minutes.

What other supervision resources are available?

ASHA has a number of resources for supervisors and those interested in clinical education. These resources include:

Student supervision Web resources Teaching tools
ASHA Certification Handbook in Speech-Language Pathology

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Professionalism Agreement

During my field experiences, I am a guest at the school site or other educational or community setting.

1. I understand that my task is to learn so that I can become a more effective educational professional.
2. I agree to abide by the specific institutional values and policies as well as highest standards of professionalism at all times.
3. I agree to maintain professional, legal, and ethical conduct at all times. I will respect the privacy of children, families, and school personnel and protect the confidentiality of confidential academic or personal information that I encounter.
4. I agree to be on site when and where I am expected. In the event that I cannot attend or will be late, I will follow proper notification procedures to let the appropriate individuals know in advance.
5. I agree to maintain a professional demeanor and appearance, in accordance with the standards of the site where I am placed.
6. I agree to complete my assigned tasks, duties, and responsibilities on time.
7. I agree to interact and communicate in a positive and professional manner with students, peers, school and university personnel, and others. I will avoid bias, prejudice, or lack of fairness toward individuals or groups of people.
8. I agree to act in a safe and responsible manner, avoiding any action that might put students at physical and emotional risk.
9. I agree to remain committed to student learning at all times. I will not make offensive or demeaning comments about students/participants or their abilities to learn or about teachers or their abilities to teach.
10. I agree to remain committed to improving my own instructional practices and teaching activities. I will remain flexible and open to feedback from others.
11. I agree to demonstrate commitment to my field of study and to the teaching profession. I understand that failure to comply with this agreement may result in the execution of a disposition assessment form (Form D-2) and/or placement termination. (The accumulation of three disposition assessment forms will result in a disciplinary review that may result in removal from the teacher education program.)

_____ _____

Graduate Student Print Name Graduate Student Signature

_____

Date

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Education Schedule

Semester_____

STUDENT INFORMATION:
Name
Address-
Cell Phone –
Email Address _____

SUPERVISING SLP INFORMATION:
Name:
Email: _____
ASHA certification number
School Corporation/COOP (*NOT INDIVIDUAL SCHOOLS- LIST THOSE BELOW)*
School Assignments and telephone number:

1. _____

2. _____

Weekly Schedule -- list school name and hours in building(s):

Monday AM PM _____

Tuesday AM PM _____

Wednesday AM PM _____

Thursday AM PM _____

Friday AM PM _____

School Breaks Dates (Christmas, Spring): _____

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Extern Supervisor Evaluation Form

Graduate Clinician:	
Supervisor:	
Externship Dates:	
University:	
University Supervisor:	
Date:	

Please use the following scale to rate the supervisor on the items below:

5	**Strongly Agree**
4	**Agree**
3	**Neutral**
2	**Disagree**
1	**Strongly Disagree**

This evaluation form will be confidential and used to identify the skill sets of the Clinical Supervisor when making assignments.

This form is to be completed at the end of Graduate School Assignments and faxed to Kenyetta Singleton @ 202-654-6099.

Feedback About **Your Supervisor**

My Supervisor:	5	4	3	2	1
1. Is dependable (prompt, available for consultation, etc.)					
2. Values supervision and expresses interest in the process					
3. Respects personal, individual differences between supervisor-supervisee					
4. Provides ongoing monitoring and feedback					
5. Works at hearing and understanding supervisee's concerns					
6. Focuses on increasing supervisee awareness of how/when to improve skill					
7. Is self-disclosing, shares own strengths and weaknesses, and makes referrals when necessary					
8. Collaborates with the supervisee to plan and suggest possible alternatives for lessons					
9. Works on establishing a climate of trust					
10. Constructively works toward conflict resolution between self and supervisee					
11. Serves as a consultant in areas where supervisee has less experience					
12. Provides guidance on ideas initiated by supervisee					
13. Recognizes supervisee's clinical strengths					
14. Recognizes supervisee's clinical weaknesses and provides recommendations for growth					
15. Gives continuous and relevant feedback					
16. Uses constructive criticism to enhance supervisee's professional growth					
17. Recognizes and is sensitive to the power differential between the supervisor and supervisee					
18. Provides a balance of relationship with mutual respect and support					
19. Demonstrates awareness of supervisee's professional level					

20. Explores personal background and history, including socio-cultural factors, which may affect the supervisee's work with clients					
My Supervisor:	**5**	**4**	**3**	**2**	**1**
21. Monitors and provides guidance regarding ethical and legal issues					
22. Advances supervisee's sensitivity and ability to work effectively with diverse clients					
23. Uses appropriate references, including scholarly materials					
24. Models and encourages a commitment to ongoing professional development					
25. Advances supervisee's ability to work effectively as a member of a professional team					
26. Advances supervisee's ability to develop and utilize therapeutic relationships					
27. Facilitates skill development of conceptualizing clients and treatment planning					
28. Facilitates skill development of effective intervention					
29. Assists supervisee in accurately and clearly articulating his or her approach to clinical practice					
30. Fostered a satisfactory level of clinical independence					

Global Evaluation:

Specific Strengths:

Specific Weaknesses:

Recommendations:

SECTION XI
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