

---

---

# Occupational Therapy and Physical Therapy in Educational Settings:

A Manual for Minnesota Practitioners

---

---

Third Edition

2014



# **OCCUPATIONAL THERAPY AND PHYSICAL THERAPY IN EDUCATIONAL SETTINGS:**

**A MANUAL FOR MINNESOTA PRACTITIONERS**

**THIRD EDITION**

**2014**

Funding for this manual is made possible with a grant from the MN Department of Education. The source of the funds is federal award Special Education - Programs to States, CFDA 84.027A. For further information, contact:

Minnesota Department of Education  
Special Education Division  
1500 Highway 36 West  
Roseville, Minnesota 55113-4266  
Phone 651.582.8200 \* TTY 651.582.8201  
<http://education.state.mn.us/MDE/index.html>

-or-

Metro ECSU  
2 Pine Tree Drive, Suite 101  
Arden Hills, MN 55112  
Phone 612.638.1500  
FAX 612.706.0811  
[info@metroecsuo.org](mailto:info@metroecsuo.org)

Permission is granted to Minnesota school districts to duplicate this publication for non-profit educational purposes. All other uses require written permission from the MN Department of Education. Inquiries should be referenced to: Division of Special Education.

## **ACCESSIBILITY AND THIS DOCUMENT**

Upon request, this material can be made available in alternate format, such as large print, Braille, computer disk or cassette tape.

This manual utilizes information, resources and documents that MDE and the Division of Compliance and Assistance has developed for purposes of providing general help to the public, and to assist school districts and parents who have raised questions about various topics. The content does not include a complete rendition of applicable state and federal law. It does not constitute legal advice, should not be relied on as a comprehensive or definitive response to specific legal situations, nor should it be regarded as substitute for consulting with a licensed attorney.

### **ACKNOWLEDGEMENTS**

Task Force/Authors of the project to revise the manual:

**Lynn Bathke, PT, MPH**  
Physical Therapist  
Intermediate District #287

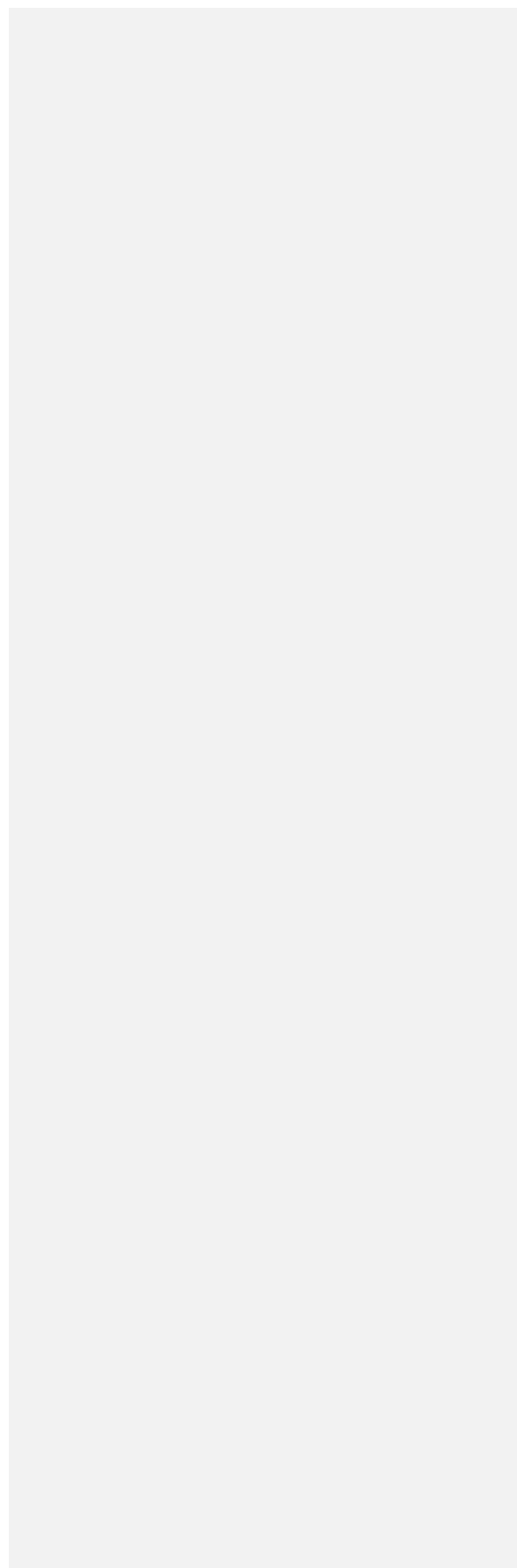
**Joanell Bohmert, PT, DPT, MS**  
Physical Therapist  
Anoka-Hennepin, ISD #11

**Lois Lillie, OTR/L**  
**Manual Revision Facilitator**  
Occupational Therapist  
Intermediate District #287  
MN Statewide Specialist:  
School Based Occupational Therapy and Physical Therapy  
Minnesota Low Incidence Grant  
[llillie@district287.org](mailto:llillie@district287.org)  
[ot-pt-practitioner@lists.state.mn.us](mailto:ot-pt-practitioner@lists.state.mn.us)

The authors wish to thank all of the people who participated in the third edition of this manual. We appreciated their willingness to review the document for publication, share their ideas, and further promote the utilization of this manual as an important resource for occupational therapists and physical therapists working in Minnesota schools.

Deb Berg  
Charisse Courteau  
Lisa Gossman

Kadi Groppoli  
Laura Kleffman  
Carol Hoffer  
Barb Lynch  
Leann Shore  
Kathy Van Deest  
Michelle Wikstrom



A special note of appreciation is given to the following individuals for their support and guidance in revising this manual:

**Ingrid Aasan, Director, Special Education Programs**  
**Kathy Pittelko, Learning Consultant, Special Education**  
Metro Educational Cooperative Service Unit  
Arden Hills, MN

# Table of Contents

Accessibility and this Document

History and Purpose of the Manual

HISTORICAL OVERVIEW OF OCCUPATIONAL THERAPY AND PHYSICAL THERAPY IN THE SCHOOL SETTING

THEORY AND PHILOSOPHY

Concepts Defining the Framework of the Occupational Therapy and Physical Therapy Professions

Continuum of Service

Client Management

Evidence-Based Practice

Research

Therapist's Clinical Experience

Client's Preferences

Brain-Based Learning and Intervention

Children With Disabilities

Life-long Condition

Management of Conditions Across the Life Span

Models of Intervention

Primary Provider Model

Coaching Model

Client Centered Care Concentric Model

Summary

THERAPIST NOTES

LAWS, REGULATIONS, AND PROFESSIONAL STANDARDS OF PRACTICE

State Regulation of Occupational Therapy and Physical Therapy

Occupational Therapy Practitioner Regulations

Physical Therapy Practitioner Regulations

Professional Standards for Occupational Therapy and Physical Therapy

Occupational Therapy Professional Standards

Physical Therapy Professional Standards

Additional Federal Regulations and State Rules Relevant to Occupational Therapy and Physical Therapy

Individuals with Disabilities Education Act (IDEA)

Third-party Billing

The Family Educational Rights and Privacy Act (FERPA)

The Health Insurance and Accountability Act (HIPPA): Privacy Rule

Section 504 of the Rehabilitation Act

The Americans with Disabilities Act (ADA)

The Assistive Technology Act (ATA)

THERAPIST NOTES

## THE INTEGRATION OF OCCUPATIONAL THERAPY AND PHYSICAL THERAPY INTO SPECIAL EDUCATION

ALTERNATIVE INTERVENTION SERVICES Alternative Intervention Services

Coordinated Early Intervening Services (CEIS)

Response to Intervention (RtI)

### IDENTIFICATION

Screening - Part C

Screening - Part B

Pre-Referral Interventions - Part B

Referral

Initial Referral: Part C

### EVALUATION

Pre-evaluation Review - Part B

Determining Need for Additional Data - Part B

Evaluation/Reevaluation Plan

Initial Evaluation and Reevaluation Procedures

Parent Involvement in Evaluation or Reevaluation

Team Members

Nondiscriminatory Evaluation Procedures

Evaluation Timelines

Evaluation Materials and Procedures

Evaluation Areas

Evaluation/Reevaluation Report

Procedures for Determining Eligibility and Placement

Developmental Adapted Physical Education (DAPE)

Section 504 of the Rehabilitation Act of 1973

## COMPONENTS OF IFSP DEVELOPMENT

IFSP Team Members

Progress Reporting

Evaluation and Assessment Summary

Child and Family Outcome(s)

IFSP (Part C) Services

Justification For Each Service Provided In Locations Other Than The Natural Environment

## COMPONENTS OF IEP DEVELOPMENT

Team Members

Present Level(s) of Academic Achievement and Functional Performance (PLAAFP)

Identifying Needs

Measurable Annual Goals, and Short-Term Objectives

Secondary Transition

Assistive Technology Consideration

Special Education and Related Services

Methods of Instruction/Types of Services

Supplementary Aids and Services

Program Modifications and Supports for School Personnel

Altered School Day & Attendance Policy

Extended School Year Services (ESY)

Least Restrict Environment (LRE) Explanation

Progress Reporting

### Other Considerations for Therapists

Statewide Testing

Common Core Standards

Restrictive Procedures

Exit Procedures -Determining the Child is Not a Child With a Disability

Discontinuation of Occupational Therapy and/or Physical Therapy Services

(PWN - Significant Change in Program or Placement)

Third Party Billing

Workload

Collaboration and Communication

THERAPIST NOTES



## ADMINISTRATIVE CONSIDERATIONS

### Personnel Considerations

- Recruitment/Retention of Staff
- Contract Options
- Role Clarification
- Practice Regulation Requirements
- Utilization of Occupational Therapists and Physical Therapists
- Retention of Records and Data Privacy
- Professional Liability

### Supporting the Therapist in the Workplace

- Workload
- Work Space
- Equipment and Supplies
- Orientation, Mentoring, and Evaluation
- Continuing Education
- Student Therapist Experiences

### THERAPIST NOTES

## RESOURCES

- Regulatory Agencies
- Professional Organizations
- Curriculum Programs in Minnesota
- Curriculum Programs in Minnesota
- Sample IEP/IFSP Services Activity Log: 2014-2015
- Sample Letter To Physician Regarding Occupational Therapy or Physical Therapy Service
- Sample Informational Letter To Physician Regarding Incoming Recommendations
- Sample Year End/Transition Form
- Electronic links to information/resources posted on the Minnesota Department of Education website

## REFERENCES

## HISTORY AND PURPOSE OF THE MANUAL

The manual Occupational Therapy and Physical Therapy Services in Schools: Minnesota State Guidelines for Practice was originally published in 1997. It quickly became an important tool for school based therapists and also to school administrators, special educators, advocacy groups, parents and other interested individuals. In 2002, based on continued demand for this resource, feedback from therapists in the field, and support from the Minnesota Department of Children, Families & Learning, efforts took place to update and reprint a second edition of the manual. Although much of the original manual's content remained accurate and relevant to most aspects of contemporary practice, the second edition was reorganized to be more user friendly, and revised to include additional information on issues of current significance, clarify persistent topics of concern, and reflect the reauthorization of IDEA and state legislative changes at that time.

In the second edition (2002) of the manual, a foundational chapter on theory and philosophy was included. Key concepts presented in this chapter were expanded upon and applied to content areas in other chapters throughout this second edition. The expansive appendices from the manual's first edition were significantly condensed by embedding relevant information from this original section into the main body of manual text. In addition, second edition content was expanded to include additional sections entitled Interpretation/Implications for Therapists, providing readers with greater detail, discussion, and examples or illustrations that are offered as clarification of specific topics or issues relevant to therapists. Finally, common questions were linked to content areas to related content areas.

Since 2002, the manual retained its importance as a tool to help define and guide the role of the occupational therapist and physical therapist in educational settings. During this period of time, public education continued to be shaped by many influences. For example, while advances in medical care have risen, so have the associated personal and societal costs for that care. Although the demand for social services and other community support systems has increased, especially in the area of mental and chemical health, the allocation of public resources to meet those demands has not kept pace. As a consequence, families face increased challenges in meeting the needs of their children, especially those who have disabilities. This burden has increasingly shifted to public education since schools have remained a primary entity in serving children and their families. Changes in federal and state funding for education have impacted resources schools have available to meet these challenges.

To date, priorities and initiatives in providing a free and appropriate public education (FAPE) to our youth continue to evolve. This dynamic system requires therapists to keep current and keep pace with change, and remain leaders in finding innovative ways to meet the needs of special learners. While providing efficient and effective services to meet these needs remains the focus for therapists, practitioners continue to face many challenges. Cultural diversity in student/family populations is growing in many

communities, requiring communication supports and new sensitivities to differing belief systems. The complexity/severity of student conditions is rising, especially those children who present safety concerns for educators due to extreme mental health or behavioral needs. Workforce shortages are occurring as staff leave the educational field, and fewer staff are choosing to enter the field. Workload burdens are becoming unmanageable as cost containment continues to limit resources, systems of documentation and accountability continue to be emphasized, and in general, staff face "doing more with less."

Occupational therapists and physical therapists in schools have continued their professional commitment to tackling these challenges, by staying current in their knowledge and skills, exploring new opportunities/advancements in their work (e.g. alternative models of service provision, technology, etc.), embracing change and aligning their role/services accordingly, and demonstrating leadership/helping others find new ways to meet student and family needs.

This third edition of *Occupational Therapy and Physical Therapy in Educational Settings: A Manual for Minnesota Practitioners*, was generated in response to demands in the field for an updated resource that continues to support this professional commitment and helps define current best practice. The continued purpose of the manual is to address changes that have occurred since 2002, and to further clarify the integration of occupational therapy and physical therapy in educational settings. Roles and services within the context of special education remain a primary focus of the manual, however information has been included to illustrate how therapists may support teachers and at-risk learners in a general education capacity.

This third edition manual, presented to you in its final form, is again the result of a collegial effort among occupational therapists, physical therapists, and other proponents of special education. As such, it continues as a testimony to a high standard of professionalism and commitment to provide effective, efficient, and state of the art, educationally relevant therapy services.

Readers will note that the organization of content and formatting of this edition of the manual has changed. Information in the Integration chapter has been increased to include citation of legislation (noted in italics) that impacts the practice of school therapists. Electronic links/web addresses for sources of technical assistance language and documents from the MDE website have been provided throughout the manual, and have been compiled in the Resources section. Electronic links/web addresses for other pertinent information have also been included. A "Common Questions" section is no longer included in this third edition of the manual. Content from that section is embedded throughout.

The manual is not meant to be a complete handbook for therapists, but rather a source of information and a guide for providing services in educational settings. As always, therapists should continue to seek additional information and support through local networks, and state and national professional organizations.

It is intended that the manual will be used among therapists and the entire community of people who support children with special education needs. This community includes but is not limited to administrators, special educators, policy makers, advocacy groups, medical providers, and families. It is our hope that this manual will promote collaboration among education and community team members and will assist in the understanding of the unique contribution that an occupational therapist and physical therapist can bring to a child's educational program.

Lois Lillie, OTR/L  
MN Statewide Specialist: School-Based Occupational Therapy & Physical Therapy  
MN Low Incidence Projects - Metro ECSU

# HISTORICAL OVERVIEW OF OCCUPATIONAL THERAPY AND PHYSICAL THERAPY IN THE SCHOOL SETTING

The practice of occupational and physical therapy in schools was relatively unknown before 1975 when the Education of All Handicapped Children Act (Public Law 94-142) was enacted. School practice consisted of a few therapists working in special schools or residential facilities. Therapy approaches were typical of those traditionally found in a hospital clinic, and usually involved a one-on-one interaction with a child and a medical orientation of treating symptoms or “fixing” deficits. Therapy services of the past were usually provided in isolated settings away from classrooms or other “natural learning environments.”

During the 1980s, school-based therapists began to question the pull-out, medically oriented approach. Therapists were learning that removal from the classroom may interfere with the student’s learning and socialization process, may not be an effective means to help the student generalize skills, and may limit the therapist’s thorough understanding of classroom expectations. New approaches to service delivery began to focus not only on the remediation of deficits, but also on assisting students to function more successfully in their classroom and around the school. The visibility of these new approaches led to increased opportunities for communication among therapists and other educators. Although services in the form of consultation were emerging, the concept of collaboration, especially during the assessment/IEP development process and when providing intervention, was not well understood or implemented.

The greatest changes impacting the provision of therapy in all settings took place in the 1990s. Neuroscientific and neurobehavioral research led to a new understanding of how motor and sensory behaviors are learned and modified. Attitudes about the role of the family and of professionals in service systems changed, contributing to major shifts in the method of delivering therapy services to children. The idea that therapy services should be integrated within the naturally occurring events of the child’s day, rather than in isolated or artificial settings, became strongly promoted as the model of best practice. Experiences then demonstrated that the majority of children benefited from interventions that were incorporated into the day’s routine. Therapists learned that the goals of therapy needed to focus on functional outcomes that help a child with a disability participate in age-appropriate activities in his/her learning environments at home, daycare, school, and work. Related to this, therapists also began to realize the importance of distinguishing between interventions that attempt to remediate a child’s impairments and compensatory interventions that accommodate the child’s disability. Teaming became a critical component of intervention, and therapists and educators became more skilled in collaboration and integration of services.

Significant changes in therapy services provided by school systems, were also taking place in the 1990s. Public Law 94-142 was amended in 1990 by the Individuals with

Disabilities Education Act (Public Law 101-476); it is the single most influential piece of federal legislation associated with the delivery of therapeutic intervention within the educational environment. This Act (IDEA) provides free, appropriate public education (FAPE), including special education and related services. The reauthorization of IDEA in 1997, involved changes and additions that further clarified the definition of parent, the provisions of FAPE, least restrictive environment (LRE) and services to children with disabilities in private schools, disciplinary procedures for children with disabilities, and the role of the federal government in funding services for infants and toddlers. Included in the IDEA legislation is a powerful definition of related services: "... services as are required to assist a child with a disability to benefit from special education."

With these words, the provision of occupational therapy and/or physical therapy by schools became linked to and lead by a special education decision making process. This definition also helped to differentiate between therapy support that is considered essential to helping a child perform within the context of their educational program, and the array of other interventions used by therapists that do not relate directly to a child's learning and school performance. Therapists learned, that related services from an occupational therapist or physical therapist are only provided when the educational team determines that this support is necessary in order for the child to accomplish their identified educational goals and objectives. These related services as part of the child's educational program are provided at no cost to parents.

Based on historical events and important principles of the 1990's, occupational therapists and physical therapists working in school systems, began to confront new concepts that further shaped and defined their services. Emphasis grew on the importance of providing client-centered services and function-based intervention that relates to occupational performance, or typical activities and roles of daily human life. Therapists helped others comprehend the idea of episodic care, or that the need for therapy support can come and go over time. In addition, therapists increased their commitment to evidence-based practice to justify and raise confidence in their services.

Since 2002, practitioners in Minnesota have experienced challenges impacting their role in special education, primarily due to issues in educational funding. In addition, legislative changes have occurred to further define restrictive procedures, and Part C services for children from birth to age three. The MN Department of Education (MDE - formerly the MN Department of Children, Families, & Learning) remains the primary agency providing technical support and guidance to schools, and extensive resources to clarify special education law and due process procedures have been developed/posted electronically on their internet website. Professional organizations and training programs for occupational therapists and physical therapists are focusing on school based therapy as a unique field, and are building instruction, training opportunities, and other professional resources for this area of practice. In addition, therapists working in schools have acknowledged the importance of advocating their needs for professional development, through continuing education, and access to collegial networks. An example of a resource that provides this type of support to therapists in schools is the

[Metro Educational Cooperative Service Unit](#) -Minnesota the Regional Low Incidence Projects. This agency has also been instrumental in supporting the initial development and associated updating of this practice manual for school occupational therapists and physical therapists in Minnesota. In the years ahead, children and their families will continue to benefit from occupational therapists and physical therapists working in schools.

Therapists will remain actively engaged in clarifying and advocating their roles in educational settings, staying current with trends and new knowledge/training in order to remain valuable, educational, team members and effective/efficient providers of services that help meet the needs of children as learners. Resources, such as this manual, will assist them do their work well.

## **THEORY AND PHILOSOPHY**

To understand the practice of occupational therapy and physical therapy in the educational setting, one first needs to understand the concepts on which these practices are based.

Therapists observe how the brain gathers information from the environment, processes this information, makes decisions on how to respond, then performs the action, task or activity. They use information from science on how the brain and body learn actions, tasks or activities in the typically developing individual. Therapists also learn how changes in typical development, either through congenital or acquired incidents, impact the various systems of the body and how these changes can affect the learning of actions, tasks and activities.

Therapists, regardless of setting, work from the same conceptual basis, the same scientific basis for how the brain and body learn actions, tasks or activities. They work from the same standards of practice and code of ethics and must follow the requirements of state law that regulates their practice. Therapists incorporate the unique regulations and standards of the specific setting (e.g. educational setting) as a part of their practice. When therapy service is contracted from an outside agency, it is essential for the therapist to remember that in this role they are functioning as a school therapist, and as such should have complete knowledge of this role. This would include functioning as part of a team, models of intervention in school, the natural environment, and the broader definition of who the client may be. It may be difficult for a contracted, hospital or clinic based therapist to fully function in this role.



## **CONCEPTS DEFINING THE FRAMEWORK OF THE OCCUPATIONAL THERAPY AND PHYSICAL THERAPY PROFESSIONS**

### **Continuum of Service**

The concept of continuum of service is that there are a variety of services available across all types of settings. This variety of services includes:

- Prevention (health, wellness and fitness)
- Habilitation (learning new skills)
- Rehabilitation (relearning skills)

Therapists provide service across all settings including home, day-care, school, community, and job sites. The needs of the individual determine the type of service and the setting in which service is provided. By using a continuum of service the therapist would provide service during a specific time or episode of need. This is considered an episode of care during which the child would work on specific goals and outcomes. Once the client has attained the goals and outcomes or it has been determined that the goals and outcomes cannot be attained, the episode would end. Clients with an on-going or life-long condition may require multiple episodes of care involving a therapist over their lifetime to ensure safety and effective adaptation following changes in physical status, cognitive maturation, caregivers, settings, task demands, or periods of rapid growth.

The variety of services may include prevention, habilitation, and rehabilitation in any of the settings listed above. It is expected that a client's needs would change with age, growth, change in setting or program, or a change in caregivers or educational staff. It would also be expected that therapists would provide episodic care based on the client's educational needs, as defined by the team in the IFSP/IEP. As a related service, therapists use their district's due process forms to document therapy services.

### **Client Management**

Client management is the process therapists use to identify the needs of the individual and determine the plan for service. Therapists use a process that includes examination, evaluation, diagnosis, prognosis and intervention to obtain the desired outcomes of the individual. The term "client" is the individual or group (family, community members, daycare providers, school staff, etc.) receiving services from occupational therapists and physical therapists in any setting.

Therapists perform an examination or a gathering of information that includes a history, systems review (clinical information gathered through brief examination, observations, interview, record review), and performance of specific tests and measures taking into consideration the age of the client; stage of recovery (acute, subacute, chronic); phase of habilitation or rehabilitation (early, intermediate, late, return to activity); home, work (job/school/play), or community situation; and other relevant factors. The client, family, and caregivers may provide information throughout the examination. Following the examination the therapist analyzes, or evaluates the information to establish a diagnosis and prognosis.

The diagnosis is the label the therapist uses to indicate the primary problem toward which interventions will be directed. It is not the medical diagnosis but a diagnosis of the impairment, functional limitation or disability that directs the plan for intervention. The prognosis is a prediction of the optimal level of improvement in function and the amount of time that will be needed to reach that level. Therapists develop a plan of care that identifies the specific interventions, proposed frequency and duration, anticipated goals and expected outcomes and discharge plans taking into consideration the expectations of the client and appropriate others, such as family, caregivers, and educational staff members. In the educational setting, the role of client is often expanded to caregivers and family members. This is especially evident in the Birth to Three programs when due process documentation addresses the needs of the entire family, as through the Individual Family Service Plan (IFSP).

In the educational setting the therapist participates as a team member in the identification and evaluation of students, determination of eligibility, and identification of needs and services. Therapists will use the conceptual framework of client management, however specific paperwork will be the responsibility of the educational agency. Therapists should not make a decision in isolation as to the need for therapy service but will provide input during team meetings as to the need for therapy service based on special education needs. Teams will also not make the determination for the need of therapy without the input of the therapist. In the educational setting, the order of the determination of needs is the student's general education needs followed by the special education needs and specific goals and objectives. Only then is the determination made regarding the need for therapy services to support stated needs, goals and objectives.

## **EVIDENCE-BASED PRACTICE**

Evidence-based practice incorporates the following three components: 1) what is known through research, 2) the therapist's clinical experience, and 3) the client's preferences, to determine the best plan of care to achieve the desired outcomes.

### **Research**

Using evidence-based practice requires a therapist to stay current with research in the areas of practice. Therapists need to read current professional journals, participate in study groups or discussions with other professionals, take continuing education courses and understand the positions of their professional associations. The research component requires therapists to evaluate their current practice and the use of tests and measures in examining clients to accurately identify problems and lead into the selection of the most appropriate intervention to attain desired outcomes.

Evidence-based practice also requires the therapist to involve the client/family/caregiver in the entire process to determine the client's goals of therapy.

### **Therapist's Clinical Experience**

A therapist's clinical experience is defined in evidence-based practice as the component that addresses the unique training and experience of that individual. It is expected that therapists will continue learning after completing their entry-level professional education program. This will result in the expertise of each therapist being unique. Evaluation of knowledge, skills, strengths, and weaknesses should be done on a routine basis to ensure increasing competence.

In clinical practice, therapists must evaluate their practice in all areas including examination and interventions as related to attaining client-centered outcomes. Therapists should collect data on individual clients to determine which factors impact change. Therapists are encouraged to establish clinical research, at the level of individuals and groups. Therapists need to evaluate the effectiveness of the interventions provided to clients, and determine which interventions provide the greatest improvement in function and which interventions may be well accepted but are no longer effective. Therapists must develop a framework from which they can evaluate an existing, new or controversial intervention. This framework needs to address the philosophy of the intervention; intensity; impact on impairments, functional limitations, disability; intrusiveness to individual or setting; resources needed to provide interventions (both human and financial); and ability to attain desired outcomes.

Therapists are frequently asked by families and outside agencies to use a specific intervention with a student at school. Before beginning any intervention at school the therapist needs to determine how the intervention addresses educational needs and goals, while maintaining LRE (least restrictive environment). The therapist should evaluate the intervention to determine its appropriate use in the educational setting, as well as effectiveness for that specific student.

### **Client's Preferences**

Involvement of the client is critical in evidence-based practice. When the age or impairments warrant, the family/caregiver, in combination with the child, becomes the client. From the initial contact, the client needs to provide the therapist with his/her preferences for outcomes and interventions. The client needs to state his/her expectations for therapy – what does he/she expect to be able to do as a result of the therapist's involvement? The client needs to discuss his/her various roles, what is interfering with his/her ability to perform the role, and what he/she is willing to do to be able to perform role. This involves discussions around the family unit, culture in the home, preferred activities, life-style, and knowledge of condition and impact on life expectations and roles.

Using the information provided by the client, the results of the evaluation, and the therapist's knowledge of the evidence related to the client's condition, the therapist determines if the client's expectations are realistic and which interventions would be the best to use to attain the client's desired goals. When the client's expectations are not realistic, it is the therapist's job to discuss this with the client, presenting the evidence and proposing alternative strategies or ways to accomplish a desired goal. For example, a client may desire to walk, however based on the client's current physical abilities and what is known about the client's condition, walking is not an expected ability. The therapist should discuss with the client that while walking is not realistic, the ability to get from place to place is. The therapist may propose the use of assistive devices such as a powered scooter or wheelchair that would allow the client to be independent in mobility.

In the educational setting, the client may not only be the student, but also the family, caregivers, or school staff. These are the people who know the student the best. Therapists are educated to understand the human body, how the body typically develops and functions, and how diseases, disorders, conditions, and injury impact body systems. They also understand the requirements to complete specific action, tasks, and activities students need to fulfill their roles. A primary role of the therapist is educating families and team members regarding appropriate outcomes for a student based on the student's condition or disability.

## **BRAIN-BASED LEARNING AND INTERVENTION**

Current evidence demonstrates that the brain learns and organizes movement based on the interaction of the child, task and environment. The brain learns best when the task or activity has meaning to the individual, is purposeful, and occurs in the natural setting. Motivation is a primary factor in learning.

Therapists want children to work on the desired activities in the setting in which they naturally occur. It is best to work in the classroom (rather than in an isolated area), using the materials that will be used (actual desk, pencil, stairs, lunch tray), during

naturally occurring events (during handwriting, passing time, physical education class, lunch time). In addition, the activity must be something the child wants to do, not something the family or therapist wants or thinks is important. To learn a skill, it must be meaningful to the child.

Evidence demonstrates that children will learn best in their natural environment; practicing tasks, actions and activities as they occur within their daily routine; using the actual equipment or furniture they will use to perform the task, action or activity. Providing service in the natural environment encourages the child to learn strategies that will be used in that environment. Goals need to be meaningful to the child and family. Utilization of a family-centered approach allows the educational team to focus on the family's priorities. This is a critical component of evidence-based practice.

The body is able to adapt and learn throughout the lifespan. Brain plasticity, readiness, and rate of change are variable and need to be evaluated for each student. Therapists should be open to providing episodes of care that align with changes in student's physiological and cognitive readiness, relevant to educational needs.

Evidence demonstrates that a student earns best when the task or activity is meaningful to him/her, which requires time for the child to develop an understanding of his/her environment and role. In addition, learning cannot occur if the body is not ready.

## **CHILDREN WITH DISABILITIES**

### **Life-long Condition**

Many of the students who receive special education services have a condition that will last throughout their lifetime. They will always have the pathology that caused the condition (e.g. the damage to the brain will not change, the chromosome abnormality cannot be fixed). In many cases their development will be atypical; it will not follow the usual sequence or timeline. This however, does not mean that these students will not be able to do the things that other children do, but it does mean that they may do them differently.

Children are life-long learners, acquiring new skills, as the tasks are meaningful to them. As their environments and roles expand, their desire to participate and learn the skills and strategies will also expand. In addition, as their cognitive skills mature, children will begin to learn how their bodies work and what they need to do in order to accomplish their desired goals.

As related service providers, therapists can help children who receive special education services by helping their families and educational staff understand the conditions and changes that may occur with growth and aging of the child. The student's desired goals will change and their motivation to accomplish them will frequently be the basis for acquiring new skills. What was not important to a 10 year old may be very important to a 16 year old. Therapists have a role in assisting the special education team to help the student prepare for the transition to adult life.

### **Management of Conditions Across the Life Span**

Students with life-long conditions will need to learn to manage their conditions to achieve what is important to them. They need to understand: the consequences of their condition on their body systems; how the condition may change as they grow and age; the natural course of their condition and what they can do to manage it; and determine what activities are important to them and what will be needed to accomplish them. Alternative methods and the use of assistive technology may be necessary.

It is imperative that students with disabilities understand the basics of a healthy lifestyle and how their specific condition impacts their life experiences as they age. Education requires addressing transition to adult life in these areas: home living, recreation and leisure, community participation, employment, and post secondary education. In addition, the areas of self-determination, personal safety, self-advocacy, disability awareness, health wellness and prevention need to be developed. Family/caregivers and educational teams must be able to assist the student with preparation for adult life.

## **MODELS OF INTERVENTION**

Therapists working in educational settings should be part of broader educational teams. These teams may provide service to students and families through a variety of intervention models. Therapists will be successful team members when they have a basic working knowledge of various modes of intervention and when they are able to work within the model implemented by the teams of which they are a part. Therapists bring their knowledge and expertise to the team, as part of a collaborative effort to provide the most appropriate services to the student. The following are examples of some of the current models of intervention being used by educational teams. Models provide a framework for provision of services. Some components within these frameworks are common to many models, such as teaming and coaching, while others are specific to only one model.

### **Primary Provider Model**

The Primary Provider Model is the recommended practice by the Minnesota Department of Education for the provision of services in Part C (Birth to Three/Infant Toddler programs). In this model, one team member acts as the primary service provider to the caregivers and families. The primary provider is selected based on the needs of the student and family. The provider must have an awareness and access to all necessary program team members. This model includes coaching and collaboration with other team members, who make less frequent intervention visits to the students and families. The primary service provider and the family function as part of an active team that has access to input and support from all necessary members of the team.

### **Coaching Model**

The Coaching Model is widely used in early childhood intervention both in classrooms and in Birth to Three home visiting, and has great application for elementary, secondary, and transition programs. It is a facilitative process, to help caregivers and educational staff build capacity to students meet goals. It consists of five major characteristics including joint planning, observation, action, reflection, and feedback. Coaching is an evidence-based practice, well supported by research, as a strategy to help therapists move from primary use of student-focused intervention to caregiver/educational staff centered intervention. It represents the collaborative process.

### **Client Centered Care Concentric Model**

Client centered care supports active involvement of clients and their families and school staff in the design of new care models and in decision-making about intervention and

goals. The client is at the center of this model, and is the main determinant of the direction of the intervention. In this model, it is recognized that the client functions as a member of many groups and interaction within the environment is crucial in the client's goals. In the educational setting, the therapist's client may be defined as the student, family and school staff working together. This model implies respect and responsiveness to client/caregiver/staff ideas and desired goals.

## **SUMMARY**

Therapists bring a unique perspective to the education of children. They have knowledge and understanding of the brain and how children learn and organize information to perform actions, tasks, and activities. Therapists work from a scientific, evidenced-based framework incorporating the concepts of disablement, continuum of care and client management. Based on this framework and these concepts, therapists in the educational setting must address the functional needs of children that are educationally relevant, through a collaborative model. The focus of educational therapy service is not on "fixing" the child but adapting the task, expectations, and environment, and facilitating successful performance of the child's activities in their multiple roles.

## **THERAPIST NOTES**



## **LAWS, REGULATIONS, AND PROFESSIONAL STANDARDS OF PRACTICE**

For the appropriate provision of therapy services, it is critical to understand federal and state education laws and regulations that guide the provision of occupational therapy (OT) and physical therapy (PT) in the educational setting, the state laws regulating the practice of OT and PT and the Professional Standards that guide the practice of OT and PT. It is important that therapy services meet the established federal and state regulations as well as meeting the respective professional standards of practice.

This 2014 manual references federal and state regulations that were current at the time this version of the manual was written and therefore information will not reflect changes in federal and state regulations or further interpretations which occur following this publication. Readers are encouraged to check federal and state websites to obtain the most current information.

Federal and state laws and regulations are frequently cited by the title of the Act and abbreviations with numbers that identify the specific legislative citation. The following are common abbreviations:

### Federal:

- C.F.R. is Code of Federal Regulations. This indicates the information cited is FEDERAL LAW and applies to all states.
- U.S.C. means United States Congress. This indicates the information cited is FEDERAL LAW and applies to all states.
- P.L. means Public Law. This indicates the information cited is FEDERAL LAW and applies to all states.

### State:

- M.S. is Minnesota Statute. This indicates the information cited is a Minnesota STATE LAW and only applies to Minnesota.
- M.R. is Minnesota Rule. This indicates the information cited is a Minnesota STATE rule and only applies to Minnesota. Rules can only be written to interpret a State Statute however Statutes can exist without Rules.

## STATE REGULATION OF OCCUPATIONAL THERAPY AND PHYSICAL THERAPY

Regulation of occupational therapy and physical therapy is at the state level. In Minnesota occupational therapists, occupational therapy assistants, physical therapists and physical therapist assistants are licensed health care providers.

Occupational therapists and occupational therapy assistants are regulated by the Minnesota Department of Health (MDH). Verification and status of an individual's license, licensing issues, the current practice act, and consumer information may be obtained at this link:

[MN Department of Health Occupations Program](#)

Physical therapists and physical therapist assistants are regulated by the Minnesota State Board of Physical Therapy (MSBPT). Verification and status of an individual's license, licensing issues, the current practice act, legislation, and consumer information may be obtained at this link:

[MN Board of Physical Therapy](#)

### Occupational Therapy Practitioner Regulations

Occupational Therapy Practitioner Regulations (M.S. 148.6401 to 148.6450) govern the practice of occupational therapists (OTR) and occupational therapy assistants (COTA) in Minnesota. OTRs and COTAs working in school settings in Minnesota, in addition to meeting the requirements of educational law, are required to meet these regulations. The Minnesota Department of Health with assistance from the Occupational Therapy Practitioners Advisory Council oversees these regulations. To view the most current version of the OT Practice Act visit this link:

<http://www.health.state.mn.us/divs/hpsc/hop/otp/>

### Practice Requirements

**License** - An occupational therapist and occupational therapy assistant must be licensed by the Minnesota Department of Health to practice in Minnesota. Licensure in another state does not permit a therapist or assistant to practice in Minnesota. Occupational therapy statutes for therapists and assistants require licensure renewal every 2 years. Continuing education requirements of 24 contact hours for an occupational therapist and 18 contact hours for an occupational therapy assistant need to be completed during the 2 years preceding licensure renewal. The status of an individual occupational therapist's or assistant's ability to practice in Minnesota can be verified with the Minnesota Department of Health on their web site at this link.

<http://www.health.state.mn.us/divs/hpsc/hop/otp/index.html>

**Evaluation** - Statutes allow the occupational therapist to evaluate a student without need for a referral from a licensed health care professional. The occupational therapist may delegate portions of the evaluation to an occupational therapy assistant when appropriate.

**Service** - Statutes allow the occupational therapist and occupational therapy assistant, under the direction and supervision of the occupational therapist, to provide service to a student without the need for a referral from a licensed health care professional. The statutes exempt school therapists from following the requirement for written communication to the appropriate licensed health care professional within 14 days of initiating treatment.

### **Definitions (M.S. 148.6402)**

**Subd. 15. Occupational therapy.** “Occupational therapy” means the use of purposeful activity to maximize the independence and the maintenance of health of an individual who is limited by a physical injury or illness, a cognitive impairment, a psychosocial dysfunction, a mental illness, a developmental or learning disability, or an adverse environmental condition. The practice encompasses evaluation, assessment, treatment, and consultation. Occupational therapy services may be provided individually, in groups, or through social systems. Occupational therapy includes those services described in section 148.6404.

### **Scope of Practice (M.S. 148.6404)**

The practice of occupational therapy by an occupational therapist or occupational therapy assistant includes, but is not limited to, intervention directed toward:

- 1) assessment and evaluation, including the use of skilled observation or the administration and interpretation of standardized or nonstandardized tests and measurements, to identify areas for occupational therapy services;
- 2) providing for the development of sensory integrative, neuromuscular, or motor components of performance;
- 3) providing for the development of emotional, motivational, cognitive, or psychosocial components of performance;
- 4) developing daily living skills;
- 5) developing feeding and swallowing skills;
- 6) developing play skills and leisure capacities;
- 7) enhancing educational performance skills;
- 8) enhancing functional performance and work readiness through exercise, range of motion, and use of ergonomic principles;
- 9) designing, fabricating, or applying rehabilitative technology, such as selected orthotic and prosthetic devices, and providing training in the functional use of these devices;
- 10) designing, fabricating, or adapting assistive technology and providing training in the functional use of assistive devices;
- 11) adapting environments using assistive technology such as environmental controls, wheelchair modifications, and positioning;
- 12) employing physical agent modalities, in preparation for or as an adjunct to purposeful activity, within the same treatment session or to meet established functional occupational therapy goals; and
- 13) promoting health and wellness.

### **Delegation of Duties; Assignment of Tasks (M.S. 148.6430)**

The occupational therapist is responsible for all duties delegated to the occupational therapy assistant or tasks assigned to direct service personnel. The occupational therapist may delegate to an occupational therapy assistant those portions of a client's evaluation, reevaluation, and treatment that, according to prevailing practice standards of the American Occupational Therapy Association, can be performed by an occupational therapy assistant. The occupational therapist may not delegate portions of an evaluation or reevaluation of a person whose condition is changing rapidly.

### **Supervision of Occupational Therapy Assistants (M.S. 148.642)**

**Subd. 2. Evaluations** - The occupational therapist shall determine the frequency of evaluations and reevaluations for each client. The occupational therapy assistant shall inform the occupational therapist of the need for more frequent reevaluation if indicated by the client's condition or response to treatment. Before delegating a portion of a client's evaluation pursuant to section 148.6430, the occupational therapist shall ensure the service competency of the occupational therapy assistant in performing the evaluation procedure and shall provide supervision consistent with the condition of the patient or client and the complexity of the evaluation procedure.

#### **Subd. 3. Treatment -**

- a. The occupational therapist shall determine the frequency and manner of supervision of an occupational therapy assistant performing treatment procedures delegated pursuant to section 148.6430, based on the condition of the patient or client, the complexity of the treatment procedure, and the proficiencies of the occupational therapy assistant.
- b. Face-to-face collaboration between the occupational therapist and the occupational therapy assistant shall occur, at a minimum, every two weeks, during which time the occupational therapist is responsible for:
  1. planning and documenting an initial treatment plan and discharge from treatment;
  2. reviewing treatment goals, therapy programs, and client progress
  3. supervising changes in the treatment plan;
  4. conducting or observing treatment procedures for selected clients and documenting appropriateness of treatment procedures. Clients shall be selected based on the occupational therapy services provided to the client and the role of the occupational therapist and the occupational therapy assistant in those services; and
  5. ensuring the service competency of the occupational therapy assistant in performing delegated treatment procedures.
- c. Face-to-face collaboration must occur more frequently than every two weeks if necessary to meet the requirements of paragraph (a) or (b).

- d. The occupational therapist shall document compliance with this subdivision in the client's file or chart.

### **Supervision of Occupational Therapy Assistants**

#### **Interpretation/Implications for Therapists:**

These statutes set the minimal legal requirement for supervision of occupational therapy assistants to maintain their license. These statutes do not exempt occupation therapists or occupational therapy assistants from meeting the supervision requirement established by an employer, facility or reimbursement source.

#### **Documentation Requirements**

Documentation requirements are specifically addressed within the Occupational Therapy Practice Act for the supervision of occupational therapy assistants. Documentation requirements for supervision of occupational therapy assistants are described in Supervision of Occupational Therapy Assistants M.S. 148.642 Subd. 3 Treatment, in the above section of this manual.

Documentation requirements and retention of records are not specifically addressed within the Occupational Therapy Practice Act however occupational therapists and occupational therapy assistants must follow appropriate Federal, State, Local, and employer regulations as well as recognized professional standards.

The following regulations are addressed later in this chapter:

**Federal Regulations** - IDEA, FERPA, and HIPPA

**State Regulations** - Education regulations, Occupational Therapy Regulations, Healthcare provider regulations, Third-party billing, and reimbursement providers where appropriate

### **Documentation Requirements/Record Retention**

#### **Interpretation/Implications for Therapists:**

Documentation required by due process includes evaluation team summary report, individual education plan (IEP), individual family services plan (IFSP), and periodic reviews which should occur as frequently as progress review for non-disabled peers. In addition, therapists follow their professional standards of practice and guidelines for documentation.

The purpose of documentation is to create a record of the student's status, needs, present level of function, progress and services. Generally, therapists document the intervention strategies, student progress, communications, and any other significant information. Therapists generally develop a plan of care or intervention for a specific student. This is similar to a teacher's lesson plan. Therapists need to be aware that any documentation is part of the student's record that a parent may request for review or which could be reviewed as a part of litigation. Refer to Resources section for sample of documentation.

Retention of records may be different for occupational therapy because in addition to being an educator, they are also licensed health care providers. Therapists and administrators should review educational and health care provider requirements as well as general legal standards to assist them in developing policies regarding retention of occupational therapy records. For example, a commonly stated general legal standard for retaining pediatric records is retention until 7 years after the age of majority (usually age 18, but can vary by state.)

## **Physical Therapy Practitioner Regulations**

Physical Therapy Regulations (M.S. 148.65 to 148.78 and M.R. 5601) govern the practice of physical therapists (PT) and physical therapists assistants (PTA) in Minnesota. Physical therapists (PT) and physical therapist assistants (PTA) working in school settings in Minnesota, in addition to meeting the requirements of educational law, are required to meet these regulations. The Minnesota Board of Physical Therapy oversees these regulations for PTs and PTAs. For the most current version of these regulations see this link for the [Minnesota Board of Physical Therapy](#) website.

### **Practice Requirements**

**License** - A physical therapist or physical therapist assistant must be licensed by the Minnesota Board of Physical Therapy to practice in Minnesota. Licensure in another state does not permit a therapist or assistant to practice in Minnesota. Physical therapy regulations require physical therapists and physical therapist assistants license renewal every year. Continuing education requirements of 20 contact hours are needed for every two-year renewal cycle. The status of an individual physical therapist's or physical therapist assistant's ability to practice in Minnesota can be obtained from the MN Board of Physical Therapy.

**Evaluation** - Regulations allow the physical therapist to evaluate a student without need for a referral from a licensed health care professional or provider. A physical therapist assistant may only assist a physical therapist in performing the evaluation.

**Service** - Regulations for service are based on the length of licensure, licensed less than one year and more than one year of experience. These regulations apply to any type of educational service that a physical therapist may provide.

- Licensure less than one year must practice either in collaboration with a physical therapist with more than one year of experience OR under a physician's orders or referrals
- More than one year of experience NO referral needed for first 90 days after admittance to treatment OR when a previous diagnosis exists indicating an ongoing condition warranting physical therapy treatment OR for prevention, wellness, education, or exercise. To continue service after 90 days of service the therapist must have either documentation of a diagnosis indicating an ongoing condition warranting physical therapy treatment OR obtain an order or referral from a licensed health care professional or licensed health care provider.

## **Definitions (M.S. 148.65) and Scope of Practice**

**Subd. 1. Physical therapy.** As used in sections 148.65 to 148.78 the term “physical therapy” means the evaluation or treatment or both of any person by the employment of physical measures and the use of therapeutic exercises and rehabilitative procedures, with or without assistive devices, for the purpose of preventing, correcting, or alleviating a physical or mental disability. Physical measures shall include but shall not be limited to heat or cold, air, light, water, electricity and sound. Physical therapy includes evaluation other than medical diagnosis, treatment planning, treatment, documentation, performance of appropriate tests and measurement, interpretation of orders or referrals, instruction, consultative services, and supervision of supportive personnel. “Physical therapy” does not include the practice of medicine as defined in section 147.081, or the practice of chiropractic as defined in section 148.01.

**Subd. 2. Physical therapist.** “Physical therapists” means a person licensed by the board who practices physical therapy as defined in sections 148.65 to 148.78.

**Subd. 3. Physical therapist assistant.** “Physical therapist assistant” means a person licensed by the board who provides physical therapy under the direction and supervision of a physical therapist, and who performs physical therapy interventions and assists with coordination, communication, documentation, and patient-client-related instruction.

**Subdivision 9. Licensed health care professional or licensed health care provider.** “Licensed health care professional” or “licensed health care provider” means a person licensed in good standing in Minnesota to practice medicine, osteopathy, chiropractic, podiatry, dentistry, or advanced practice nursing.

## **Prohibited Conduct (M.S. 148.76) / Referral Requirements**

### **Subd. 2. Prohibitions.**

(a) No physical therapist may: (1) treat human ailments by physical therapy after an initial 90-day period of patient admittance to treatment has lapsed, except by the order or referral of a person licensed in this state to practice medicine as defined in section 147.081, the practice of chiropractic as defined in section 148.01, the practice of podiatry as defined in section 153.01, the practice of dentistry as defined in section 150A.05, or the practice of advanced practice nursing as defined in section 62A.15, subdivision 3a, when orders or referrals are made in collaboration with a physician, chiropractor, podiatrist, or dentist, and whose license is in good standing; or when a previous diagnosis exists indicating an ongoing condition warranting physical therapy treatment, subject to periodic review defined by Board of Physical Therapy rule. The 90-day limitation of treatment by a physical therapist



without an order or referral does not apply to prevention, wellness, education, or exercise;

(b) No physical therapist licensed less than one year may treat human ailments, without referral, by physical therapy treatment without first having practiced one year in collaboration with a physical therapist with more than one year of experience or under a physician's orders or referrals as verified by the board's records.

**Prohibited Conduct/Referral Requirement  
Interpretations/Implications for Therapists:**

Physical therapists practicing in the school setting must comply with the same requirements as physical therapists practicing in other settings.

**Delegation and Supervision of Physical Therapy  
Physical Therapist Assistants, Aides, and Students (M.S. 148.706)**

**Subd. 1. Supervision.** Every physical therapist who uses the services of an assistant or aide for the purpose of assisting in the practice of physical therapy is responsible for functions performed by the assistant or aide while engaged in such assistance. The physical therapist shall delegate duties to the physical therapist assistant and assign tasks to the physical therapy aide in accordance with subdivision 2. Physical therapists who instruct student physical therapists and student physical therapists assistants are responsible for the functions performed by the students and shall supervise the students as provided under section 148.65, subdivisions 5 and 6. A licensed physical therapist may supervise no more than two physical therapist assistants at any time.

**Subd. 2. Delegation of duties.** The physical therapist may delegate patient treatment procedures on to a physical therapist assistant who has sufficient didactic and clinical preparation. The physical therapist may not delegate the following activities to the physical therapist assistant or to other supportive personnel: patient evaluation, treatment planning, initial treatment, change of treatment, and initial or final documentation.

**Subd. 3. Observation of physical therapist assistants.** When components of a patient's treatment are delegated to a physical therapist assistant, a physical therapist must provide on-site observation of the treatment and documentation of its appropriateness at least every six treatment sessions. The physical therapist is not required to be on site, but must be easily available by telecommunications.

## **Documentation Requirements**

Documentation requirements and retention of records are specifically addressed within the Physical Therapy Practice Act. In addition physical therapists and physical therapists assistants must follow appropriate Federal, State, Local, and employer regulations as well as recognized professional standards.

The following regulations are addressed later in this chapter:

**Federal Regulations** - IDEA, FERPA, and HIPPA

**State Regulations** - Education regulations, Occupational Therapy Regulations, Healthcare provider regulations, Third-party billing, and reimbursement providers where appropriate

### **Retention of Patient Records (M.R. 5601.1300)**

All patient records including directions and orders within the control of the physical therapist shall be retained for at least seven years, or six years after the patient's majority. The physical therapist shall provide access to these records to the board.

## **Documentation Requirements/Record Retention**

### **Interpretation/Implications for Therapists:**

Documentation required by due process includes evaluation team summary report, individual education plan (IEP), individual family services plan (IFSP), and periodic reviews which should occur as frequently as progress review for non-disabled peers. In addition, therapists follow their professional standards of practice and guidelines for documentation.

The purpose of documentation is to create a record of the student's status, needs, present level of function, progress and services. Generally, therapists document the intervention strategies, student progress, communications, and any other significant information. Therapists generally develop a plan of care or intervention for a specific student. This is similar to a teacher's lesson plan. Therapists need to be aware that any documentation is part of the student's record that a parent may request for review or which could be reviewed as a part of litigation. Refer to Resources section for sample of documentation.

Retention of records may be different for physical therapy because in addition to being an educator, they are also licensed health care providers. Therapists and administrators should review educational and health care provider requirements as well as general legal standards to assist them in developing policies regarding retention of occupational therapy records. For example, a commonly stated general legal standard for retaining pediatric records is retention until 7 years after the age of majority (usually age 18, but can vary by state.)

## **PROFESSIONAL STANDARDS FOR OCCUPATIONAL THERAPY AND PHYSICAL THERAPY**

Professional Standards is a broad term that includes statements usually from the profession's organization that state expected performance of the profession. This term may also include statements of expected moral or ethical behaviors that are generally titles Code of Ethics or Professional Conduct. While these documents may not be legally binding they may be used to determine the appropriateness of service. These documents also serve to educate others on the minimum and expected requirements of therapists and assistants.

- The American Occupational Therapy Association (AOTA) is the national professional organization for Occupational Therapists and Occupational Therapy Assistants. Information may be obtained from this link: [www.aota.org](http://www.aota.org)
- MNOTA is the Minnesota Occupational Therapy Association. Information may be obtained from this link: <http://www.motafunctionfirst.org/>
- The American Physical Therapy Association (APTA) is the national professional organization for Physical Therapists and Physical Therapist Assistants. Information may be obtained from this link: [www.apta.org](http://www.apta.org)
- MNPTA is the Minnesota Physical Therapy Association that is the local representative of the APTA. Information may be obtained from this link: [www.mnapta.org](http://www.mnapta.org)

### **Occupational Therapy Professional Standards**

Professional standards for OT developed by the American Occupational Therapy Association (AOTA) include the Standards of Practice for Occupational Therapy (2010) and Occupational Therapy Code of Ethics and Ethical Standards (2010).

AOTA states "The Standards of Practice for Occupational Therapy are requirements for occupational therapists and occupational therapy assistants for the delivery of occupational therapy services."

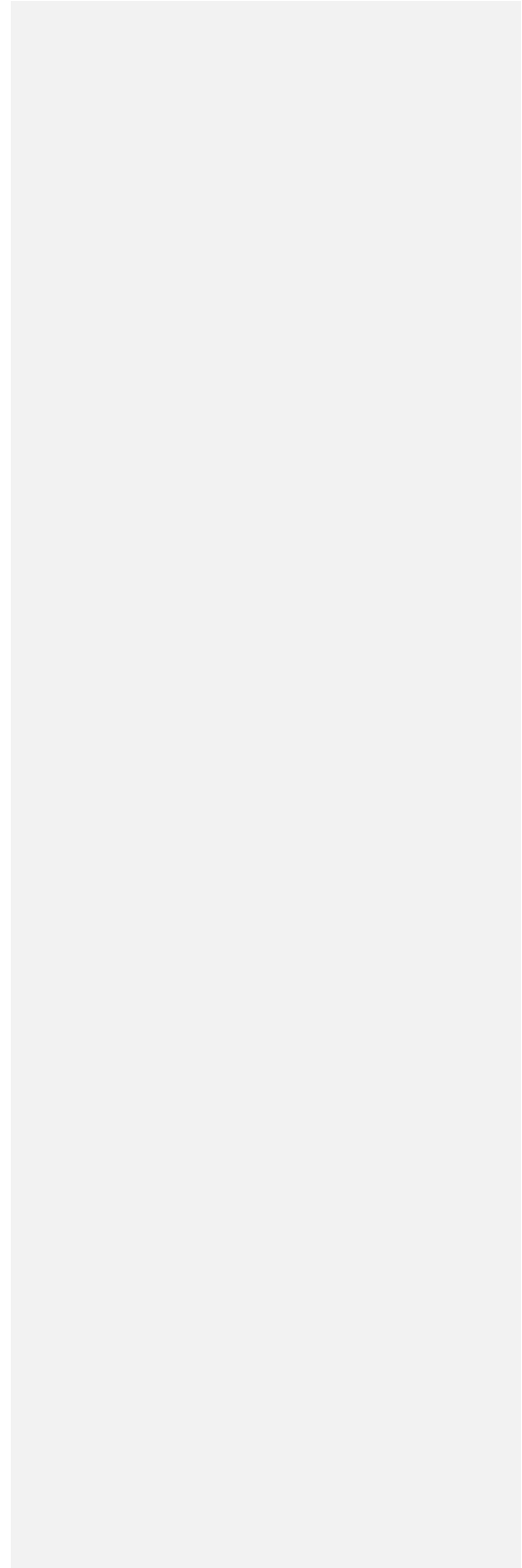
#### [Standards of Practice for Occupational Therapy](#)

AOTA states "The Occupational Therapy Code of Ethics and Ethics Standards (2010) ("Code and Ethics Standards") is a public statement of principles used to promote and maintain high standards of conduct within the profession."

#### [Occupational Therapy Code of Ethics and Ethics Standards](#)

Additional guidance regarding the distinction between the roles and responsibilities of occupational therapists and occupational therapist assistants has been developed by AOTA.

[Guidelines for Supervision, Roles and Responsibilities During the Delivery of Occupational Therapy Services \(edited 2009\)](#)



## **Physical Therapy Professional Standards**

Professional standards for physical therapy developed by the American Physical Therapy Association (APTA) include the *Standards of Practice for Physical Therapy (2013)*, the *Code of Ethics for the Physical Therapist (2009)* and the *Standards of Ethical Conduct for the Physical Therapist Assistant (2009)*.

APTA states the *Standards of Practice for Physical Therapy* “are the profession’s statement of conditions and performances that are essential for provision of high-quality professional service to society, and they provide a foundation for assessment of physical therapist practice.”

### [Standards of Practice for Physical Therapy](#)

APTA states the *Code of Ethics for Physical Therapists* “delineates the ethical obligations of all physical therapists as determined by the House of Delegates of the American Physical Therapy Association (APTA).” (2009)

### [Code of Ethics for the Physical Therapist](#)

APTA states the *Standards of Ethical Conduct for the Physical Therapist Assistant* “delineate the ethical obligations of all physical therapist assistants as determined by the House of Delegates of the American Physical Therapy Association (APTA). The Standards of Ethical Conduct provide a foundation for conduct to which all physical therapist assistants shall adhere.” (2009)

### [Standards of Ethical Conduct for the Physical Therapist Assistant](#)

APTA states that *Guidelines: Physical Therapy Documentation of Patient/Client Management* do not reflect all of the unique documentation requirements associated with the many specialty areas within the physical therapy profession. Applicable for both hand written and electronic documentation systems, these guidelines are intended to be used as a foundation for the development of more specific documentation guidelines in clinical areas, while at the same time providing guidance for the physical therapy profession across all practice settings. Documentation may also need to address additional regulatory or payer requirements.” (2014)

### [Guidelines: Physical Therapy Documentation](#)

## **ADDITIONAL FEDERAL REGULATIONS AND STATE RULES RELEVANT TO OCCUPATIONAL THERAPY AND PHYSICAL THERAPY**

### **Individuals with Disabilities Education Act (IDEA)**

Individuals with Disabilities Education Act (IDEA) is the federal law that describes the provision of educational services for children with disabilities. It requires school districts to provide free, appropriate public education (FAPE) that includes special education and related services to all eligible children with disabilities. It also defines the requirements for identifying children suspected of having a disability and the process of implementing special education service. The federal education laws and regulations provide the basis for the state education laws and regulations. State laws and regulations cannot be more restrictive than federal laws.

The following terms are defined at a Federal and State Level. In some cases Minnesota State Law has a definition that is separate and must also be considered.

**Special Education (34 C.F.R. 300.39)** - Special education means specially designed instruction, at no cost to the parents, to meet the unique needs of a child with a disability including:

- a. instruction conducted in the classroom, in the home, in hospitals and institutions, and in the other settings; and
- b. instruction in physical education.

The term includes speech language pathology services, or any other related service, if the service is considered special education rather than a related service under state standards. (This gives states the Federal authority to determine if a related service would be considered a primary special education service in their state.)

The term also includes travel training and vocational education.

**Special Education (M.R. 3525.0210 subp. 42)** - Special education means any specially designed instruction and related services to meet the unique cognitive, academic, communicative, social and emotional, motor ability, vocational, sensory, physical, or behavioral and functional needs of a pupil as stated in the IEP.

**Regular Education (M.R. 3525.0210 subp.38)** - Regular education means the program in which the pupil would be enrolled if the pupil did not have disabilities.

## **Related Services Definitions**

Occupational therapy and physical therapy are defined by federal law (IDEA) as related services for Part B and as early intervention services for Part C. Part B of IDEA provides for special education services for children with disabilities ages 3 through 21. Part C of IDEA provides for comprehensive interagency, early intervention services for infants and toddlers with disabilities and their families. Occupational therapy and physical therapy have separate definitions in Part B and Part C of IDEA. Minnesota law defines occupational therapy and physical therapy as related services for Parts B and C.

**Related Services (34 C.F.R. 300.34)** - means transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. Related services also include school health services and school nurse services, social work services in schools, and parent counseling and training.

**Occupational Therapy (34 C.F.R. 300.34)** - means services provided by a qualified occupational therapist; and includes improving, developing or restoring functions impaired or lost through illness, injury, or deprivation; improving ability to perform tasks for independent functioning if functions are impaired or lost; preventing, through early intervention, initial or further impairment or loss of function.

**Physical Therapy (34 C.F.R. 300.34)** - means services provided by a qualified physical therapist.

**Occupational Therapy for Infant or Toddler (34 C.F.R. 303.13)** - includes services to address the functional needs of a child related to adaptive development, adaptive behavior, and play, and sensory, motor, and postural development. These services are designed to improve the child's functional ability to perform tasks in home, school, and community settings, and include:

- a. identification, assessment, and intervention;
- b. adaptation of the environment, and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills; and
- c. prevention or minimization of the impact of initial or future impairment, delay in development, or loss of functional ability.

**Physical Therapy for Infant or Toddler (34 C.F.R. 303.13)** - includes services to address the promotion of sensorimotor function through the enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardio-pulmonary status, and effective environmental adaptation. These services include:

- a. screening, evaluation, and assessment of infants and toddlers to identify movement dysfunction;
- b. obtaining, interpreting, and integrating information appropriate to program planning to prevent, alleviate, or compensate for movement dysfunction and related functional problems; and
- c. providing individual and group services or treatment to prevent, alleviate, or compensate for movement dysfunction and related functional problems.

## **Related Services Definitions**

### **Interpretation/Implications for Therapists:**

In Minnesota, a related service is not a primary special education service. In order for a student to receive occupation therapy or physical therapy, he/she must be identified as a special education student and both demonstrate a need for special education instruction and demonstrate a need for supplementary/complementary support services. These services must relate to primary educational goals. The team just determine that without the expertise of the therapist as a team member, a student could not achieve the goals and objectives of the IEP.

It should be noted, however, that in the birth to three population, the student's primary needs might be in the motor area. While the occupational or physical therapist may be the primary provider of educational service, the goals and objectives still must relate to the child's functional needs that affect the child's development and learning.

Refer to the INTEGRATION chapter for more information on this topic.

## **Assistive Technology Definitions**

**Assistive technology service (34 C.F.R. 300.6 and 303.13)** - means any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. Such term includes:

- a. the evaluation of the needs of such child with a disability, including a functional evaluation of the child in the child's customary environment;
- b. purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities;
- c. selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;
- d. coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;
- e. training or technical assistance for a child with a disability, or, if appropriate, that child's family; and



- f. training or technical assistance for professionals (including individuals providing education or rehabilitation services), employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of children with disabilities.

**Assistive technology device (34 C.F.R 300.5 and 303.13)** - means any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of children with disabilities. The term does not include a medical device that is surgically implanted, or the replacement of such device.

### **Assistive Technology**

#### **Interpretation for/Implications for Therapists:**

IDEA requires student planning teams to consider whether assistive technology devices or services are needed for all students with disabilities.

The school district is responsible for providing access to and training for, but not necessarily purchasing, assistive technology devices and services when the IEP/IFSP team determines it is necessary for the student to benefit from free and appropriate public education (FAPE.) Therapists are involved in evaluation, selection, providing for acquisition, adaptation and maintenance, training, and technical assistance in connection with assistive devices.

Refer to the INTEGRATION chapter for more information on this topic.

### **Travel Training Definition**

**Travel Training (34 C.F.R. 300.39(b)(4))** - means providing instruction, as appropriate, to children with significant cognitive disabilities, and any other children with disabilities who require this instruction, to enable them to: develop and awareness of the environment in which they live; and learn the skills necessary to move effectively and safely from place to place within that environment (e.g. in school, in the home, at work, and in the community).

### **Travel Training**

#### **Interpretation/Implications for Therapists:**

IDEA defines travel training as separate from orientation and mobility, and requires IEP/IFSP teams to consider whether travel training is needed for all students with disabilities. Therapists are involved in evaluation and services related to travel training.

## **Third-party Billing**

### **Methods of ensuring services (34 C.F.R. 300.154)**

(a) Establishing responsibility for services. The Chief Executive Officer of a State or designee of that officer must ensure that an interagency agreement or other mechanism for interagency coordination is in effect between each noneducational public agency described in paragraph (b) of this section and the SEA, in order to ensure that all services described in paragraph (b)(1) of this section that are needed to ensure FAPE are provided, including the provision of these services during the pendency of any dispute under paragraph (a)(3) of this section. The agreement or mechanism must include the following:

(1) An identification of, or a method for defining, the financial responsibility of each agency for providing services described in paragraph (b)(1) of this section to ensure FAPE to children with disabilities. The financial responsibility of each noneducational public agency described in paragraph (b) of this section, including the State Medicaid agency and other public insurers of children with disabilities, must precede the financial responsibility of the LEA (or the State agency responsible for developing the child's IEP).

(2) The conditions, terms, and procedures under which an LEA must be reimbursed by other agencies.

(3) Procedures for resolving interagency disputes (including procedures under which LEAs may initiate proceedings) under the agreement or other mechanism to secure reimbursement from other agencies or otherwise implement the provisions of the agreement or mechanism.

(4) Policies and procedures for agencies to determine and identify the interagency coordination responsibilities of each agency to promote the coordination and timely and appropriate delivery of services described in paragraph (b)(1) of this section.

(b) Obligation of noneducational public agencies.

(1) (i) If any public agency other than an educational agency is otherwise obligated under Federal or State law, or assigned responsibility under State policy or pursuant to paragraph (a) of this section, to provide or pay for any services that are also considered special education or related services (such as, but not limited to, services described in §300.5 relating to assistive technology devices, §300.6 relating to assistive technology services, §300.34 relating to related services, §300.41 relating to supplementary aids and services, and §300.42 relating to transition services) that are necessary for ensuring FAPE to children with disabilities within the State, the public agency must fulfill that obligation or responsibility, either directly or through contract or other arrangement pursuant to paragraph (a) of this section or an agreement pursuant to paragraph (c) of this section.

(ii) A noneducational public agency described in paragraph (b)(1)(i) of this section may not disqualify an eligible service for Medicaid reimbursement because that service is provided in a school context.

## **The Family Educational Rights and Privacy Act (FERPA)**

The Family Educational Rights and Privacy Act (20 U.S.C. 1232 g) protects the privacy of student education records. The law applies to any school that receives funds from the Department of Education. The Act gives parents or eligible student rights including the right to inspect and review the student's education records; to request an amendment of the records to ensure that they are accurate, not misleading, or otherwise in violation of the student's privacy or other rights; and to know who, besides the parents and authorized school personnel, has access to this information. FERPA allows disclosure of information to other school officials within the agency or institution, including teachers, who have been determined to have legitimate educational interests. The U.S. Department of Education has developed a side-by-side comparison of IDEA and FERPA confidentiality requirements that may be helpful for therapists and administrators ([IDEA and FERPA Confidentiality Provisions](#)).

## **The Health Insurance and Accountability Act (HIPAA): Privacy Rule**

The Health Insurance Portability and Accountability Act (P. L. 104-191) of 1996 protects health insurance coverage for workers and their families when they change or lose their jobs. In enacting HIPAA Congress mandated the establishment of standards for the privacy of individually identifiable health information. The Standards for Privacy of Individually Identifiable Health Information (the Privacy Rule) provides the first comprehensive federal protection for the privacy of health information.

The Standards for Privacy of Individually Identifiable Health Information is the final rule that implements the privacy provisions of the HIPAA and sets forth complex limitations of the use of individually identifiable health information by most health care providers, plans and clearing houses. This rule does not apply to educational records covered by the Family Education Rights and Privacy Act (FERPA), including those education records designated as education records under Parts B, C, and D or the Individuals with Disabilities Education Act (IDEA) unless the activities performed are considered "covered transactions" under HIPAA. Covered transactions includes electronic submission of health information for reimbursement which includes submission for third-party billing.

## **FERPA/HIPPA**

### **Interpretations/Implications for Therapists:**

FERPA protects the privacy of education records while the Health Insurance Portability and Accountability Act (HIPAA) protects the privacy of health information. Generally, schools are exempt from HIPAA requirements and are covered by FERPA requirements however there are situations in which schools/therapists are required to meet HIPAA. If a school performs activities defined as "covered transactions" the school becomes a covered entity of HIPAA and is required to meet its standards.

Therapists need to obtain signed parent permission for exchange of information with any outside agency, such as medical facilities, physicians, therapists, and county agencies. Permission needs to be renewed yearly and the parents have the right to rescind this permission at any time.

### **Section 504 of the Rehabilitation Act**

Section 504 of the Rehabilitation Act of 1973, with amendments in 1986, is a civil rights law protecting the rights of individuals of all ages with disabilities participating in programs that receive federal financial assistance from the U.S. Department of Education. Section 504 defines a person with a disability as "any person who has a physical or mental impairment which substantially limits one or more of the major life activities, has a record of such impairment, or is regarded as having such impairment," [34 C.F.R 104.3(j)(1)]. Students whose disability does not adversely affect their educational performance but substantially limits one or more major life activities may be eligible for accommodations under Section 504. Therapists may be involved to determine needs and provide reasonable accommodations as defined by the 504 plan. It is the responsibility of school districts to meet the needs of these students through general education. Special education funding should not be used to support this program.

### **The Americans with Disabilities Act (ADA)**

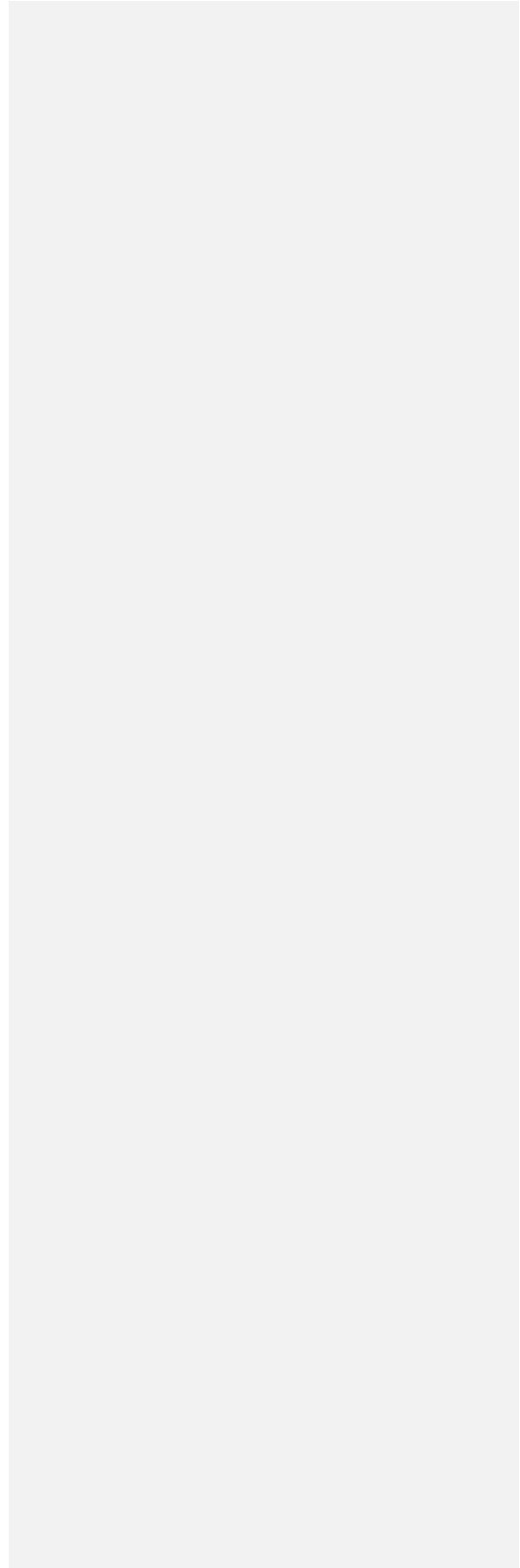
The Americans with Disabilities Act (42 U.S.C. 12101) is a civil rights law protecting the rights of individuals of all ages with disabilities participating in public and private programs unlike Section 504 of the Rehabilitation Act which only applies to public programs. The definition of a person with a disability is the same for ADA and Section 504 of the Rehabilitation Act. Therapists need to be aware of the need for reasonable accommodations in all community, vocational, and postsecondary sites for students with disabilities.

### **The Assistive Technology Act (ATA)**

The Assistive Technology Act of 1998 (P.L. 105-394) affirms that technology is a valuable tool that can be used to improve the lives of individuals with disabilities. The Act supports state wide technology programs and strengthens the capacity of each state to address the assistive technology needs of individuals with disabilities.

States are required to conduct the following activities: support public awareness programs; promote interagency coordination; provide technical assistance and training; and provide outreach support to community-based organizations that provide assistive devices or services.

**THERAPIST NOTES**



## **THE INTEGRATION OF OCCUPATIONAL THERAPY AND PHYSICAL THERAPY INTO SPECIAL EDUCATION**

The roles of the occupational therapist and physical therapists serving schools are evolving and expanding. In addition to responsibilities associated with and defined by special education due process, a therapist may be instrumental in providing services that have relevance in a general education capacity.

The content of this chapter has increased substantially to include specific (although not comprehensive) language found in federal and state law and other language from resources and technical assistance documents provided by the Minnesota Department of Education (MDE). Including this information is intended to align with current MDE practice of citing legislation affecting a district's responsibilities for educating children. It is also an effort to consolidate sources of information relevant to defining and clarifying the role of the occupational therapist and physical therapist in schools. The content of this chapter is current and accurate to the date of this publication. The reader is advised to check current legislation and the MDE website for the most recent updates in information. In addition, local district due process policies and procedures should be considered.

This chapter contains extensive information, resources and documents that MDE and the Division of Compliance and Assistance has developed for purposes of providing general help to the public, and to assist school districts and parents who have raised questions about various topics. The content does not include a complete rendition of applicable state and federal law. It does not constitute legal advice, should not be relied on as a comprehensive or definitive response to specific legal situations, nor should it be regarded as substitute for consulting with a licensed attorney.

To benefit the most from this chapter, the reader should recognize the organization of the information presented:

- aspects of general education involvement relative to the interests and roles of a school therapist have been included;
- content is organized according to special education due process from early identification, evaluation, IFSP/IEP development, to dismissal,
- citation of federal and state legislation is noted in italic text,
- within topic areas, differences or variations in information relative to in Part C (Infants & Toddlers) and Part B (ages 3 to 21) services have been noted/labeled separately;
- interpretation/implication sections further describe or illustrate how therapy services are integrated into the systems;
- electronic links/web addresses for sources of technical assistance language and documents from the MDE website have been provided throughout this chapter of the manual;

## **ALTERNATIVE INTERVENTION SERVICES**

A school district shall use alternative intervention services, including the assurance of mastery program under Minnesota Statutes, section 124D.66, or an early intervening services program under Subdivision 2 to serve at-risk pupils who demonstrate a need for alternative instructional strategies or interventions. [Minn. Stat. § 125A.56(b)]

An LEA may not use more than 15 percent of the amount the LEA receives under Part B of the Act for any fiscal year, less any amount reduced by the LEA pursuant to § [300.205](#), if any, in combination with other amounts (which may include amounts other than education funds), to develop and implement coordinated, early intervening services, which may include interagency financing structures, for students in kindergarten through grade 12 (with a particular emphasis on students in kindergarten through grade three) who are not currently identified as needing special education or related services, but who need additional academic and behavioral support to succeed in a general education environment.  
[34 C.F.R. 300.226]

### **Coordinated Early Intervening Services (CEIS)**

Coordinated Early Intervening Services (CEIS) is defined as assistance given to students who haven't been identified yet as needing special education and related services, but who may need additional support to succeed in general education environment.

The Coordinated Early Intervening Services (CEIS) Plan is a narrative describing the local education agency's (LEA) plan for implementing coordinated, early intervening services for students K-12 with an emphasis on students in kindergarten through grade three who are not identified as needing special education or related services and do not have an Individual Education Program (IEP) but who need additional academic or behavioral support to succeed in general education environment [34 C.F.R. 300.226]. The plan should describe activities needed to implement the LEA's.

### **Response to Intervention (RtI)**

A growing body of information and resources addressing RtI is available. Although use of this term is becoming more prevalent, there is no federal or state legislative language that specially mandates that districts use the framework of RtI as part of their coordinated early intervening services. RtI is not used to replace a district's responsibility to determine and provide comprehensive evaluation of children who may be in need of special education, but rather, it can be an effective model in meeting the educational needs of all children.

Information regarding RtI that is available from the MN Department of Education is as follows:

Response to Intervention (RtI) is a framework that is used to improve outcomes for all students. RtI helps to ensure the provision of high-quality instruction and interventions that are matched to the needs of students requiring additional academic and behavioral supports. After initial screening of all students, changes in instruction or goals can be made according to the level of student need. Student progress is monitored frequently and instruction is then differentiated and modified, as necessary (adapted from NASDSE, 2005).

The Department (MDE) is learning more about integrating continuums of support across academic, behavioral, social-emotional, and physical health domains using the RtI framework, and will share that knowledge through division staff as they work with districts and schools.

## **Universal Design**

Universal Design for Learning (UDL) is a framework for curriculum development that promotes equity and equal access to learning for the widest possible range of students throughout their entire 13-year school experience. Schools implementing UDL do this by increasing access to learning for all students and providing more ways for students to participate and demonstrate their learning. The goal of UDL is to reduce barriers to learning and increase the knowledge, skills and enthusiasm for learning that children need to be successful after graduation without reducing academic rigor.

UDL provides a blueprint for creating instructional goals, methods, materials and assessments that gives all students the opportunity to learn and meet high academic standards. UDL coordinates with a variety of initiatives, including integrated units; multi-sensory teaching; multiple intelligences; differentiation of goals, methods, materials, assessment, and instruction in curriculum/lesson planning; technology integration; one-to-one device projects; and performance-based assessments.

Efficiency is also a benefit of UDL. Incorporating the critical components of UDL, which are supported in the Minnesota English Language Arts (ELA) Common Core Standards, will ultimately save schools and districts time and money. Building in differentiation during lesson development reduces the amount of time teachers need to differentiate instruction in general and increases accountability.

Administrators should assess the extent to which current standards have been universally designed at their sites so that their curricular and instructional choices follow UDL principles as ELA Common Core Standards are implemented.

Universal design has the meaning given the term in section 3 of the Assistive Technology Act of 1998, as amended, 29 U.S.C. 3002. [34 C.F.R. 300.44]

(19) Universal design. The term “universal design” means a concept or philosophy for designing and delivering products and services that are usable by people with the widest possible range of functional capabilities, which include products and services that are directly accessible (without requiring assistive technologies) and products and services that are interoperable with assistive technologies. [29 U.S.C. 3002]



## **Alternative Intervention Services**

### **Interpretation/Implications for Therapists:**

Therapists should be aware of alternative intervention conversations and efforts where the terms Response to Intervention (RtI) and Universal Design for Learning (UDL) are being used. Therapists have specialized training and skills in interventions and supports that can benefit the function of children in schools, not only for children who are identified as having disabilities, but also for the population of general education learners, particularly those who may be considered struggling or at-risk. RtI and UDL are systems of support to children that would result in a broader role for the therapist in both general education and special education capacity.

Within their special education role, a primary function of the therapist is collaboration. Service aimed at supporting the function of a child in their classroom, rather than using a pull out service delivery model, helps teachers acquire the knowledge and skills they need to promote the child's access and response to learning activities. Therapists also utilize progress monitoring and data-based decision making as critical components of their special education service delivery. All these functions are also applicable and essential to the role a therapist may assume in providing services within a general education alternative intervention context.

A therapist functioning in this capacity may work with individual teacher to help them enhance their competencies in promotion success of a particular student who is struggling/at-risk. In addition, the therapist should consider how their knowledge base can be shared on a larger scale through district/school wide staff development opportunities.

Inservice/training events or other forms of information sharing, can be provided by a therapist to help teacher groups build their capacity to address common concerns or problems seen among clusters of students.

A therapist could also be involved with general education curriculum development committees to help a district identify where areas of instructional deficiency exist. The therapist may be able to suggest ways to incorporate universal design or use additional/alternative instruction strategies or interventions within regular curriculum. These types of efforts would be design to impact the effectiveness of general education, and may help reduce inappropriate or excessive referrals to special education.

A therapist should review expectations and workload responsibilities with their special education supervisor/administrator to determine what portion of their work time may be allocated to these types of general education support.

Additional information and resources on this topic is available from MDI and is posted at these links/web addresses:

Response to Intervention (RtI):  
<http://education.state.mn.us/MDE/EdExc/BestPrac/Resplnterv/>

Universal Design for Learning (UDL) /

<http://education.state.mn.us/MDE/EdExc/StandImpIToolkit/Installation/Efec/CoreInstruc/CriticalComp/>

## IDENTIFICATION

**Identification** means the continuous and systematic effort by the district to identify, locate, and screen students, birth through age 21, who may need special education services. Identification encompasses the district's public awareness efforts within the community; efforts to identify children in private schools; and comprehensive child find efforts that include programs to identify homeless and migratory children and children who may need special education even though they are advancing from grade to grade.

Each district must develop a comprehensive identification system that identifies students with disabilities from birth; students with disabilities attending both public and nonpublic schools; and students of school age who are not attending school. This identification system must be included in the district's TSES (Total Special Education System) Manual.

*A district shall submit to the commissioner the district's plan for providing instruction and related services upon request for all pupils as required by Minnesota Statutes, sections 125A.03 to 125A.24. The plan may be for a single district or for the member districts of a formal special education cooperative. The plan shall be considered as part of the annual school district application for program review, but will not be required to be resubmitted annually. If a cooperative changes administrative organization, it shall submit a revised plan. The new plan must be submitted before the beginning of the next school year. The plan shall include descriptions of the district's Child study procedures for the identification and evaluation of students or other persons suspected of having a disability beginning at birth that include a plan for receiving referrals from parents, physicians, private and public programs, and health and human services agencies. [Minn. R. 3525.1100, subp. 2(A)]*

*A school district, group of districts, or special education cooperative, in cooperation with the health and human service agencies located in the county or counties in which the district or Identification Standards cooperative is located, must establish an Interagency Early Intervention Committee for children with disabilities under age five and their families under this section, and for children with disabilities ages three to 22 consistent with the requirements under Minnesota statutes, sections 125A.023 and 125A.027. Committees must include representatives of local health, education, and county human service agencies, county boards, school boards, early childhood family education programs, Head Start, parents of young children with disabilities under age 12, child care resource and referral agencies, school readiness programs, current service providers, and may also include representatives from other private or public agencies and school nurses. The committee must elect a chair from among its members and must meet at least quarterly. [Minn. Stat. § 125A.30(a)]*

## Identification

### Interpretation/Implications for Therapists:

A school district is required to have a documented plan (TSES Manual) that addresses their responsibilities and the associated procedures for finding children, birth through age 21, in public and non-public schools, and in the community, who may need special education services. Occupational therapists and physical therapists should be familiar with a district's TSES manual, and have understanding of child study procedures, and plans for receiving referrals from parents and partner in the community, as included therein.

Because of their knowledge of development and health/medical conditions, therapists are able to help identify children exhibiting signs of impairment or deviation in function who may be in need of special education.

A therapist may be asked to participate in activities designed to survey the performance of a large number of children on a district wide basis, (e.g. early childhood screening, Kindergarten round up), or to consult with/train other school personnel who perform these duties.

Additional information on this topic is available from MDE and is posted at these links/web addresses:

Early Childhood Screening /

<http://education.state.mn.us/MDE/StuSuc/EarlyLearn/EarlyChildScreen/index.html>

Identification Standards /

[http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&DocName=048250&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&DocName=048250&RevisionSelectionMethod=latestReleased&Rendition=primary)

Commented [LW1]:

Commented [LW2]: REVIEW THIS LINK: We could not make it work and had to frame of reference to copy the exact link. Reminder: cut/paste made the original text box reappear so we had to rekey anything that was in a text box in this document.

## Screening

Part C/Infants & Toddlers: (An optional response to a referral)

Part C federal regulations require a prior written notice to be given to parents for screening procedures.

Section 303.320 of the final regulations of the Individuals With Disabilities Education Act Part C: Early Intervention Program for Infants and Toddlers With Disabilities, defines screening as activities carried out by, or under the supervision of, the lead agency or an early intervention service provider to identify, at the earliest possible age, infants and toddlers suspected of having a disability and in need of early intervention services; and includes the administration of appropriate instruments by personnel trained to administer those instruments. This section adds new screening procedures and confirms that such screening procedures are not required under the Act; rather, using

screening procedures is an option that a state may choose to include as a part of its comprehensive child find system.

Screening is included as a “core early intervention service” in Minnesota Statutes, section 125A.27(3).

Based on information available at or immediately following the referral of a child to a local Part C program, the program may determine eligibility based on a review of medical or other records, propose an initial evaluation, or propose to [screen a child referred to the part C](#) program to determine whether they are suspected of having a disability.

Screenings conducted in response to a referral must follow these guidelines:

1. Screening must include the administration of appropriate instruments by personnel trained to administer those instruments.
2. Prior written notice (PWN) must be provided to the parent that includes all requirements of a Part C prior written notice and explains the right of the parent to request an evaluation at any point during the screening process.
3. Written consent must be obtained from the parent before screening a child.
4. The district must take appropriate action based on the results of the screening. Actions may include:
  - a. If the child is suspected of having a disability, provide a prior written notice to propose an initial evaluation. Once parental consent is obtained, an evaluation and assessment of the child must be conducted.
  - b. If the child is not suspected of having a disability, provide notice of that determination to the parent. That prior written notice must describe the parent's right to request an evaluation.
5. If the parent of the child requests and consents to an evaluation at any time during the screening process, evaluation of the child must be conducted, even if the early intervention program has determined the child is not suspected of having a disability.

## SCREENING/EVALUATION PART C

### Interpretation/Implications for Therapists:

For children from birth to age three, screening procedures may be used by a district for purposes of determining whether a child is suspected of having a disability. Screening is not necessary when a district already suspects a child has a disability, in which case, evaluation and assessment are then required. As members of special education teams responsible for children birth to age 3, a therapist must follow current requirements for providing Prior Written Notice and securing written parental consent prior to screening a child.

Following screening procedures, the team then determines that results indicate no suspicion of disability or need to evaluate, or that further evaluation and assessment is needed. In either case, the parent is again provided Prior Written Notice that reflects: a) child is not eligible for Part C services, or b) the plan for conducting assessment to determine the child's needs and eligibility for Part C services.

Additional information and resources on this topic is available from MDE and it posted at these links/web addresses:

[Early Childhood Special Education /  
http://education.state.mn.us/MDE/EdExc/EarlyChildRes/EarlyChildSpecEd/](http://education.state.mn.us/MDE/EdExc/EarlyChildRes/EarlyChildSpecEd/)

[Screening: An optional response to a referral to Minnesota's Early Intervention System /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=047021&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=047021&RevisionSelectionMethod=latestReleased&Rendition=primary)

[MNCIMP: SC Record Review Training - Part C Notification /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=051947&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=051947&RevisionSelectionMethod=latestReleased&Rendition=primary)

[MNCIMP: SR Record Review Training - Part C Evaluation, Eligibility and Assessment /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=051945&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=051945&RevisionSelectionMethod=latestReleased&Rendition=primary)

#### Part B:

*The screening of a student by a teacher or specialist to determine appropriate instructional strategies for curriculum implementation shall not be considered to be an evaluation for eligibility for special education and related services. [34 C.F.R. 300.302] [20 U.S.C. 1414(a)(1)(E)]*

*As part of an initial evaluation (if appropriate) and as part of any reevaluation under this part, the IEP Team and other qualified professionals, as appropriate, must (1) Review existing evaluation data on the child, including (i) Evaluation and information provided by the parents of the child; (ii) Current classroom-based, local, or State assessments,*

*and classroom-based observations; and (iii) Observations by teachers and related services providers. [34 C.F.R. § 300.305(a)(1)]*

*(1) Parental consent is not required before (i) Reviewing existing data as part of an evaluation or a reevaluation; or (ii) Administering a test or other evaluation that is administered to all children unless, before administration of that test or evaluation, consent is required of parents of all children.  
[34 C.F.R. § 300.300(d)(1)]*

## **Screening-Part B**

### **Interpretation/Implications for Therapists:**

It may be helpful for a therapist to screen a child as part of a pre-evaluation review prior to evaluation planning. This may help the child study team to verify and clarify concerns surrounding the student, justify further involvement of the therapist if the need for evaluation is determined, or may allow the therapist to help circumvent the need for special education evaluation by providing in-service information or general suggestions to the classroom teacher as an effective pre-referral intervention.

A therapist may be asked to informally observe a student. These observations may be considered screening and take place prior to or as part of a pre-referral review process. When screening a school aged child, it is not appropriate for a therapist to remove the child from class or administer isolated procedures/activities to solicit responses from the child, in order to gather information about the child. A therapist may, however, collaborate with a classroom teacher to design an activity in the classroom or other relevant school setting that would allow a therapist to observe a child's performance within the group as it relates to his/her peers. Visual examination of class work samples or a child's functional mobility may also provide relevant screening information. Although Prior Written Notice and signed parent consent is not required for these screening activities, the therapist should ensure that communication between the child's parent and teachers regarding the rationale for screening has occurred. The therapist must maintain confidentiality practices and may not have access to student specific information (e.g. file review, other student specific data) prior to participating in a pre-referral review by the child study team.

MN rules governing OT service specify that the occupational therapist is responsible for all duties delegated or tasks assigned to the occupational therapy assistant. These therapy assistants may participate in screening and pre-referral support activities, however the supervising occupational therapist should assure their service competencies in these areas. According to the Physical Therapist Practice Act, physical therapist assistants may not participate in screening procedures.



### **Pre-Referral Interventions: Part B**

Before a pupil is referred for a special education evaluation, the district must conduct and document at least two instructional strategies, alternatives, or interventions using a system of scientific, research-based instruction and intervention in academics or behavior, based on the pupil's needs, while the pupil is in the regular classroom. The pupil's teacher must document the results. A special education evaluation team may waive this requirement when it determines the pupil's need for the evaluation is urgent. This section may not be used to deny a pupil's right to a special education evaluation. [Minn. Stat. § 125A.56(a)]

### **Pre-Referral Interventions - Part B**

#### **Interpretation/Implications for Therapists:**

As a result of screening, or as part of pre-referral review by the child study team, a therapist may be a resource in providing instructional strategies, alternatives and interventions designed to assist others in supporting the student, prior to determining the need for special education evaluation. Suggestions or materials provided should be general in nature and easily implemented by the parent/care givers, classroom teacher, and other educational support staff when appropriate. Due to the level of informal involvement at this stage, it would be inappropriate for the therapist to provide a written, individualized program of interventions for the child. However, informational handouts on select topics of inservice or additional readings/resources may be an efficient means of providing information that is helpful to others. The time a therapist spends in pre-referral support activities should be monitored and balanced against the array of other duties/responsibilities that are allocated and accounted for as special education service.

### **Referral**

Referral is a formal, ongoing process for receiving and responding to referrals when a student shows signs of potential need for special education and related services. The referral process includes district review of screening and other information on referred students, and the district's decision about whether to conduct a formal special education evaluation.

*The district's child study procedures must include a plan for receiving referrals. Those child study procedures must be included in the district's TSES Manual. [Minn. R. 3525.1100, subp. 2(A)]*

*Notwithstanding any age limits in laws to the contrary, special instruction and services must be provided from birth until July 1 after the child with a disability becomes 21 years old but shall not extend beyond secondary school or its equivalent, except as provided in Minnesota Statutes, section 124D.68, Subd. 2. Local health, education, and social service agencies must refer children under age five who are known to need or suspected of needing special instruction and services to the school district. Districts with*

*less than the minimum number of eligible children with a disability as determined by the commissioner must cooperate with other districts to maintain a full range of programs for education and services for children with a disability. This section does not alter the compulsory attendance requirements of Minnesota Statutes, section 120A.22. [Minn. Stat. § 125A.03(b)]*

*The [Interagency Early Intervention Committee] must develop and implement interagency policies and procedures concerning the following ongoing duties: (3) establish and evaluate the identification, referral, child and family assessment systems, procedural safeguard process, and community learning systems to recommend, where necessary, alterations and improvements. [Minn. Stat. § 125A.30 (b)(3)]*

## **Part C/Infants & Toddlers: Initial Referral**

*(a) General. (1) The lead agency's child find system described in Code of Federal Regulations, title 34, section 303.302 must include the State's procedures for use by primary referral sources for referring a child under the age of three to the part C program. (2) The procedures required in paragraph (a)(1) of this section must (i) Provide for referring a child as soon as possible, but in no case more than seven days, after the child has been identified; and (ii) Meet the requirements in paragraphs (b) and (c) of this section. (b) Referral of specific at-risk infants and toddlers. The procedures required in paragraph (a) of this section must provide for requiring the referral of a child under the age of three who (1) Is the subject of a substantiated case of child abuse or neglect; or (2) Is identified as directly affected by illegal substance abuse or withdrawal symptoms resulting from prenatal drug exposure. [34 C.F.R. § 303.303(a)-(b)]*

*Primary referral sources include: Hospitals, including prenatal and postnatal care facilities; Physicians; Parents, Child care programs and early learning programs; Local Educational Agencies and schools; Public health facilities; Other public health or social service agencies; Other clinics and health care providers; Public agencies and staff in the child welfare system, including child protective service and foster care; Homeless family shelters; and Domestic violence shelters and agencies. [34 C.F.R. § 303.303(c)]*

## **Referral**

### **Interpretation/Implications for Therapists:**

Therapists need to be aware of their district's plan and protocols/procedures for responding to referrals for children suspected of having a disability. Referrals may be initiated by parents, the child's teacher, or other agencies/entities in the community.

If a parent makes a request for evaluation, either initial or reevaluation, the school district must ensure that evaluation is conducted. If parents specifically request that the evaluation include an occupational therapist and/or physical therapist, then these professionals automatically become members of the educational team in reviewing existing data and subsequently planning/conducting the evaluation.

Responding to referrals typically involves a team process where the involvement of various professionals is guided by their area of individual expertise/scope of practice that is relevant to the concerns presented about a child's performance and the areas of suspected disability.

For children birth to age three, occupational therapists and physical therapists function as members of a team of early childhood specialists who routinely meet to review new referrals received by the school district. The OT and/or PT collaborate with service coordinators and other team members to determine the parameters of their individual roles in the screening/evaluation process, and subsequent IFSP development and provision of services.

At the child study team level, a therapist may participate in the pre-evaluation review for select children/students. Through this process, a therapist is able to assist the team in identifying/further defining the child's educational problem and impact on school performance, assist the team in determining additional pre-referral interventions, and subsequently determine if the expertise of the therapist is needed as a part of evaluation planning.

Due to the itinerant role of most therapists, it may be unrealistic to expect their presence at all child study team meetings. It is therefore important for the therapist to communicate with building level teams regarding a method for determining when it may be appropriate to involve a therapist in a pre-evaluation review, as well as the most efficient means of informing the therapist of that need in a timely fashion. A therapist may not access student specific information (e.g. file review, other data) unless a referral/pre-evaluation review has been initiated.

Additional information on this topic is available from MDE and is posted at this link/web address:

[Referral Standards /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=048251&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=048251&RevisionSelectionMethod=latestReleased&Rendition=primary)

## EVALUATION / REEVALUATION

The Minnesota Department of Education Division of Compliance and Assistance provides training and extensive resources pertaining to the Evaluation/Re-evaluation process found at this website address:

<http://education.state.mn.us/MDE/EdExc/ProDev/SpecEdRecRev/>

### Pre-evaluation Review: Part B

After a referral is submitted and before conducting an evaluation, the team shall conduct a review of the child's/student's performance in the following areas: intellectual functioning, academic performance, communicative status, motor ability, vocational potential, sensory status, physical status, emotional and social development, behavior and functional skills. The referral review shall include a review of any additional screening, referral, or other data about the person and a review of the regular education-based pre-referral interventions.

The reevaluation process requires a review of existing evaluation data about the child. Based on that review and input from the child's parents, the team must identify what additional data, if any, are needed to determine whether the child continues to have a disability. The team must also identify the educational needs of the child; the present levels of academic achievement and related developmental needs of the child; whether the child continues to need special education and related services; and whether any additions or modifications to the special education and related services are needed to enable the child to meet the measurable annual goals set out in the individual education program (IEP) of the child and to participate, as appropriate, in the general education curriculum.

*As part of an initial evaluation, if appropriate, and as part of any reevaluation under this part, or a reinstatement under part 3525.3100, the IEP team and other qualified professionals, as appropriate, shall: 1) review existing evaluation data on the pupil, including evaluations and information provided by the parents of the pupil, current classroom-based assessments and observations, and teacher and related services providers observation; [Minn. R. 3525.2710, subp. 4]*

### Pre-evaluation Review

#### Interpretation/Implications for Therapists:

Prior to creating an evaluation plan, a pre-evaluation review is conducted by the child study team. This is done to consider educational concerns surrounding the child, analyze what is known about the child, and determine if additional information is needed

in order to more fully understand the child's function/educational needs, and their eligibility for special education.

For school aged children who have not been previously identified as a child with a disability (i.e. when considering initial evaluation/special education eligibility), an occupational therapist and/or physical therapist as related service providers would not generally be involved in a pre-evaluation review and subsequent evaluation planning. Instead, an OT and PT would work with building level child study teams to establish the conditions under which it is appropriate to request their involvement. An example is a child with no history of special education services who is demonstrating obvious problems in their physical/neurological function such that medical condition is suspected. In this situation, the therapist would become involved in the pre-evaluation review, serving as a resource for providing pre-referral interventions, and participating in the process of reviewing existing data/making decisions leading to subsequent planning of the initial evaluation.

Similarly, an OT or PT would not generally be involved in pre-evaluation review or subsequent evaluation planning for school aged children who require reevaluation, unless the student has not made satisfactory progress toward their educational goals, or new/additional concerns have arisen that the current educational team has not be able to address. Examples to illustrate when it is appropriate to solicit the therapist's involvement in a pre-evaluation review are: a student who has received written language/handwriting support from an SLD teacher but is no longer able to keep up with classroom writing assignments, or; a student who has received DAPE services, but is experiencing increased fatigue/difficulty in completing their personal fitness program in the weight room.

An occupational therapist or physical therapist would be involved in the pre-evaluation review process for all students undergoing reevaluation who have been receiving OT and PT services identified on their IEPs. This process provides opportunity for the educational team to engage in thoughtful consideration of the student's current performance in all areas, which is then the basis for developing an evaluation plan. The evaluation plan will reflect the areas of performance where the team has determined there is a need for additional information about the child, and the tools/procedures to be used to gather this additional information. This plan may also reflect areas of performance where there is no need for additional information, since the existing information known about the child is considered sufficient for purposes of identifying the child's educational needs and the supports/programming required to meet those needs. As part of the educational team, the OT and PT will determine through the pre-evaluation review, if they have sufficient information about the child's performance (existing data), or if they must administer assessment tools/procedures to more fully understand the child's function and their educational needs.

Additional information on this topic is available from MDE and is posted at this link/web address:

[Q&A: Reevaluations under Part B of IDEA /  
http://education.state.mn.us/MDE/SchSup/ComplAssist/QA/IEP/050232/](http://education.state.mn.us/MDE/SchSup/ComplAssist/QA/IEP/050232/)

### **Determining need for additional Data: Part B**

The reevaluation process requires a review of existing evaluation data about the child. Based on that review and input from the child's parents, the team must identify what additional data, if any, are needed to determine whether the child continues to have a disability. The team must also identify the educational needs of the child; the present levels of academic achievement and related developmental needs of the child; whether the child continues to need special education and related services; and whether any additions or modifications to the special education and related services are needed to enable the child to meet the measurable annual goals set out in the individual education program (IEP) of the child and to participate, as appropriate, in the general education curriculum.

*(1) Parental consent is not required before (i) Reviewing existing data as part of an evaluation or a reevaluation; or (ii) Administering a test or other evaluation that is administered to all children unless, before administration of that test or evaluation, consent is required of parents of all children. [34 C.F.R. § 300.300(d)(1)].*

*As part of an initial evaluation (if appropriate) and as part of any reevaluation under this part, the IEP Team and other qualified professionals, as appropriate, must (1) Review existing evaluation data on the child, including (i) Evaluation and information provided by the parents of the child; (ii) Current classroom-based, local, or State assessments, and classroom-based observations; and (iii) Observations by teachers and related services providers. [34 C.F.R. § 300.305(a)(1)] Prior to the completion of the evaluation process, the IEP team and any additional qualified professionals must determine if any additional data is needed to determine if a child is a child with a disability and to determine the educational needs of the student. [34 C.F.R. §300.305(a)(2)]*

*On the basis of that review, and input from the child's parents, identify what additional data, if any, are needed to determine (i)(A) Whether the child is a child with a disability, as defined in section 300.8, and the educational needs of the child; or (B) In case of a reevaluation of a child, whether the child continues to have a disability, and the educational needs of the child; (ii) The present levels of academic achievement and related developmental needs of the child; (iii)(A) Whether the child needs special education and related services; or (B) In the case of a reevaluation of a child, whether the child continues to need special education and related services; and (iv) Whether any additions or modifications to the special education and related services are needed to enable the child to meet the measurable annual goals set out in the IEP of the child and*

to participate, as appropriate, in the general education curriculum. [34 C.F.R. § 300.305(a)(2)]

**1. Additional Data Required:** *The public agency must administer such assessments and other evaluation materials as may be needed to produce the data identified under paragraph (a) of this section. [34 C.F.R. § 300.305(c)]*

**2. No Additional Data Required:** *(1) If the IEP Team and other qualified professionals, as appropriate, determine that no additional data are needed to determine whether the child continues to be a child with a disability, and to determine the child's educational needs, the public agency must notify the child's parents of (i) That determination and the reasons for the determination; and (ii) The right of the parents to request an assessment to determine whether the child continues to be a child with a disability, and to determine the child's educational needs. (2) The public agency is not required to conduct the assessment described in paragraph (d)(1)(ii) of this section unless requested to do so by the child's parents. [34 C.F.R. § 300.305(d)]*

#### **Determining the Need for Additional Data / Review of Existing Data Interpretation/Implications for Therapists:**

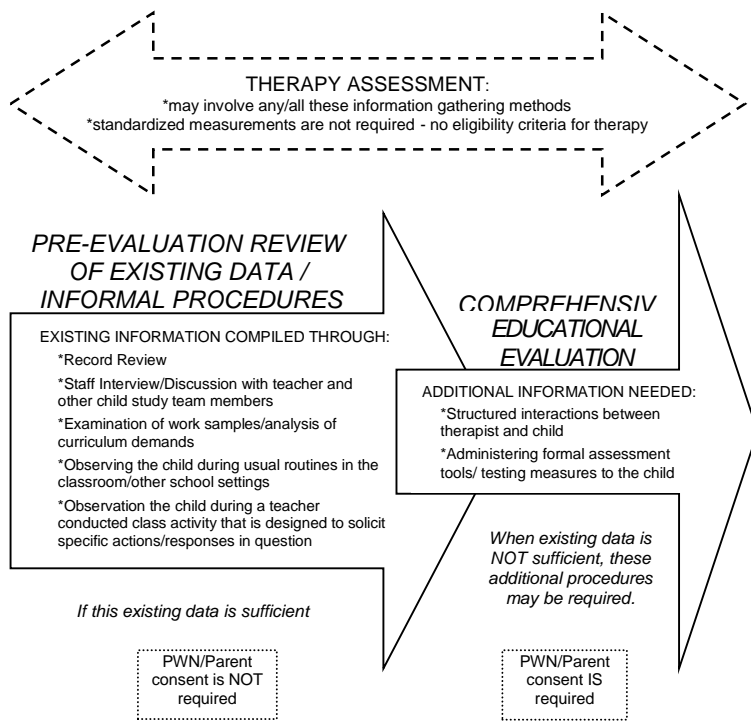
As described previously, an occupational therapist and physical therapist may participate in the pre-evaluation review of a child/student in order to assist the team in determining needs for additional data. It is not appropriate for the child/student study team to determine that a therapist will be added to an evaluation/reevaluation plan or an IEP, if the therapist has not been involved at the level of pre-evaluation review. Also, it is not appropriate for an educational team to consider a "stand alone" evaluation by an OT or PT.

For purposes of clarification, the terms "therapy assessment" in this paragraph, are used relative to the therapist's professional standards of practice. Therapy assessment is a systematic process used to determine the justification and plan for providing occupational therapy and physical therapy services. The assessment process used by the therapist, will involve informal information gathering techniques such as observation of the child, examination of work samples, review of educational records and data from screening activities, and information reported by the parents and other team members. These methods may be sufficient to allow the therapist to determine the child's educational needs and whether therapy services are required to address those needs. The "therapy assessment" process may also include formal information gathering such as the administration of standardized testing or techniques involving structured interaction with the child. These procedures are conducted when the therapist determines that the measurement outcomes of an assessment tool/technique are essential to understanding the function of the child and their educational needs. Therapists do not use formal test scores to "qualify" students for therapy service.



Further information on types of standardized testing is presented later in the Evaluation/Reevaluation Interpretation section of this chapter. The following diagram is an illustration of information gathering methods that comprise "therapy assessment" within the framework of educational due process and a distinction between review of existing data and comprehensive educational evaluation. Many methods make use of existing data and informal procedures that do not isolate the child from their peers/typical learning environment. When it is determined that other methods/tools must be administered to the child because there is need for additional data, the need for comprehensive educational evaluation/reevaluation has been justified.

**Illustration of "Therapy Assessment" Components Within the Process of Pre-evaluation Review/Comprehensive Educational Evaluation:**



*ACCESSIBLE CHART TRANSLATION: Therapy Assessment Components Chart contains: Pre-Evaluation Review of Existing Data/Information Procedures (if existing data is sufficient) through record review, staff interview, examination of work samples, observing child during usual routines and during a teacher conducted class activity. Comprehensive Educational Evaluation (if existing data is not sufficient) through structured interactions between therapist and child and administering formal assessment tolls/testing measure to the child. If existing data is sufficient, PWN/Parent consent is not required. When existing data is not sufficient PWN/Parent consent is required.*

**Review Of Existing Data/Interpretation (Continued):**

Comprehensive educational reevaluation is not always required when teams are considering the need for occupational therapy and physical therapy prior to the child's three year reevaluation due date. When the following components have been addressed, the team (including therapist) may determine the necessity for therapy service as part of a child's IEP, without having to conduct comprehensive educational reevaluation:

1. the child study team, including therapist, conducts a pre evaluation review of a child with an IEP;
2. there is a current concern/lack of progress in an area of performance that was assessed in the previous comprehensive educational evaluation of the child;
3. the concern/area of performance is relevant to the therapist's scope of practice/field of expertise;
4. pre referral interventions relative to the area of concern have been implemented and determined insufficient;
5. the therapist reviews existing data (including observation findings) and determines information from these informal therapy assessment methods is sufficient to understand the child's function/educational needs (i.e. other, formal test procedures do not need to be administered to the child);
6. the team concludes NO ADDITIONAL DATA is needed in any/all areas of performance.

When it is determined that NO ADDITIONAL DATA is needed, information is updated in present levels of the IEP to include the therapist's interpretation of existing data and other information from screening procedures. Similarly, revisions or additions to educational needs, goals/outcomes, and/or accommodations are made to the IEP. These changes, including any addition of therapy services, are documented and provided to the parent/guardian through a Prior Written Notice of Proposed Action or Denial (PWN). The PWN should document the therapist's role in the pre-evaluation review of existing data. Since comprehensive reevaluation was not needed, there are no changes to the 3 year evaluation date noted on the IEP.

A therapist and other members of the child's team determine the need to conduct comprehensive educational reevaluation (prior to the child's three year due date), when these components have been addressed:

1. the child study team, including therapist, conducts a pre-evaluation review of a child with an IEP;
2. there is a current concern in an area of performance that was NOT assessed in the previous comprehensive educational evaluation of the child; or pre referral

interventions related to the area of concern have been implemented and determined insufficient;

3. the concern/area of performance is relevant to the therapist's scope of practice/field of expertise;
4. the therapist reviews existing data and determines the information is NOT sufficient to fully understanding the child's condition and associated educational implications, (i.e. there is a need to administer additional test measures or procedures to the child);
5. the team concludes **ADDITIONAL DATA REQUIRED** in one or more areas of performance.

In this case, the therapist assists the educational team in creating an evaluation plan that identifies the area(s) of performance to be evaluated, the tools/procedures that will be administered, and the individual(s) who will be involved in conducting the evaluation. Any area(s) of performance where it has been determined there is no need for additional data

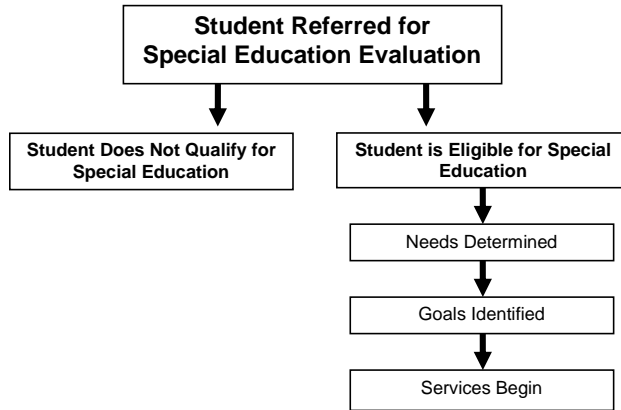
(i.e. no need to repeat/re administer test measures or procedures) would be noted as such on the evaluation plan. The documented evaluation plan and Prior Written Notice of Proposed Action or Denial is then provided to the parent/guardian.

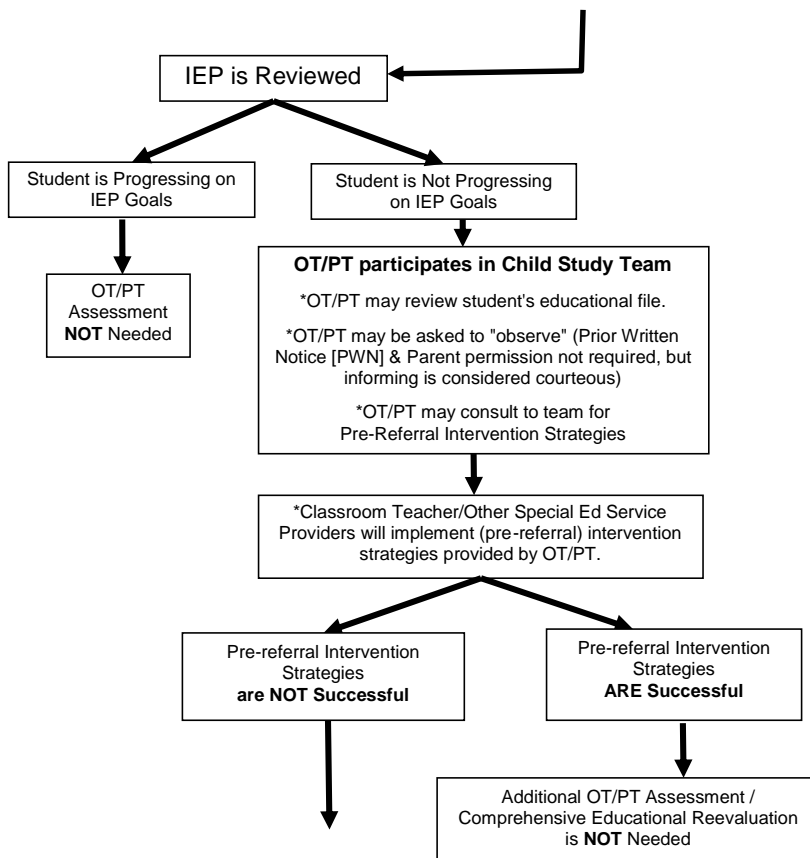
Comprehensive reevaluation is then conducted and a new evaluation report would be generated, thus creating a new 3 year evaluation date. Although the team may have determined that there was no need to conduct/repeat assessment in some areas of performance, a summary of previous assessment results and what is currently known about the child in those areas (e.g. changes in present levels of performance) would be pulled forward and presented in the new evaluation report.

The following diagram/flowchart illustrates pathways for a therapist's involvement using the child study process, and involving pre-evaluation review, pre-referral interventions, and determining the need for additional data/comprehensive educational reevaluation.

### Illustration of the Process for Considering the Need for Occupational Therapy and/or Physical Therapy - Part B

*ACCESSIBLE CHART TRANSLATION: Student is referred to Special Education evaluation and is either not eligible (process stops) or is eligible. If eligible, needs are determined, goals identified and services begin. IEP is reviewed and either progresses on goals or does not. If the student progresses, an OT/PT assessment is not needed. If they do not progress, OT/PT participates in a Child Study Team including review of the student's educational life. OT/PT may be asked to observe or many consult team for Pre-Referral Intervention Strategies. Next the classroom teacher/other special ed service providers will implement intervention strategies provided by OT/PT. If pre-referral intervention is successful, additional OT/PT assessment is not needed. If it is not successful, and data is sufficient, re-evaluation is not required. If data is not sufficient, a re-evaluation is required.. NOTE: Due to the length of this translation, not all re-evaluation steps could be included in this caption.*





### **Evaluation/Reevaluation Plan**

Evaluation or reevaluation is the process of utilizing formal and informal procedures to determine specific areas of a child's or student's strengths, needs, and eligibility for special education services. Each district must conduct a full and individual evaluation of a child or student, for the purposes of special education that meets all state and federal requirements.

An initial evaluation of a child is the first complete assessment to determine if the child has a disability under the IDEA and the nature and extent of special education and related services required. Once a child has been fully evaluated, a decision has been rendered that a child is eligible for services under the IDEA, and the required services have been determined, any subsequent evaluation of a child is considered a reevaluation.

Once it has been determined that a referral for evaluation is appropriate, an evaluation plan is developed. The evaluation must be conducted by a multidisciplinary team with an evaluation plan developed as part of the referral review. The team shall conduct a comprehensive assessment in those areas of suspected disability using technically adequate instruments and procedures.

An evaluation must be conducted when a person's academic, behavioral, emotional, social, physical, communication, or functional skill acquisition in the present educational placement indicates a disability and a need for a special educational placement, program, or service. An evaluation may be conducted if the student or other agency requests, and must be conducted if the parent or student over age 18 requests.

The evaluation must be performed in accordance with recognized professional standards that include recognition or accommodation for persons whose differences or conditions cause standardized instruments to be invalid and otherwise in accordance with the requirements of nondiscrimination.

A district must include in its TSES Manual a description of its child study procedures for the evaluation, beginning at birth, of students who may have a disability. [Minn. R. 3525.1100, subp. 2(A)]

*"Evaluation" or "re-evaluation" means an appropriate individual educational evaluation of a pupil's performance or development conducted by appropriately licensed personnel according to recognized professional standards, parts 3525.2550 and part 3525.2710. [Minn. R. 3525.0210, subp. 18]*

*The public agency must ensure that the child is observed in the child's learning environment (including the regular classroom setting) to document the child's academic performance and behavior in the areas of difficulty. . . In the case of a child of less than school age or out of school, a group member must observe the child in an environment appropriate for a child of that age. [34 C.F.R. § 300.310 (a) and (c)]*

## **Evaluation/Reevaluation Plan**

### **Interpretation/Implications for Therapists:**

Generally speaking, the terms "evaluation", "assessment", and "testing" are frequently used interchangeably. Within the context of special education, comprehensive educational "evaluation" refers to the process of determining the child's eligibility for special education defined by the IEP or IFSP. This evaluation process is comprised of various "assessment" tools/"tests" and other techniques used to gather information about the child/student.

When determining the need for evaluation, and planning appropriate performance areas to assess, the individual expertise of the therapist and other team members should be

considered. Although therapists have a broad base of training in many aspects of function, it would be inappropriate to expect that a therapist will be involved in assessing all children and all areas of performance. Although some therapy practitioners take on broad "developmental therapist" role with infants and toddlers, planning and carrying out evaluations must include the participation of other professionals. Conducting the evaluation process in a joint, cohesive manner among team members will help parents/caregivers focus on the actual learning and educational needs of the child, rather than identifying the therapist or therapy as the primary need.

It is inappropriate to assume that a therapist must be routinely involved in assessing children with specific disabilities or when a typical concern arises (i.e. not all children with autism or handwriting difficulties require assessment by an occupational therapist). Responsibilities assumed or assigned in this manner, hinder the role of the therapist as a "related service," and may contribute to others relinquishing their role or being excluded in the assessment process.

Therapists should always work collaboratively when planning and conducting evaluations. For example, it is not appropriate for an occupational therapist to evaluate the impact of hand function on handwriting without other special education personnel assessing the child's written language skills. Similarly, if it is determined that an occupational therapist needs to assess the impact of a child's sensory function on behavior, then it would also be necessary to include others with expertise in assessing the child's social interactions, emotional responses, behavioral patterns, and perhaps communicative abilities. As another example, the team may determine that it is necessary for a physical therapist to assess the components of physical function affecting the child's gross motor development and/or mobility. This does not preclude the need for a D/APE instructor to assess the child's potential to develop physical fitness and recreational/leisure interests, and adaptations to the physical education curriculum needed to promote this.

Generally it is appropriate for educational teams to involve the therapist in evaluation planning when it is evident that a child has a physical impairment or medically diagnosed condition. The need to involve a therapist in the evaluation process often occurs if concerns are presented regarding the physical function of the child/student.

For infants or toddlers, concerns in the areas of physical and/or adaptive development may precipitate therapist involvement. For school aged children, the determination to involve a therapist in an evaluation often occurs when concerns lie in the areas of functional mobility and access, physical status, and/or sensory status. It is important to note that a therapist may also be capable of helping to evaluate other areas of performance (i.e. emotional/social development and behavior, components of post secondary transition, etc.) as affected by the child's/student's physical or sensorimotor status. In all cases of evaluation planning, a therapist must incorporate a focus on helping the team to determine if a child's/student's disability impacts their ability to access all learning areas and opportunities in home, daycare, school and community settings. This implies that an evaluation could be conducted in a variety of sites such as



a home, preschool, classroom, playground, restroom, cafeteria, bus, hallways, work place, athletic center, or other relevant locations depending on the typical learning environments for the child's age.

Information about the child's/student's functioning may be collected in many ways. As part of a pre-evaluation review, therapists may have gathered existing information about the child through procedures such as record review, work samples, observation, and interview of teachers/care givers. Observation of the child/student in the natural learning environments in which he/she is expected to perform is essential and is a required component of comprehensive educational evaluation. This is always documented on the plan. The evaluation plan may also include other informal strategies such as completing skill checklists/surveys of development, and probing the child's responses through structured interactions during play or work activities.

When selecting formal standardized assessment tools, great care should be taken. Although the evaluation team considers that certain tools are administered for purposes of addressing discrepancy criteria needed to determine eligibility for special education, a therapist is not required to conduct a formal testing measure since there is no eligibility criteria for Occupational Therapy or Physical Therapy services. The selection of any formal testing measure to be administered by the therapist, should be based on consideration of the theoretical framework of the tool, the population on which the tool was standardized, and the applicable value of the quantitative data the tool may yield for the student.

Norm referenced testing is designed to compare a child's skill level to an average range of skills demonstrated by typically developing age peers. This type of testing tends to place the child along a continuum of development, and often emphasizes the skill components the child is lacking. Use of these tests may cause the therapist and team to make an assumption that a child with a disability can be made to follow a sequence or achieve a level of development considered normal. Although a child may have delays in cognitive, physical or motor areas, it does not mean that they will be delayed in their adaptive behaviors or functional skill acquisition within their educational setting.

Criterion referenced testing identifies a child's abilities according to a defined standard or desired objective. The intent of criterion-referenced tests is to measure what a child can do and what they know. Tests that focus on acquisition of functional skills, such as the Pediatric Evaluation of Disability Inventory (PEDI) or School Function Assessment (SFA), are useful both in determining a child's level of function as well as helping to design a plan of intervention. A child's ability to perform or not perform a specific task of norm referenced testing, may not correlate with the success and independence a child has in performing a day-to-day, real life activity. For example, young children who do not yet walk at twelve to fifteen months of age would meet the criteria for developmental delay based on norm referenced testing (e.g. Bayley Scales of Infant Development). However these children are still within the range of normal development and would be expected to achieve typical motor development. Another example of a norm referenced test limitation is the Peabody Developmental Motor Scale, which will illustrate a child's

ability (and changes in that ability) to perform specific motor tasks, but will not give information relating those motor tasks to functional skills. There are other tools such as the Hawaii Early Learning Profile (HELP) that are used for documenting developmental progress and parent education. However, this measure does not substitute for the Bayley in determining eligibility. It is therefore preferential for a therapist to select evaluation tools that measure a child's independence in performing meaningful, functional activities in natural environments, and considers their needs for assistance/adaptation. The PEDI or SFA are examples of formal testing that will illustrate growth, demonstrate functional skills in natural settings, and provide information for program planning and IEP development.

Evaluation planning may also include the consideration of any specialized or unique skills/training the therapist may have relative to the global needs of a particular disability group (e.g. autism, cerebral palsy, etc.), services for particular age range (e.g. infant/toddler programs, transition programs, etc.), or specific forms of intervention/support (e.g. assistive technology, oral-motor/feeding strategies). In general, the breadth of a therapist's involvement in the evaluation process may vary depending upon the expertise and availability of other team members in school and/or through community agencies. Care should be taken to coordinate collaboration and meaningful overlap, yet avoid duplication among professionals during the evaluation planning process. In most cases, it is appropriate to plan and conduct portions of an assessment jointly with other professionals, especially if certain assessment tools are used in common, or if collecting relevant observational data in a structured manner. Likewise, the areas of the therapist's focus during assessment may be closely associated with another team member's area of expertise (e.g. occupational therapists and speech-clinicians may both have unique training in oral-motor function). A therapist should collaborate with other team members in order to determine how individual professional skills and interests compliment each other.

When documenting the evaluation plan, the therapist should attempt to provide a thorough description of their intended involvement in any relevant areas of performance. The following are examples that can be modified according to due process formats used by individual districts:

- The occupational therapist will assist the educational team in determining this student's current level of performance in the areas of academic performance, motor ability, functional skills and physical status, specifically related to his ability to manage manipulative learning tools/materials, complete written assignments, and perform personal care activities at school, through the following assessment tools/strategies: record review, work samples, informal classroom interactions, observation, teacher/parent/student interview, surveys and/or checklists, Developmental Test of Visual-Motor Integration, School Function Assessment.

- The occupational therapist will assist the educational team in determining this student's current level of performance in the areas of social, emotional, behavioral performance, sensory status, and functional skills, specifically related to his ability to cope with sensory demands of the classroom/school environments, manage his behaviors appropriately, and actively focus/engage in learning and personal care activities at school, through the following assessment tools/strategies: record review, observation, informal play interactions, work samples, teacher/parent interview, questionnaires on developmental and sensorimotor history, Sensory Profile, School Function Assessment or Pediatric Evaluation of Disability Inventory depending on the child's level of function and setting.
- The physical therapist will assist the educational team in determining this student's physical and adaptive development, specifically related to his ability to acquire independent mobility, access play/learning opportunities and maintain optimal physical health (flexibility, circulation and respiratory function) through movement and positioning, using the following assessment tools/strategies: record review, observation, informal play and movement interactions, teacher/parent interview, questionnaires on developmental and sensorimotor history, Early Intervention/Preschool Developmental Profile, Pediatric Evaluation of Disability Inventory.
- The physical therapist will assist the educational team in determining this student's vocational interests and possible work opportunities relative to their physical capabilities/limitations. In addition, the physical therapist will help determine this student's ability to access work environments, perform work tasks with safe/effective body movements and positioning, and self-advocate for their physical needs in the workplace. The following assessment strategies will be used: observation, student/staff interview, vocational interest inventories, and physical capacity evaluation.

### **Initial Evaluation and Reevaluation Procedures**

**Initial Evaluation:** *Each public agency must conduct a full and individual initial evaluation, in accordance with the Code of Federal Regulations, title 34, sections 300.305 and 300.306, before the initial provision of special education and related services to a child with a disability under this part.*

*[34 C.F.R. § 300.301(a)]*

*Consistent with the consent requirements in section 300.300, either a parent of a child or a public agency may initiate a request for an initial evaluation to determine if the child is a child with a disability.*  
[4 C.F.R. § 300.301(b)]

*The initial evaluation: (2) Must consist of procedures (i) To determine if the child is a child with a disability under section 300.8; and (ii) To determine the educational needs of the child.* [34 C.F.R. § 300.301(c)(2)]

*A school district shall conduct a full and individual initial evaluation, according to this part before the initial provision of special education and related services to a pupil under this chapter. The initial evaluation shall consist of procedures to determine whether a child is a pupil with a disability that adversely affects the child's educational performance as defined in Minnesota Statutes, section 125A.02, who by reason thereof needs special education and related services, and to determine the educational needs of the pupil. The district proposing to conduct an initial evaluation to determine if the child qualifies as a pupil with a disability shall obtain an informed consent from the parent of the child before the evaluation is conducted. Parental consent for evaluation shall not be construed as consent for placement for receipt of special education and related services. If the parents of the child refuse consent for the evaluation, the district may continue to pursue an evaluation by utilizing mediation and due process procedures.* [Minn. R. 3525.2710, subp. 1]

**Reevaluation:** *A public agency must ensure that a reevaluation of each child with a disability is conducted in accordance with sections 300.304 through 300.311 (1) If the public agency determines that the educational or related service needs, including improved academic achievement and functional performance, of the child warrant a reevaluation; or (2) If the child's parent or teacher requests a reevaluation.* [34 C.F.R. § 300.303(a)]

*The district shall administer such tests and other evaluation materials as may be needed to produce the data identified by the IEP team under item A, subitem (2).* [Minn. R. 3525.2710, subp. 4(B)]

*A reevaluation conducted under paragraph (a) of this section (1) May occur not more than once a year, unless the parents and the public agency agree otherwise; and (2) Must occur at least once every 3 years, unless the parent and the public agency agree that a reevaluation is unnecessary.*  
[34 C.F.R. § 300.303(b)]

*A district shall ensure that a reevaluation of each pupil is conducted if conditions warrant a reevaluation or if the pupil's parent or teacher requests a reevaluation, but at least once every three years and in accordance with subparts 3 and 4.* [Minn. R. 3525.2710, subp. 2]

### **Prior Written Notice of Proposed Action or Refusal/ Parental Consent for Evaluation or Reevaluation**

*The public agency must provide notice to the parents of a child with a disability, in accordance with the Code of Federal Regulations, title 34, section 300.503, that describes any evaluation procedures the agency proposes to conduct. [34 C.F.R. § 300.304(a).]*

**Written Notice Requirement:** *A copy of the procedural safeguards available to the parents of a child with a disability must be given to the parents only one time a school year, except that a copy also must be given to the parents (1) Upon initial referral or parent request for evaluation; (2) Upon receipt of the first State complaint under the Code of Federal Regulations, title 34, sections 300.151 through 300.153 and upon receipt of the first due process complaint Evaluation under section 300.507 in a school year; (3) In accordance with the discipline procedures in section 300.530(h); and (4) Upon request by a parent. [34 C.F.R. § 300.504(a).]*

**Contents of Written Notice:** *The notice required under paragraph (a) of this section must include (1) A description of the action proposed or refused by the agency; (2) An explanation of why the agency proposes or refuses to take the action; (3) A description of each evaluation procedure, assessment, record, or report the agency used as a basis for the proposed or refused action; (4) A statement that the parents of a child with a disability have protection under the procedural safeguards of this part and, if this notice is not an initial referral for evaluation, the means by which a copy of a description of the procedural safeguards can be obtained; (5) Sources for parents to contact to obtain assistance in understanding the provisions of this part; (6) A description of other options that the IEP Team considered and the reasons why those options were rejected; and (7) A description of other factors that are relevant to the agency's proposal or refusal. [34 C.F.R. § 300.503(b).]*

**When Parent Consent is Required:** *The public agency proposing to conduct an initial evaluation to determine if a child qualifies as a child with a disability under the Code of Federal Regulations, title 34, section 300.8 must, after providing notice consistent with sections 300.503 through 300.504, obtain informed consent, consistent with section 300.9, from the parent of the child before conducting the evaluation. [34 C.F.R. § 300.300(a)(1)(i)]*

*The public agency must make reasonable efforts to obtain the informed consent from the parent for an initial evaluation to determine whether the child is a child with a disability. [34 C.F.R. § 300.300(a)(1)(iii)] To meet the reasonable efforts requirement in paragraphs (a)(1)(iii), (a)(2)(i), (b)(2), and (c)(2)(i) of this section, the public agency must document its attempts to obtain parental consent using the procedures in section 300.322(d). [34 C.F.R. § 300.300(d)(5)]*

*(1) Subject to paragraphs (c)(2) of this section, each public agency (i) Must obtain informed parental consent, in accordance with section 300.300(a)(1), prior to conducting any reevaluation of a child with a disability. (2) The informed parental consent described in paragraph (c)(1) of this section need not be obtained if the public agency can demonstrate that (i) It made reasonable efforts to obtain such consent; and (ii) The child's parent has failed to respond. [34 C.F.R. § 300.300(c)(1)(i) and (c)(2)]*

*The district must not proceed with the initial evaluation of a child, the initial placement of a child in a special education program, or the initial provision of special education services for a child without the prior written consent of the child's parent. A district may not override the written refusal of a parent to consent to an initial evaluation or reevaluation. [Minn. Stat. § 125A.091, Subd. 5]*

**When Parent Consent is Not Required:** *(1) Parental consent is not required before (i) Reviewing existing data as part of an evaluation or a reevaluation; or (ii) Administering a test or other evaluation that is administered to all children unless, before administration of that test or evaluation, consent is required of parents of all children. [34 C.F.R. § 300.300(d)(1)]*

*Each district shall obtain informed parental consent, in accordance with subpart 1, prior to conducting any reevaluation of a pupil, except that such informed parental consent need not be obtained if the district can demonstrate that it had taken reasonable measures to obtain such consent and the pupil's parent has failed to respond. [Minn. R. 3525.2710, subp. 4(C)]*

*For initial evaluations only, if the child is a ward of the State and is not residing with the child's parent, the public agency is not required to obtain informed consent from the parent for an initial evaluation to determine whether the child is a child with a disability if (i) Despite reasonable efforts to do so, the public agency cannot discover the whereabouts of the parent of the child; (ii) The rights of the parents of the child have been terminated in accordance with State law; or (iii) the rights of the parent to make educational decisions have been subrogated by a judge in accordance with State law and consent for an initial evaluation has been given by an individual appointed by the judge to represent the child. [34 C.F.R. § 300.300(a)(2)]*

### **Parent Involvement in Evaluation or reevaluation**

*(b) Conduct of evaluation. In conducting the evaluation, the public agency must— (1) Use a variety of assessment tools and strategies to gather relevant functional, developmental, and academic information about the child, including information provided by the parent, that may assist in determining... [34 C.F.R. § 300.304]*

*(a) The parents of a child with a disability must be afforded, in accordance with the procedures of sections 300.613 through 300.621, an opportunity to inspect and review all education records with respect to (1) The identification, evaluation, and educational placement of the child; and (b)(1) The parents of a child with a disability must be afforded an opportunity to participate in meetings with respect to (i) The identification, evaluation, and educational placement of the child; and (ii) The provision of FAPE to the child.*

*[34 C.F.R. § 300.501(a) & (b)(1)]*

*Upon completion of administration of tests and other evaluation materials, the determination of whether the child is a pupil with a disability as defined in Minnesota Statutes, section 125A.02, shall be made by a team of qualified professionals and the parent of the pupil in accordance with item E, and a copy of the evaluation report and the documentation of determination of eligibility will be given to the parent.*

*[Minn. 3525.2710, subp. 3(D).]*

#### **Part C/Infants & Toddlers: Family Directed Assessment**

*(2) A family-directed assessment must be conducted by qualified personnel in order to identify the family's resources, priorities, and concerns and the supports and services necessary to enhance the family's capacity to meet the developmental needs of the family's infant or toddler with a disability. The family-directed assessment must—*

- (i) Be voluntary on the part of each family member participating in the assessment;*
- (ii) Be based on information obtained through an assessment tool and also through an interview with those family members who elect to participate in the assessment; and*
- (iii) Include the family's description of its resources, priorities, and concerns related to enhancing the child's development. [34 C.F.R. § 303.321(b)(2)]*

#### **Parent Involvement**

##### **Interpretation/Implications for Therapists:**

As part of the evaluation process, the team including therapist should determine the parental input needed and how it will be obtained. With infants & toddlers, a family directed assessment can be the basis for establishing a coaching model of support. Assessment that is family directed helps create an understanding of the information, skills/abilities, and other resources they require to meet the needs of their child. A family directed assessment can also establish and empower parental/family roles and responsibilities, as opposed to a perception/expectation that the child needs to be "handed over" to some one else in order to have their needs met.

Additional information on this topic is available from MDE and is posted at this link/web address:

[Q&A: Identification of Parent for Participation in Special Education Planning / http://education.state.mn.us/MDE/SchSup/ComplAssist/QA/DueProcRight/042359](http://education.state.mn.us/MDE/SchSup/ComplAssist/QA/DueProcRight/042359)

## **Team Members**

### **Part C/Infants & Toddlers:**

Evaluators or assessors of the child must be multidisciplinary, but may include one individual who is qualified in more than one discipline or profession. The IFSP must indicate how an evaluator or assessor has participated in an IFSP meeting. The four alternatives for this participation are:

- Attended meeting;
- Participated through telephone conference call;
- Made pertinent records available at the meeting; or
- Had a knowledgeable, authorized representative attend the meeting.

IFSP team members include -

- The parent or parents of the child;
- Other family members, as requested by the parent, if feasible to do so;
- An advocate or person outside of the family, if requested by the parent;
- The service coordinator; designated by the district/public agency to be responsible for implementing the IFSP. The participation of the service coordinator is a minimum requirement for the development of an interim IFSP;
- a person(s) directly involved in conducting the evaluations and assessments (these individuals may participate in a periodic review if warranted), and
- as appropriate, persons who will be providing early intervention services to the child.

The IFSP team must be multidisciplinary. It must include the involvement of the parent and two or more individuals from separate disciplines or professions. One of these individuals must be the service coordinator.

**IFSP Service Coordination Services** - *Service coordination services include (1) Assisting parents of infants and toddlers with disabilities in obtaining access to needed early intervention services and other services identified in the IFSP, including making referrals to providers for needed services and scheduling appointments for infants and toddlers with disabilities and their families; (2) Coordinating the provision of early intervention services and other services (such as educational, social, and medical services that are not provided for diagnostic or evaluative purposes) that the child needs or is being provided; (3) Coordinating evaluations and assessments; (4) Facilitating and participating in the development, review, and evaluation of IFSPs; (5) Conducting*



*referral and other activities to assist families in identifying available EIS providers; (6) Coordinating, facilitating, and monitoring the delivery of services required under this part to ensure that the services are provided in a timely manner; (7) Conducting follow-up activities to determine that appropriate part C services are being provided; (8) Informing families of their rights and procedural safeguards, as set forth in subpart E of this part and related resources; (9) Coordinating the funding sources for services required under this part; and (10) Facilitating the development of a transition plan to preschool, school, or, if appropriate, to other services.*

*[34 C.F.R. § 303.34(b)]*

*The team developing the IFSP under Minnesota Statutes, section 125A.32 must select a service coordinator to carry out service coordination activities on an interagency basis. Service coordination must actively promote a family's capacity and competency to identify, obtain, coordinate, monitor, and evaluate resources and services to meet the family's needs. Service coordination activities include: (1) coordinating the performance of evaluations and assessments; (2) facilitating and participating in the development, review, and evaluation of individualized family service plans; (3) assisting families in identifying available service providers; (4) coordinating and monitoring the delivery of available services; (5) informing families of the availability of advocacy services; (6) coordinating with medical, health, and other service providers; (7) facilitating the development of a transition plan at least 90 days before the time the child is no longer eligible for early intervention services, or, at the discretion of all parties, not more than nine months prior to the child's eligibility for preschool services, if appropriate; (8) managing the early intervention record and submitting additional information to the local primary agency at the time of periodic review and annual evaluations; and (9) notifying a local primary agency when disputes between agencies impact service delivery required by an IFSP. A service coordinator must be knowledgeable about children and families receiving services under this section, requirements of state and federal law, and services available in the interagency early childhood intervention system. [Minn. Stat. § 125A.33]*

## **Part B:**

**Evaluation Team** - *"Evaluation" or "re-evaluation" means an appropriate individual educational evaluation of a pupil's performance or development conducted by appropriately licensed personnel according to recognized professional standards, parts 3525.2550 and part 3525.2710. [Minn. R. 3525.0210, subp. 18]*

*Upon completion of administration of tests and other evaluation materials, the determination of whether the child is a pupil with a disability as defined in Minnesota Statutes, section 125A.02, shall be made by a team of qualified professionals and the*

*parent of the pupil in accordance with item E, and a copy of the evaluation report and the documentation of determination of eligibility will be given to the parent.*  
[Minn. R. 3525.2710, subp. 3(D)]

*For each pupil, the district shall conduct an evaluation of secondary transition needs and plan appropriate services to meet the pupil's transition needs. The areas of evaluation and planning must be relevant to the pupil's needs and may include work, recreation and leisure, home living, community participation, and postsecondary training and learning opportunities. To appropriately evaluate and plan for a pupil's secondary transition, additional IEP team members may be necessary and may include vocational education staff members and other community agency representatives as appropriate.*  
[Minn. R. 3525.2900, subp. 4(A)]

**ASD** - *The team determining eligibility and educational programming must include at least one professional with experience and expertise in the area of ASD due to the complexity of this disability and the specialized intervention methods. The team must include a school professional knowledgeable of the range of possible special education eligibility criteria.* [Minn. R. 3525.1325, subp. 4]

**Multi-Disability Team Teaching Model** - *The team member licensed in a pupil's disability shall be responsible for conducting the pupil's evaluation and participating at team meetings when an IEP is developed, reviewed, or revised. Consultation and indirect services as defined in part 3525.0210 must be provided to the general or special education teacher providing instruction if not licensed in the disability. The frequency and amount of time for specific consultation and indirect services shall be determined by the IEP team.* [Minn. R. 3525.2350, subp. 3]

**Required IEP team members - include:**

- *Parents of the student;*
- *At least one regular education teacher of the student (if the student is, or may be, participating in the regular education environment);*
- *At least one special education teacher of the student or, where appropriate, not less than one special education services provider of the student;*
- *An administrative designee, also called a representative of the agency, who is qualified to provide or supervise the provision of specially designed instruction to meet the unique needs of students with disabilities, is knowledgeable about the general curriculum, and is knowledgeable about the availability of resources of the district; and,*
- *An individual who can interpret the instructional implications of evaluation results, who may also be a member of the team as described above.*  
[34 C.F.R. § 300.321(a)(1)-(5) and Minn. R. 3525.2810, Subp. 1(B)]

**Additional IEP team members - may include:**

- *At the discretion of the parent or the district, other individuals who have knowledge or special expertise regarding the student, including related services personnel, as appropriate;*

- *The student with a disability, whenever appropriate. The district must invite a student with a disability to attend the student's IEP team meeting if a purpose of the meeting will be the consideration of the postsecondary goals for the student and the transition services needed to assist the student in reaching those goals under 34 C.F.R § 300.320(b). If the student does not attend the IEP team meeting, the school district must take other steps to ensure that the student's preferences and interests are considered; and,*
- *To the extent appropriate, with the consent of the parents or a student who has reached the age of majority in implementing the transition requirements, the school district must invite a representative of any participating agency that is likely to be responsible for providing or paying for transition services. If a participating agency, other than the local school district, fails to provide the transition services described in the IEP the school district shall reconvene the IEP team to identify alternative strategies to meet the transition objectives for the student set out in that program. [34 C.F.R. § 300.321(a)(6)-(7), 34 C.F.R. § 300.321(b)(1)-(3), and Minn. R. 3525.2810, Subp. 1(B) and Subp. 4]*

**IEP Manager** - The district shall assign a teacher or licensed related service staff who is a member of the pupil's IEP team as the pupil's IEP manager to coordinate the instruction and related services for the pupil. The IEP manager's responsibility shall be to coordinate the delivery of special education services in the pupil's IEP and to serve as the primary contact for the parent. A district may assign the following responsibilities to the pupil's IEP manager: assuring compliance with procedural requirements; communicating and coordinating among home, school, and other agencies; coordinating regular and special education programs; facilitating placement; and scheduling team meetings. [Minn. R. 3525.0550]

#### **IEP Team:**

Districts are required to ensure that each IEP team includes the following required members:

Parent(s) of the student, which may include a legal guardian, surrogate parent, and student if age 18 or older; and at least one special education teacher of the student or where appropriate, not less than one special education provider. This person should be the person who is, or will be, responsible for implementing the IEP. For example, if the student's disability is a speech impairment, the special education teacher or special education provider could be the speech language pathologist.  
34 C.F.R. § 300.321 cmts. at 71 F.R. 46670

The district must take steps to ensure that one or both parents are present at each IEP team meeting or are given the opportunity to participate. This means the district must: 1) Notify parents of the meeting early enough to ensure they will have an opportunity to attend; and 2) Schedule the meeting at a mutually agreed-upon time and place.

If neither parent can attend the IEP team meeting, the district must use other methods to ensure parent participation, including individual or conference telephone calls. A meeting may be conducted without a parent in attendance if the district is unable to convince the parents that they should attend. In this case, the district must keep a record of its attempts to arrange a mutually agreed-upon time and place, such as: 1) Detailed records of telephone calls made or attempted and the results of those calls; 2) Copies of correspondence sent to the parents and any responses received; and 3) Detailed records of visits made to the parent's home or place of employment and the results of those visits.

## **Team Members**

### **Interpretation/Implications for Therapists:**

The student's educational team, both for evaluation and subsequent service delivery, can be comprised of a variety of individuals, but always includes the parent(s)/guardian(s) of the child. Therapists are considered appropriately licensed and qualified professionals who may become members of these teams when it is determined that their unique training and expertise is required in order to fully understand the child's limitations and their potential to acquire skills/develop their abilities. A question to assist the team in determining the necessity for therapist involvement is: "What is the knowledge and skill set that the therapist has, that is not addressed by others?" The therapist helps the team answer this question based on thoughtful consideration of the performance concerns and needs surrounding an individual child/student.

Occupational therapy and physical therapy are different, distinct professions that should never be regarded as interchangeable. It is important for therapists to acknowledge similarities/differences in their training and experience, especially in the early childhood area of practice where they may be regarded as a motor development specialist. The roles of both OT and PT should be driven by defined parameters of each of their professional skills/abilities, which is then matched to associated areas of dysfunction and need demonstrated by the child. Each therapist may be involved in evaluating and providing subsequent service, based on this analysis. Although the roles of an OT and PT will overlap, services should compliment but not duplicate each other. Occupational therapy and physical therapy services may occur in tandem during a period of time, or may occur separately during other periods of time. As the needs of the child change, so may the occurrence or timing of each of these services.

An occupational therapist and a physical therapist may be assigned the role of an IEP manager (may be commonly referred to as a "case manager"). However, workload responsibilities, wide spread itinerant assignments and variable schedules should be carefully considered before that determination is made. It is preferable that the IEP

manager be an individual who is easily accessible to the student, parents/guardians, and other members of the child's team.

As noted previously in this chapter, a therapist could be assigned responsibilities as an IFSP service coordinator, however it is not advisable for a therapist to function in a dual capacity in this role and as a primary provider of services for the same child. The functions of each of these roles could pose a conflict of interest, particularly related to the family's potential needs for advocacy, monitoring the delivery of services, and/or managing service dispute.

It should be noted therapy assistants (i.e. occupational therapy assistants, physical therapist assistants) providing therapy services under the direction of a licensed therapist, cannot act as IEP managers/IFSP service coordinators.

Please refer to the IFSP team member section that occurs later in this chapter, for further information regarding Primary Provider model for Infant/Toddler services.

## **Nondiscriminatory Evaluation Procedures**

### **Part C/Infants & Toddlers:**

*Each lead agency shall adopt nondiscriminatory evaluation and assessment procedures. The procedures must provide that public agencies responsible for the evaluation and assessment of children and families under this part shall ensure, at a minimum, that (a) tests and other evaluation materials and procedures are administered in the native language of the parents or other mode of communication, unless it is clearly not feasible to do so; (b) any assessment and evaluation procedures and materials that are used are selected and administered so as not to be racially or culturally discriminatory; (4) All evaluations and assessments of the child and family must be conducted by qualified personnel, in a nondiscriminatory manner, and selected and administered so as not to be racially or culturally discriminatory. [34 C.F.R. § 303.321(a)(4)]*

### **Part B:**

*Each public agency must ensure that (1) Assessments and other evaluation materials used to assess a child under this part (ii) Are provided and administered in the child's native language or other mode of communication and in the form most likely to yield accurate information on what the child knows and can do academically, developmentally, and functionally, unless it is clearly not feasible to so provide or administer. [34 C.F.R. § 300.304 (c)(1)(ii)]*

*As defined in this section, every district shall ensure the following: (6) in accordance with recognized professional standards, testing and evaluation materials and procedures used for the purposes of classification and placement of children with a disability are selected and administered so as not to be racially or culturally discriminatory. [Minn. Stat. § 125A.08(b)(6)]*

*Each district shall ensure that: (1) tests and other evaluation materials used to evaluate a child under this part are selected and administered so as not to be discriminatory on a racial or cultural basis, and are provided and administered in the pupil's native language or other mode of communication, unless it is clearly not feasible to do so. [Minn. R. 3525.2710, subp. 3(C)(1)]*

## **Nondiscriminatory Evaluation Procedures Interpretation/Implications for Therapists:**

Therapists need to consider the purpose for assessment when determining which procedure/tools will be used. They also need to be sensitive to the population on which the tool was standardized and how that impacts the assessment of the child's disability.

### **Evaluation Timelines**

#### **Part C/Infants & Toddlers:**

*(a) Except as provided in paragraph (b) of this section, any screening under section 303.320 (if the State has adopted a policy and elects, and the parent consents, to conduct a screening of a child); the initial evaluation and the initial assessments of the child and family under section 303.321; and the initial IFSP meeting under section 303.342 must be completed within 45 days from the date the lead agency or EIS provider receives the referral of the child.*

*(b) Subject to paragraph (c) of this section, the 45-day timeline described in paragraph (a) of this section does not apply for any period when (1) The child or parent is unavailable to complete the screening (if applicable), the initial evaluation, the initial assessments of the child and family, or the initial IFSP meeting due to exceptional family circumstances that are documented in the child's early intervention records; or (2) The parent has not provided consent for the screening (if applicable), the initial evaluation, or the initial assessment of the child, despite documented, repeated attempts by the lead agency or EIS provider to obtain parental consent.*

*(c) The lead agency must develop procedures to ensure that in the event the circumstances described in (b)(1) or (b)(2) of this section exist, the lead agency or EIS provider must (1) Document in the child's early intervention records the exceptional family circumstances or repeated attempts by the lead agency or EIS provider to obtain parental consent; (2) Complete the screening (if applicable), the initial evaluation, the initial assessments (of the child and family), and the initial IFSP meeting as soon as possible after the documented exceptional family circumstances described in paragraph (b)(1) of this section no longer exist or parental consent is obtained for the screening (if applicable), the initial evaluation, and the initial assessment of the child; and (3) Develop and implement an interim IFSP, to the extent appropriate and consistent with section 303.345.*

*(d) The initial family assessment must be conducted within the 45-day timeline in paragraph (a) of this section if the parent concurs and even if other family members are unavailable. [34 C.F.R. § 303.310]*

**Part B:**

*The team shall conduct an evaluation for special education purposes within a reasonable time not to exceed 30 school days from the date the district receives parental permission to conduct the evaluation or the expiration of the 14-calendar day parental response time in cases other than initial evaluation, unless a conciliation conference or hearing is requested. [Minn. R. 3525.2550, subp.2]*

**Evaluation Timelines**

**Interpretation/Implications for Therapists:**

Therapists must establish a method of communication that assures timely and efficient notification that parent permission for evaluation/reevaluation has been received. It is critical to avoid any delay in this process that may restrict the therapist's ability to complete a thorough assessment within the appropriate time frame.

**Evaluation Materials and Procedures**

**Part C/Infants & Toddlers:**

*(2) As used in this part (i) Evaluation means the procedures used by qualified personnel to determine a child's initial and continuing eligibility under this part, consistent with the definition of infant or toddler with a disability in section 303.21. An initial evaluation refers to the child's evaluation to determine his or her initial eligibility under this part; (ii) Assessment means the ongoing procedures used by qualified personnel to identify the child's unique strengths and needs and the early intervention services appropriate to meet those needs throughout the period of the child's eligibility under this part and includes the assessment of the child, consistent with paragraph (c)(1) of this section and the assessment of the child's family, consistent with paragraph (c)(2) of this section; and (iii) Initial assessment refers to the assessment of the child and the family assessment conducted prior to the child's first IFSP meeting.  
[34 C.F.R. § 303.321(2)]*

*(ii) Qualified personnel must use informed clinical opinion when conducting an evaluation and assessment of the child. In addition, the lead agency must ensure that informed clinical opinion may be used as an independent basis to establish a child's eligibility under this part even when other instruments*



do not establish eligibility; however, in no event may informed clinical opinion be used to negate the results of evaluation instruments used to establish eligibility under paragraph (b) of this section. [34 C.F.R. § 303.321(a)(3)(ii)].

**Health Status and Medical History:** (3)(i) A child's medical and other records may be used to establish eligibility (without conducting an evaluation of the child) under this part if those records indicate that the child's level of functioning in one or more of the developmental areas identified in section 303.21(a)(1) constitutes a developmental delay or that the child otherwise meets the criteria for an infant or toddler with a disability under section 303.21. If the child's part C eligibility is established under this paragraph, the lead agency or EIS provider must conduct assessments of the child and family in accordance with paragraph (c) of this section. [34 C.F.R. § 303.321(a)(3)(i)]

**Levels of Functioning:** (b) Procedures for evaluation of the child. In conducting an evaluation, no single procedure may be used as the sole criterion for determining a child's eligibility under this part. Procedures must include (1) Administering an evaluation instrument; (2) Taking the child's history (including interviewing the parent); (3) Identifying the child's level of functioning in each of the developmental areas in section 303.21(a)(1); (4) Gathering information from other sources such as family members, other care-givers, medical providers, social workers, and educators, if necessary, to understand the full scope of the child's unique strengths and needs; and (5) Reviewing medical, educational, or other records. [34 C.F.R. § 303.321(b)]

**Unique Needs:** (b) Procedures for evaluation of the child. In conducting an evaluation, no single procedure may be used as the sole criterion for determining a child's eligibility under this part. Procedures must include (1) Administering an evaluation instrument; (2) Taking the child's history (including interviewing the parent); (3) Identifying the child's level of functioning in each of the developmental areas in section 303.21(a)(1); (4) Gathering information from other sources such as family members, other care-givers, medical providers, social workers, and educators, if necessary, to understand the full scope of the child's unique strengths and needs; and (5) Reviewing medical, educational, or other records. [34 C.F.R. § 303.321(b)]

**Family Evaluation:** (B) A family-directed assessment of the resources, priorities, and concerns of the family and the identification of the supports and services necessary to enhance the family's capacity to meet the developmental needs of that infant or toddler. The assessments of the child and family are described in paragraph (c) of this section and these assessments may occur simultaneously with the evaluation, provided that the requirements of paragraph (b) of this section are met. [34 C.F.R. § 303.321(B)]

(c) Procedures for assessment of the child and family. (1) An assessment of each infant or toddler with a disability must be conducted by qualified personnel in order to identify the child's unique strengths and needs and the early intervention services appropriate to

meet those needs. The assessment of the child must include the following (i) A review of the results of the evaluation conducted under paragraph (b) of this section; (ii) Personal observations of the child; and (iii) The identification of the child's needs in each of the developmental areas in section 303.21(a)(1). [34 C.F.R. § 303.321(c)]

#### **Part B:**

**District to Provide Relevant Evaluation Tools:** Each public agency must ensure that (c)(7) Assessments tools and strategies that provide relevant information that directly assists persons in determining the educational needs of the child are provided. [34 C.F.R. § 300.304(c)(7)]

Each district shall ensure that: (5) evaluation tools and strategies that provide relevant information that directly assists persons in determining the educational needs of the pupil are provided.[Minn. R. 3525.2710, subp. 3(C)(5)]

**Evaluation Materials Designed Measure Special Education Needs:** Each public agency must ensure that (3) Assessments are selected and administered so as best to ensure that, if an assessment is administered to a child with impaired sensory, manual, or speaking skills, the assessment results accurately reflect the child's aptitude or achievement level or whatever other factors the test purports to measure, rather than reflecting the child's impaired sensory, manual, or speaking skills (unless those skills are the factors that the test purports to measure). [34 C.F.R. § 300.304(c)(3)]

Each district shall ensure that: (2) materials and procedures used to evaluate a child with limited English proficiency are selected and administered to ensure that they measure the extent to which the child has a disability and needs special education and related services, rather than measure the child's English language skills. [Minn. R. 3525.2710, subp. 3(C)(2)]

Each public agency must ensure that (c)(2) Assessments and other evaluation materials used include those tailored to assess specific areas of educational need and not merely those that are designed to provide a single general intelligence quotient. [34 C.F.R. § 300.304(c)(2)]

**Validity and Reliability of Evaluation Materials:** Each public agency must ensure that (1) Assessments and other evaluation materials used to assess a child under this part (iii) Are used for the purposes for which the assessments or measures are valid and reliable. [34 C.F.R. § 300.304(c)(1)(iii)]

Each public agency must ensure that (c)(1) Assessments and other evaluation materials used to assess a child under this part (iv) Are administered by trained and knowledgeable personnel; and (v) Are administered in accordance with any instructions provided by the producer of the assessments

[34 C.F.R. § 300.304(c)(1)(iv)-(v)]

*Each district shall ensure that: (3) any standardized tests that are given to the child have been validated for the specific purpose for which they are used, are administered by trained and knowledgeable personnel, and are administered in accordance with any instructions provided by the producer of such tests. [Minn. R. 3525.2710, subp. 3(C)(3)]*

**Comprehensive Evaluation:** *Each public agency must ensure that (6) In evaluating each child with a disability under sections 300.304 through 300.306, the evaluation is sufficiently comprehensive to identify all of the child's special education and related service needs, whether or not commonly linked to the disability category in which the child has been classified.[34 C.F.R. § 300.304(c)(6)]*

*In conducting the evaluation, the public agency must (4) Use technically sound instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors. [34 C.F.R. § 300.304(b)(3)]*

*In conducting the evaluation, the district shall: (3) use technically sound instruments that are designed to assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors. [Minn. R. 3525.2710, subp. 3(B)(3)]*

*Each public agency must ensure that (4) The child is assessed in all areas related to the suspected disability, including, if appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status, and motor abilities.[34 C.F.R. § 300.304(c)(4)]*

*Each district shall ensure that: (9) in evaluating each pupil with a disability, the evaluation is sufficiently comprehensive to identify all of the pupil's special education and related service needs, whether or not commonly linked to the disability category in which the pupil has been classified. [Minn. R. 3525.2710, subp. 3 (C)(9)]*

**Need to Use Multiple Procedures:** *In conducting the evaluation, the public agency must (1) Use a variety of assessment tools and strategies to gather relevant functional, developmental, and academic information about the child, including information provided by the parents, that may assist in determining (i) Whether the child is a child with a disability under section 300.8; and (ii) The content of the child's IEP, including information related to enabling the child to be involved in and progress in the general education curriculum (or for a preschool child, to participate in appropriate activities).[34 C.F.R. § 300.304(b)(1)]*

*In conducting the evaluation, the district shall: (1) use a variety of evaluation tools and strategies to gather relevant functional and developmental information, including information provided by the parent, that are designed to assist in determining whether the child is a pupil with a disability and the content of the pupil's individualized education program, including information related to enabling the pupil to be involved in and progress in the general curriculum or, for preschool pupils, to participate in appropriate activities. [Minn. R. 3525.2710, subp. 3(B)(1)]*

*In conducting the evaluation, the public agency must (2) Not use any single measure or assessment as the sole criterion for determining whether a child is a child with a disability and for determining an appropriate educational program for the child. [34 C.F.R. § 300.304(b)(2)]*

*In conducting the evaluation, the district shall: (2) not use any single procedure as the sole criterion for determining whether a child is a pupil with a disability or determining an appropriate education program for the pupil. [Minn. R. 3525.2710, subp. 3(B)(2)]*

*In interpreting evaluation data for the purpose of determining if a child is a child with a disability under section 300.8, and the educational needs of the child, each public agency must (i) Draw upon information from a variety of sources, including aptitude and achievement tests, parent input, and teacher recommendations, as well as information about the child's physical condition, social or cultural background, and adaptive behavior; and (ii) Ensure that information obtained from all of these sources is documented and carefully considered. [34 C.F.R. § 300.306(c)(1)]*

**Variance from Standard Evaluation Conditions:** *Each district shall ensure that: (6) if an evaluation is not conducted under standard conditions, a description of the extent to which it varied from standard conditions must be included in the evaluation report. [Minn. R. 3525.2710, subp. 3(C)(6)]*

**Use of Assessments Transferred from Other Public Schools:** *Each public agency must ensure that Assessments of children with disabilities who transfer from one public agency to another public agency in the same academic year are coordinated with those children's prior and subsequent schools, as necessary and as expeditiously as possible, consistent with section 300.301(d)(2) and (e), to ensure prompt completion of full evaluations. [34 C.F.R. § 300.304(c)(5)]*

## Evaluation Areas

### Part C/Infants & Toddlers:

All of the following domains for an initial evaluation and for an annual review of the IFSP are to be addressed:

- Physical development such as:
  - Health (includes medical, dental, nutrition);
  - Vision/Hearing (screening, glasses, hearing aids, history of ear infections);
  - Fine motor (use of hands and upper body);
  - Gross motor (quality and function of movement, equipment/devices); and
  - Other Sensory issues, if appropriate
- Communication (understanding, expression, intelligibility, use of language, language skills and pre-literacy)
- Cognition (thinking, play skills, problem solving)
- Social Emotional (engagement, response to caregivers, coping)
- Adaptive (feeding, dressing, toileting, sleeping)

### Part B:

*Each district shall ensure that: (4) the child is evaluated in all areas of suspected disability, including, if appropriate,*

- *health,*
- *vision,*
- *hearing,*
- *social and emotional status,*
- *general intelligence,*
- *academic performance,*
- *communicative status, and*
- *motor abilities. [Minn. R. 3525.2710, subp. 3 (C)(4)]*

### Secondary Transition Evaluation

By grade nine or age 14, whichever comes first, the IEP plan shall address the pupil's needs for transition from secondary services to post-secondary education and training, employment, and community living.

*For each pupil, the district shall conduct an evaluation of secondary transition needs and plan appropriate services to meet the pupil's transition needs. The areas of evaluation and planning must be relevant to the pupil's needs and may include work, recreation and leisure, home living, community participation, and postsecondary training*

*and learning opportunities. To appropriately evaluate and plan for a pupil's secondary transition, additional IEP team members may be necessary and may include vocational education staff members and other community agency representatives as appropriate. [Minn. R. 3525.2900, subp. 4(A)]*

*Secondary transition evaluation results must be documented as part of an evaluation report. Current and secondary transition needs, goals, and instructional and related services to meet the pupil's secondary transition needs must be considered by the team with annual needs, goals, objectives, and services documented on the pupil's IEP. [Minn. R. 3525.2900, subp. 4]*

### **Functional Behavioral Assessment (FBA)**

An FBA is a process to gather information to assist individualized education program (IEP) teams in developing appropriate and individualized positive behavioral interventions and supports. An FBA's purpose is to determine when and why a student exhibits problem behaviors, what reinforces the problem behavior, and what types of positive behavioral supports and interventions would reduce the negative behaviors and increase the desired behaviors.

*"Functional behavioral assessment" or "FBA" means a process for gathering information to maximize the efficiency of behavioral supports. An FBA includes a description of problem behaviors and the identification of events, times, and situations that predict the occurrence and nonoccurrence of the behavior. An FBA also identifies the antecedents, consequences, and reinforcers that maintain the behavior, the possible functions of the behavior, and possible positive alternative behaviors. An FBA includes a variety of data collection methods and sources that facilitate the development of hypotheses and summary statements regarding behavioral patterns. [Minn. R. 3525.0210, subp. 22]*

## **Evaluation/Reevaluation Report**

### **Part C/Infants & Toddlers:**

The Evaluation/Assessment Summary section of an initial IFSP will include information gathered from the initial Part C evaluation and assessment procedures. The Evaluation/Assessment Summary of subsequent IFSPs must document information integrated from ongoing assessment, reports of parent and other caregivers and observations made by service providers. There is no requirement for a separate Evaluation Report under Part C. For children who are determined eligible, the Evaluation Summary provides evaluation results to parents and documents developmental status within the IFSP.

For children who are determined to not be eligible for Part C, or if parents of an eligible child decline services, the Evaluation Summary section together with the completed cover page should be provided to parents.

If a separate evaluation is written, either because your district requires you to write an Evaluation Report or if you are documenting the results of an evaluation that addressed eligibility under both Part C and Part B (the Evaluation Report is a Part B requirement), you must still complete the Summary of All Developmental Areas (Part C required IFSP information). You may not state “see attached Evaluation Report.”

### **Part B:**

For the person evaluated, results of any or all evaluations shall be summarized in a report. The evaluation report shall include the following:

- the results and interpretation of the evaluation;
- the person’s present level of performance in the areas evaluated (secondary transition evaluation results must be documented as part of the evaluation report);
- the team’s judgments regarding eligibility for services (Specific Learning Disability Documentation, and Team Override Documentation if appropriate); and
- the team members’ names, titles, and date of report.

A summary of evaluation results pertaining to the following areas must be documented as part of all evaluation reports:

- Aptitude and achievement tests
- Parent input
- Teacher recommendations
- Physical condition
- Social or cultural background
- Adaptive behavior
- Social/emotional/behavioral functioning
- Transition (if appropriate)

The summary should be written in parent-friendly language and include the type(s) and sources of data, describe the evaluation tools/procedures, and summarize existing data, formal assessment results, and pertinent test scores in a format compatible with the criteria component standards.

The team shall give due consideration to evaluation results provided by outside sources but need not implement recommendations unless agreed to by the team.

In the case of initial evaluations, the report must document whether the pupil has a particular category of disability and whether the child needs special education and related services.

In the case of a reevaluation, the report must document whether the pupil continues to have such a disability and whether the pupil continues to need special education and related services.

Based on data provided in the present levels of performance section, the educational needs of the student are described. Educational need statements must address skills and/or behaviors that need improvement in order for the child to participate and progress in the general curriculum.

The report must document whether any additions or modifications to the special education and IEP are needed to enable the student to meet the measurable annual goals set out in the IEP and to participate, as appropriate, in the general curriculum.

*In interpreting evaluation data for the purpose of determining if a child is a child with a disability under section 300.8, and the educational needs of the child, each public agency must (i) Draw upon information from a variety of sources, including aptitude and achievement tests, parent input, and teacher recommendations, as well as information about the child's physical condition, social or cultural background, and adaptive behavior; and (ii) Ensure that information obtained from all of these sources is documented and carefully considered. [34 C.F.R. § 300.306(c)(1)]*

*Upon completion of the administration of assessments and other evaluation measures (1) A group of qualified professionals and the parent of the child determines whether the child is a child with a disability, as defined in section 300.8, in accordance with paragraph (b) of this section and the educational needs of the child; and (a) Upon completion of the administration of assessments and other evaluation measures (2) The public agency provides a copy of the evaluation report and the documentation of determination of eligibility to the parent. [34 C.F.R. § 300.306(a)(2)]*

*Upon completion of administration of tests and other evaluation materials, the determination of whether the child is a pupil with a disability as defined in Minnesota Statutes, section 125A.02, shall be made by a team of qualified professionals and the parent of the pupil in accordance with item E, and a copy of the evaluation report and the documentation of determination of eligibility will be given to the parent. [Minn. R. 3525.2710, subp. 3(D)]*

*An evaluation report must be completed and delivered to the pupil's parents within the specified evaluation timeline. At a minimum, the evaluation report must include: A. a summary of all evaluation results; B. documentation of whether the pupil has a particular category of disability or, in the case of a reevaluation, whether the pupil continues to have such a disability; C. the pupil's present levels of performance and educational needs that derive from the disability; D. whether the child needs special education and related services or, in the case of a reevaluation, whether the pupil continues to need special education and related services; and E. whether any additions or modifications to the special education and related services are needed to enable the*



*pupil to meet the measurable annual goals set out in the pupil's IEP and to participate, as appropriate, in the general curriculum. [Minn. R. 3525.2710, subp. 6]*

*Secondary transition evaluation results must be documented as part of an evaluation report. Current and secondary transition needs, goals, and instructional and related services to meet the pupil's secondary transition needs must be considered by the team with annual needs, goals, objectives, and services documented on the pupil's IEP. [Minn. R. 3525.2900, subp. 4(B)]*

### **Evaluation/Reevaluation Report**

#### **Interpretation/Implications for Therapists:**

A separate evaluation report for children determined eligible under part C is not required, as evaluation results are documented with the IFSP. For all other children, an evaluation report is a requirement.

Evaluation information compiled by therapists should be integrated into a single, team generated, evaluation report (i.e. not be a separate and attached therapy report). When composing the written report, assessment results and test scores, should not be noted in isolation without interpretation of the impact on the student's functioning in his/her current and anticipated environments. For example, reporting a low-scaled score on a motor skills test indicating poor gross motor skills without addressing how the student moves around the classroom, or poor fine motor skills without addressing actual handwriting function, would be inappropriate.

Information reported in an evaluation performance or developmental area should include the child's strengths and abilities, or what they can do. It should be meaningful and written in such a manner that it translates/flows easily into a present level of academic achievement and functional performance (PLAAFP) IEP area, or present level of development in the IFSP process. Refer to inappropriate/appropriate examples noted later in the PRESENT LEVELS section of IEP/IFSP DEVELOPMENT chapter of this manual.

Examples of appropriate ways to interpret/summarize assessment findings follow:

- While lying on his back, this child turns his head to locate sights/sounds presented to each side. When positioned on his tummy or when held upright, the child does not respond to sights/sound by lifting/turning their head, and shows signs of discomfort by crying and struggling with his breathing. This difficulty has limited the variety of ways the parents and family members can move their child and interact with him in play.
  
- The child is able to play on his tummy for several minutes, lifting his head while beginning to reach forward for a toy. He is able to sit with low trunk support, and is beginning to prop on his hands during sitting. He is not yet able to make transitions between positions, such as between the floor and sitting.
  
- This child demonstrates perceptual and motor limitations related to his/her medical diagnosis of cerebral palsy. Although these limitations impact the student's ability to carry out functional and academic tasks in a conventional fashion, the student's performance can be enhanced given supports and accommodations to promote:
  - -safe and timely movement during transitions between classes,
  - -postural alignment and comfort in sitting,
  - -access to and organization of instructional materials,
  - -written work that is completed in a timely and legible manner, and
  - -using self-advocacy to request/direct assistance from others.

An evaluation report must contain descriptions of the child's educational needs. As members of the educational team, occupational therapists and physical therapists share responsibility for helping to identify the child's educational needs. Great care and collaboration should take place among team members when writing need statements. Refer to inappropriate/appropriate examples noted later in the NEEDS section of IEP DEVELOPMENT chapter of this manual. Needs identified in the evaluation report are later addressed in the IEP through one or more of the following methods;

goals/objectives, adaptations/modifications, transition activities, or through a statement identifying prioritization of needs, how they will or will not be addressed by the team, and the use of outside service providers.

An evaluation report should also contain any additions or modifications to the special education and IEP that are needed to enable the student to meet the measurable annual goals set out in the IEP and to participate, as appropriate, in the general curriculum.

Examples of additions/modifications cited in the evaluation report include:

- The student's schedule will be adjusted to allow extra passing time between classes.
- Staff will be trained in methods of adjusting seating position and managing physical transfers of the student during the school day.
- The student will require work surfaces that accommodate access to their wheelchair and instructional materials.
- The student will be provided access to and instruction in using a computer to complete written assignments.
- Staff will be trained in methods of adapting assignments into an electronic format allowing computer use by the student.
- The student will be provided disability awareness instruction and opportunities to practice asking for help and directing assistance provided by others.

More specific accommodations should be developed by the team at the IEP meeting.

An evaluation report must indicate whether the child has or continues to have a particular category of disability, and whether the child needs or continues to need special education and related services. This is based on the compilation of evaluation results and the team's consensus whether eligibility criteria for a categorical disability area has been met, and may be addressed in checkbox fashion or through written, summarizing statements within the format of the evaluation report.

An evaluation report does not include a specific recommendation regarding occupational therapy or physical therapy services. This determination occurs later, as part of the IEP process. Families and teams may incorrectly assume that there are criteria for therapy service, similar to those established for the individual disability categories. It is important to explain this difference and clarify expectations regarding evaluation reporting through dialogue or inservice.

Based on the Physical Therapist Practice Act, physical therapist assistants do not participate in writing evaluation reports. MN Statutes governing occupational therapy practice allow an occupational therapy assistant to assist when an occupational therapist is writing evaluation reports, however interpretation of evaluation results relative to program planning is a responsibility of the supervising occupational therapist.

Additional information on this topic is available from MDE and is posted at these web addresses:

[Q&A: Reevaluations under Part B of the Individuals with Disabilities Education Act\(IDEA\)/  
http://education.state.mn.us/MDE/SchSup/CompAssist/QA/IEP/050232](http://education.state.mn.us/MDE/SchSup/CompAssist/QA/IEP/050232)

[Q&A: Part C Evaluations /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=002416&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=002416&RevisionSelectionMethod=latestReleased&Rendition=primary)

## **Procedures for Determining Eligibility and Placement**

### **Part C/Infants & Toddlers:**

A child from birth through age 2, may be determined eligible for Part C services, based on criteria listed below:

- Developmental Delay – 1.5 SD delay in one or more areas. The instrument and score used in each developmental area is recorded.
- Developmental Delay – Diagnosed physical or mental condition or disorder that has a [high probability of resulting in developmental delay](#). This specific condition(s) and the source of the child’s diagnosis is recorded.
- Categorical Disability – One of the categorical disability areas set out in Minnesota Rules is selected.
- Informed Clinical Opinion-This option may be used as an independent basis to establish a child’s eligibility for Part C services even when other instruments do not establish eligibility.

The team shall determine that a child from birth through the age of two years is eligible for infant and toddler intervention services if:

- A. the child meets the criteria of one of the disability categories in United States Code, title 20, chapter 33, sections 1400, et seq., as defined in Minnesota Rules; or

B. the child meets one of the criteria for developmental delay in sub-item (1) or the criteria in sub-item (2):

*(1) the child has a diagnosed physical or mental condition or disorder that has a high probability of resulting in developmental delay regardless of whether the child has a demonstrated need or delay; or*

*(2) the child is experiencing a developmental delay that is demonstrated by a score of 1.5 standard deviations or more below the mean, as measured by the appropriate diagnostic measures and procedures, in one or more of the following areas:*

- (a) cognitive development;*
- (b) physical development, including vision and hearing;*
- (c) communication development,*
- (d) social or emotional development; and*
- (e) adaptive development. [Minn. R. 3525.1350, subp. 2]*

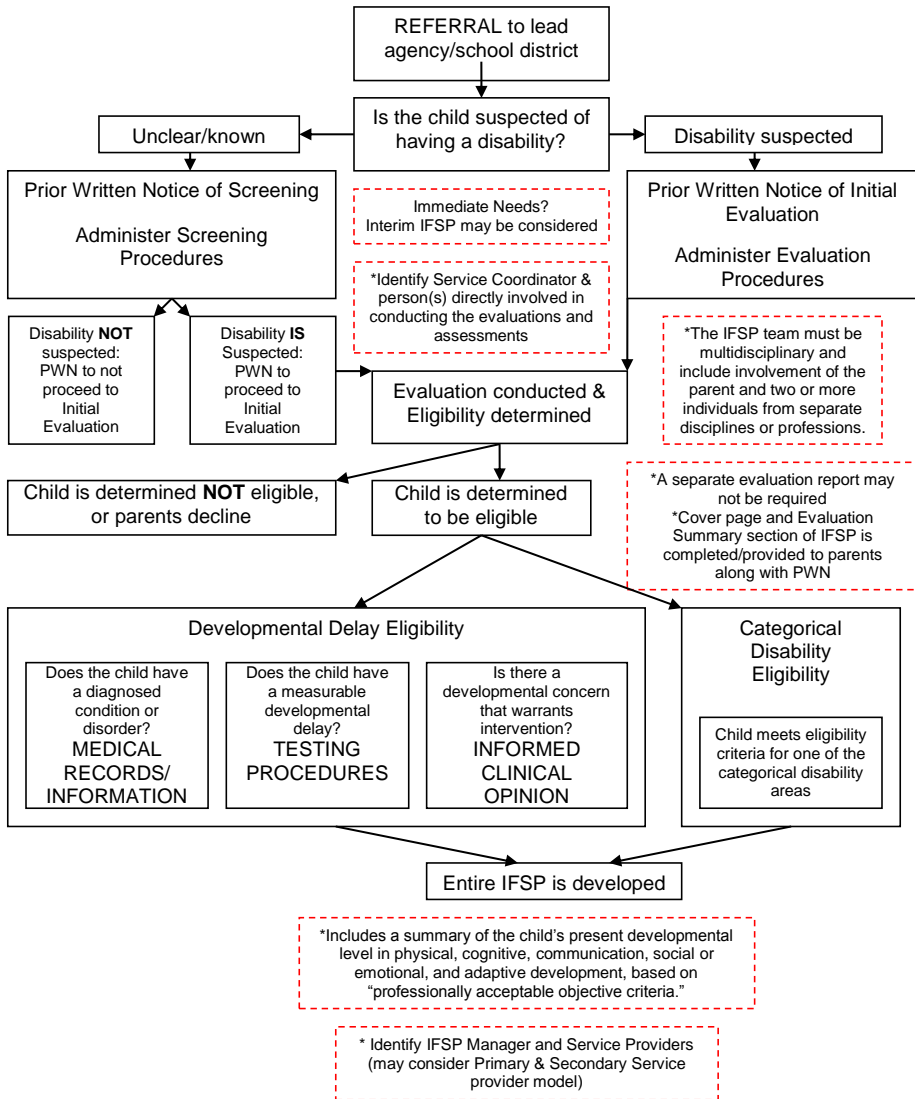
**Interim IFSP.** *Early intervention services for an eligible child and the child's family may commence before the completion of the evaluation and assessment in section 303.321, if the following conditions are met:*

- (a) Parental consent is obtained.*
- (b) An interim IFSP is developed that includes*
  - (1) The name of the service coordinator who will be responsible, consistent with section 303.344(g), for implementing the interim IFSP and coordination with other agencies and persons; and*
  - (2) The early intervention services that have been determined to be needed immediately by the child and the child's family.*
- (c) Evaluations and assessments are completed within the 45-day timeline in section 303.310. [34 C.F.R. § 303.345.]*

The following flow chart on the following page further illustrates the process of identifying infants/toddlers who may be eligible for Part C services:

ACCESSIBILITY NOTE: The process is explained in the above text and is too detailed to practically outline in a caption or alternative text tag.

**Illustration of Referral, Screening/Evaluation, and Eligibility Determination Process for Part C (Infant & Toddlers)**



**Part B:**

**Children Experiencing Developmental Delays (ages three through six years):** *"Child with a disability" for children aged three through nine (or any subset of that age range, including ages three through five), may, subject to the conditions described in section 300.111(b), include a child (1) Who is experiencing developmental delays, as defined by the State and as 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, or adaptive development; and (2) Who, by reason thereof, needs special education and related services. [34 C.F.R. § 300.8(b)]*

*The team shall determine that a child from the age of three years through the age of six years is eligible for special education when:*

*A. the child meets the criteria of one of the categorical disabilities in United States Code, title 20, chapter 33, sections 1400 et seq., as defined in Minnesota Rules; or*

*B. the child meets one of the criteria for developmental delay in subitem (1) and the criteria in subitem (2). Local school districts have the option of implementing these criteria for developmental delay. If a district chooses to implement these criteria, it may not modify them.*

*(1) The child: (a) has a diagnosed physical or mental condition or disorder that has a high probability of resulting in developmental delay; or (b) has a delay in each of two or more of the areas of cognitive development; physical development, including vision and hearing; communication development; social or emotional development; and adaptive development, that is verified by an evaluation using one or more technically adequate, norm-referenced instruments. The instruments must be individually administered by appropriately trained professionals and the scores must be at least 1.5 standard deviations below the mean in each area.*

*(2) The child's need for special education is supported by: (a) at least one documented, systematic observation in the child's daily routine setting by an appropriate professional or, if observation in the daily routine setting is not possible, the alternative setting must be justified; (b) a developmental history; and (c) at least one other evaluation procedure in each area of identified delay that is conducted on a different day than the medical or norm-referenced evaluation; which may include criterion-referenced instruments, language samples, or curriculum-based measures. [Minn. R. 3525.1351]*

**Determining the Child is a Child With a Disability (Other Areas of Eligibility):** *Upon completion of the administration of assessments and other evaluation measures (1) A group of qualified professionals and the parent of the child determines whether the child*

is a child with a disability, as defined in section 300.8, in accordance with paragraph (b) of this section and the educational needs of the child; and (a) Upon completion of the administration of assessments and other evaluation measures (2) The public agency provides a copy of the evaluation report and the documentation of determination of eligibility to the parent. [34 C.F.R. § 300.306(a)(2)]

"Child with a disability" means a child identified under federal and state special education law as deaf or hard of hearing, blind or visually impaired, deaf-blind, or having a speech or language impairment, a physical impairment, other health disability, developmental cognitive disability, an emotional or behavioral disorder, specific learning disability, autism spectrum disorder, traumatic brain injury, or severe multiple impairments, and who needs special education and related services, as determined by the rules of the commissioner. A licensed physician, an advanced practice nurse, or a licensed psychologist is qualified to make a diagnosis and determination of attention deficit disorder or attention deficit hyperactivity disorder for purposes of identifying a child with a disability. [Minn. Stat. § 125A.02, Subd. 1]

Eligibility criteria for each area of disability is further defined by Minnesota Rules. Those areas of disability with associated links are as follows:

- [3525.1325](#) : AUTISM SPECTRUM DISORDERS (ASD).
- [3525.1327](#) : DEAF-BLIND.
- [3525.1329](#) : EMOTIONAL OR BEHAVIORAL DISORDERS.
- [3525.1331](#) : DEAF AND HARD OF HEARING.
- [3525.1333](#) : DEVELOPMENTAL COGNITIVE DISABILITY.
- [3525.1335](#) : OTHER HEALTH DISABILITIES.
- [3525.1337](#) : PHYSICALLY IMPAIRED.
- [3525.1339](#) : SEVERELY MULTIPLY IMPAIRED.
- [3525.1341](#) : SPECIFIC LEARNING DISABILITY.
- [3525.1343](#) : SPEECH OR LANGUAGE IMPAIRMENTS.
- [3525.1345](#) : VISUALLY IMPAIRED.
- [3525.1348](#) : TRAUMATIC BRAIN INJURY (TBI).

**Team Override on Eligibility Decisions.** *The team may determine a pupil is eligible for special instruction and related services because the pupil has a disability and needs special instruction even though the pupil does not meet the specific requirement in parts 3525.1325 to 3525.1345, and 3525.2335. The team must include the documentation in the pupil's special education record according to items A, B, C, and D.*

- A. The record must contain documents that explain why the standards and procedures, that are used with the majority of pupils, resulted in invalid findings for this pupil.*
- B. The record must indicate objective data supporting the conclusion, and which data had the greatest relative importance for the eligibility decision.*
- C. The over ride decision must also be signed by the team members who agree. D. For team members who disagree, a statement of why they disagree and their signature must be included. [Minn. R. 3525.1354]*



**Determining the Child is Not a Child With a Disability.** *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); (ii) Lack of appropriate instruction in math; or (iii) Limited English proficiency; and (2) If the child does not otherwise meet the eligibility criteria under section 300.8(a). [34 C.F.R. § 300.306(b)]*

*In making a determination of eligibility under item D, a child shall not be determined to be a pupil with a disability if the determinant factor for such determination is lack of instruction in reading or math or limited English proficiency, and the child does not otherwise meet eligibility criteria under parts 3525.1325 to 3525.1351. [Minn. R. 3525.2710, subp. 3(E)]*

*A child with a short-term or temporary physical or emotional illness or disability, as determined by the rules of the commissioner, is not a child with a disability. [Minn. Stat. § 125A.02, Subd. 2]*

## **PROCEDURES FOR DETERMINING ELIGIBILITY**

### **Interpretation/Implications for Therapists:**

Therapists need to be aware of current special education disability categories and associated criteria defined by special education law, and any subsequent changes that occur.

Occupational therapy and physical therapy are Related Services that do not have separate eligibility criteria defined by law. The need for these services is determined by the therapist and other team members, once it has been established that the child is a child with a disability according to special education, categorical eligibility criteria. As part of the IEP/IFSP process, the team then determines if services from a therapist are necessary to address the educational needs of the child, help the child meet their educational goals/outcomes, and/or implement program modifications and accommodations for the child.

On occasion, an evaluation process may determine that the child is not a child with a disability because eligibility criteria for a categorical disability area have not been met. This may be more likely to occur when the child approaches age 3 and requires reevaluation for transition from Part C to Part B, or when they approach age 7 and require reevaluation to address eligibility beyond the Developmental Delay disability category. In situations where it is determined the child is no longer eligible for special education and related services, the therapist will have considered how their knowledge and support has created capacity in others to promote the child's development and success in school. The final evaluation report should contain thorough information about the child and any recommendations that will support the child in general

education. In some instances, it may be appropriate to consider if a Section 504 plan is needed. Further information on this is noted in the following section.

Additional information on Determining Part C Eligibility is available from MDE and is posted at this link/website address:

Part C Eligibility Determination Flowchart /

[http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=048062&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=048062&RevisionSelectionMethod=latestReleased&Rendition=primary)

Additional information and resources on eligibility procedures is available from MDE and is posted at these links/web addresses:

Categorical Disabilities /

<http://education.state.mn.us/MDE/EdExc/SpecEdClass/DisabCateg/index.html>

Evaluation Standards /

[http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=048252&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=048252&RevisionSelectionMethod=latestReleased&Rendition=primary)

## **Developmental Adapted Physical Education (DAPE)**

“Developmental adapted physical education: special education” means specially designed physical education instruction and services for pupils with disabilities who have a substantial delay or disorder in physical development. Developmental adapted physical education: special education instruction for pupils age three through 21 may include development of physical fitness, motor fitness, fundamental motor skills and patterns, skills in aquatics, dance, individual and group games, and sports. Students with conditions such as obesity, temporary injuries, and short-term or temporary illness or disabilities are termed special needs students. Special needs students are not eligible for developmental adapted physical education: special education. Provisions and modifications for these students must be made within regular physical education. [Minn. R. 3525.1352, subp. 1]

A pupil is eligible for developmental adapted physical education: special education if the team determines the pupil meets the criteria in items A and B.

A. The pupil has one of the following disabilities in each respective criteria in parts 3525.1325 to 3525.1341, 3525.1345, and 3525.1354: autism spectrum disorders, deaf-blind, emotional or behavioral disorders, deaf or hard of hearing, specific learning disability, developmental cognitive disability, severely multiply impaired, other health disability, physically impaired, visually impaired, traumatic brain injury or part 3525.1351.

B. The pupil is determined by the team to need specially designed physical education instruction because:

*(1) the pupil's performance on an appropriately selected, technically adequate, norm-referenced psychomotor or physical fitness instrument is 1.5 standard deviations or more below the mean. The instrument must be individually administered by appropriately licensed teachers; or*

*(2) the pupil's development or achievement and independence in school, home, and community settings is inadequate to allow the pupil to succeed in the regular physical education program as supported by written documentation from two or more of the following: motor and skill checklists; informal tests; criterion-referenced measures; deficits in achievement related to the defined curriculum; medical history or reports; parent and staff interviews; systematic observations; and social, emotional, and behavioral assessments. [Minn. R. 3525.1352, subp. 2]*

## DAPE

### Interpretation/Implications for Therapists:

When serving school aged children with special education needs, therapists will frequently have interactions with DAPE instructors.

It is important to know that this special education service has its own specific state defined eligibility criteria. Services from a therapist may not be used as a replacement for this service, nor may DAPE services be used as a substitute for therapy services. Collaboration between therapists and DAPE instructors is essential when assessing and providing special education services to address a child's need for physical education and activity in school.

Challenges arise when districts make decisions about the availability of DAPE services that are contingent upon the provision of Physical Education (PE) as core curriculum, particularly for children ages 3 through Kindergarten age. The following 3 resources support the importance of PE/DAPE at these early age ranges:

- [SHAPE America \(Society of Health and Physical Educators\)](#) identifies the "goal of physical education is to develop physically literate individuals who have the knowledge, skills and confidence to enjoy a lifetime of healthful physical activity." Resources for [Appropriate Instructional Practice Guidelines](#) for children ages 3-5, elementary, middle school and high school are promoted through this organization.
- In October 2004, the Health and Physical Education Quality Teaching Network (HPE QTN), in cooperation with MDE, drafted national standards and associated benchmarks/activities for Physical Education in MN in Kindergarten through grade 10.
- MN Rule 3525.1352 provides consideration of DAPE eligibility for children age 3 through 21.

When DAPE is not made available to children with special education needs in preschool and Kindergarten settings, therapists are often turned to as a solution for gross motor services to students in this age group. This can conflict with the therapist's role as a related service provider.

For preschoolers, the ECSE teacher is a primary service provider who is trained and responsible for structuring a rich learning environment that includes opportunities to

promote movement skills and motor development. A therapist may collaborate with and relate to the ECSE teacher in planning and co-implementing gym, playground or motor room activities. Although this service approach would provide generalized developmental benefit to all participating children, it may also be an opportunity to target specific children with an identified deficit for whom occupational therapy and /or physical therapy services has been defined on their IEPs. A DAPE instructor could also be assigned to serve preschoolers in the same capacity, with the understanding that students receiving IEP defined DAPE services will have met state eligibility criteria for that service.

It is not appropriate to assume that the therapist should take responsibility for providing additional gym/motor room activities or provide direct/pull out motor services to a child in Kindergarten, to accommodate for the lack of PE, to serve as a replacement for DAPE, or to function as primary provider of motor oriented activities. An additional challenge exists if a child's IEP from the preschool setting identifies goals that focus on milestones or benchmarks of typical motor development, rather than the functional implications of the child's physical ability to participate in the curriculum. Also, there are children who may not demonstrate motor needs or receive therapy services during their preschool experience, as they are functional and safe in their access to play and learning activities in that setting. However, some of these children may have difficulty in the Kindergarten setting, when motor skill expectations become higher, the school day becomes longer and more sedentary (i.e. increasing desk time), or if the curriculum/instructional experiences have fewer opportunities for movement based learning.

To address these types of challenges and prepare for a smooth transition to Kindergarten, the child's IEP (from preschool) would be reviewed/revise to anticipate and address the child's ability to function within the context of the Kindergarten setting. It is also important at this time, to address differences in the typical array of activities/events between a preschool and Kindergarten setting, and whether the child's physical function warrants the need to assess for DAPE services (if not currently provided). As a member of the child's special education team, the therapist uses their knowledge of the child's physical function to help define concerns related to the child's need for physical activity/exercise and other associated supports during the Kindergarten day. This discussion should project how the child's function may impact their ability to participate in Physical Education (and the goal to develop "physically literate" individuals), and whether DAPE may be needed as a bridge to further prepare the child to access the PE curriculum, and/or a supplemental, adapted version of that curriculum.

The therapist maintains their role as a related service provider, working in a collaborative capacity with the child's Kindergarten teacher, the building level IEP manager, the specialist with licensure associated with the child's disability area, and other team members. The therapist continues to promote the team's understanding of the child's physical condition//disability/diagnosis and its impact on their educational performance. To maximize the child's access to the curriculum and their response to

instruction, the therapist continues to provide strategies of support and/or accommodations that can be used by others and integrated within the context of the school day. A common role of a therapist and DAPE instructor would be consultative support to Kindergarten and PE teachers regarding appropriate physical activities to incorporate in to their curriculum, and ways that those activities may be adapted to benefit children in their class who have special education needs. A broader role of the therapist and DAPE/PE instructor is providing Response to Intervention (RTI) support, utilizing collaboration with classroom teachers about the connection between movement/learning (brain-body skills) for all children.

Additional information and resources are available at the following links/web addresses:

[MN Rule 3525.1352 /  
http://www.revisor.mn.gov/rules/?id=3525.1352](http://www.revisor.mn.gov/rules/?id=3525.1352)

[Developmental Adapted Physical Education /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=005628&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=005628&RevisionSelectionMethod=latestReleased&Rendition=primary)

[National Physical Education Standards and Minnesota Benchmarks /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=005243&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=005243&RevisionSelectionMethod=latestReleased&Rendition=primary)

[National Standards and Grade Level Outcomes for K-12 Physical Education /  
http://www.shapeamerica.org/standards/pe/index.cfm?cid=print](http://www.shapeamerica.org/standards/pe/index.cfm?cid=print)

[SHAPE America - Society of Health and Physical Educators /  
http://www.shapeamerica.org/standards/pe/index.cfm](http://www.shapeamerica.org/standards/pe/index.cfm)

### **Section 504 of the Rehabilitation Act of 1973**

Section 504 of the Rehabilitation Act of 1973 is a federal civil rights statute that assures individuals will not be discriminated against based on their disability. All school districts that receive federal funding are responsible for the implementation of this law. This law protects a student with a covered disability that substantially limits one or more major life activities, whether the student receives special education services or not.

The U.S. Department of Education, Office for Civil Rights (OCR) administers Section 504. The Minnesota Department of Education (MDE) has no enforcement authority for this law.

If a student qualifies under IDEA, the student also qualifies under Section 504 and, therefore, is covered under its nondiscrimination protections. A student who has been determined to be qualified under Section 504, however, is not necessarily considered disabled under IDEA if the student does not meet one of the thirteen specific criteria (See 34 C.F.R. § 300.8(c)(1-13).

The Minnesota Department of Education, Division of Compliance and Monitoring, has developed several resources including a Compliance Manual for Section 504 of the Rehabilitation Act of 1973, as an effort to provide technical assistance to districts and parents pertaining to students with disabilities and Section 504 of the Rehabilitation Act.

**Students may be identified as potentially needing services under Section 504, when:**

- a parent, teacher or child frequently expresses a concern about the child's performance.
- suspension or expulsion is being considered for a student.
- retention of a student is being considered.
- a student demonstrates a pattern of not benefiting from teacher instruction, including failing grades or inability to progress through grade level curriculum.
- a student returns to school after a serious illness or injury and/or has a chronic health condition or learning disability.
- a student is evaluated and is found to not qualify for special education services under IDEA.
- a student has been identified as having an attention deficit disorder (ADD) or attention deficit hyperactive disorder (ADHD), Autism Spectrum Disorder (ASD) or any other chronic mental, emotional, behavioral, medical or physical condition that substantially limits a major life activity.
- a student is identified as "at risk" for whatever reason or exhibits the potential for dropping out of school (e.g., inconsistent attendance, behavioral issues, substance or child abuse in the family; substance abuse by student).
- a child is suspected of having or known to have a disability of any kind.

**Section 504**

**Interpretation/Implications for Therapists:**

Consideration of a 504 plan may be important if child has been evaluated and subsequently determined that they are not/no longer a child with a disability, or they are not eligible for special education service under existing criteria for categorical disabilities.

Services under this law are the responsibility of general education and are not regarded as Special Education. Therefore, costs associated with therapists providing services under 504 plans (e.g. percentage of time/salary) should be funded by regular education.

The role of the therapist may vary, but must specifically relate to helping a student to access educational programming and activities. Examples of possible services include the provision of information and training in the use of assistive technology, and other modifications/accommodations that can be applied to the school environment to support the student's participation.

It is inappropriate to implement a 504 plan for a student simply as a means to provide therapy in school, either as a convenience or replacement for services in the families should pursue in the community. Similar to the therapists role within the context of special education, the service a therapist may provide as part of a student's 504 plan should not be delivered in an isolated/non-integrated, clinic-like fashion. The focus remains on addressing the student's educational needs and their access to instructional opportunities, not the provision of clinical services, or specialized instruction in the educational setting. If the therapist thinks a student has additional needs for therapy that are not educational, the therapist should dialogue with the family about outside services.

A therapist should be familiar with 504 procedures in a district/school, however any requests for a therapist's involvement in 504 plans for specific students, should be discussed with administrators responsible for supervising/directing the duties of the therapist.

Given limitations in the current school therapist workforce, and the common itinerant nature of their work in a district, it would be highly unusual and inefficient to assign an occupational therapist or physical therapist responsibilities for coordinating the evaluation for, and implementation/review of Section 504 Plans for a student. It is important that case management for a 504 plan be assigned to a person who is on site and readily available, and whose time for this responsibility is paid for by regular education funds.

Additional information and resources are available from MDE and is posted at these links/ web addresses:

[Section 504 /](#)

<http://education.state.mn.us/MDE/StuSuc/StuRight/Sect504/index.html>

[Compliance Manual for Section 504 of the Rehabilitation Act of 1973 /](#)

[http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=040445&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=040445&RevisionSelectionMethod=latestReleased&Rendition=primary)



## COMPONENTS OF IFSP DEVELOPMENT

Philosophy of the Individualized Education Program (IEP) and Individualized Family Service Plan (IFSP) are similar for therapists. However, there are differences in focus, format, emphasis, and language. For this reason, the two documents are addressed separately in this edition of the manual.

The focus and emphasis of the IFSP is the function of the child and family in the home environment. The focus and emphasis of the IEP is the function of the student in current school and future environments. The structure of the IFSP differs from the IEP in all areas of the document, because it is family focused. Statements are often directly derived from the family, especially in the areas of outcomes and identification of needs.

Additional information and resources available on the MDE website that have been used throughout this IFSP Development section, can be located at the following links/web addresses:

[Individual Family Service Plan \(IFSP\) Form Guidance /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=043815&RevisionSelectionMethod=latest&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=043815&RevisionSelectionMethod=latest&Rendition=primary)

[MNCIMP: SR Record Review Training Part C - IFSP /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=051946&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=051946&RevisionSelectionMethod=latestReleased&Rendition=primary)

[MNCIMP: Record Review Training Part C- Timelines /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=051948&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=051948&RevisionSelectionMethod=latestReleased&Rendition=primary)

[MNCIMP: Record Review Training Part C - Notification /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=051947&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=051947&RevisionSelectionMethod=latestReleased&Rendition=primary)

[Q&A: Individualized Family Service Plan \(IFSP\) /  
http://education.state.mn.us/MDE/SchSup/ComplAssist/QA/002418](http://education.state.mn.us/MDE/SchSup/ComplAssist/QA/002418)

[Q&A: Individualized Family Service Plan \(IFSP\): Statement on Reporting Progress /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=002417&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=002417&RevisionSelectionMethod=latestReleased&Rendition=primary)

[Individualized Education Program \(IEP\) Planning and Individualized Family Service Plan \(IFSP\) Planning/](#)

[http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=048253&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=048253&RevisionSelectionMethod=latestReleased&Rendition=primary)

As changes in web address links occur, the reader will need to use the search mechanism on the MDE website to locate these resources, or to locate any updated or additional information that may be posted in the future.

### **IFSP Team Members**

IFSP team members include:

- The parent or parents of the child;
- Other family members, as requested by the parent, if feasible to do so;
- An advocate or person outside of the family, if requested by the parent;
- The service coordinator; designated by the district/public agency to be responsible for implementing the IFSP. The participation of the service coordinator is a minimum requirement for the development of an interim IFSP;
- a person(s) directly involved in conducting the evaluations and assessments and as appropriate, persons who will be providing early intervention services to the child (these individuals may participate in a periodic review if warranted).

The IFSP team must be multidisciplinary. It must include the involvement of the parent and two or more individuals from separate disciplines or professions. One of these individuals must be the service coordinator.

Evaluators or assessors of the child must be multidisciplinary, but may include one individual who is qualified in more than one discipline or profession. The IFSP must indicate how an evaluator or assessor has participate in an IFSP meeting. The four alternatives for this participation are:

- Attended meeting;
- Participated through telephone conference call;
- Made pertinent records available at the meeting; or
- Had a knowledgeable, authorized representative attend the meeting.

All members are required to attend in order for a meeting to be considered an IFSP team meeting, with the exception of evaluators and assessors who can participate in alternative formats.

### **IFSP Team Members**

#### **Interpretation/Implications for Therapists:**

As addressed previously in the THEORY & PHILOSOPHY section, the Primary Service Provider model is widely used in Part C (Infant/Toddler) services. Occupational therapists and physical therapists often function as primary service providers (PSP), as do early childhood teachers. The PSP should be determined for each child based on

the family priorities, child needs, environmental factors, and team members. This model is based on four foundational components: 1) role expectation, 2) role overlap, 3) role gap, and 4) role assistance. Regular team meetings and role assistance to the primary provider are essential components of the PSP model. All team members (OT, PT, ECSE teacher, Speech Language pathologist, etc.) must be available to serve as either PSP or SSP (secondary service provider).

Children with motor needs can be well served in the PSP role by a variety of team members. Therapists can be effective in both the PSP and SSP roles. In the secondary service provider role, therapists provide role assistance to the team member who is the PSP when there is an identified role gap. Coaching both families/caregivers as well as other team members is an essential component of the PSP model. With these components in place, the therapist would have confidence that the service model is working well. Concerns can be addressed through effective communication on teams, as well as effective role assistance.

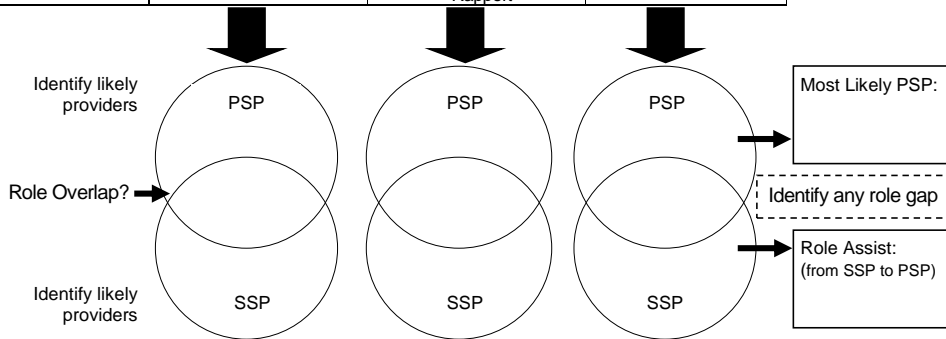
The following is an illustration of a process for determining the most likely PSP(s) based on the factors of the Parent/Family, the Child, the Environment and the Practitioner:

**Illustration of the Decision Making Process for Primary Service Provider (PSP) / Secondary Service Provider (SSP)**

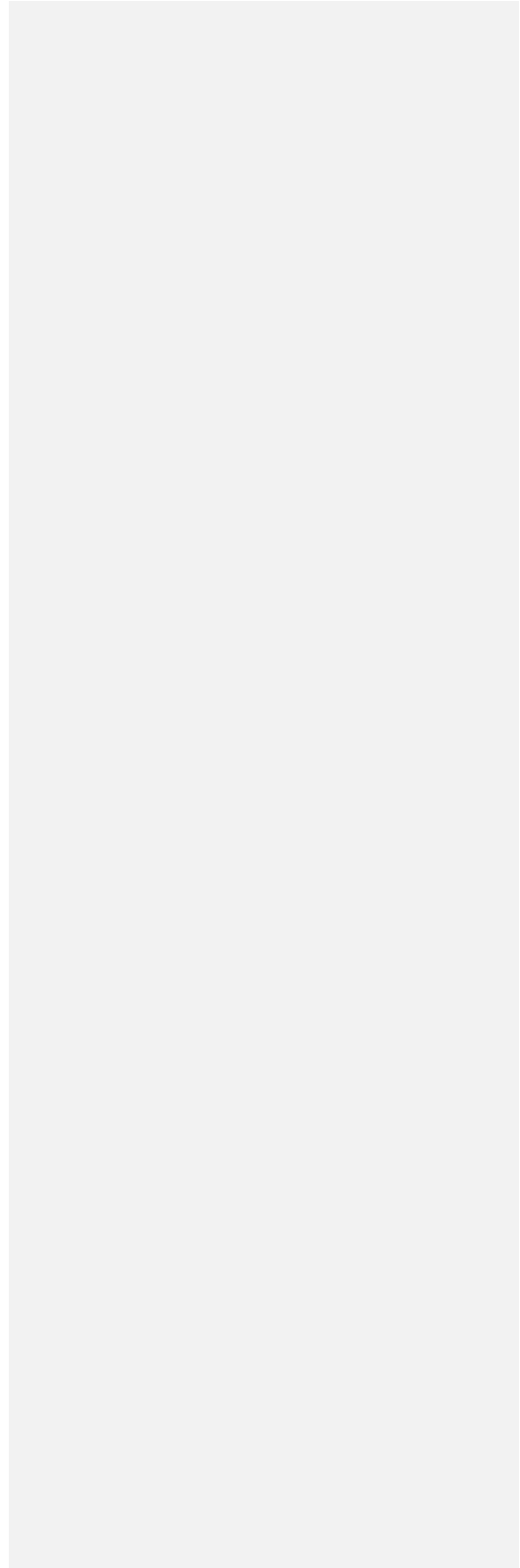
Core Team Options: Early Childhood Specialist (EC), Occupational Therapist (OT), Physical Therapist (PT), Speech-Language Pathologist (SLP), Other

*ACCESSIBILITY CHART TRANSLATION: A table and chart combination illustrating the Decision Making Process for the Primary and Secondary Service Provider. Detail too great to contain in caption.*

	First Level Considerations	Second Level Considerations	Third Level Considerations
<b>PARENT/FAMILY</b>	* Priorities with contexts * Parent/physician request	* Family dynamics * Individual parent/caregiver characteristics: -Language/culture -Knowledge/expertise -Diagnosis/condition -Other	* Availability
<b>CHILD</b>	* Diagnosis / condition / needs * Interests / activity settings		
<b>ENVIRONMENT</b>	* Natural learning environments: Home, Community, Preschool, Child Care, Other	* Safety * Distance from program office	
<b>PRACTITIONER</b>	* Knowledge / expertise	* Primary service area in geographic region * Prior relationship * Rapport	* Availability



*Adapted from: The Early Intervention Teaming Handbook: The Primary Service Provider Approach by M'Lisa L. Sheldon, Dathan D. Rush. Paul H. Brooks Publishing Co. 2013*



## **Progress Reporting**

Part C federal regulations require, at a minimum, a 6-month periodic review and an annual IFSP meeting to evaluate the IFSP. [34 C.F.R. § 303.342].

The IFSP periodic review shall take place every six months or more frequently if warranted or if requested by parent. Participants in a periodic review include:

- The parent or parents of the child;
- Other family members, as requested by the parent, if feasible to do so;
- An advocate or person outside of the family, if requested by the parent;
- The service coordinator; designated by the public agency to be responsible for implementing the IFSP; and
- If warranted, a person or persons directly involved in conducting the evaluations and assessments and as appropriate, persons who will be providing early intervention services to the child.

At the periodic review the progress made by the child and the family related to the outcome is described. Options to describe the degree of progress include: accomplished, continue, modify/revise, or discontinue.

## **Evaluation and Assessment Summary**

The initial IFSP and subsequent IFSPs must include a statement of the child's present levels of development in each of the five domains. These levels of development must be addressed by an appropriately comprehensive evaluation and assessment procedures under Part C. The Evaluation/Assessment Summary section of an initial IFSP will include information gathered from the initial Part C evaluation and assessment procedures. The Evaluation/Assessment Summary of subsequent IFSPs must document information integrated from ongoing assessment, reports of parents and other caregivers and observations made by service providers. There is no requirement for a separate Evaluation Report under Part C. For children who are determined eligible, the Evaluation Summary provides evaluation results to parents and documents developmental status within the IFSP.

For children who are determined to not be eligible for Part C, or if parents of an eligible child decline services, the Evaluation Summary section together with the completed cover page should be provided to parents.

If a separate evaluation is written, either because your district requires you to write an Evaluation Report or if you are documenting the results of an evaluation that addressed eligibility under both Part C and Part B (the Evaluation Report is a Part B requirement), you must still complete the Summary of All Developmental Areas (Part C required IFSP information). You may not state "see attached Evaluation Report."

**Summary of All Developmental Areas.** By integrating the evaluation summary into the IFSP, the federal requirement to include a summary of all developmental areas in the IFSP is addressed. The 5 domain/developmental areas are:

- Physical development such as Health (includes medical, dental, nutrition); Vision/Hearing (screening, glasses, hearing aids, history of ear infections); Fine motor (use of hands and upper body); Gross motor (quality and function of movement, equipment/devices); and Other Sensory issues, if appropriate
- Communication (e.g., understanding, expression, intelligibility, use of language, language skills and pre-literacy)
- Cognition (e.g., thinking, play skills)
- Social Emotional (e.g., engagement, response to caregivers, coping)
- Adaptive (e.g., feeding, dressing, toileting, sleeping)

This information should be updated during annual IFSP reviews. Emphasis should be given to the child's functional abilities and strengths within daily routines. Include information on what the child can do and what he needs to learn. The child's learning style may be addressed so that natural abilities can be more easily identified and strengthened.

### **Summary of Developmental Areas**

#### **Interpretation/Implications for Therapists:**

The section of an IFSP describing a child's developmental status, should be composed in an integrated fashion incorporating information and ideas from all team members. Therapists should be careful to avoid noting therapy specific details, using therapy jargon, or taking sole responsibility for writing these sections. It is important to write statements that reflect evaluation results, and describe what the child is able to do and not do, in a functional, concise and meaningful manner that all team members understand.

It is inappropriate to write summary information that contains therapy jargon and focuses on impairments such as:

- The child has limitations in active range of motion of his right lower extremity, with only 30 degrees of hip abduction, and a lack of the terminal 15 degrees of knee extension.
- The child has 8 degrees of residual head tilt from torticollis.
- The child demonstrates symmetrical and asymmetrical tonic neck reflexes.

Examples of functional, meaningful and appropriate summaries for the above examples are as follows:

- When standing and playing at a table with peers, the child is comfortable and stable with movement.

- When sitting/standing the child is able to see and interact with family members and toys in front and to the sides.
- When laying on their back, the child is able to turn their head in both directions, but is not yet able to bring their hands together to reach for a toy/desired object. The child needs assistance to roll and to prop on their forearms in a tummy position.

**Eligibility Determination.** Based on evaluation findings, and the associated summary of all developmental areas, this section of the IFSP is completed to reflect that the child is either:

1. Not eligible under Part C  
-or-
2. Eligible for Part C according to one of the following criteria-
  - Developmental Delay (1.5 SD or more in at least one area of development, instrument and scores are indicated)
  - Developmental Delay (diagnosed physical or mental condition/disorder which has a high probability of resulting in a developmental delay, condition and source of diagnosis are specified)
  - Categorical Disability
  - Informed Clinical Opinion

**Family Directed Assessment.** This section is considered voluntary on the part of the family. The family's description of their concerns, priorities, and resources related to enhancing the development of the child is recorded here. This is used as the basis for developing outcomes and identifying strategies and activities to address the child's identified needs. If the family does not agree to participate in a family directed assessment, "Family Member(s) Declined" is indicated.

### **Child and Family Outcome(s)**

Functional outcomes identified with families are the focal point of the IFSP document. They provide direction for future collaboration between the parents and providers of infant and toddler intervention services. The outcomes specify what should happen for families and children as a result of their participation in early intervention services. Outcomes reflect parents' priorities, build upon identified strengths, build capacity in parents and other caregivers and promote the development of functional skills in children served. Outcomes should be meaningfully tied to everyday learning contexts and family routines. The format of the Outcomes section of the IFSP includes these components:



- **Measureable result or measureable outcome:** Outcomes should be worded as observable skills, behaviors, products or events the team wishes to see within 6 months to 1 year.
- **Why is this result or outcome being addressed:** A rationale statement that makes clear to all members of the IFSP why the outcome has been prioritized and is included.
- **What is already happening:** A section (equating to the PLAAFP section of an IEP) describing what the child and family are currently doing specific to this functional outcome.
- **We will know we are successful when (include criteria and procedures):** This section is a description of how achievement of the functional outcome will be measured; the acquisition criterion. Measurable criteria track an action or behavior that can be seen or heard reliably by others, and do not require interpretation or guessing to determine when an outcome has been achieved.
- **Timeline that will be used to determine the extent to which progress is being made:** A description of the timeline that will be used to determine the extent to which progress is being made towards achieving the outcomes and the timelines that will be used to determine whether modifications or revisions of the expected outcomes or early intervention services identified in the IFSP are necessary. The timeline should reflect the anticipated date by which an outcome is expected to be achieved, and the points at which, and by whom, the progress will be monitored.
- **What will happen within the child and family's everyday routines and activities and places:** A description of how the selected intervention methodologies will be implemented throughout the natural learning opportunities that are part of the family's daily routines. This section should clearly describe how members of the IFSP team or other caregivers of the child are embedding intervention into activities such as meals, play, bath, bed and other important daily routines.

### **Child and Family Outcome(s)**

#### **Interpretation/Implications for Therapists:**

Outcomes on IFSPs should be written in family language, and ideally should be quoted from the family's priorities and concerns.

These examples are inappropriate outcome statements, since they lack functionality and the context of family priorities and concerns:

- The child will ring sit without propping on hands for 15 seconds when observed by adult.

- The child will use both hands to pop bubbles that are blown to him, 3 of 4 times.
- The child will demonstrate tongue retraction/lip closure to drink 4 ounces from a bottle without spilling during each feeding.

The following are examples of the various components of well written outcome statements:

- Mom and other caregivers in the family, want this child to use his muscles to be able to sit by himself and move better during play, especially with bubbles which is a desired activity of the child and his brothers and sisters.
- Mom will be able to feed sufficient amounts of food and nutrition on a regular basis and the child will be an active participant in all feedings.

There is a specific section called "Needs" on the IEP. Although there is no separate section labeled this on an IFSP, each functional outcome must address the question "Why is this outcome being addressed", which is based on priorities and concerns of the family. Addressing this question involves a thinking process similar to that used for determining IEP needs, and by using understandable language, helps the family further understand the child's function and the hopes they have for their child.

The following are examples of using family friendly language to address the "Why" and "What is Already Happening" outcome sections in an IFSP:

- The child's family would like him to grow and do things like other children his age. He has a diagnosis of Down's Syndrome, so his development is delayed in all areas.
- The child loves bubble play, but has shown frustration because he cannot sit and play well with them without tipping over due to his motor difficulties. This made his family sad, so they have stopped using bubbles for play.
- Parents are concerned that their child is fussy and doesn't drink enough from his bottle, so feedings occur frequently, laying down and cradled in mom's arms. Because the child is no longer baby size, they would like him to learn to eat and drink like their other children, and join the family during mealtimes.

The following statements, that include criteria and procedures associated with knowing success or measuring the child's achievement, are examples of "We will know we are successful when:"

- The ECSE team and family will observe the child sitting without tipping over, and using one or both hands to bat at bubbles or engage in upright play with other

toys, for up to 5 minutes in duration. Family will report this happens at least once a day.

- The ECSE team and family will observe the child drinking liquids from a cup/sippy cup. Family will report this happens on a daily basis.
- The ECSE team and family will observe the child exploring food tastes/textures in hands to mouth play, and tasting or eating some pureed food fed to him from a spoon. Family will report this happens during each daily mealtime.

Examples of "Timeline" statements that could be linked to each outcome are as follows:

- The child's family and ECSE team think that he will accomplish the above outcomes by a family picnic in September/fall 2014.
- The child's family and ECSE team thinks he will be able to accomplish this in six months by his birthday (date).

The following additional statements are examples that address "What will happen within everyday routines, activities and places:"

- The child's family will give him many opportunities move and use upright positions during daily routines. They will use bubble play and floor time to practice these skills. The team will work with the family to provide ideas, and will demonstrate the ways they can help their child move/play.
- The child's family and ECSE team will provide suggestions and information regarding feeding skills and routines that the family will be able to incorporate into their daily mealtime. This will include how to: place the child in an upright, supported sitting position near the family dining table; wean from bottle use by introducing a liquids from a cup/soft food from a spoon; and encourage the child to use their hands to explore food and mealtime items. This will include how to prepare liquids/foods for texture and thickness, and the use of adapted cups/utensils.
- The ECSE team will create chart of the child's accomplishments over time so that the family can see and better understand his rate of development as it relates to Down's Syndrome. The ECSE team will coach the child's family regarding ideas for next steps in his motor development.

### IFSP (Part C) Services

The following are examples of how services may be documented in grid fashion on an IFSP:

#### Illustration of IFSP Service Grid (high frequency/team service model)

*ACCESSIBILITY CHART TRANSLATION: Illustration of IFSP Service Grid: high frequency/team service model. Detail too great to contain within caption.*

Services	Projected Start Date	Length:	Frequency	Intensity	Method	Actual Location -	Anticipated Duration	Funding Source if Other than School
Family Coaching: ECSE Teacher	9/7/13	30 minutes	3x/month (weekly)	Individual	*Monitoring/consultation with parent/caregiver and OT/PT	Home and day care.	1/6/14 (3 months)	
Family Coaching: ECSE Teacher	9/7/13	60 minutes	1x/month - joint visit with other service providers	Individual	*Face to face interactions with the child.  *Consultation/ demonstration teaching to parent/caregiver	Home and day care.	3/6/14 (6 months - see service description)	
Family Coaching: Physical Therapy	9/7/13	60 minutes	2x/month (alternating weeks, will include 1 joint visit per month with other service providers)	Individual	*Face to face interactions with the child.  *Consultation/ demonstration teaching to parent/caregiver.	Home and day care.	3/6/14 (6 months - see service description)	
Family Coaching: Occupational Therapy	9/7/13	60 minutes	2x/month (alternating weeks, will include 1 joint visit per month with other service providers)	Individual	*Face to face interactions with the child.  *Consultation/ demonstration teaching to parent/caregiver.	Home and day care.	3/6/14 (6 months - see service description)	

**Illustration of IFSP Service Grid (diminished frequency/team model)**

*ACCESSIBILITY CHART TRANSLATION: Illustration of IFSP Service Grid: diminished frequency/team model. Detail too great to contain within caption.*

Services	Projected Start Date	Length:	Frequency	Intensity	Method	Actual Location -	Anticipated Duration	Funding Source if Other than School
ECSE Teacher	3/7/13	60 minutes	1x/month	Individual	*Direct interactions with the child.  *Monitoring/consultation with parent/caregiver and OT/PT	Home and day care.	9/6/14 (remainder of IFSP year)	
ECSE Teacher Teaming	3/7/13	15 minutes	1x/month	Individual	*Consultative (collaboration/coaching with OT/PT)	ECSE Office	9/6/14 (remainder of IFSP year)	
Physical Therapy	3/7/14	60 minutes	6x/year (alternating months will be joint visit with other service providers)	Individual	*Consultative/demonstration teaching to parent/caregiver.	Home and day care.	9/6/14 (remainder of IFSP year)	
Physical Therapy Teaming	3/7/14	15 minutes	1x/month	Individual	*Consultative collaboration/coaching with OT/ECSE Teacher	ECSE Office	9/6/14 (remainder of IFSP year)	
Occupational Therapy	3/7/14	60 minutes	6x/year (alternating months will be joint visit with other service providers)	Individual	*Consultative/demonstration teaching to parent/caregiver.	Home and day care.	9/6/14 (remainder of IFSP year)	
Occupational Therapy Teaming	3/7/14	15 minutes	1x/month	Individual	*Consultative/collaboration/coaching with PT/ECSE Teacher	ECSE Office	9/6/14 (remainder of IFSP year)	

## **Justification For Each Service Provided In Locations Other Than The Natural Environment**

*The IFSP must include a statement of the specific early intervention services based on peer-reviewed research (to the extent practicable), that are necessary to meet the unique needs of the child and the family to achieve the results or outcomes identified in paragraph (c) of this section, including—(ii) A statement that each early intervention service is provided in the natural environment for that child or service to the maximum extent appropriate, consistent with sections 303.13(a)(8), 303.26 and 303.126, or, subject to paragraph (d)(1)(ii)(B) of this section, a justification as to why an early intervention service will not be provided in the natural environment. [34 C.F.R. § 303.344(d)(1)(ii)]*

*Early intervention services means developmental services that—(8) To the maximum extent appropriate, are provided in natural environments, as defined in section 303.26 and consistent with sections 303.126 and 303.344. [34 C.F.R. § 303.13(a)(8).]*

*(5) to the maximum extent appropriate, children with a disability, including those in public or private institutions or other care facilities, are educated with children who are not disabled, and that special classes, separate schooling, or other removal of children with a disability from the regular educational environment occurs only when and to the extent that the nature or severity of the disability is such that education in regular classes with the use of supplementary services cannot be achieved satisfactorily; [Minn. Stat. § 125A.08]*

The IFSP must include a statement of the specific early intervention services necessary to meet the unique needs of the child and family to achieve the outcomes identified in the law including the natural environments (i.e. settings that are natural or normal for the child's age peers who have no disability) in which early intervention services will be provided, and a justification of the extent, if any, to which the services will not be provided in a natural environment. To the maximum extent appropriate to the needs of the child, early intervention services must be provided in natural environments, including the home and community settings in which children without disabilities participate. Preference shall be given to providing special instruction and services to children under age three and their families in the residence of the child with the parent or primary caregiver, or both, present.

Any of the services identified in the Part C Services Early Intervention grid that are provided in locations other than the natural environment, must be addressed in this section of the IFSP. The IFSP team must describe how/why they determined that the child's outcomes could not be met if the early intervention services were provided in the child's natural environment. If services are provided in a segregated setting, the team needs to explain how these services will support the child's ability to function in his/her

natural environment or in the least restrictive environment for children nearing three years old.

### **Natural Environment**

#### **Interpretation/Implications for Therapists:**

This section of an IFSP involves the same type of thinking as when addressing least restrictive environment for children with IEPs.

School therapists working with infants and toddlers have a unique role, working with families in their home, as well as day cares, and other community settings. Part of that role must be looking to the future, while incorporating the priorities and concerns of the family into an educational plan for the child. The intervention is family centered and the recommended model of intervention is coaching the family and caregivers. Coaching is defined as a collaborative effort between the therapist and family, which acknowledges the family's existing abilities while helping them to build skills and form goals for their child. The coaching model is an evidence-based practice that is supported by significant research, and should be used by therapists to help them in moving from primary use of child-focused interventions to interventions that support the adults who care for young children.

### **Planning for transition from Part C services**

This section of the IFSP was developed to assist IFSP teams in appropriately implementing and documenting the steps necessary to appropriately transition a child from services under Part C to other community services or to services under Part B if the child is eligible.

The documentation of transition steps and services is required for all children served under Part C regardless of whether the team believes the child is potentially eligible for services under Part B. Staff should record each step of transition planning on the IFSP form and identify what will happen and the timeline for the transition steps and services. For example, an important transition step may be to administer a Part B evaluation to determine eligibility for students moving out of Part C (reaching the age of three).

In the case of transition to preschool services, the IFSP shall be in writing and contain the steps to be taken to support the transition of the toddler with a disability to preschool or other appropriate services. The steps required include: discussions with, and training of, parents regarding future placements and other matters related to the child's transition; procedures to prepare the child for changes in service delivery, including steps to help the child adjust to, and function in, a new setting; and with parental

consent, the transmission of information about the child to the LEA (Local Educational Agency) to ensure continuity of services, including evaluation and assessment information, and copies of IFSPs that have been developed and implemented.

### **Transition to Preschool Services**

#### **Interpretation/Implications for Therapists:**

Therapists who work with children and their families in the home setting, need to prepare parents/caregivers for changes in the child's needs as they move toward preschool opportunities. Therapists who have conducted home visits in a manner that involves observing parent/caregiver interactions with the child, discussion of changes demonstrated by the child, and demonstration/feedback and cooperative planning regarding techniques that support the child's daily function, will have helped to cultivate an understanding of how therapy can be a support and resource to others who become involved their child in other settings. It is important to avoid the perception/expectation that the child can be handed over to the visiting therapist who will then go off to work in isolation on a "therapy" activity. Therapists also need to work and collaborate with ECSE teachers and other specialists who are/will become involved with the child, particularly as the child approaches preschool age. This helps to establish the role of the therapist as a "related" special education service, and allows opportunities for the team to address specific learning demands/opportunities the child will encounter as they move toward educational experiences in a school setting. It is also important for therapists to understand the role and availability of Developmental Adapted Physical Education (DAPE) for children of preschool age. The evaluation for determining the child's eligibility from Part C to Part B services, is a natural and important time when assessment/eligibility determination for DAPE services can be considered for children who have had difficulties/delays in their motor development. Please note the previous EVALUATION: Developmental Adapted Physical Education section for further information on this topic.

Collaboration with teachers and day care providers is essential to ensure the student's future success, as well as establishing the role of the therapist as a "related" special education service. The school therapist working with infants and toddlers must have a strong awareness of future needs of the student, always remembering that the role of early childhood education is to prepare the student for school and transitions, including graduation and the workplace. School therapists working with infants and toddlers should make opportunities to learn about lifelong needs and essential skills of students, through shadowing, observation, and working with therapists serving older students.

## **COMPONENTS OF IEP DEVELOPMENT**



Additional information and resources available on the MDE website that have been used throughout this IEP Development section, can be located at the following links/web addresses:

[Individualized Education Program \(IEP\) Form \(US Department of Education model IEP\) /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=055549&RevisionSelectionMethod=latest&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=055549&RevisionSelectionMethod=latest&Rendition=primary)

[Individualized Education Program \(IEP\) Rubric /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=055587&RevisionSelectionMethod=latest&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=055587&RevisionSelectionMethod=latest&Rendition=primary)

[Individualized Education Program \(IEP\) Planning and Individualized Family Service Plan \(IFSP\) Planning/  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=048253&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=048253&RevisionSelectionMethod=latestReleased&Rendition=primary)

[MNCIMP: SR Record Review Training - IEP Standards /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=049209&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=049209&RevisionSelectionMethod=latestReleased&Rendition=primary)

[MNCIMP: Record Review Training Part B- Timelines /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=051948&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=051948&RevisionSelectionMethod=latestReleased&Rendition=primary)

[MNCIMP: Record Review Training - Notification Standards /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=048337&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=048337&RevisionSelectionMethod=latestReleased&Rendition=primary)

[Q&A: Individualized Education Program \(IEP\) Team Meeting Attendance /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=002398&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=002398&RevisionSelectionMethod=latestReleased&Rendition=primary)

[Q&A: Needs-Based Goals /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=043874&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=043874&RevisionSelectionMethod=latestReleased&Rendition=primary)

[Q&A: Related Services /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=002396&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=002396&RevisionSelectionMethod=latestReleased&Rendition=primary)

As changes in web address links occur, the reader will need to use the search mechanism on the MDE website to locate these documents, or to locate any updated or additional information that may be posted in the future.

## Team Members

Districts are required to ensure that each IEP team includes the following required members:

- Parent(s) of the student, which may include a legal guardian, surrogate parent, and student if age 18 or older;
- At least one general education teacher (if the student is, or may be, participating in the regular education environment);
- At least one special education teacher of the student or where appropriate, not less than one special education provider. This person should be the person who is, or will be, responsible for implementing the IEP. For example, if the student's disability is a speech impairment, the special education teacher or special education provider could be the speech language pathologist. [34 C.F.R. § 300.321 cmts. at 71 F.R. 46670];
- A district representative who is:
  - qualified to provide, or supervise the provision of, specially designed instruction to meet the unique needs of students with disabilities;
  - knowledgeable about the general education curriculum; and
  - knowledgeable about the availability of resources of the public agency;
- An individual who can interpret the instructional implications of evaluation results, who may be a member of the team described above;
- At the discretion of the parent or the agency, other individuals who have knowledge or special expertise regarding the student, including related services personnel as appropriate; and
- Whenever appropriate, the student.

In addition to the required IEP team members listed above, the following team members must be invited to IEP meetings when the purpose of the meeting is to consider the postsecondary goals for the student and the transition services needed to assist the student in reaching those goals:

- The student, when appropriate; and
- With the consent of the parents, a representative of any participating agency that is likely to be responsible for providing or paying for transition services (the agency may designate the administrative designee of the IEP to also serve as the agency representative).

**IEP Manager** - *The district shall assign a teacher or licensed related service staff who is a member of the pupil's IEP team as the pupil's IEP manager to coordinate the instruction and related services for the pupil. The IEP manager's responsibility shall be to coordinate the delivery of special education services in the pupil's IEP and to serve as the primary contact for the parent. A district may assign the following responsibilities to the pupil's IEP manager: assuring compliance with procedural requirements; communicating and coordinating among home, school, and other agencies;*

*coordinating regular and special education programs; facilitating placement; and scheduling team meetings. [Minn. R. 3525.0550]*

### **Present Level(s) of Academic Achievement and Functional Performance (PLAAFP)**

*The IEP includes a statement of the child's Present Levels of Academic Achievement and Functional Performance, including how the child's disability affects the child's involvement and progress in the general education curriculum (i.e. the same curriculum as for nondisabled children); or for preschool children, as appropriate, how the disability affects the child's participation in appropriate activities.*

*[34 C.F.R. § 300.320 (a)(1)]*

A. *"Individualized education program" or "IEP" means a written statement for each pupil that is developed, reviewed, and revised in a meeting in accordance with this part and that includes*

*(1) a statement of the pupil's present levels of educational performance, including how the pupil's disability affects the pupil's involvement and progress in the general curriculum, or for preschool pupils, as appropriate, how the disability affects the pupil's participation in appropriate activities*

*(2) a statement of measurable annual goals, including benchmarks or short-term objectives, related to meeting the pupil's needs that result from the pupil's disability to enable the pupil to be involved in and progress in the general curriculum, and meeting each of the pupil's other educational needs that result from the pupil's disability;*

*(3) a statement of the special education and related services and supplementary aids and services to be provided to the pupil, or on behalf of the pupil, and a statement of the program modifications or supports for school personnel that will be provided for the pupil to advance appropriately toward attaining the annual goals, to be involved and progress in the general curriculum in accordance with subitem (1) and to participate in extracurricular and other nonacademic activities, and to be educated and participate with other pupils and students in the activities described in this paragraph;*

*[Minn. R. 3525.2810]*

The foundation of the IEP is the statement of the student's present levels of academic achievement and functional performance (PLAAFP). Functional performance is generally understood to refer to skills or activities that are not considered academic or related to a child's academic achievement. Instead, "functional" is often used in the context of routine activities of everyday living. The PLAAFP relates to information contained and needs identified in the evaluation report. It is more than just test scores, and it should contain information that provides a measurable baseline that would be reflected in annual goals/short term objectives. It must describe how the student's

disability affects his or her involvement in the general education curriculum. The general education curriculum is the same curriculum as for nondisabled students.

If the student is a preschool student, the PLAAFP must describe how the student's disability affects his or her participation in appropriate activities. In addition, for student's ages 14-21, the PLAAFP must address the present level of performance in each of the transition areas per Minnesota Rule 3525.2900. These areas may include work, recreation and leisure, home living, community participation, and postsecondary training and learning opportunities.

### **Present Level of Academic Achievement & Functional Performance Interpretation/Implications for Therapists:**

The present levels of academic achievement and functional performance of an IEP are typically organized according to these performance areas: intellectual, academic, communication, emotional/social/behavioral, health/medical, sensory, motor skills/physical development, self-help/functional skills.

Information contained in present levels should be composed in an integrated fashion incorporating information and data from all team members. A therapist may contribute information relevant to several areas of performance. It should never be assumed that a therapist has entire "ownership" or sole responsibility for summarizing information in a particular area of performance (i.e. the therapist is not the only provider of information in areas of motor skills/physical development). When composing information to be included in present levels, therapists should be careful to avoid noting therapy specific details, and using therapy jargon. It is important to write statements that reflect evaluation results, and describe what the child is able to do and not do, in a functional, concise and meaningful manner that all team members understand. The information contained in present levels would also include relevant baseline data that could be referenced when later creating associated goals, and subsequently reviewing the child's progress toward those goals.

For example, it would be inappropriate to write present level information in the following manner:

- (This child) demonstrates a 12-month delay in development of visual-motor skills.
- Tactile defensiveness is seen in (this child).
- (This child) demonstrates a weakness in hand strength, as measured by dynamometer readings of 15 psi for gross grasp, and 2 psi for three point pinch.
- (This child) lacks 15 degrees and 12 degrees range of motion in right and left knee extension respectively.
- (This child) demonstrates grade 3/5 strength in quadriceps bilaterally.

- (This child), who is 15 years old, is functioning at a two month-old level in head and trunk control.

The following examples of well-written, present level statements (PLAAPF) are noted in bold face type:

- **(This child) has difficulty coloring and drawing pictures with a level of independence, detail and organization comparable to other preschool peers. He/she holds a crayon/marker with their whole hand in an arm turned down approach, and makes large, irregular, self directed scribbling motions on paper. He/she is beginning to imitate simple/single strokes, demonstrated by an adult.**
- **(This child) has a tendency to push, yell, or strike out if bumped when standing in line, or when touched lightly without warning. This behavior occurs a minimum of X times a day. Art activities involving messy mediums (finger painting, getting glue on fingers) may be resisted by this child. He/she will attempt to wipe their hands on their clothing immediately after engaging in the activity.**
- **(This child) has difficulty printing/coloring for long periods of time (does not persist or will immediately say "I can't do this"), opening resistant containers/packaging (asks for help to open milk carton during each opportunity), fastening clothing snaps (consistently leaves school with coat open), and performing other school activities requiring forceful or sustained grip.**
- **(This child) has difficulty maintaining their balance when standing, moving quickly, or walking in crowded hallways at school. Without support (hanging on to an adult's hand or leaning on the wall), he/she stumbles or falls at least X times a day.**
- **(This child) has decreased strength in leg muscles, as demonstrated in difficulty climbing stairs and walking between classes. This causes him/her to arrive late/be the last to arrive on a daily basis, at least X times a day.**
- **(This child) has limited purposeful movement to access learning environments/activities. He/she consistently turns their head toward the source of nearby sights/sounds, but this causes locked positioning in arms and restricts controlled reaching.**

These examples include a level of specificity that will lead to establishing educational needs for the child/student. Educational goals and objectives can then be created from this baseline data. Therapists should follow their district directives on the customary style and amount of detail used.

The manner in which a therapist composes present level information, may allow it to be placed within many performance areas. Although a therapist might have a tendency to note this type of information under the areas of motor skills/physical development, or sensory status, placing it in other performance areas may emphasize its importance or impact in another way. For example, any of the above statements would merge appropriately under the area of functional skills, particularly if the child's condition requires the use of adaptive strategies to promote participation or independence, the ability to follow school routines with appropriate behavior is an overall focus, or if it is important for the child to acquire disability awareness and self-advocacy skills. Team collaboration when documenting present levels of performance is necessary to avoid compartmentalizing the child's function or assigning isolated areas of performance according to service providers.

### **Identifying Needs**

In developing each student's IEP, the IEP Team must consider:

- The strengths of the student;
- The concerns of the parents for enhancing the education of their student;
- The results of the initial or most recent evaluation of the student; and
- The academic, developmental, and functional needs of the student.
- In the case of a student whose behavior impedes the student's learning or that of others, consider the use of positive behavioral interventions and supports, and other strategies, to address that behavior.
- In the case of a student with limited English proficiency, consider the language needs of the student as those needs relate to the student's IEP.
- In the case of a student who is blind or visually impaired, provide for instruction in Braille and the use of Braille unless the IEP Team determines, after an evaluation of the student's reading and writing skills, needs, and appropriate reading and writing media (including an evaluation of the student's future needs for instruction in Braille or the use of Braille), that instruction in Braille or the use of Braille is not appropriate for the student.

- The communication needs of the student, and in the case of a student who is deaf or hard of hearing, consider the student's language and communication needs, opportunities for direct communications with peers and professional personnel in the student's language and communication mode, academic level, and full range of needs, including opportunities for direct instruction in the student's language and communication mode.
- Consider whether the student needs assistive technology devices and services.

## **Needs**

### **Interpretation/Implications for Therapists:**

Based on the student's strengths and weakness within various performance areas, concerns of the parent, and results of the initial or most recent evaluation of the student the team formulates corresponding statements of need as the next step in IEP development. As members of the educational team, occupational therapists and physical therapists share responsibility for helping to identify and prioritize these needs.

Great care and collaboration should take place among team members when writing statements of need since they form the basis for the child's special education plan, and ultimately, for determining the appropriate array of necessary services. Needs identified on an IEP may lead to goals/objectives for the child. Needs may also be addressed through adaptations/modifications; transition activities; through a statement identifying prioritization of needs, how they will or will not be addressed by the team; and the use of outside service providers.

Thoughtfully written needs statements on IEPs are based on the team's analysis of the student's functioning, taking into account the skills the child has, the potential to learn, their learning environments, and limitations imposed by a child's lifelong condition. Need statements should focus on the child's learning, and should identify the specific activities/tasks the child needs to perform, through instruction/intervention and/or adaptations/accommodations. As team members, therapists should strive to replace discipline specific jargon with practical, functional and school-referenced terms to assure meaning and educational relevance, (e.g. "flexibility for performing educational activities" vs. "range of motion").

It is inappropriate to designate that a child requires a specific service in a need statement (e.g. "needs occupational therapy", "needs physical therapy"). It is also improper to define methods of intervention as an educational need (e.g. "needs sensory integration", "needs strengthening activities"). Although the student may require specific adaptations in order to perform a task (e.g. foot braces for walking, enlarged print for reading), they should be referenced in the Adaptations section of the IEP rather than referenced in a need statement. Another error can occur when terms such as

"improve", "increase", "maintain", "reduce", etc. are incorporated, giving the impression of a goal rather than a need statement (e.g. "needs to improve handwriting"). This represents ambiguity and short sightedness.

Teams can avoid these pitfalls when writing need statements by continually probing, "What does the child need to learn?", "What does the child need to be able to do?" and asking, "Why does the child need this?"

This process of refining IEP statements of need is illustrated below. Examples of inappropriate statements appear in regular type. Examples of appropriately written statements appear in bold face type.

**Inappropriate -**

- Needs occupational therapy.
- Needs to improve fine motor skills.
- Needs to improve hand strength.
- Needs to improve pencil control for drawing/printing.

**Appropriate -**

- **Needs (to be able) to use a writing tool with comfort/ease for the purpose of timely/legible work production.**

**Inappropriate -**

Needs to improve visual perception skills.  
Needs to improve sense of directionality, spatial relationships, movement, and position.

**Appropriate -**

- **Needs (to be able) to utilize and demonstrate understanding of instructional information presented on a blackboard/overhead or of instructional materials in charts/diagrams/map types of formats.**
- **Needs (to be able) to know when and how to request assistance when confronted by visually confusing instructional materials.**
- **Needs (to be able) to navigate in the school environment without becoming confused/lost.**

**Inappropriate -**

- Needs physical therapy.
- Needs to improve gross motor skills.
- Needs to improve range of motion.
- Needs to improve head/trunk control.



**Appropriate -**

- **Needs (to be able) to attend and work in a comfortable and well-aligned sitting position.**
- **Needs (to be able) to move through the school environment in a timely, safe, and independent fashion.**
- **Needs (to be able) to actively participate in body movement activities for the purpose of physical fitness and recreational/leisure interest opportunities.**
- **Needs to develop an individual lifelong fitness plan incorporating strength, flexibility, and cardiovascular function.**

A well written need statement targets a specific learning activity/school task, allows consideration of a broad array of intervention and/or accommodations, promotes "ownership" by many/all members of the team, and can be transformed easily into a goal/outcome by adding phrases of directional change and measurement methods. Needs addressed in a child's IEP must relate to a child's educational program, although children may have additional needs related to their lifelong conditions.

### **Measurable Annual Goals, and Short-Term Objectives**

Measurable annual academic and functional goals drive the services in the IEP. For transition age students, the measurable postsecondary goals will drive the annual goals and activities. The measurable academic and functional goals should meet all of the student's needs that result from his or her disability. The goals must include benchmarks or short-term objectives that will demonstrate whether the student is making progress toward the goal. The purpose of the goals is to enable the student to be involved in and make progress in the general education curriculum and to meet each of the student's other educational needs that result from the student's disability. See 34 C.F.R. § 300.320(a)(2)(i)(B).

Typically, the benchmarks or short-term objectives will identify how progress is measured. Progress reports must inform a parent of the extent to which the progress is sufficient to enable the student to achieve the goal by the end of the year. See Minn. R. 3525.2810.

## **Annual Goals and Short-Term Objectives**

### **Interpretation/Implications for Therapists:**

When developing an IEP, a therapist is responsible for working with the team to identify educational goals for the child/pupil. Often, therapists will be asked to submit their page of goals and objectives when the IEP is being compiled. An IEP should not contain "therapy goals." This approach represents a weakness in the team process, and limited understanding of the therapist's role as a related service. An annual goal cannot be developed in isolation by a therapist. It is important for a therapist to dialogue with or provide inservice to other team members, including parents, regarding appropriate expectations and collaborative practices for developing "educational" goals.

Goals should focus on offsetting or reducing the problems resulting from the child's disability that interfere with learning and educational performance. Goals are statements that describe what a child with a disability can reasonably be expected to accomplish within a twelve-month period. There should be a direct relationship between annual goals and the present levels of performance and associated educational needs. Goal statements must contain the expected direction of change, the behavior to be changed, the present skill level, and a level of attainment expected in a year. Examples of well-written goals that a therapist may participate in writing with the team are as follows:

- This student will increase his/her ability to manage personal care tasks during the school day, from his/her current level of relying on physical assistance from an adult for all activities, to a level of needing only initial set up and intermittent verbal prompting, 50% of targeted opportunities.
- This student will improve his/her ability to complete written assignments in a timely and legible fashion, from his/her current level of completing less than 50% to a level of completing at least 80% of assigned work.
- This student will increase his/her access to his school environment from a level of needing cues and intermittent assistance, to a level of independent access, 80% of the time.
- This student will increase self advocacy skills from a level of needing adult cues and assistance to a level of letting others know what assistance he needs, directing others to complete a task, and taking responsibility for independently completing tasks he is able to manage.
- This student will increase responsibility in managing their physical needs, from his/her current level of participating only in an adult directed/assisted exercise program at school, to actively exploring and pursuing community based health/recreation/fitness resources.

- This student will develop a lifelong fitness plan that addresses their disability, incorporating strength, flexibility and cardiovascular function, from having no plan to having a plan.

An IEP includes benchmarks or short-term objectives that are smaller components or incremental measures of annual goals/outcomes. Each goal must be supported by more than one objective. Short term objectives should be written so that the target or specific behavior is identified, conditions for behavior occurrence are specified (e.g. environment, specialized instructional materials/equipment, assistance), acceptable performance/ attainment criteria is noted, and procedures that evaluate the performance (e.g. method, instrument, course of action) are described. Behaviors must be observable, measurable, and verifiable. Therapists may generate short term objectives, relative to measuring a child's response to a therapy designed intervention, provided the objective(s) relate to an "educational" goal defined by the team. Examples of well-written objectives that a therapist may write are as follows:

- Given a system of visual cuing and supports, and environmental accommodations (lights dimmed, private play space) this child will play at a sensory table, using either of their hands or an object to scoop, fill and dump a container, sustaining their interactions without adult prompting for a period of at least 5 minutes, 3 of 4 opportunities, as measured by staff observation/report.
- Given clothing modifications for intricate fasteners, a picture poster to cue the dressing sequence, extra time, and stand-by adult monitoring, this student will remove and store outdoor clothing in their locker/cubby, with no more than 3 verbal cues, 50% of opportunities, as measured by staff observation/report.
- Given instruction/practice, a cue card for PIN number, and stand-by adult monitoring, this student will slide his/her tray along the lunch counter, enter their lunch code, and transport their tray to the table, with no more than 3 verbal cues, 50% of opportunities, as measured by staff observation/report.
- Given an assignment that needs to be written, this student will ask an adult to write for him and dictate what he wants written, 80% of opportunities, as measured by staff observation/report.
- Given a modified writing assignment at the computer and set up when needed (i.e. opening up programs due to time constraints), this student will attend to the task and complete the assignments within an appropriate amount of time, 4 of 5 opportunities, as measured by staff observation/report.

- Given use of a walker, this student will move between the bus and the school building independently 4 of 5 days, as measured by staff observation/report.
- Given extra time and assistance to open doors, this student will independently propel his/her wheelchair to and from the bus and between classrooms, 80% of opportunities, as measured by staff observation/report.
- Given an unfamiliar adult (i.e. substitute), this student will give complete instructions on wheelchair management (including putting his chair in and out of gear, setting him up to drive, driving independently), 4 of 5 opportunities, as measured by staff observation/report.
- Given instruction on accessing community recreation, sports, and health club facilities in the community, and training in a customized/adapted weight training, flexibility, and cardiovascular program, this student will demonstrate responsibility for physical health, by engaging in out of school exercise opportunities, at least 10 times during the school semester, as measured by student and/or parent/caregiver report.
- Given a script developed with adult assistance, this student will use the phone to call and schedule Metro Mobility transportation for at least three community outings, as measured by student, parent/caregiver, and/or staff report.

Although most examples are written with extensive detail, the therapist should keep in mind the reader's level of experience and need for practical information.

## **Secondary Transition**

*During grade 9, the program must address the student's needs for transition from secondary services to postsecondary education and training, employment, community participation, recreation, and leisure and home living. In developing the program, districts must inform parents of the full range of transitional goals and related services that should be considered. The program must include a statement of the needed transition services, including a statement of the interagency responsibilities or linkages or both before secondary services are concluded; [Minn. Stat. 125A.08 (b) (1)]*

Secondary Transition Planning is the process of preparing students for life after high school and includes planning for postsecondary education or training, employment, and independent living.

**Measurable Postsecondary Goals (Education & Training, Employment, Independent Living).** *[Transition-aged students' IEPs must include] a statement of*

*measurable annual goals ... designed to meet the child's [postsecondary] needs. [34 C.F.R. § 300.320(a)(2)]*

A postsecondary goal is an outcome that occurs after the child leaves high school. The IEP must include two postsecondary goal areas: one in the area of education/training and one in the area of employment, whether or not the child's skill levels related to education/training or employment are age appropriate. The only area in which an IEP team may determine whether or not a third postsecondary goal is necessary for the student to receive FAPE is in the area of independent living skills. Postsecondary goals must be based on at least two age-appropriate transition assessments that may be formal or informal. Postsecondary goals are updated annually, and must be measurable and stated in such a way that the extent to which the child has achieved the goal can be determined.

**Courses of Study.** *[Transition-aged students' IEPs must include] transition services (including courses of study) needed to assist the child in reaching those goals. [34 C.F.R. § 300.320(b)(2)]*

"Courses of Study" are defined as a multi-year description of coursework to achieve the child's desired post-school goals. They are the projection of future coursework, updated annually, and which minimally includes the student's current academic year through the following academic year (2 years of courses of study). Courses of study include specific classes (functional or academic), vocational/technical classes, job shadowing or work-based learning, and instruction in daily living and/or community participation skills. Courses of study should correlate to and support the child's measurable postsecondary goals. The courses of study for a child with a moderate or severe disability may be described by course content area, i.e. "mobility," "self-advocacy," "personal relationships," but it is not acceptable to merely state "functional living classes."

**Transition Services.** *Transition services must meet the definition of a "results-oriented process that facilitates the child's movement from school to post-school activities including: post-secondary education, vocational education, integrated employment (including supported employment), continuing and adult education, adult services, independent living, or community participation." [34 C.F.R. § 300.43(a)]*

*[Transition services in the IEP are] focused on improving the academic and functional achievement of the child with a disability to facilitate the child's movement from school to post-school activities. [34 C.F.R. § 300.43(a)(1)]*

Transition services are based on the student's needs, taking into account their strengths, preferences and interests and include: specialized instruction, related services, courses of study, community experiences, the development of employment and other post-school adult living objectives, and if appropriate, the acquisition of daily living skills and the provision of a functional vocational evaluation. If a functional vocational assessment is a needed to determine a student's strengths, abilities, and

needs in an actual or simulated work setting or in real work experiences, then the IEP must include documentation of this transition service or activity.

## **Secondary Transition**

### **Interpretation/Implications for Therapists:**

When occupational therapists and physical therapists serve students of transition age, they have responsibilities as team members, to consider how the student's disability will impact the life plans for the student after they leave high school. Transition planning, as part of the IEP, gives the student and his/her team the opportunity to consider goals toward becoming an adult, and includes post high school education and training, employment, and independent living.

The OT and PT will apply their knowledge of the student's condition and their function/needs in the current school settings, to other settings/activities planned for the student after they leave high school. This may include the student's plans to go on to college, pursue career and technical education/training, engage in work experiences/become employed, develop/pursue recreation and leisure interests, participate activities in their community, and acquire home living skills. When the student becomes entitled to transition planning, it is appropriate to consider how information from existing areas of performance (i.e. present levels/needs/goals identified in the intellectual, academic, communication, emotional/social/behavioral, health/medical, sensory, motor skills/physical development, self-help/functional skills), can be meaningfully translated to the transition areas of performance.

The role of the therapist in supporting a student's needs in areas of educational performance, will be similar to the role the therapist has in supporting a student's needs in areas of transition. Collaboration/consultation with other service providers will remain a primary focus. The therapist may provide disability awareness inservice, resources and skill training, task analysis/adaptation, modification of materials, work hardening strategies, and in some cases, additional assessment of the student's physical capacity as part of their functional vocational evaluation.

Additional information and resources is available from MDE and is posted at this link/web address:

[Secondary Transition Planning /  
http://education.state.mn.us/MDE/StuSuc/SpecEdProg/SecTrans/index.html](http://education.state.mn.us/MDE/StuSuc/SpecEdProg/SecTrans/index.html)

## **Assistive Technology Consideration**

*The IEP Team must consider whether the child needs assistive technology devices and services. [34 C.F.R. § 300.324(a)(2)]*

*The term assistive technology device means “any item, piece of equipment, or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability.” [34 C.F.R. §300.5]*

*The term “assistive technology service” means any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device. The term includes—*

- (a) The evaluation of the needs of a child with a disability, including a functional evaluation of the child in the child’s customary environment;*
- (b) Purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices by children with disabilities;*
- (c) Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices;*
- (d) Coordinating and using other therapies, interventions, or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs;*
- (e) Training or technical assistance for a child with a disability or, if appropriate, that child’s family; and*
- (f) Training or technical assistance for professionals (including individuals providing education or rehabilitation services), employers, or other individuals who provide services to, employ, or are otherwise substantially involved in the major life functions of that child. [20 U.S.C. 1401(2)]*

*(a) Each public agency must ensure that assistive technology devices or assistive technology services, or both, as those terms are defined in §§300.5 and 300.6, respectively, are made available to a child with a disability if required as a part of the child’s—*

- (1) Special education under §300.36;*
- (2) Related services under §300.34; or*
- (3) Supplementary aids and services under §§300.38 and 300.114(a)(2)(ii).*

*(b) On a case-by-case basis, the use of school-purchased assistive technology devices in a child’s home or in other settings is required if the child’s IEP Team determines that the child needs access to those devices in order to receive FAPE. [34 CFR 300.105]*

The Minnesota Department of Education (MDE) supports a variety of Assistive Technology (AT) initiatives designed to help ensure students with disabilities have access to appropriate assistive technology and receive a free, appropriate public education. These initiatives include professional development, information dissemination and technical assistance.

## **Assistive Technology**

### **Interpretation/Implications for Therapists:**

Students with disabilities frequently need to use supportive devices and/or equipment to enhance their function and access to learning opportunities in school. Assistive technology should align with modifications and accommodations to be used with the student. Assistive technology includes a broad range of possibilities for students, ranging from low technology (pencil grips/specialty paper) to more sophisticated, high technology (computers, augmentative communication devices). Therapists often utilize various pieces of adaptive equipment (standers, special chairs) to enhance a child's positioning. Other examples of assistive technology may include but are not limited to adaptive equipment or products for mobility, personal care, work production, or access to other educational tasks/learning opportunities. Adaptive equipment is considered a subset of assistive technology.

An initial evaluation or reevaluation should include information regarding areas where assistive technology should be considered. Although the evaluation report may not contain information about specific AT devices or services, it should include information needed by the team to better consider AT needs when the IEP meeting is held. This information should identify the strategies or features a device could have to meet the student's needs. When several devices may be considered, and there are questions regarding which device may best benefit the student, an extended period of consideration may be needed. The process of determining specific AT devices does not need to be completed within the evaluation timeframe. However, the team should have a documented plan that identifies the procedures and reasonable time frames needed to make these decisions.

Schools are not necessarily required to pay for assistive technology. Schools have the responsibility to provide the services and products that are included in the IEP, however may utilize a variety of funding mechanisms to pay for them.

A school therapist may be asked to submit a letter of medical necessity documenting the child's need for assistive technology that has relevance to the expertise of the therapist. This can be a time consuming task and should be considered when evaluating the therapist's workload. If the equipment or device is purchased by the child's insurance company (i.e. public or private insurance) the device belongs to the individual child not the school.

**Consideration of specialized equipment/devices:** Therapists may be interested in or may be asked by others, to provide special equipment/devices that could be shared among several students in a classroom or in a separate sensory-motor room part of the day (e.g. squeeze machine, hammock swings, weighted vests/blankets, etc.). Due to liability risks, great care and caution should be used when considering these items, particularly if it is assumed that the equipment/device will have mass benefit or it is anticipated that it may be used in a generic fashion among students. The decision to provide this type of equipment should be child specific, guided by evaluation findings



(including the assistive technology component), and associated needs defined and addressed in each student's IEP. The actual use of the device should also be child specific, including documented instructions and parameters of its use, and staff training/monitoring procedures.

The use of assistive technology and equipment/devices for positioning should focus on allowing the student to access the environment and learning activities. The therapist will have assessed how a device promotes a desired physical action or response in the student. If a student is experiencing impairments or limitations in their ability to move themselves, they may need physical assistance from an adult for placement in a positioning device (e.g. standers).

Devices/equipment commonly used to assist optimal physical positioning of a student, should never be used for behavior purposes unless specifically addressed within the child's IEP and based on Functional Behavior Assessment (FBA) and an associated Behavior Intervention Plan (BIP). Students with behavioral issues and high levels of resistance should never be maneuvered into a device by an adult using physical holding that restricts the student's movements. Static positioning or total immobilization of the student should never be the focus. In addition, the adult should never use forceful words/actions when maneuvering them into a device. Examples of devices/equipment relevant to this situation are use of a squeeze machine for a student with autism, or use of a seat belt on a chair to keep a highly impulsive/physically active, cognitively impaired student from standing up and leaving their desk.

When using any device or equipment that limits movements in any way, the student must be closely monitored for signs of discomfort/pain, fear and/or increased agitation. The therapist should maintain documentation that includes the assessment, implementation plan, staff training/monitoring, and ongoing data collection regarding the student's tolerance and the effectiveness of the device/equipment in supporting their function and the actions/responses that are desired.

Many districts in Minnesota have identified individuals who are assigned to conduct assessment, provide consultation, or furnish training/staff development in the field of AT. There is no licensure or certification required to function as an "AT Specialist" or the local expert on AT issues, however professionals expected to function in that role (which may include occupational therapists and physical therapists) should examine their own skill set and knowledge base, and seek ongoing training needed to acquire competencies in this area. The National Association of State Directors of Special Education (NASDSE) has distributed to each state agency, a list of competencies in the area of Assistive Technology.

Additional information and resources is available from MDE and is posted at these links/web addresses:

[Assistive Technology \(AT\) /  
http://education.state.mn.us/MDE/EdExc/SpecEdClass/](http://education.state.mn.us/MDE/EdExc/SpecEdClass/)

[Minnesota Assistive Technology Manual 2003 Edition /  
http://education.state.mn.us/search?q=Assistive+Technology&searchbutton=Go&output=xml\\_no\\_dtd&oe=UTF-8&ie=UTF-8&client=New\\_frontend&proxystylesheet=New\\_frontend&site=default\\_collection](http://education.state.mn.us/search?q=Assistive+Technology&searchbutton=Go&output=xml_no_dtd&oe=UTF-8&ie=UTF-8&client=New_frontend&proxystylesheet=New_frontend&site=default_collection)

## Special Education and Related Services

*The IEP must include a statement of the special education and related services and supplementary aids and services based on peer-reviewed research to the extent practicable, to be provided to the child or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided to enable the child: 1) to advance appropriately toward attaining the annual goals, 2) to be involved and progress in the general curriculum and 3) to participate in extracurricular and other nonacademic activities. [34 C.F.R. § 300.320(a)(4)]*

Each service to be provided to the child or on behalf of the child must be clearly and specifically described in the IEP, and must be sufficient in frequency and duration to address the child's educational needs and annual goal(s). If any of the special education and related services, supplementary aids and services, program modifications or supports for school personnel that will be provided are only needed in a specific situation or under certain circumstances, the conditions under which they are needed must be clearly documented. Using phrases such as "as needed," "may need," "when necessary," or "and/or" in the IEP are not acceptable.

**Related Service definition.** *Related services are defined 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. [34 C.F.R. § 300.34(a)]*

*Related services include "speech-language pathology and audiology services, interpreting services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. Related services also include school health services and school nurse services, social work services in schools, and parent counseling and training. [34 C.F.R. § 300.34(a)]*

*Each student's need for related services, like his need for special education, must be determined on an individual basis, as part of the IEP process and must be based on an assessment of the student's individual needs. [34 C.F.R. §§ 300.301 and 300.304 through 300.311]*

## **Special Education and Related Services Interpretation/Implications for Therapists:**

When determining the need for support from an occupational therapist or physical therapist, the educational team must consider the knowledge and skills that are unique to these related services. The therapist should ask her/himself "What do I know or do that is different than the knowledge and set of skills used by others who are working with this child?" It is important to consider various methods of intervention that may be used to help the child acquire specific skills/abilities. It is equally important to consider the array of modifications and/or adaptations that accommodate the child's limitations. The educational team must determine that specific strategies of intervention or methods of accommodation require the unique expertise of the therapist, and that this expertise is needed in order for the child/student to attain their educational goals.

Although it is no longer required to provide a written justification for related services as part of the educational plan, the therapist may choose to include an introductory statement that justifies the need for related services, as part of a therapy service description. The following are examples of service justification statements:

- It has been determined that consultative support from the occupational therapist is necessary in order to help the educational team understand how impairments in this child's sensory function impact his behavior at school and his/her ability to meet classroom demands, and to help the team implement environmental accommodations and modifications in instructional approaches to support classroom functioning.
- It has been determined that consultative support from the physical therapist is necessary to help the educational team in assisting the child to physically move through and access the school environment, and for safe evacuation.

If the array of supports or intervention strategies a therapist might use with a child, includes duplication of services other staff may provide, then therapy service would not be necessary. It would be inappropriate for a team to consider providing therapy to replace or to supplement/increase the frequency of support that should be provided by other primary service providers (e.g. using a physical therapist to conduct sports skill training to replace adaptive physical education support; using an occupational therapist to provide instruction in a handwriting program commonly used by other specialists). It is also inappropriate for a team to consider providing therapy at school, simply as a benefit to the child, his/her family, or to others (e.g. working on non-essential skills, eliminating the inconvenience of out of school therapy, providing support to relieve scheduling conflicts, etc.).

In addition to considering the unique expertise of an occupational therapist and/or physical therapist, the team must determine how this support relates to the educational needs and instructional goals of the child, and services provided by others. The

therapist should ask, "Who else is supporting the child in a goal area where my skills may be necessary?" If an IEP is developed using a collaborative approach, then a decision to have a therapist provide service to a child within an isolated area of function that no other team member is helping to support would not happen.

For students who qualify for special education under the disability categories of Specific Learning Disability or Speech or Language Impairments, it is often difficult to demonstrate the need for occupational therapy or physical therapy as a Related Service. Interventions that may be provided by the therapist should relate to the child's primary educational disability, and the associated educational needs/goals and primary services within that context. In some situations, it may be concluded that occupational therapy and/or physical therapy do not relate.

For example, if a student is eligible for SLD services only in the area of math, it will be challenging to justify the need for occupational therapy to support handwriting/written production. As another example, if a student is only eligible for services from a speech clinician under the language disorder component of the Speech or Language Impairments disability category, it will be challenging to demonstrate how handwriting support from an occupational therapist relates to educational needs/goals in the context of this primary disability/service area.

Conversely, if a student is eligible for services from a speech clinician under the voice disorder component of the Speech or Language Impairments disability category, and physical positioning/breath control are significantly interfering factors, services from an occupational therapist and/or physical therapist could be easily related to educational needs/goals in the context of this primary disability/service area. In some cases, the child's underlying physical condition/medical diagnosis, will substantiate the connection between the primary service providers and related services from an occupational therapist or physical therapist. For example, a diagnosis of apraxia which is associated with motor planning problems, could impact a student's articulation/ability to speak, as well as perform other movement activities in school.

It is important to acknowledge that determining the necessity of related services of an occupational therapist and/or physical therapist will vary from team to team, year to year, and/or setting to setting. As team members work with an occupational therapist or physical therapist, it is to be expected that they will learn and acquire proficiency in using various techniques and support strategies that a therapist may use. Dependency on certain interventions may be lessened/eliminated as a child/student grows and learns. Expectations of student performance may change relative to the demands of new learning environments. Therapists should routinely facilitate these discussions when developing IEPs. It is a positive outcome when teams determine that support from an occupational therapist or physical therapist is not necessary in order for the child to attain their educational goals.

### **Methods of Instruction/Types of Services**

**Direct services.** *"Direct services" means special education services provided by a teacher or a related service professional when the services are related to instruction, including cooperative teaching.*

*[Minn. R. 3525.0210, subp.14]*

**Indirect services.** *"Indirect services" means special education services which include ongoing progress reviews; cooperative planning; consultation; demonstration teaching; modification and adaptation of the environment, curriculum, materials, or equipment; and direct contact with the pupil to monitor and observe. Indirect services may be provided by a teacher or related services professional to another regular education, special education teacher, related services professional, paraprofessional, support staff, parents, and public and nonpublic agencies to the extent that the services are written in the pupil's IEP and IFSP. [Minn. R. 3525.0210, subp.27]*

### **Methods of Instruction/Types of Services Interpretation/Implications for Therapists:**

The IEP form/format will vary among districts. Some IEPs utilize a structure where both indirect and direct services are documented together under the section labeled "Special Education and Related Services". The service grid examples provided below are illustrations of that type of format. In other cases, districts may use an IEP format that is structured so that primarily direct instruction and services are listed in the section labeled "Special Education and Related Services", and the section labeled Program Modifications and Supports for School Personnel is used to designate the indirect services. Regardless of the format or structure of this part of the IEP, the array of services and supports that are being provided should be documented and clear to the parent.

Options for the delivery of therapy service in an educational setting are based on the identified student's needs as determined through the IEP process. The team will collaborate on the most beneficial service delivery option. Services should be flexible; they will need to change, as the student's needs change. Intervention will be most beneficial when provided in natural settings, and when goals and objectives are integrated into the daily routines of the child/student. This can be accomplished whether indirect or direct service is selected.

The only providers of occupational therapy services may be the occupational therapist (OT) or the occupational therapy assistant under the direction and supervision of the occupational therapist (OTA). It is the responsibility of the OT to determine if and when an OTA will be the service provider. An OTA may provide direct or indirect service as determined by the supervising OT. Supervision of the therapy services delivered by an OTA can only be done by the OT and not another therapy professional (i.e. physical therapist).

Paraprofessionals who work with a child using strategies of support designed by the occupational therapist, are providing "Paraprofessional Service" which is documented as such on the IEP. The service from a paraprofessional is not considered "occupational therapy". The collaboration the occupational therapist has with the paraprofessional is considered occupational therapy service.

The only providers of physical therapy services may be the physical therapist (PT) or the physical therapist assistant under the direction and supervision of the physical therapist. It is the responsibility of the PT to determine if and when a physical therapist assistant will be the service provider. A physical therapist assistant may provide direct or indirect service as determined by the supervising PT. Supervision of the therapy services delivered by a physical therapist assistant can only be done by the PT, and not another therapy professional (i.e. occupational therapist).

Paraprofessionals who work with a child using strategies of support designed by the physical therapist, are providing "Paraprofessional Service" which is documented as such on the IEP. The service from a paraprofessional is not considered "physical therapy". The collaboration the physical therapist has with the paraprofessional is considered physical therapy service.

Indirect service from an occupational therapist and/or physical therapist is chosen when information, materials and techniques/strategies of support can be shared with or taught to others who work with the child/student on a routine basis. It is appropriate to consider this type of service when regular input of the therapist is required in order to build and support the effectiveness of others in meeting the child's educational needs in natural settings and during naturally occurring events. Examples of indirect intervention include teaching a paraprofessional to work with a student on eating skills during lunch or snack time, on writing/computer skills during written language class time, and on mobility skills during transitions with the home/classroom/work setting or around the building/community.

Indirect service will often include a face-to-face interaction between the therapist and the child/student. This occurs when providing demonstration training to staff, or when assuring the effectiveness of an intervention strategy by monitoring for changes in the child's performance. For example, it is considered indirect service when a physical therapist provides weekly interactions with a child/student in order to demonstrate techniques to a parent, paraprofessional, or another teacher, that will help the child learn to move and position their body. As another example, it can also be considered indirect service when an occupational therapist interacts weekly with a child who is practicing a technique related to paper-pencil printing skills, because subtle adjustments in approach or materials need to be clarified with other staff supporting this skill. Obviously, as proficiency and effectiveness of recommended approaches/techniques are acquired and assured, adjustments in the frequency of indirect therapy service would be made.

Therapists often spend a great deal of time providing indirect services that may occur away from or be invisible to other school staff or parents. Researching and preparing in-service or resource information, ordering/constructing/adapting/repairing adaptive materials and equipment, acting as a liaison between school/ home/medical community, and performing documentation/record-keeping duties are examples.

It is incorrect to assume that indirect services are less important or less valuable than direct services. It is also incorrect to assume that indirect service will involve less time or effort on the therapist's part. Professionals who are accustomed to working with children, primarily using a pull out service model, may be hesitant in acknowledging and documenting indirect services on an IEP/IFSP. A therapist should be prepared to explain the types and array of supports that will be involved, and an adequate amount and frequency of time needed, when proposing the provision of indirect service. Refer to examples of services descriptions noted below.

In some cases, the educational team may determine that direct support from a therapist is necessary. Direct service may be chosen when a therapist is the only one qualified to provide the intervention. This may be appropriate when:

- it is anticipated that the child's/student's rate of change will require continuous modification of support strategies and intervention techniques;
- the child/student requires interventions that cannot be readily provided by others (Special note: The therapist should closely examine the educational appropriateness, functional impact/effectiveness, and safety/liability risks of unusual or complex strategies of support that are difficult for others to implement.)
- the therapist needs to work directly with the child/student for a short time in order to identify strategies that can be effectively implemented by others.

Direct service does not imply that the child/student must be "pulled out" of their natural learning environments. Many interventions can and should be implemented within the timeframes and places in which children are expected to perform. For example, mobility instruction should occur during hallway transitions or on the playground during recess, facilitation of eating or self-feeding skills should occur during snack or lunchroom periods, or instruction/practice of printing or typing skills should occur during periods of written language work in the classroom. Direct service should not be regarded as needing to occur indefinitely, nor according to a traditionally prescribed formula based on therapist availability or workload demands (e.g. 2x/week frequency, 30 minute sessions). When considering direct service, therapists must regard each child individually, documenting frequency and duration of service based on a reasonable prediction of: how often the therapist must gauge the student's response to a unique strategy of support; how often these strategies will be used and aligned with natural learning opportunities; and how long it will take to demonstrate that intervention strategies are effective in making a functional change in the child's skills. Direct

services by a therapist can occur in bursts, or in time frames that are less than a year. Direct services by a therapist can also occur intermittently or in episodes throughout a child's school career, depending on the student's abilities and demands related to changes in the learning environment.

Some examples of situations in which a burst or an episodic, defined period of direct service by a therapist may be appropriate are: a very young child that has had no prior intervention and demonstrates an immediate and fast paced skill acquisition in response to learning opportunities using movement skills, helping a student who is in the rapid recovery phase following a traumatic brain injury regain educationally related functional skills, a child with a complex neurology who responds inconsistently to intervention strategies, working with a child with a physical impairment for a short time in order to determine an appropriate typing strategy and computer adaptations to facilitate speed and accuracy, or providing instruction in a customized exercise routine using school/community health club weight room to a high school aged student with a cognitive or physical impairment. This last example also illustrates a therapist's role relative to supporting attainment of a physical education credit/graduation requirement, and/or common core standards such as regular participation in physical activity, achieving/maintaining a health-enhancing level of fitness, and the intrinsic value of physical activity (e.g. enjoyment, challenge, self-expression, social interaction). It also illustrates a therapist's role in how they may support a student's transition needs relative to recreation and leisure, and community participation.

It would be inappropriate for a child/student to receive only direct services from an occupational or physical therapist. This would imply that the therapist is not participating in collaborative practices with others regarding the student's educational program, or that there was an oversight in IEP development. In addition, direct therapy service should never be regarded as a long term or permanent need of the child. Direct service from a therapist that persists for several years as part of a child's special education program, should be closely examined to assure that goals and interventions are educationally relevant, and that sufficient progress toward gaining a functionally defined skill is being attained by the child/student. The therapist must be responsible in assuring the effectiveness of direct interventions through evidenced-based practice. In addition, it is appropriate to consider how intervention strategies used by the therapist in direct service can be effectively taught to others involved with the child/student on a daily basis. If the types of interventions being provided by a therapist using direct service, can but are not being implemented by others, the team should discuss if the needs of the child warrant a more integrated team approach and if therapy resources are being used in an efficient and cost conscious manner.

The educational team should not make decisions to provide direct service from the physical therapist or occupational therapist based on factors of preference, assumption, convenience, or financial benefit. The following are examples:

- individuals assuming that direct service is better and therefore more preferential than other services,



- physicians writing a prescription for therapy at school, or community based service providers writing reports that recommend direct therapy at school,
- unwillingness/unavailability of other resources to appropriately support the child,
- predisposition to selecting direct service based on perceptions of third party reimbursement.

Therapists bring unique skills and provide important service to students in the educational setting. It is essential to realize, however, that a student's therapy service will change in type and duration, or be discontinued altogether, reflecting his/her educational needs. When students are served in natural settings (home, daycare, classroom, work place, etc.), frequent practice of skills can occur and other educational personnel and caregivers can observe and learn how to provide guidance and assistance when the therapist is not present. This integration of activities into the student's daily routines will help the team understand and focus on the attainment of actual skills/function for the student which will ultimately enhance their educational experience. When therapy occurs in isolated settings or outside of a student's natural routines, collaborative practices are impaired. This can lead to an obscure understanding of therapy and a common misperception that direct services occurring in a clinic like or pull out fashion have greater value.

When confusion is encountered regarding the rationale for selecting direct vs. indirect or the frequency of therapy service, it is often helpful for the therapist to provide additional description of therapy services proposed for the child/student. This description may be included in narrative areas of the Supplementary Aids & Services or Program Modifications & Supports sections of the IEP or as an addendum to further clarify areas support, types of interventions, and the frequency/duration of service. The following are just two examples of these service descriptions:

- **The occupational therapist will monitor this student's ability to manage dressing tasks relevant to the school day, through observation, staff interview and/or dressing interactions with the child, a minimum of once per week during the first month of the school year. Consultation and demonstration teaching will be provided to school staff (paraprofessionals, regular & special education teachers) and parents regarding adaptive materials and modifications for intricate fasteners and dressing techniques to promote independence during arrival/departure and bathroom routines. The therapist will also provide parents and school staff with commercial resources for adaptive devices (e.g. button hook, elastic laces). Other services from the OT will include preparation of instructional materials (e.g. picture poster of dressing sequence), and development of customized dressing techniques. Given staff proficiency in using recommended**

**strategies of support, it is anticipated that the frequency of OT services will diminish to once per month thereafter, although a short term burst of weekly visits will occur when inclement weather demands footwear changes.**

- **The physical therapist will monitor this child's mobility skills and positioning needs in the home and daycare settings, through observation, caregiver interview, and/or movement and play interactions with the child, twice monthly alternating between home and daycare sites for six months. Consultation and demonstration teaching will be provided to parents and other caregivers regarding child friendly set up of the home, techniques of physical prompting/assistance to facilitate body movements, and special equipment to physically support the child in various positions for play and physical care activities. The physical therapist will assist parents in determining needs for mobility equipment, and will communicate with the physician and other agencies to facilitate this process when deemed appropriate by the educational team. In six months, when this child begins a preschool experience, it is anticipated that PT support to caregivers in the home/daycare settings will change to a once per month, alternating frequency of indirect service to monitor/provide consultation on the child's ongoing function in these settings. The frequency of PT service relative to supporting the needs of the child in the preschool setting will then be monthly.**

Thorough service descriptions that are embedded in a child's IEP can function as the therapist's "treatment plan," thereby eliminating the need to keep a separate document for this purpose.

When documenting therapy services, it is important to be specific. Therapists should not record an "average" weekly time for services that occur on a less frequent basis. Nor is it appropriate to record that service will be provided "as needed." An accurate reflection of how the service will occur should be recorded (e.g. weekly, monthly, quarterly, X times per year). Anticipated changes or fluctuations in service frequency and duration should be noted. The following table/grids are examples of how these services can be illustrated within the format of an IEP.

### **Illustration of IEP Services Grid**

The Integration of Occupational Therapy and Physical Therapy into Special Education - 141 -

*ACCESSIBILITY CHART TRANSLATION: Illustration of IEP Services Grid. Detail contained within the table too great to show in caption.*

Instruction or Service Provided	Location - General Education	Location - Special Education	Anticipated Frequency	Minutes/Session Indirect	Minutes/Session Direct	Start Date	Anticipated Duration
Functional-Occupational Therapy (Refer to service description)	Relevant school settings: clothing storage areas and bathroom.		1x/week	50	10	9/7/14	10/7/14 (1 month)
Functional-Occupational Therapy	Relevant school settings: clothing storage areas and bathroom		1x/month	60	0	10/7/14	9/6/15 (remainder of IEP year)
Functional-Occupational Therapy	Relevant school settings: clothing storage areas and bathroom		1x/week	30	10	11/01/14	12/1/14 (1 month)

Instruction or Service Provided	Location - General Education	Location - Special Education	Anticipated Frequency	Minutes/Session Indirect	Minutes/Session Direct	Start Date	Anticipated Duration
Functional-Physical Therapy (Refer to service description)	Home and day care.		2x/month: alternating between home & daycare	45	15	9/7/14	3/7/15 (6 months)
Functional-Physical Therapy	Home and day care.		1x/month: alternating between home & daycare	15	0	3/8/15	9/6/15 (remainder of IEP year)
Functional-Physical Therapy	Preschool classroom, playground, motor room		1x/month	30	15	3/8/15	9/6/15 (remainder of IEP year)

## **Supplementary Aids and Services**

*Supplementary aids and services means aids, services, and other supports that are provided in regular education classes, other education-related settings, and in extracurricular and nonacademic settings, to enable children with disabilities to be educated with nondisabled children to the maximum extent appropriate in accordance with §§ 300.114 through 300.116. 20 U.S.C. 1401(33)*

Examples of supplementary aids and services include: adapted equipment (such as a special seat or a cut-out cup for drinking); adapted materials (such as books on tape, large print books, or highlighted notes); special technology (such as a word processor, unique software, or a communication system); training and consultation for staff, student, and/or parents on the use of supplementary aids; peer tutors; an aide.

Supplementary aids and services must be based on peer-reviewed research to the extent practicable. See 34 C.F.R. § 300.320(a)(4). Specificity is required to document what kind of research aids or services are to be provided to demonstrate compliance and to provide clear direction to staff. The aids and services must enable the student to advance appropriately toward attaining the annual goals, to be involved in and make progress in the general curriculum, and meet each of the student's other educational needs that result from the student's disability. See 34 C.F.R. § 300.320(a)(2)(i)(B). Federal regulations require that in providing or arranging for the provision of nonacademic and extracurricular services and activities, including meals, recess periods, and the services and activities set forth in § 300.107, each public agency must ensure that each student with a disability participates with nondisabled students in the extracurricular services and activities to the maximum extent appropriate to the needs of that student. The public agency must ensure that each student with a disability has the supplementary aids and services determined by the student's IEP Team to be appropriate and necessary for the student to participate in nonacademic settings. See 34 C.F.R. § 300.117. Assistive technology, classroom accommodations, paraprofessional support and indirect services to assist teachers working with the student are examples of supplementary aids and services. If paraprofessional services are required, both the student's need for and the specific responsibilities of the paraprofessional must be documented under the statement of supplementary aids and services.

## **Program Modifications and Supports for School Personnel**

**(modified instruction delivery or other regular program component, indirect services, specialized training for staff, behavior interventions, etc.)**

*[The IEP includes] a statement of the program modifications or supports for school personnel. [34 C.F.R. § 300.320(a)(4)]*

*The program modifications and supports for school personnel must enable the student to advance appropriately toward attaining the annual goals, be involved in and make progress in the general curriculum and meet each of the student's other educational needs that result from the student's disability. [34 C.F.R. § 300.320(a)(2)(i)(B)]*

Program modifications and supports for school personnel responsible for implementing the IEP, when deemed necessary, must be documented in the IEP. It is the responsibility of the IEP team to determine what types of program modifications are necessary to support staff and to specify these in the IEP. Examples might include: shortening the student's assignments, getting assistance or consultation from the student's special education case manager, having an aide in the classroom, or getting special equipment or teaching materials.

- A modification is a change in what is being taught to or expected from the student. Shortening an assignment so the student is not doing the same amount of work as other students is an example of a modification.
- The IEP must clearly describe any program modifications that staff must provide to the child. Program modifications may be documented as indirect services such as consultation or training, or
- A list or description of specific program modifications staff must provide in order to support the student's advancement toward the annual goals and participation with general education.

### **Supplementary Aids and Services / Program Modification and Supports for School Personnel**

#### **Interpretation/Implications for Therapists:**

There is no longer a section identified as Adaptations in General and Special Education on an IEP. Instead, this is now defined as Supplementary Aids and Services (supports that are provided to the student), and; Program Modifications and Supports for School Personnel (supports that are provided to staff). Supplementary Aids and Services includes accommodations, assistive technology, paraprofessional support, etc. Program Modifications and Supports includes modified instruction delivery or other regular program component, indirect services, specialized training for staff, behavior interventions, etc. These two areas should be specific enough to include a statement of the service, the start date, frequency per day/week/ month or other, minutes per session, location (e.g. regular classroom, pull-out/resource room, special education room, home), and anticipated duration. IEP forms/formats will vary among districts, and these sections may be addressed in either a narrative space, or in a table/grid.

As part of the educational team, the occupational therapist and/or physical therapist may provide input regarding these sections of a child's IEP. Supplementary aids and services /Program Modifications and Supports for School Personnel are determined by the IEP team, based on individual student need, and may include but are not limited to: instructional techniques, methods, or curriculum materials; modifications or alternatives

for producing assignments and test taking; grading procedures; behavior management techniques; transportation; facilities; staff responsibilities and needs for training; and adaptive devices, equipment, or other materials that may be considered assistive technology. Information contained in these sections of the IEP is particularly important when a student is nearing the completion of their high school experience. This documentation substantiates the associated supports the student will require as they transition to post-secondary educational settings and work settings.

The student's need for and the specific responsibilities of a paraprofessional can also be described in the Supplementary Aids and Services section of the IEP. A therapist may contribute information that helps describe the types of assistance the child might need, and the skills and training that the paraprofessional will need to assist the child. This may include transfers, use of adaptive equipment, specific procedures for managing personal care activities (feeding, dressing, toileting), and modifications to class work.

Therapists are also valuable to the planning process when teams are addressing assistive technology for the student in the Supplementary Aids and Services section of the IEP. An assistive technology device is any item, piece of equipment or product system, whether acquired commercially off the shelf, modified, or customized, that is used to increase, maintain, or improve functional capabilities of a child with a disability. The therapist should note which devices the student is using and whether they are student-owned or school property. An assistive technology service is any service that directly assists a child with a disability in the selection, acquisition, or use of an assistive technology device.

Program Modifications and Supports can include indirect physical and occupational therapy services. Indirect services may be recorded in this section of the IEP, if the Special Education and Related Service section (service table/grid) does not include this type of service designation. Indirect services are still determined by the team to be necessary to meet the student's educational needs, but may occur on an infrequent or incidental basis. Examples include providing training to staff on topics relevant to the student's disability, incidental information regarding environmental access, providing adaptive materials to support classroom function or adaptive equipment for daily cares (toileting, eating), and providing evacuation plans. Frequently there is need for technical assistance from the therapist during transitions to new settings.

Therapists should note that when creating narrative service descriptions under the Program Modifications and Supports section, there should be sufficient detail to specifically define the service and conditions under which the service will be provided (i.e. what the therapist will do, when and to whom the service will be available). Examples of appropriate descriptions of this type of IEP service include:

- **Twice per school year the occupational therapist will monitor student performance, through observation, staff interview, and/or work sampling, in the areas of self-care and functional work skills. The OT will initiate contact with school staff to provide inservice/consultation**

regarding appropriate expectations and methods of adaptation to accommodate this student's level of cognitive and physical development.

- **At the beginning of the school year, the physical therapist will initiate contact with school staff and train staff in transfer techniques, evacuation procedures, and appropriate mobility expectations for the student, with follow up monitoring of student/staff performance occurring midyear.**
- **In order to assist the student's transition to a new classroom setting, the occupational therapist and physical therapist will train staff in positioning techniques/equipment use during September, and will follow-up by contacting school staff twice thereafter during the remainder of the school year in order to monitor this program.**
- A physical therapist is available for consultation to team members in the areas of mobility, evacuation, fitness, and positioning. The physical therapist will initiate contact quarterly/4X per year.

The service examples described in bold faced above, are illustrated on the following table/grid format:

### Illustration of Program Modifications and Supports for School Personnel

*ACCESSIBILITY CHART TRANSLATION: Table showing illustration of Program Modifications and Supports for School Personnel. Detail too great to describe in caption.*

Statements of program modifications and supports for school personnel	Start date	Frequency per week/month/other (e.g. daily, X per week, each test)	Minutes per session for services	Location (e.g. regular classroom, pull-out/resource room, special education room, home)	Anticipated duration
Occupational Therapy monitoring, inservice & training: self care and functional work skills	IEP start date	2x/year:	60 minutes	Regular & special ed. classrooms, locker/cubby storage areas, lunchroom, bathroom	IEP end date
Physical Therapy consultation & training: transfers, evacuation, mobility	IEP start date	2x/year: September & January	30 minutes	Regular & special ed. classrooms, hallways, playground, bus loading areas	IEP end date



## **Altered School Day & Attendance Policy**

In preparing an IEP, the district shall include alteration of the pupil's school day, when needed, which must be based on student needs and not administrative convenience.

### **Altered School Day**

#### **Interpretation/Implications for Therapists:**

Occasionally the educational team determines that the standard length of the school day needs to be altered. The decision to alter a school day may be based on a variety of reasons. A physical therapist or occupational therapist may be involved in this decision making when a child's health/medical condition impacts their physical ability to endure the demands of the school day, or the school day needs to accommodate the occurrence of supplemental support services the child receives outside of school. The latter may occur when a child has an acute rehabilitation need, or parents wish to pursue a specialty therapy that exceeds educational constraints/necessity. An IEP may be written to reflect this additional agency involvement, and the days and times that the child/student will leave school early or arrive later. It is also important to note the duration, or an anticipated length of time the student will be involved in this out of school support.

Occupational therapy and/or physical therapy services that occur in a clinic or medical facility should not be regarded as a replacement for services that may be necessary during the school day as part of the child's special education program. Through evaluation and IEP development, the team determines educational needs that warrant therapy services provided by the school district. It is possible that families may wish to pursue therapy from outside agencies, even though there may be no needs that warrant special education support from an occupational therapist and/or physical therapist at school.

On occasion, therapists may be asked to provide services to a child before or after school hours in order to reduce the amount of classroom time a student may miss. This may be more likely to occur when parents/team members perceive a need for direct, pull out therapy support. Teams should closely analyze the conditions under which direct service may be warranted, as described previously. If interventions are designed to promote a child's functional performance of school tasks, and are implemented during natural learning events and settings, then therapy support would most appropriately occur during the school day. It is also often appropriate for the therapist to provide parents/caregivers with a program of interventions/activities that they can do at home, creating a partnership that supports the child's educational performance.

A physical therapist or occupational therapist may also have a role when there is a need to consider the delivery of homebound services for a student with a disability, particularly when the student has a chronic medical condition that affects their health/physical function, and limits their ability to make satisfactory progress toward their educational goals due to attendance. A therapist may function as a liaison to the physician, to report changes in the student's physical condition noted at school that may be linked to a decline in medical status or side-effects of medical intervention/treatment. When the student with a health condition experiences frequent episodes of absenteeism, but the duration of those periods of absence is more intermittent, a therapist may also assist the team in securing documentation from the physician that authorizes the provision of homebound services based on an adjusted/individualized threshold of absent days for the student (rather than a minimum limit of consecutive days absent established by the district for other students). The OT or PT may also provide consultation regarding expectations/approaches that the homebound teacher needs to use (e.g. positioning, assistive technology) when providing instruction to the student in the home setting.

### **Extended School Year Services (ESY)**

The responsible district shall provide extended school year services for those pupils when it is determined:

- that the pupil will experience "significant regression" in the absence of an educational program.
- the time required to relearn the skills lost is excessive; or
- the effects of the breaks in programming are such that they will prevent the student from attaining the state of self-sufficiency that the student would otherwise reasonably be expected to reach.

*"Extended school year (ESY) services" means special education instruction and related services for pupils who demonstrate the need for continued service on days when school is not in session for all students as a necessary component of a free appropriate public education. [Minn. R. 3525.0210 Subp. 19]*

*School districts are required to provide extended school year (ESY) services to a pupil if the IEP team determines the services are necessary during a break in instruction in order to provide a free appropriate public education. [Minn. R. 3525.0755 Subp. 1]*

*At least annually, the IEP team must determine a pupil is in need of ESY services if the pupil meets the conditions of item A, B, or C.*

*A. there will be significant regression of a skill or acquired knowledge from the pupil's level of performance on an annual goal that requires more than the length of the break in instruction to recoup unless the IEP team determines a shorter time for recoupment is more appropriate*

*B. services are necessary for the pupil to attain and maintain self-sufficiency because of the critical nature of the skill addressed by an annual goal, the pupil's age and level of development, and the timeliness for teaching the skill; or*  
*C. the IEP team otherwise determines, given the pupil's unique needs, that ESY services are necessary to ensure the pupil receives a free appropriate public education.*

*[Minn. R. 3525.0755 Subp. 3]*

*"Level of performance" refers to a child's progress toward annual IEP goals immediately prior to a break in instruction as seen in the progress measurements. "Regression" refers to the significant decline in the performance of a skill or acquired knowledge, specified in the annual goals as stated in the child's IEP that occurs during a break in instruction. "Recoupment" refers to a child's ability to regain the performance of a skill or acquired knowledge to approximately the same level of performance just prior to the break in instruction. [Minn. R. 3525.0755, subp. 2(A), (B) and (C)]*

*"Self-sufficiency" refers to the functional skills necessary for a pupil to achieve a reasonable degree of personal independence as typically identified in the annual IEP goals for a child requiring a functional curriculum. [Minn. R. 3525.0755, subp. 2(D)]*

*To attain self-sufficiency, a pupil must maintain skills consistent with the child's IEP goals in any of these skill areas:*

- 1) basic self-help, including toileting, eating, feeding, and dressing;*
- 2) muscular control;*
- 3) physical mobility;*
- 4) impulse control;*
- 5) personal hygiene;*
- 6) development of stable relationships with peers and adults;*
- 7) basic communication; or*
- 8) functional academic competency, including basic reading and writing skills, concepts of time and money, and numerical or temporal relationships. [Minn. R. 3525.0755 subp. 2]*

## **Extended School Year**

### **Interpretation/Implications for Therapists:**

When determining the need for ESY services, the educational team will need to consider data collected on a child's regression/recoupment rates during a break in instruction. If a child loses skills in an area of performance during periods of time they are not in school, and it takes a longer period of time to regain those skills, then ESY can be justified. For students who have IEP goals and a curriculum that focuses on functional skills, the need for ESY services may be substantiated by data which demonstrates that the student did not progress or lost levels of self-sufficiency during a break in service.

Working from the existing IEP, the team identifies performance area goals that will be targeted, supplementary aids/services and program modifications/supports, and the special education and related services to be provided during the period of ESY. The occupational therapist and/or physical therapist, assists the educational team in determining if therapy services are related to and critical to supporting the child's performance, goals and supports to be addressed during their ESY program.

Keeping in mind the role of therapy as a "related service," it would be unlikely that a therapist would be a sole provider of extended school year service. School districts may vary in their application of extended school year services. In the birth to three populations, in districts following a "stretch" calendar (i.e. extending a 38 week school year over a full calendar year) the extended year component would not apply.

### **Least Restrict Environment (LRE) Explanation**

*The IEP includes an explanation of the extent, if any, to which the child will not participate with nondisabled children in the regular class [and in extracurricular and nonacademic activities].*

*[34 C.F.R. § 300.320(a)(5)]*

*Each district must ensure that to the maximum extent appropriate, children with disabilities ... are educated with children who are nondisabled and [that] special classes, separate schooling, or other removal of children with disabilities from the regular educational environment occurs only if the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily. [34 C.F.R. § 300.114(a)(2)]*

*(5) to the maximum extent appropriate, children with a disability, including those in public or private institutions or other care facilities, are educated with children who are not disabled, and that special classes, separate schooling, or other removal of children with a disability from the regular educational environment occurs only when and to the extent that the nature or severity of the disability is such that education in regular classes with the use of supplementary services cannot be achieved satisfactorily; [Minn. Stat. § 125A.08]*

In preparing the IEP, the district shall include a statement of the specific special education and related services to be provided to the pupil and the extent that the pupil will be able to participate in regular educational programs. Every district must ensure to the maximum extent appropriate, children with a disability, including those in public or private institutions or other care facilities are educated with children who are not disabled.

Special classes, separate schooling, or other removal of children with a disability from the regular educational environment/program occurs only when and to the extent that the nature or severity of the disability is such that education in regular classes with the

use of supplementary services cannot be achieved satisfactorily. Furthermore, there must be an indication that the pupil will be better served outside of the regular program. The needs of the pupil shall determine the type and amount of services needed. When planning programs for the education of children with a disability in the regular classroom, school districts are encouraged to consider the size of the regular class and to provide the support services necessary to ensure successful mainstreaming.

The state board shall provide assurance that vocational education program and activities for individuals with disabilities will be provided in the least restrictive environment in accordance with IDEA and will, whenever appropriate, be included as a component in the IEP.

### **Least Restrictive Environment**

#### **Interpretation/Implications for Therapists:**

Federal and state law mandates that children with disabilities shall receive appropriate education with non-disabled peers in a regular school environment to the maximum extent possible. The IEP team, which may include an occupational therapist and/or physical therapist, determines the Least Restrictive Environment (LRE). LRE also needs to be considered when determining the type and location of therapy services. The first consideration for location should be within the setting where the child is experiencing difficulties (e.g. handwriting in the classroom, mobility in the hallways, feeding skills at daycare). A pull out model of therapy service is more restrictive than providing supports/interventions within the context of the child's natural setting for learning. The decision to use this model must be carefully considered by the team, and justification to do so must be documented in the LRE section of the IEP.

Some modalities or types of therapy interventions may be considered too restrictive if implementation involves removing/isolating the student from their peers and customary learning routines, highly invasive procedures/techniques, and use of equipment/materials/supplies that are exceedingly dissimilar to the normal array used in the regular classroom. Examples are physical agent modalities or sensory integration treatment as might be used in a rehabilitation or clinic setting. When a therapy intervention requires a level of intensity or equipment that interferes with the child's education, does not relate to an identified educational need, may compromise child safety, or causes questions regarding school liability/professional accountability, it is usually inappropriate to implement in school. Conversely, a therapist should strive to use intervention techniques that are effective and supported by evidence based practice, are relevant to the educational needs of the child, and are incorporated into the child's daily routines in school and in their home environment.

## **Progress Reporting**

*The IEP includes a description of how the child's progress toward the annual goals will be measured. [34 C.F.R. § 300.320(a)(3)(i)]*

*The IEP includes a statement of when periodic reports on the progress the child is making toward meeting the annual goals (such as through the use of quarterly or other periodic reports, concurrent with the issuance of report cards) will be provided. [34 C.F.R. § 300.320(a)(3)(ii)]*

*The IEP includes a statement of how the pupil's parents will be regularly informed by such means as periodic report cards, at least as often as parents are informed of their nondisabled student's progress. [Minn. R. 3525.2810, subp. 1(A)(9)]*

*The extent to which progress is sufficient to enable the pupil to achieve the goals by the end of the year is reported. [Minn. R. 3525.2810, subp. 1(A)(9)]*

*Pupil's progress toward the annual goals is reported. [Minn. R. 3525.2810, subp. 1(A)(9)]*

The IEP must indicate when progress will be reported and how parents will be regularly informed. "When" indicates as frequent as nondisabled peers and the total and individual number of progress report methods (i.e. 4 total; 3 written, 1 conference). Progress for children with a disability should be shared with parents at least as often as children who do not have a disability. "How" indicates the type of method (i.e. written progress reports, IEP meeting, conference with parents, etc.).

Components of a written progress report include: date, the progress the child is making on addressing the goals and objectives, and the extent to which progress is sufficient for the child to meet the goal by the end of the year. It is insufficient to report "adequate progress" for extent of progress made.

### **Progress Reporting**

#### **Interpretation/Implications for Therapists:**

As members of a child's special education team, therapists have responsibility to periodically report information on the child's performance, relative to the service/supports that the therapist provides. A separate therapy progress report is not written. Instead, a therapist's collection/compilation of data on the child's performance, using collaboration, observation, work sampling, staff report, and other measurement probes, is summarized/shared with the child's IEP manager. The therapist's information and other progress information is integrated into a single document.

Collaborative review and reporting should show positive changes in the child's performance as indicated by incremental objectives should be evident. If the child is not making adequate progress toward achieving those objectives and the eventual annual goal, the team must consider the factors/reasons that may account for this. When this occurs, the therapist in collaboration with the team uses data to determine if: a) the intervention is ineffective or inadequate in producing significant change in the child, or; b) the predicted growth was an overestimate of the child's rate of development in response to the intervention. Option a) leads to a decision to discontinue/change the intervention, and option b) leads to the need to revise/change the annual goal and associated short term objectives. Carefully written annual goals/short term objectives, data collection, and progress review documentation is extremely important, especially when an intervention strategy is considered experimental, controversial, or it is unclear that it will be of academic and functional benefit to the child/student.

## OTHER CONSIDERATIONS FOR THERAPISTS

### Statewide Testing

The federal Individuals with Disabilities Education Act (IDEA 2004) and No Child Left Behind Act (NCLB) mandate that all Minnesota students, including students with disabilities, participate in statewide assessments in the areas of reading and mathematics using the Minnesota Comprehensive Assessments (MCA-II) or an appropriate alternate assessment. An alternate assessment is designed exclusively for use with students who receive special education services and is a way for states to measure the achievement of these students based on alternate achievement standards.

### Statewide Testing

#### Interpretation/Implications for Therapists:

Therapists should consider how their role supports a student's access to instruction and the measures used to determine their achievement. As a member of a child's special education team, a therapist may participate in the process of determining the need for an alternate assessment and contribute information about the child's performance reflected in that assessment. For other students, a therapist's knowledge of a child's physical and/or sensory function may help guide the team in determining appropriate accommodations that allow participation in state testing.

Additional information on this topic can be found at the following MDE link/website address:

[Statewide Assessments: Students with Disabilities /  
http://education.state.mn.us/MDE/StuSuc/SpecEdProg/StateAssessStuDisab/index.html](http://education.state.mn.us/MDE/StuSuc/SpecEdProg/StateAssessStuDisab/index.html)

### Common Core Standards

The Minnesota K-12 Academic Standards define expectations for the educational achievement of public school students across the state in grades K-12. The standards and benchmarks are important because they: 1) identify the knowledge and skills that all students must achieve by the end of a grade level or grade band; 2) help define the course credit requirements for graduation; and, 3) serve as a guide for the local adoption and design of curricula. Student mastery of the standards is measured through state and local assessments.



State standards are in place for English language arts, mathematics, science, social studies and physical education. State standards also are available in the arts, or districts may choose to develop their own. Local standards must be developed by districts for health, world languages, and career and technical education.

In 2010, Minnesota adopted the Common Core English language arts standards in their entirety and added some supplementary content. Public schools in Minnesota were required to implement the 2010 Minnesota K-12 Academic Standards - English Language Arts no later than the 2012-2013 school year.

Minnesota has not adopted the Common Core mathematics standards. The academic standards are revised according to a timetable specified in state statute (Minn. Stat. § 120B.023, Subd. 2). Since the 2007 Minnesota K-12 Academic Standards – Mathematics were revised prior to the development of the Common Core mathematics standards, legislative action would be needed in order for the state to adopt the Common Core mathematics standards before the next scheduled revision, in 2015.

## **Common Core State Standards Interpretation/Implications for Therapists:**

Many states, including Minnesota, are establishing Common Core State Standards (CCSS), which are used to provide a consistent, clear understanding of what students are expected to learn. By establishing these standards, teachers and parents will know what is needed to help prepare students with the knowledge and skills needed for success in college and careers. Many districts are working to incorporate these standards in IEPs for students with disabilities. Instruction for special education learners can address academic standards through collaborative teaching, interdisciplinary collaboration, universal design for learning, and the use of technology to ensure student success. There is no legislative requirement that each IEP goal must be linked to a common core standard, and for some students, their IEPs may continue to include goals that are primarily aimed at functional skill development. Methods and accommodations used to promote the student's access to the general education classroom and curriculum, will allow multiple avenues of presentation and response. These are critical components of an IEP which can be aligned to CCSS.

Occupational therapists and physical therapists are encouraged to consider how they can apply their unique knowledge and skills to support the implementation of Common Core State Standards for students of all ability levels. Having an understanding of CCSS will reinforce the role of the school based therapist to think "educationally" by promoting the student's access to the general education curriculum to the maximum extent possible.

For example, grade level standards or benchmarks established for writing, provide definition of the types, purposes and process of writing instruction and assessment in the general education curriculum. Occupational therapists have specific knowledge of adaptive devices and assistive technology that may be used as accommodations/alternative tools for written production.

As another example, a state physical education state standard is "participate regularly in physical activity" with an associated benchmark to "have the skills, knowledge, interest and desire to independently maintain an active lifestyle throughout life." A physical therapist's knowledge of neuromuscular function, the student's disability, and the impact of it on movement and physical capacity may assist the determination of accommodations needed to promote their access to the physical education curriculum. A PT could customize a weight lifting program within that context, and ultimately in the community outside of school.

Developing Standards-Based IEP Goals and Objectives: A Discussion Guide has been developed to help IEP teams develop standards-based IEP goals and objectives for students taking the MCA-Modified. This information is available at the following link/web address:

[Developing Standards-Based IEP Goals and Objectives: A Discussion Guide /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=050483&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=050483&RevisionSelectionMethod=latestReleased&Rendition=primary)

Additional information on this topic can be found at the following MDE links/website addresses:

[Standards and Benchmarks /  
http://education.state.mn.us/MDE/EdExc/StandImpIToolkit/Exploration/ArchStand/](http://education.state.mn.us/MDE/EdExc/StandImpIToolkit/Exploration/ArchStand/)

[K-12 Academic Standards /  
http://education.state.mn.us/MDE/EdExc/StanCurri/K-12AcademicStandards/](http://education.state.mn.us/MDE/EdExc/StanCurri/K-12AcademicStandards/)

[Standards, Curriculum and Instruction /  
http://education.state.mn.us/MDE/EdExc/StanCurri/](http://education.state.mn.us/MDE/EdExc/StanCurri/)

## Restrictive Procedures

### Definitions.

(a) *The following terms have the meanings given them.*

(b) *"Emergency" means a situation where immediate intervention is needed to protect a child or other individual from physical injury. Emergency does not mean circumstances such as: a child who does not respond to a task or request and instead places his or her head on a desk or hides under a desk or table; a child who does not respond to a staff person's request unless failing to respond would result in physical injury to the child or other individual; or an emergency incident has already occurred and no threat of physical injury currently exists.*

(c) *"Physical holding" means physical intervention intended to hold a child immobile or limit a child's movement, where body contact is the only source of physical restraint, and where immobilization is used to effectively gain control of a child in order to protect a child or other individual from physical injury. The term physical holding does not mean physical contact that:*

- (1) helps a child respond or complete a task;*
- (2) assists a child without restricting the child's movement;*
- (3) is needed to administer an authorized health-related service or procedure; or*
- (4) is needed to physically escort a child when the child does not resist or the child's resistance is minimal.*

(d) *"Positive behavioral interventions and supports" means interventions and strategies to improve the school environment and teach children the skills to behave appropriately.*

(e) *"Prone restraint" means placing a child in a face down position.*

(f) *"Restrictive procedures" means the use of physical holding or seclusion in an emergency. Restrictive procedures must not be used to punish or otherwise discipline a child.*

(g) "Seclusion" means confining a child alone in a room from which egress is barred. Egress may be barred by an adult locking or closing the door in the room or preventing the child from leaving the room. Removing a child from an activity to a location where the child cannot participate in or observe the activity is not seclusion. [Minn. Stat. § 125A.0941]

### **Standards for Restrictive Procedures.**

*Subdivision 1. Schools that intend to use restrictive procedures shall maintain and make publicly accessible a restrictive procedures plan for children that includes at least the following: (1) the list of restrictive procedures the school intends to use; (2) how the school will monitor and review the use of restrictive procedures, including conducting post-use debriefings and convening an oversight committee; and (3) a written description and documentation of the training staff completed under subdivision 5.*

*Subd. 2. (a) Restrictive procedures may be used only by a licensed special education teacher, school social worker, school psychologist, behavior analyst certified by the National Behavior Analyst Certification Board, a person with a master's degree in behavior analysis, other licensed education professional, paraprofessional under Minnesota Statutes, section 120B.363, or mental health professional under Minnesota Statutes, section 245.4871, subdivision 27, who has completed the training program under subdivision 5. (b) A school shall make reasonable efforts to notify the parent on the same day a restrictive procedure is used on the child, or if the school is unable to provide same-day notice, notice is sent within two days by written or electronic means or as otherwise indicated by the child's parent under paragraph (d). (c) When restrictive procedures are used twice in 30 days or when a pattern emerges and restrictive procedures are not included in a child's individualized education program or behavior intervention plan, the district must hold a meeting of the individualized education program team, conduct or review a functional behavioral analysis, review data, consider developing additional or revised positive behavioral interventions and supports, consider actions to reduce the use of restrictive procedures, and modify the individualized education program or behavior intervention plan as appropriate. At the meeting, the team must review any known medical or psychological limitations that contraindicate the use of a restrictive procedure, consider whether to prohibit that restrictive procedure, and document any prohibition in the individualized education program or behavior intervention plan. (d) An individualized education program team may plan for using restrictive procedures and may include these procedures in a child's individualized education program or behavior intervention plan; however, the restrictive procedures may be used only in response to behavior that constitutes an emergency, consistent with this section. The individualized education program or behavior intervention plan shall indicate how the parent wants to be notified when a restrictive procedure is used.*

*Subd. 3. Physical holding or seclusion may be used only in an emergency. A school that uses physical holding or seclusion shall meet the following requirements: (1) the physical holding or seclusion must be the least intrusive intervention that effectively responds to the emergency; (2) physical holding or seclusion must end when the threat*

of harm ends and the staff determines that the child can safely return to the classroom or activity;(3) staff must directly observe the child while physical holding or seclusion is being used;(4) each time physical holding or seclusion is used, the staff person who implements or oversees the physical holding or seclusion shall document, as soon as possible after the incident concludes, the following information:(i) a description of the incident that led to the physical holding or seclusion; (ii) why a less restrictive measure failed or was determined by staff to be inappropriate or impractical; (iii) the time the physical holding or seclusion began and the time the child was released; and (iv) a brief record of the child's behavioral and physical status; (5) the room used for seclusion must: (i) be at least six feet by five feet; (ii) be well lit, well ventilated, adequately heated, and clean; (iii) have a window that allows staff to directly observe a child in seclusion; (iv) have tamperproof fixtures, electrical switches located immediately outside the door, and secure ceilings;(v) have doors that open out and are unlocked, locked with keyless locks that have immediate release mechanisms, or locked with locks that have immediate release mechanisms connected with a fire and emergency system; and (vi) not contain objects that a child may use to injure the child or others; (6) before using a room for seclusion, a school must: (i) receive written notice from local authorities that the room and the locking mechanisms comply with applicable building, fire, and safety codes; and (ii) register the room with the commissioner, who may view that room; and (7) until August 1, 2012, a school district may use prone restraints under the following conditions: (i) a district has provided to the department a list of staff who have had specific training on the use of prone restraints; (ii) a district provides information on the type of training that was provided and by whom; (iii) prone restraints may only be used by staff who have received specific training; (iv) each incident of the use of prone restraints is reported to the department within five working days on a form provided by the department or on a district's restrictive procedure documentation form; and (v) a district, prior to using prone restraints, must review any known medical or psychological limitations that contraindicate the use of prone restraints. The department will report back to the chairs and ranking minority members of the legislative committees with primary jurisdiction over education policy by February 1, 2012, on the use of prone restraints in the schools.

Subd. 4. The following actions or procedures are prohibited: (1) engaging in conduct prohibited under Minnesota Statutes, section 121A.58; (2) requiring a child to assume and maintain a specified physical position, activity, or posture that induces physical pain; (3) totally or partially restricting a child's senses as punishment; (4) presenting an intense sound, light, or other sensory stimuli using smell, taste, substance, or spray as punishment; (5) denying or restricting a child's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the child's functioning, except when temporarily removing the equipment or device is needed to prevent injury to the child or others or serious damage to the equipment or device, in which case the equipment or device shall be returned to the child as soon as possible; (6) interacting with a child in a manner that constitutes sexual abuse, neglect, or physical abuse under Minnesota Statutes, section 626.556; (7) withholding regularly scheduled meals or water; (8) denying access to

bathroom facilities; and (9) physical holding that restricts or impairs a child's ability to breathe.

*Subd. 5 .(a) To meet the requirements of subdivision 1, staff who use restrictive procedures shall complete training in the following skills and knowledge areas: (1) positive behavioral interventions; (2) communicative intent of behaviors; (3) relationship building; (4) alternatives to restrictive procedures, including techniques to identify events and environmental factors that may escalate behavior; (5) de-escalation methods; (6) standards for using restrictive procedures; (7) obtaining emergency medical assistance; (8) the physiological and psychological impact of physical holding and seclusion; (9) monitoring and responding to a child's physical signs of distress when physical holding is being used; and (10) recognizing the symptoms of and interventions that may cause positional asphyxia when physical holding is used. (b) The commissioner, after consulting with the commissioner of human services, must develop and maintain a list of training programs that satisfy the requirements of paragraph (a). The district shall maintain records of staff who have been trained and the organization or professional that conducted the training. The district may collaborate with children's community mental health providers to coordinate trainings.*

*Subd. 6. School districts are encouraged to establish effective school wide systems of positive behavior interventions and supports. Nothing in this section or Minnesota Statutes, section 125A.0941 precludes the use of reasonable force under Minnesota Statutes, sections 121A.582; 609.06, subdivision 1; and 609.379. [Minn. Stat. § 125A.0942]*

## **Restrictive Procedures**

### **Interpretation/Implications for Therapists:**

Therapists may be assigned to work in educational programs where children demonstrate extreme behaviors that threaten the student's physical safety and/or the safety of other individuals in their environment. Therapists need to understand the definition and standards associated with restrictive procedures. If an OT or PT is expected to intervene when extreme behaviors occur, and there is an emergency need to protect the child or others from physical injury by physical holding or providing seclusion, the therapist must have completed training in the 10 areas specified by state statute noted above. Without this training, therapists should not be expected to use restrictive procedures.

A therapist may use or recommend a variety of strategies to support a child's physical or behavioral function, which if applied in an emergency situation in response to a child's behavior, could be viewed as a restrictive or prohibited procedure.

Careful consideration and documentation should occur if items like lap belts or special chairs/trays are used to help the child remain seated during instruction, as they may possibly be viewed as a form of restraint. Parameters surrounding the use of these

items to support a child's behavior should be addressed in a behavioral intervention plan, and/or documented in the child's IEP.

Likewise, if an intervention involves physical contact with a child that may cause aversive reactions in the child, (e.g. manually applied touch pressure joint compression that the child resists or responds to with signs of discomfort), or interventions that remove a child from their typical setting and confine them to an isolated space (e.g. removal of the child to a sensory motor calming room), should be carefully considered and well documented if intended as methods of providing positive behavioral support to the child. If used in response to an emergency situation, these interventions could potentially be viewed as physical holding or seclusion and thus considered restrictive procedures.

Any item/activity that has the potential to be used as a form of punishment, cause pain to the child, or cause a restriction in the child's breathing, is considered prohibited.

When considering the use of restrictive procedures, the team must follow and document the three criteria/processes described in Standards, Subdivision 1 above.

Additional information on this topic can be found at the following MDE link/website address:

[Restrictive Procedures /  
http://education.state.mn.us/MDE/SchSup/ComplAssist/RestProc/](http://education.state.mn.us/MDE/SchSup/ComplAssist/RestProc/)

## **Exit Procedures -**

### **Determining the Child is Not a Child With a Disability**

*(1) Except as provided in paragraph (e)(2) of this section, a public agency must evaluate a child with a disability in accordance with sections 300.304 through 300.311 before determining that the child is no longer a child with a disability.*

*(2) The evaluation described in paragraph (e)(1) of this section is not required before the termination of a child's eligibility under this part due to graduation from a secondary school with a regular diploma, or due to exceeding the age eligibility for FAPE under State law.*

*(3) For a child whose eligibility terminates under circumstances described in paragraph (e)(2) of this section, a public agency must provide the child with a summary of the child's academic achievement and functional performance, which shall include recommendations on how to assist the child in meeting the child's postsecondary goals. [34 C.F.R. § 300.305(e)]*

**Follow-Up Review Requirements.** *Pupils who are discontinued from all special education services may be reinstated within 12 months. If data on the pupil's present levels of performance are available and an evaluation had been conducted within three years pursuant to part 3525.2710, the district is not required to document two prereferral interventions or conduct a new evaluation. [MN Rule 3525.3100]*

## **Exit Procedures**

### **Interpretation/Implications for Therapists:**

An evaluation is required in order to determine that a child is no longer a child with a disability and therefore is no longer eligible to receive special education.

An evaluation is not required when the student graduates from high school with a regular diploma, or exceeds age 21. Instead, an exit summary (as noted above) is written. A therapist would participate in this process if their services were part of the current IEP for the student.

These exit procedures do not apply to therapists when a decision is made to discontinue therapy, but the student continues to be eligible for other special education services (i.e. continues to be a child with a disability).

Additional information on this topic can be found at the following MDE link/website address:

[Q&A: Evaluations - Dismissal and Reinstatement of Services /  
http://education.state.mn.us/MDE/SchSup/ComplAssist/QA/002348](http://education.state.mn.us/MDE/SchSup/ComplAssist/QA/002348)

## **Discontinuation of Occupational Therapy and/or Physical Therapy Services (PWN - Significant Change in Program or Placement)**

Significant change in program or placement means the IEP goals have been completed or require modification based on a progress report; there is a need to add or delete a service based on a progress report or evaluation; there is a change in the type of site or setting within which the pupil receives special education; the amount of time a pupil spends with non-disabled peers is changed; the amount of special education to accomplish the goals or objectives needs to be increased or decreased; or the team determines there is a need for a conditional intervention procedure.



**Discontinuation of OT and/or PT Services  
(Prior Written Notice of Change in Program or Placement)**

**Interpretation/Implications for Therapists:**

Any proposed, significant changes in the type, frequency or duration of therapy services must be documented and shared with the parent/guardian. Examples include addition of a therapy service or determination that a therapy service is no longer deemed necessary.

Therapy may be discontinued for a variety of reasons and the decision to do so should be made by the team on a case-by-case basis. A progress review or annual IEP/IFSP meeting is the typically occurring event during which discontinuation of therapy service is addressed. Best practice would assert that the therapist should be present at this meeting, to summarize information and to respond to any questions/concerns that may arise regarding the proposal to significantly change therapy services.

The therapy services discontinues when:

- the student graduates, having successfully completed graduation requirements, or the student exceeds the age of 21;
- the student is no longer considered a child with a disability and no longer qualifies for special education;
- the student has met therapy supported educational goal(s)/objective(s), and no new needs/goals are identified;
- the educational setting or program has changed and the student is functional in that setting/program;
- the student's educational performance and progress toward attaining annual goals is being adequately supported by other educational staff;
- despite multiple interventions by the therapist, the student's educational performance remains constant, and the IEP/IFSP is changed to reflect attainable goals/objectives not requiring the expertise of the therapist.

Documentation supporting the therapist's and team's decision to discontinue therapy services should be reflected in a progress review. The meeting to develop an annual IEP/IFSP may also be considered a progress review. The therapist would provide data and other information that substantiates their service has addressed the child's current educational performance/needs, attainment of IEP goals/objectives, and/or any accommodations needed to access learning environments and instructional opportunities.

Significant changes to the existing IEP document (PLAAPF, needs, goals, services) would then be made, and a Prior Written Notice of Proposed Action/Denial containing a description of the action, an explanation why the action is taken, a description of other

options considered and reasons why the options were rejected, a description of information used as a basis for the action, and a description of any other factors relevant to the action, would be generated and provided to the parent/guardian.

These documents (progress review, revised or new annual IEP, and a PWN) may be generated and submitted to the parent/guardian simultaneously. The parent may immediately respond to the PWN by signing they approve the proposed changes, or they must be allowed a time frame of 14 calendar days to either object to the changes in writing, or by not responding, allow the proposed changes to automatically take effect.

For further explanation and examples, refer to the following Illustration of the Process to Discontinue Therapy Services.

## Illustration of the Process for Discontinuing OT/PT Services

First:

**Occupational Therapist or Physical Therapist makes determination that therapy services are no longer necessary to support the student's educational program:**

- student has attained maximum level of function expected for their condition/demonstrates maximum response to strategies of intervention and/or accommodations
- staff demonstrate proficiency in implementing strategies of intervention and/or accommodations to address student needs
- no changes in the student's condition and educational program are expected

Then:

**Student's IEP manager/IFSP Service Coordinator is notified of plan/rationale to discontinue OT/PT services.**

- Collaborative planning/scheduling occurs with the child's team, for purposes of conducting a progress review and/or annual IFSP/IEP meeting
- Notice of a team meeting is processed

Then:

**A Periodic Progress Review or Annual IEP/IFSP meeting occurs and associated due process documentation is completed.**

- Information/data supporting discontinuation of OT/PT services is documented on a Progress Review report.

An example of a description that an OT may document on a progress review is: The student has met his objective to correctly use a name stamp to label his papers. He continues to demonstrate gradual improvements in his functional ability to print his name using a pencil and a customized system of incremental and multisensory practice that is implemented into his daily schedule. His skill in this area remains commensurate to overall cognitive development and academic growth. The student responds to instructional written language worksheets (adapted to his level of comprehension) by underlining, circling, or marking an X on the answers. The student also physically accesses a variety of computer software and touch pad applications to supplement instruction in this area. These adaptations and alternatives are used to allow the student to participate in the general education classroom when the regular written language curriculum is presented. Classroom staff report no further concerns regarding their ability to promote the student's performance in this area.

- A Prior Written Notice of Proposed Action/Denial (PWN) reflecting the discontinuation of OT/PT service (and any other changes) is completed.

The following is an example of information documented by a therapist on the PWN:

Description- Occupational therapy services will be discontinued at this time.

Explanation- OT services are no longer deemed necessary to support this child's access to general education, and their ability to progress toward their special education goals. The

child continues to demonstrate a level of written work production commensurate with their level of cognitive development, and continues to be provided appropriately adjusted instructional support. He is using assistive technology and other accommodations to successfully promote independence and participation in classroom writing activities.

Other options considered- The team considered continuing OT services, however adjustments in the type/frequency/intensity of services over the past 3 years, have not had a significant impact on changing the growth rate nor range of discrepancy between skill level and age expectations in the area of written language. Regression is not anticipated since this has not been demonstrated following a break in service, and instructional and adaptive strategies promoted by the OT have been routinely incorporated by classroom staff working with this child.

Description of information used- The decision to discontinue OT was based on information and data obtained from file review, observation, instructional interactions, work sampling and staff report.

Description of other factors- Parents expressed a desire to continue OT services as a preventative measure against possible future problems. The team clarified that the need for occupational therapy services can be readdressed at any time in the future, if a concern arises.

- The date of the current IEP remain in effect, but significant changes/updates are made to relevant sections (i.e. present levels/needs, goals/objectives, accommodations, services),or
- a new IEP (including all significant changes) is created/rewritten to reflect the student's program for the subsequent annual time period

Then:

**The parents/guardians are in agreement with proposed changes, and indicate their approval/ signs the PWN, or**

**If the parent/guardian does not object in writing, the IEP changes take effect within 14 calendar days of receiving the Prior Written Notice.**

### **Third Party Billing**

Federal and state law require all public Minnesota schools to request payment for Individualized Education Program (IEP) health-related services from public and private health insurers. Minnesota Health Care Programs (MHCP) pays the federal share of covered health-related services described on a child's IEP or Individualized Family Service Plan (IFSP).

Schools are reimbursed when a child has as a disability and an IEP or IFSP, requires health-related services in order to benefit from special education and is eligible for Minnesota Health Care Programs (MHCP) (which includes Medical Assistance (MA), MinnesotaCare and other public, government health programs).

Occupational therapy and physical therapy are some of several health related services that can be considered reimbursable.

Parents of children with disabilities must be fully informed before consenting to schools sharing information with DHS and to bill.

#### **Third Party Billing**

##### **Interpretation/Implications for Therapists:**

School districts are required by law to have a system for third party billing of health related services. Responsibilities for coordinating and implementing this system are usually delegated to select staff in a district, and therapists should know who these people are and how to contact them.

Therapists should be trained to understand the requirements of third party billing, and their associated duties/practices relative to it. **This manual does not address how schools can bill for therapy services.** The MN Department of Human Services (DHS) has developed a wide array of resources to help districts implement third party billing, and a particularly important document is their Individualized Education Program (IEP) Services Technical Assistance Guide. This document is updated regularly.

There are two basic areas of therapy service that are defined as "covered" or eligible for reimbursement. Those are:

- evaluation activities (up to but not including assessment share meetings) resulting in an IEP/IFSP that includes therapy services, and
- IEP/IFSP driven therapy services that are delivered to the child in a face to face fashion (including interactive telecommunications equipment).

The definition of direct and indirect services from a special education standpoint, is often questioned as it relates to third party billing. It is erroneous to conclude that only direct IEP services are considered reimbursable, as the array of indirect services a therapist may provide, can and usually do include periodic face to face interactions with the child.

It is inappropriate for a district to limit a therapist's role to only those services/activities that are considered reimbursable through third party billing. Likewise, it is inappropriate to influence the development of an IEP/IFSP toward a favoring of the types of services that may be reimbursable (i.e. inflating the frequency/time of direct service or face to face interactions within indirect service). A district must provide services that are necessary based on the student's identified needs and goals, regardless of the types of services for which reimbursement agencies will pay.

Documentation is a professional responsibility for a therapist. In addition to documentation required for special education due process, therapists are accountable for maintaining logs of the therapy services each child receives and the child's response to those services. This service log information can equate to documentation components required for third party billing. It is an inefficient use of resources and an unreasonable workload demand to expect a therapist to transcribe their professional service documentation from one source/system, to a separate third party billing documentation system. Excessive or duplicated paperwork demands on the therapist can be avoided by providing clerical support and/or use of electronic documentation tools/systems that serve multiple purposes.

It is reasonable for therapists to have conversations with their supervisors and other special education administrators regarding the revenue generated from third party billing. Money a district gets for third party billing can only be used for three things:

1. For the benefit of students with IFSPs/IEPs in the district;
2. To pay for the cost of doing third party billing; and
3. To get training that helps to increase the amount of third party billing.

In districts where a therapist's workload has become excessive and therapy services have been constrained, it may be important to consider if a portion of the funds generated from third party billing could be used to:

- increase therapy positions (relative to service deficiencies) that are needed to benefit and better serve children in special education, and
- adjust work load to better accommodate the time a therapist needs to do third party billing.

Additional information and resources on this topic are available at these links/ web addresses:

[Third Party Billing /](#)

<http://education.state.mn.us/MDE/SchSup/SpecEdComp/ThirdPartyBill/index.html>

[\(DHS\) MHCP Enrolled Providers - IEP /](#)

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id\\_009280](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=id_009280)

[\(DHS\) IEP Services Provider Manual /](#)

[http://www.dhs.state.mn.us/main/idcplg?IdcService=GET\\_DYNAMIC\\_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16\\_151385](http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_151385).

## Workload

The issue of workload remains a long standing concern for special educators. In 2003, the MN Department of Children, Families & Learning (now referred to as MN Department of Education) endorsed the formation of a task force to study and make recommendations regarding this issue. Changes ensued in the political and economic climate and positive momentum toward addressing workload concerns stalled. September 2013 marks renewed efforts of this task force. Transparency regarding the work has been implemented and is posted on the MDE website at this link/address:

<http://education.state.mn.us/MDE/Welcome/AdvBCT/SpecEdCaseLoadsTaskForce/index.html>

Current MN Rule relative to caseloads for teachers functioning in a traditional classroom model, is as follows:

### Case loads for school-age educational service alternatives.

- A. *The maximum number of school-age pupils that may be assigned to a teacher:*
- (1) *for pupils who receive direct special instruction from a teacher 50 percent or more of the instructional day, but less than a full school day:*
    - (a) *deaf-blind, autism spectrum disorders, developmental cognitive disability: severe-profound range, or severely multiply impaired, three pupils;*
    - (b) *deaf-blind, autism spectrum disorders, developmental cognitive disability: severe-profound range, or severely multiply impaired with one program support assistant, six pupils;*
    - (c) *developmental cognitive disability: mild-moderate range or specific learning disabled, 12 pupils;*
    - (d) *developmental cognitive disability: mild-moderate range or specific learning disabled with one program support assistant, 15 pupils;*
    - (e) *all other disabilities with one program support assistant, ten pupils; and*
    - (f) *all other disabilities with two program support assistants, 12 pupils; and*
  - (2) *for pupils who receive direct special education for a full day:*
    - (a) *deaf-blind, autism spectrum disorders, developmental cognitive disability: severe-profound range, or severely multiply impaired with one program support assistant, four pupils;*
    - (b) *deaf-blind, autism spectrum disorders, developmental cognitive disability: severe-profound range, or severely multiply impaired with two program support assistants, six pupils; and*
    - (c) *all other disabilities with one program support assistant, eight pupils.*
- B. *For pupils who receive direct special education less than 50 percent of the instructional day, caseloads are to be determined by the local district's policy based on the amount of time and services required by pupils' IEP plans. [Minn. R. 3525.2340, subp.4]*



Current MN Rule relative to caseloads for teachers serving children birth through age 6, is as follows:

**Case loads for early childhood program alternatives.** *A teacher's case load must be adjusted downward based on pupils' severity of disability or delay, travel time necessary to serve pupils in more than one program alternative, and if the pupils on the teacher's case loads are receiving services in more than one program alternative or the pupils are involved with other agencies. The maximum number of pupils that can be assigned to a teacher in any early childhood program alternative is:*

*A. birth through two years: 12 pupils per teacher;*

*B. three through six years: 16 pupils per teacher; and*

*C. birth through six years: 14 pupils per teacher.*

*District early childhood special education (ECSE) classes must have at least one paraprofessional employed while pupils are in attendance. The maximum number of pupils in an ECSE classroom at any one time with a teacher and a program support assistant is eight. The maximum number of pupils in an ECSE classroom at any one time with an early childhood team is 16. [Minn. R. 3525.2340, subp. 5]*

For infants/toddlers served in their home/daycare (item A noted above), districts often interpret the caseload limit further to mean children served by the teacher on a weekly basis. If a child receives weekly ECSE teacher services, then those children are counted as 1. If a child receives less than 1 time per week, then they are prorated. For example, 2x/month frequency equals 1/2, or 1x/month equals 1/4 of a full child count.

## **Workload**

### **Interpretation/Implications for Therapists:**

At this time there is no law or rule that addresses caseloads/workload for occupational therapists and physical therapists working in Minnesota schools. Although Minnesota legislation does not define workload restrictions for occupational and physical therapists, many factors enter into determining appropriate workloads for therapists, including the time required for the following:

- therapy service, as defined by the IEP;
- program planning, documentation, and scheduling (i.e. timing therapy services in accordance with hours of student attendance, classroom schedules, schedules of other specialists, etc.);
- assessments;
- collaboration with team members, families, caregivers, and community agencies;
- supervision and training of therapy assistants, educational staff, and caregivers;
- IEP/IFSP case management duties;
- special education and required general education meetings;
- training of students from professional programs;
- third party payer documentation requirements;
- travel (i.e. the number of sites);
- prereferral support; and participation in other general education initiatives (e.g. Rtl)
- 504 assessment/case management

Experience of the therapist and availability of clerical services and other support assistance also influences workload. Because of the number and variability of the factors affecting appropriate workloads for therapists, it is not possible to determine specific guidelines. However, attention to workload size will affect the quality of service delivery to children and families. It is important to remember that services to children should be based on their needs, not the availability of therapists.

Workload assignments for therapists are determined by individual districts. Since reasonable workload generally remains a concern for therapists in Minnesota schools, each therapist needs to share the responsibility with administration for evaluating his/her workload level. It continues to be important for therapists and their supervisors to have regular discussions regarding workload concerns. Decisions and directives should be guided by the use of data (e.g. service obligations documented on IEPs/IFSPs, time studies, analysis of service delivery models and their effectiveness on child/student performance), and careful consideration of the other factors/variables affecting the therapist's workload. Service activity logs (sample provided in the Resources section) are another source of information that will be useful when evaluating appropriate workload.

All duties and responsibilities of the therapists should be considered when addressing workload. It is incorrect to assume that indirect services are less valuable or less demanding than direct services. Indirect service often involves a high level of communication/collaboration with others, and as such, may require more of a therapist's time and effort than direct service.

When examining workload, some important questions to consider include:

- Does the role of the therapist utilize their expertise to address "unique" needs of children/students?
- Does the role of the therapist exclude activities that duplicate or replace services/interventions that others can provide?
- Does the role of the therapist focus on creating capacity in others to meet the needs of children/students through collaboration, coaching and knowledge/skill building?
- Does the role of the therapist make use of flexible scheduling and inclusive practices delivered in natural settings, and limit services delivered in an isolated/non-integrated, clinic-like fashion?
- Does the role of the therapist accommodate all aspects of special education due process?
- Does the role of the therapist allow for a continuum of service delivery, ranging from broader types of supports that benefit the general education of at risk learners, to specialized interventions aimed at the individual educational needs of a child with a disability?
- Does the role of the therapist conform to legislative mandate, professional practice governance, and current best practice?

Although it may be determined that OT and PT positions can not be immediately increased as a solution to excessive workload, it is a professional responsibility of the therapist to continually examine and reflect upon their workload demands, and the effectiveness of their services. A therapist should always consider models of service

delivery that may yield creative/innovative ways to lessen workload burdens, meet professional standards of practice, and still meet the educational needs of children and students.

Additional professional information on this topic is available at the following link/web address:

[AOTA/APTA/ASHA-Workload Approach: A Paradigm Shift for Positive Impact on Student Outcomes /  
http://www.aota.org/-/media/Corporate/Files/Practice/Children/APTA-ASHA-AOTA-Joint-Doc-Workload-Approach-Schools-2014.pdf](http://www.aota.org/-/media/Corporate/Files/Practice/Children/APTA-ASHA-AOTA-Joint-Doc-Workload-Approach-Schools-2014.pdf)

Additional information and resources are available from MDE at the following links/web addresses:

[Special Education Case Loads Task Force /  
http://education.state.mn.us/MDE/Welcome/AdvBCT/SpecEdCaseLoadsTaskForce/053350](http://education.state.mn.us/MDE/Welcome/AdvBCT/SpecEdCaseLoadsTaskForce/053350)

[Minnesota Special Education Case Load Task Force /  
http://education.state.mn.us/MDE/Welcome/AdvBCT/SpecEdCaseLoadsTaskForce/053952](http://education.state.mn.us/MDE/Welcome/AdvBCT/SpecEdCaseLoadsTaskForce/053952)

[Recommendations for Special Education Case Load and Rule Alignment /  
http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=054246&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=054246&RevisionSelectionMethod=latestReleased&Rendition=primary)

## **Collaboration and Communication**

An essential role of the school therapist is collaboration and communication, both within the educational environment and with outside agencies. School therapists acknowledge the primary role of a child as a student/learner, and apply their practice in natural settings and during natural routines of the child. This provides school therapists a distinct advantage of seeing a child's function over time, in various environments, and in relationship to the demands and resources within those environments. Clinical therapists see a snapshot of a student's life, while school therapists have the advantage of seeing the student's movie of life. It is well documented through research that a child-centered, functional approach in natural environments can have optimal results. It is important for the school therapist, clinical therapist, and other medical providers to communicate with each other. One way to facilitate this is for clinical providers to request a consent to release information between their setting and the school setting. The school therapist should also request permission of the parents to share information with medical providers. This collaborative model will benefit students, caregivers, and staff.

It is inappropriate for a clinical therapist to provide non-educationally related therapy services in the school setting. Being removed from school routines for clinical therapy violates the requirements for least restrictive environment (LRE) and presents additional liability issues for the school district, as well as for the clinical therapist. In addition, it is inappropriate to bus a student to a clinical setting for therapy services for the same reasons.

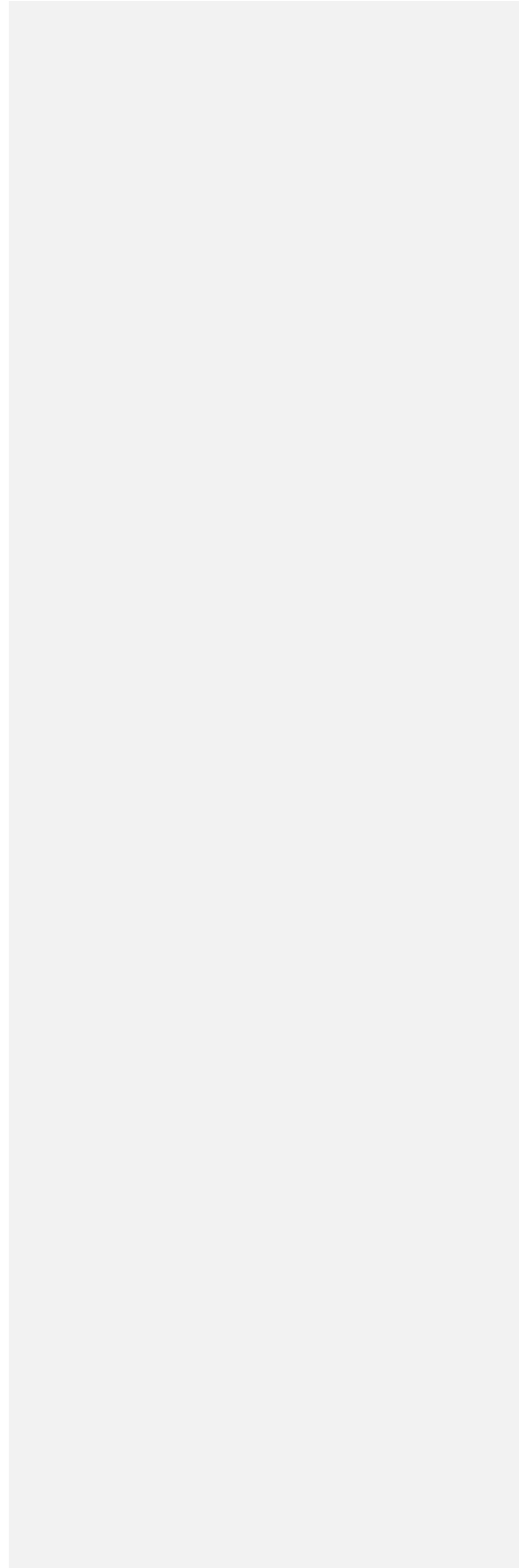
Students who have physical impairments or other health disabilities, may encounter medical needs that require surgery during their school career. When this occurs, and the student returns to school following surgery, it is important for the educational team to review the student's current function and the existing IEP to determine if the needs, goals/objectives, and associated services are appropriate. In many cases, supplementary aids and services, and program modifications and supports for school personnel will change in order to accommodate the post-surgical status of the child. The IEP should be revised, or a new IEP developed, to reflect these changes. Communication with the medical community is essential to fully understand the child's post-surgical status. Therapy in school is not adjusted to replace the need for therapy in the medical community. The school is responsible to address the educational needs of the child. If the child requires post-surgical rehabilitation, it should be provided in the medical community. To clarify further, school is a student's work setting and it is not an expectation of a work setting to provide rehabilitation for any worker.

It is often assumed that children with a disability can automatically receive therapy services in the school. While having a medical condition or diagnosis may meet one of the eligibility criteria for special education service in the schools, the student must also demonstrate a need and require specialized instruction in order to be considered for school therapy services. This is an area where collaboration and communication is

critical, to determine if there is an educational need or if services would be more appropriately provided in a clinical setting.

The lack of collaboration and communication can lead to misconceptions and perceptions that school therapy is less professional or important than clinic therapy. It must be remembered that school therapists have the advantage of seeing the students over time in natural settings, and this knowledge leads to benefits for the student.

**THERAPIST NOTES**



## **ADMINISTRATIVE CONSIDERATIONS**

Administrators in school districts frequently have backgrounds in teaching and educational administration. This leads to the unique experience of supervision of occupational and physical therapists, whose educational background, experience, and work responsibilities are very different than themselves. Therapists' work responsibilities should reflect their unique expertise, knowledge of medical conditions, and a primary focus on function. Therapist's roles in educational settings involve working with students, families, and staff, as well as coaching and teaching others to build capacity to meet student needs. It is important that administrators and therapists maintain an open communicative relationship to provide effective service to students, families, and staff.

## **PERSONNEL CONSIDERATIONS**

The special education director or a designee is responsible for the administration of occupational and physical therapy services in the school district. Variations in the details of this administration will occur between districts.

### **Recruitment/Retention of Staff**

Therapists are faced with providing more service with fewer resources, both in rural and urban settings.

Administrators should make every attempt to hire therapists who have prior school experience or at least pediatric experience. However, if it is necessary to hire a therapist without this experience, provision should be made for additional professional development. This could be accomplished through a mentoring relationship with an experienced school therapist and other supports such as additional continuing education, or collaboration with state agency resources. Extreme caution should be taken regarding hiring new graduates, without this support, in order to meet the professional regulations and recommendations regarding the first year of practice.

When an unplanned vacancy occurs during the school year, it is necessary to make every effort to provide the therapy services outlined on the IEP. A school district may need to contract with an outside agency to satisfy those requirements.

There are many factors contributing to retention of therapists in the school district. These include adequate orientation and initial training, good working conditions, opportunities for professional growth and net-working, manageable workloads,



mentoring opportunities, flexible scheduling, the challenge and enjoyment of working with children and families, competitive salaries and benefits, opportunities for financial advancement, involvement in district-wide program development, and collaboration with other team members.

### **Contract Options**

School districts may hire therapists in a variety of ways. These include the master contract that governs teachers, separate employee contracts with therapists, or purchase of service contracts with outside agencies.

A purchase of service agreement should include the following: purpose of the agreement, evidence of appropriate licensure of therapist, professional liability insurance, availability of replacement therapists from agency, working conditions, documentation of expectations, identification of supervisory relationships and evaluation of staff performance, identification of how the parties will resolve differences, payment schedule, cost of service and travel, effective dates, renewal conditions and liability.

It should be stated within the terms of the contract that therapy services should be provided within the educational setting. These settings may include home, school, and other community and work site settings identified by the educational team. Consideration of LRE requirements implies it is not appropriate for students to be bussed to the contract agency for their therapy services. Also, as additional rationale, current research supports the importance of a child-centered, functional approach in natural environments. To understand how a student functions in the educational setting, it is necessary for the therapist to be in that setting to determine the student's skills and abilities to participate in and perform learning tasks. The student needs to practice skills in the educational environment in which he/she is expected to use these skills, and the therapist must assess/work with the resources (e.g. staff and equipment) available within that environment.

Contracts should include compensation for essential non-student contact time, such as orientation, preparation, travel, documentation, coordination/communication with team members and meetings.

### **Role Clarification**

Although occupational therapy and physical therapy have areas of overlap in providing therapy services, the professions are unique and the services are not interchangeable. Administrators must be aware of regulations regarding the differences between physical therapists and physical therapist assistants and between occupational therapists and certified occupational therapy assistants. A physical therapist assistant must work under the supervision of a physical therapist. An occupational therapy assistant must work under the supervision of an occupational therapist. Therefore, an assistant cannot

be hired without also hiring a therapist to meet the licensure requirements for direction and supervision. Refer to the chapter on Laws and Regulations for further information. Training and job requirements will determine the appropriate level of therapy staff needed.

### **Practice Regulation Requirements**

In order to work in Minnesota, occupational therapists, physical therapists, occupational therapy assistants, and physical therapist assistants must be licensed by the state. Therapists and assistants should be expected to provide the employer with evidence of current state licensure at each licensure renewal. In situations in which agencies contract therapy services to school districts, verification of licensure for each therapist should be available to the districts.

When hiring therapists and assistants, school administrators need to be aware of state licensure and graduations requirements. In addition to the educational regulation requirements, therapists must meet the requirements of their state professional practice laws and regulations.

A therapist hired in a school district works only in the position for which they were hired. If they are hired in a different capacity they cannot work as a therapist at the same time, in that district. For example, an occupational therapist hired as a paraprofessional cannot provide therapy services. A therapist who holds dual licensure must work under the licensure and scope of practice of the job for which she/he was hired. For example, an occupational therapist with a PTA license cannot work in both capacities at the same time.

For additional information administrators should contact the regulatory boards for an applicant's current status. The following resources may be helpful:

[MN Board of Physical Therapy](#)

[MN Department of Health Occupations Program](#)

### **Utilization of Occupational Therapists and Physical Therapists**

Therapists have specific knowledge and skills and should be used to meet unique needs of students that cannot be met by other team members. Careful analysis of family and student needs should be considered when determining service provision in models such as the primary service provider model (PSP). A therapist may be the best choice for primary service provider for students, but it is not recommended that therapists serve as case managers for students, because this does not require the unique skills and expertise of a therapist. The decision making process for determining if a therapist is the best choice for PSP would be to consider the need for global knowledge versus the need for specific knowledge held by a therapist. It is also

important to recognize the difference between being a primary service provider and a case manager. The PSP work is directed at service to students and caregivers, while the duties of a case manager involve scheduling and managing due process.

## **Retention of Records and Data Privacy**

Therapists need to follow documentation requirements of the setting, but there may be additional requirements for documentation related to practitioner regulations. See the chapter on Laws, Regulations, and Professional Standards for more information. There also are additional documentation and record retention requirements related to third party billing.

## **Professional Liability**

It is the responsibility of the therapist and the administrator to understand the type and extent of liability coverage needed by a school therapist. While most school districts and teacher unions provide professional liability insurance against claims of negligence or malpractice, it is advisable for a therapist to determine his/her need for additional malpractice insurance. Information regarding this insurance can be obtained through the occupational therapy and physical therapy professional organizations. Therapists working with students in isolation need to be aware of liability issues related to the type of interventions used, the setting in which they occur, the intrusiveness of the intervention, the child's reaction and ability to understand, and others perceptions of that intervention. It is important to note that supervising therapists have ultimate responsibility for therapy activities performed by therapist assistants or student therapists.

## **SUPPORTING THE THERAPIST IN THE WORKPLACE**

Administrative support has many benefits to therapists working in the schools as well as to the children, families and staff they serve. Whether in an urban or rural setting, the therapist often works in isolation from fellow therapists, limiting the opportunities for collaboration with peers on a day-to-day basis. Support of therapists may take many forms including good working conditions, appropriate workload, financial support of the program, professional development, and networking opportunities with other therapists working in schools.

### **Workload**

Minnesota does not define workload restrictions for occupational and physical therapists. Many factors enter into determining appropriate workloads for therapists, including the time required for planning, service, documentation, collaboration, travel, and training. Management of non-special education activities should also be considered when determining workload. These include RTI (Response to Intervention Initiatives),

pre referral intervention/support, and 504 responsibilities, etc. Communication should be ongoing about management of student needs, workload, and resources.

A therapist's position in a school district is often autonomous, with travel between sites. Therapists should embrace these opportunities by determining the best way to meet all of the student needs in their assigned area. This requires ongoing reevaluation and redistribution of their professional resources, prior to determining if there is a need for additional staff or hours. Flexible schedules and telecommuting may enhance therapist efficiency, in order to meet immediate or varying needs. Administration should support therapists to be flexible and make decisions to provide a continuum of service to meet student needs.

## **Work Space**

Therapy intervention should always take place during student's natural routines, in natural environments, including spaces in school buildings such as classroom, lunchroom, playground, bathroom, gym, weight room, as well as work sites, homes, day cares, and other community sites. Clinical spaces are not appropriate in school or home settings for therapy intervention, as they are not a natural setting for students. There is a need for confidentiality and data privacy, so space for secure storage of records is necessary. Therapists may work in a variety of settings throughout their day.

## **Equipment and Supplies**

Students may need specialized equipment and materials for use at school. Therapists may also need equipment and materials for assessment. Funding for equipment can come from a variety of sources. Students may also own their own equipment that they bring to school for their use. Therapists may have a variety of equipment available for short-term loan or trial. Therapists may also work with vendors for acquisition and trial of equipment.

## **Orientation, Mentoring, and Evaluation**

School district administration is responsible for orientation, mentoring and evaluation of therapists who are employees of the school district, at the same level as other licensed staff members. School therapists are not just "therapists just working in schools." Instead, the therapist must function as a member of an educational team, and for this reason, must value/have skills using collaboration. In addition, a therapist must understand their supportive role in helping to meet a child's needs as a student in natural educational environments. If the therapist does not have experience in this area, he/she may need additional mentoring and training for this unique role. This should be recognized and addressed during hiring, training, and evaluation activities. Orientation should include district policies and procedures, due process, and documentation system procedures and requirements.

Therapists in school districts should have access to the same evaluation process as teachers in the districts, for common job performance elements. Content specific job elements require a peer review, because of the unique roles and expertise of therapists. If districts do not have access to peer review, they may find assistance through the professional therapy organizations within the state. Professional development and peer interaction opportunities should be provided for therapists working in school settings.

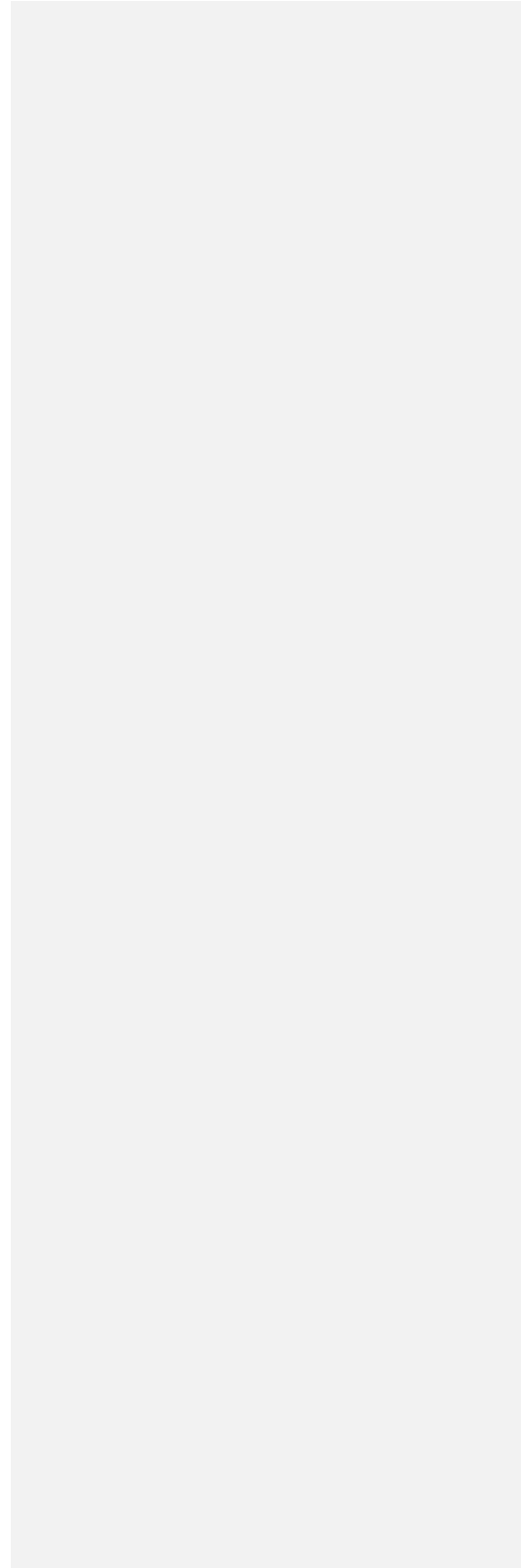
### **Continuing Education**

Professional development is a shared responsibility of the therapist and the administration of the school district. Most district-wide continuing education focuses on the needs of educators, and will not fulfill state licensure requirements of an occupational therapist or physical therapist. Therefore, it is important to provide staff development opportunities that address the unique needs of therapists. Therapists in neighboring districts may be able to combine staff development resources and opportunities.

### **Student Therapist Experiences**

District policies addressing student teacher experiences would apply to student therapist experiences. These policies may include contracts, liability, and requirements for the students in the areas of health and safety before the experience begins. Supervision of student therapists has advantages for the therapists and school districts through the sharing of current information, continuing education opportunities, providing a pool of prospective employees with experience in the school setting, and opportunities for dialogue with colleagues in higher education.

**THERAPIST NOTES**





## RESOURCES

The following information is a compilation of resources for occupational therapists and physical therapists working in education settings.

The list of documentation examples in this resource section is not meant to be extensive. They are offered as rudimentary, supplemental forms, which may be used to support the therapist's practice regulations, professional standards and individual district policies for documentation. These forms/formats may be used and/or adapted by therapists as needed. Other mandatory due process documentation responsibilities for the therapist, as established at the district level, still apply.

The list of MDE links included in this resource section, although fairly extensive, is not comprehensive and is current as of July 2014. It is included in this section as a means to quickly locate MDE guidance documents posted electronically and available at this point in time. As the MDE website organization and content is updated, these links may become obsolete, requiring the reader to conduct further search for any revised information and associated changes in web addresses.

### Regulatory Agencies

#### Occupational Therapy

Minnesota Department of Health  
Health Occupations Program  
PO Box 64882  
St. Paul, MN 55164-0882  
651-201-3725  
Fax 651-201-3839  
<http://www.health.state.mn.us/divs/hpsc/hop/contactus.html>

#### Physical Therapy

Minnesota State Board of Physical Therapy  
2829 University Ave SE, Suite 420  
Minneapolis, MN 55414-3222  
612-627-5406  
Fax 612-627-5403  
<http://mn.gov/health-licensing-boards/physical-therapy/>

**Education**

Minnesota Department of Education  
1500 Highway 36 West  
Roseville, MN 55113  
651-582-8200  
<http://education.state.mn.us/MDE/index.html>

## Professional Organizations

### Occupational Therapy

American Occupational Therapy Association, Inc.  
4720 Montgomery Lane, Suite 200  
Bethesda, MD 20824-3449  
1-800-SAY-AOTA (729-2682)  
301-652-6611  
TDD # 800-377-8555  
Fax 301-652-7711  
<http://www.aota.org/>

Minnesota Occupational Therapy Association  
1000 Westgate Drive, Suite 252  
St. Paul, Minnesota 55114-2264  
651- 290-7498  
Fax 651- 290-2266  
<http://www.motafunctionfirst.org/>

### Physical Therapy

American Physical Therapy Association  
1111 Fairfax Street  
Alexandria, VA 22314-1488  
1-800-999-APTA (2782)  
Fax 703-684-7343  
TDD # 703-683-6748  
<http://www.apta.org/>

Minnesota Chapter, American Physical Therapy Association  
970 Raymond Avenue, Suite 205  
St. Paul, MN 55114  
651-635-0902  
Fax 651-635-0903  
<http://www.mnapta.org/>

## Curriculum Programs in Minnesota

### Occupational Therapist Programs

College of St. Scholastica  
1200 Kenwood Avenue  
Duluth, MN 55811  
218-723-6046

St. Catherine University  
2004 Randolph Avenue, Mailbox # 4027  
St. Paul, MN 55105  
651-690-6933

University of Minnesota  
Phillips-Wangenstein Building, Room 15-194 MMC 714  
516 Delaware Street SE  
Minneapolis, MN 55455  
877-334-2659

### Physical Therapist Programs

College of St. Scholastica  
1200 Kenwood Avenue  
Duluth, MN 55811  
218-723-6046

Mayo School of Health Sciences  
Physical Therapy Program  
Siebens 11-04  
Rochester, MN 55905  
507-284-2054

St. Catherine University  
601 - 25th Avenue South  
Minneapolis, MN 55454  
651-690-7825

University of Minnesota  
Program in Physical Therapy  
420 Delaware Street SE (MMC 388)  
Minneapolis, MN 55455  
612-624-2662

For information regarding curriculum programs in other states, contact the websites of the national professional organizations.

## **Curriculum Programs in Minnesota**

### **Occupational Therapy Assistant Programs**

Anoka Technical College  
1355 West Hwy 10  
Anoka, MN 55303  
612-0576-4936

Herzing University – Crystal, MN  
5700 West Broadway, Crystal, MN 55428  
763-535-3000

Northland Community and Technical College  
2022 Central Avenue NE  
East Grand Forks, MN 56721  
218-793-2889

St. Catherine University - Minneapolis Campus  
601 - 25th Avenue South  
Minneapolis, MN 55454  
651-690-7872

### **Physical Therapist Assistant Programs**

Anoka-Ramsey Community College  
11200 NW Mississippi Blvd.  
Coon Rapids, MN 55433  
763-433-1100

Lake Superior College  
2101 Trinity Rd.  
Duluth, MN 55811  
218-733-7601

Northland Community and Technical College  
2022 Central Avenue NE  
East Grand Forks, MN 56721  
218-793-2565






Intervention code: F=Face to Face Student Contact T=Training A=Student Absent  
E=Evaluation M=Meeting NA=Student not Available  
C=Consult (personal, phone, etc.) TA=Therapist Absent

Signature/Title: \_\_\_\_\_

### Sample Letter To Physician Regarding Occupational Therapy or Physical Therapy Service

This letter could be used as a fax-back form or mailed to the physician.  
Be aware of confidentiality practices.

DATE: \_\_\_\_\_

TO: \_\_\_\_\_, MD

FROM: \_\_\_\_\_, PT or OT

STUDENT: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SCHOOL YEAR: \_\_\_\_\_ SCHOOL/PROGRAM: \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

CURRENT MEDICAL STATUS: \_\_\_\_\_

PRECAUTIONS OR RESTRICTIONS ON STUDENT ACTIVITY: Please comment  
specifically for... \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



CURRENT SCHOOL THERAPY PLAN OF CARE: \_\_\_\_\_

\_\_\_\_\_

COMMENTS: \_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Sample Informational Letter To Physician  
Regarding Incoming Recommendations**

This letter could be used as a fax-back form or mailed to the physician.  
Be aware of confidentiality practices.

DATE: \_\_\_\_\_

TO: \_\_\_\_\_, MD

FROM: \_\_\_\_\_, PT or OT

STUDENT: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

SCHOOL YEAR: \_\_\_\_\_ SCHOOL/PROGRAM: \_\_\_\_\_

\_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_

\_\_\_\_\_

CURRENT MEDICAL STATUS: \_\_\_\_\_

\_\_\_\_\_

CURRENT SCHOOL THERAPY PLAN OF CARE: \_\_\_\_\_

\_\_\_\_\_

---

---

I have received (communication, prescription, etc.) from you regarding (student), requesting (therapy services and frequency). The process for determining the need for provision of services in the school setting is through the IEP. Therapy services provided in the school setting are educational rather than medical and are designed to enhance the student's function in the school setting and are always related to their educational program. Your request will be considered as part of the IEP process. If it does not meet the student's educational needs, your specific request for therapy will not be implemented.

Thank you for your communication regarding this student. He/she will benefit from coordination of all of his/her needs. The information you are providing will be helpful in continuing the planning for the student's function in school. Often students receive private therapy for medical needs and educational therapy to meet needs in school. If you would like to receive a copy of the student's educational plan or have questions regarding this communication, please contact me at:

---

Signature \_\_\_\_\_ Date \_\_\_\_\_

### Sample Year End/Transition Form

This example is intended to serve as an internal form to facilitate fall planning and/or transition to another therapist or building. In addition to the IEP/IFSP, this form may function as further documentation of a Therapy Care Plan.

STUDENT: \_\_\_\_\_ DOB: \_\_\_\_\_  
DIAGNOSIS: \_\_\_\_\_  
DISTRICT/SCHOOL: \_\_\_\_\_  
CASEMANAGER/TEACHER: \_\_\_\_\_  
OTHER SIGNIFICANT STAFF: \_\_\_\_\_

DESCRIPTION OF STUDENT/CAREGIVER/STAFF STATUS & NEEDS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CURRENT IEP THERAPY SERVICE DESCRIPTION: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SERVICES PROVIDED DURING THE PAST YEAR: (areas of emphasis, services provided, risks/contraindications, student response to intervention, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

---

---

SCHOOL FOR THE NEXT YEAR: \_\_\_\_\_

TO DO - FALL/TRANSITION: (equipment/materials, staff inservice, etc.) \_\_\_\_\_

---

---

---

---

IMPORTANT CONSIDERATIONS: (3 year evaluation, planned health/medical events, therapy services from outside agency, etc.) \_\_\_\_\_

---

---

---

---

Providing Therapist: \_\_\_\_\_ Date: \_\_\_\_\_

The following is a list of electronic links to information/resources posted on the Minnesota Department of Education website current as of July, 2014. This is in addition to links embedded throughout the content of this manual. As changes in web address links occur, the reader will need to use the search mechanism on the MDE website to locate these documents, or to locate any updated or additional information that may be posted in the future.

### **Referral/Screening/Evaluation:**

[Referral Standards](#) (Rev. August 2012)

[Post Referral Actions Flowchart and Word Description of Flowchart](#) (7/25/12)

[Screening: An optional response to a referral](#) (7/16/12)

[Part C Eligibility Determination Flowchart](#) (8/3/12)

[Informed Clinical Opinion](#) (7/15/12)

[Prior Written Notice for Part C](#) (7/15/12)

[Evaluation Compendium \(GUIDE\): A User's Guide to Comprehensive Evaluation of Young Children Birth to Age Six](#) (11/23/11)

[Evaluation Compendium for Early Childhood Special Education](#) (2/27/12)

[Evaluation Standards](#) (Rev. August 2012)

[Evaluation Report Form](#) (October 2011)

[Q&A: Autism Spectrum Disorders Eligibility](#) (4/17/12)

[Q&A: Evaluations: Dismissal and Reinstatement of Services](#) (5/28/14)

[Q&A: Functional Behavioral Assessments and Behavioral Intervention Plans](#) (2/14/12)

[Q&A: Individualized Education Programs \(IEP's\), Evaluations and Reevaluations](#)

[Q&A: Other Health Disabilities Criteria and Attention Deficit Disorder or Attention Deficit Hyperactivity Disorder](#) (2/24/12)

[Q&A: Part C Evaluations](#) (10/12/11)

[Q&A: Part C Prior Written Notice Requirements](#) (8/6/13)

[Q&A: Part C Screening Requirements](#) (8/6/13)

[Q&A: Reevaluations under Part B of the Individuals with Disabilities Act](#) (3/11/13)

Minnesota Continuous Improvement Process: Self Review (MNCIMP:SR)  
Record Review Training

- [Part B – Evaluation/Re-evaluation and Eligibility Requirements for Special Education](#) (9/18/13)
- [Part B – Notification Standards](#) (9/18/13)
- [Part B – Timelines](#) (9/18/13)
- [Record Review Checklist - Part B](#) (8/20/13)

- [Part C – Evaluation, Eligibility and Assessment](#) (9/18/13)
- [Part C – Notification](#) (9/18/13)
- [Part C – Timelines](#) (9/18/13)
- [Record Review Checklist - Part C](#) (8/20/13)

### **Categorical Disabilities / Eligibility Checklists**

- [Autism Spectrum Disorder](#) (8/15/12)
- [Deaf and Blind](#) (8/15/12)
- [Deaf and Hard of Hearing](#) (8/15/12)
- [Developmental Adapted Physical Education](#) (8/15/12)
- [Developmental Cognitive Disability](#) (8/15/12)
- [Developmental Delay - Ages 3 through 6](#) (8/15/12)
- [Developmental Delay - Birth through Age 2](#) (8/15/12)
- [Emotional or Behavioral Disabilities](#) (8/15/12)
- [Other Health Disabilities](#) (8/15/12)
- [Physically Impaired](#) (8/15/12)
- [Severely Multiply Impaired](#) (8/15/12)
- [Specific Learning Disability](#) (8/15/12)
- [Speech Language Impairment](#) (8/15/12)
- [Traumatic Brain Injury](#) (8/15/12)
- [Visual Impairment Checklist](#) (8/15/12)

### **IEP/IFSP DEVELOPMENT:**

- [Individualized Education Program \(IEP\) Form](#) (May 2014)
- [Individualized Education Program \(IEP\) Rubric](#) (June 2014)
- [Individual Family Service Plan \(IFSP\) Form](#) (May 2012)
- [Individual Family Service Plan \(IFSP\) Form Guidance](#) (May 2012)
- [Q&A: Individualized Education Program \(IEP\) Team Meeting Attendance](#) (10/12/11)
- [Q&A: Needs-Based Goals](#) (5/17/12)
- [Q&A: Related Services](#) (4/30/12)
- [Q&A: Individualized Family Service Plan \(IFSP\) Service Delivery](#) (8/6/13)

[Q&A: Individualized Family Service Plan \(IFSP\) Statement on Reporting Progress](#)  
(10/12/11)

[Q&A: Secondary Transition](#) (Rev. September 2011)

Minnesota Continuous Improvement Process: Self Review (MNCIMP:SR)  
Record Review Training

- [Part B – Individual Education Program \(IEP\) Standards](#) (9/18/13)
- [Part C – Individual Family Service Plan \(IFSP\)](#) (9/18/13)

Occupational therapists and physical therapists working in MN schools, are encouraged to participate in regional network and training opportunities supported by the Minnesota Low Incidence Projects. These projects address identified gaps and needs in special education programs and related services for students identified with any Low Incidence disability. Coordination of these activities is accomplished through planning and collaboration between Regional Low Incidence Facilitators (RLIFs) that cover all eleven regions of the state. To connect to a network of school based therapists in your region of practice, contact an RLIF noted in the following link:

[MN Regional Low Incidence Facilitators](#)

[http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=004283&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=004283&RevisionSelectionMethod=latestReleased&Rendition=primary)

Other information and technical assistance is available by contacting the Low Incidence personnel/specialists noted in the following link:

[MN LIS Contacts](#)

[http://education.state.mn.us/mdeprod/idcplg?IdcService=GET\\_FILE&dDocName=043541&RevisionSelectionMethod=latestReleased&Rendition=primary](http://education.state.mn.us/mdeprod/idcplg?IdcService=GET_FILE&dDocName=043541&RevisionSelectionMethod=latestReleased&Rendition=primary)

## REFERENCES

American Occupational Therapy Association. Occupational Therapy in School Settings. 2010.

[www.aota.org/-/media/Corporate/Files/AboutOT/Professionals/WhatsOT/CY/Fact-Sheets/School%20Settings%20fact%20sheet.pdf](http://www.aota.org/-/media/Corporate/Files/AboutOT/Professionals/WhatsOT/CY/Fact-Sheets/School%20Settings%20fact%20sheet.pdf) Accessed November 21, 2014.

American Occupational Therapy Association. Occupational Therapy and Universal Design for Learning. 2010.

[www.aota.org/-/media/Corporate/Files/AboutOT/Professionals/WhatsOT/CY/Fact-Sheets/UDL%20fact%20sheet.pdf](http://www.aota.org/-/media/Corporate/Files/AboutOT/Professionals/WhatsOT/CY/Fact-Sheets/UDL%20fact%20sheet.pdf) Accessed November 21, 2014.

American Occupational Therapy Association. Occupational Therapy - Response to Intervention - Consumer Brochure. 2010.

[www.aota.org/-/media/Corporate/Files/AboutOT/Professionals/WhatsOT/CY/Rti%20Brochure%20Oct%204%202011.pdf](http://www.aota.org/-/media/Corporate/Files/AboutOT/Professionals/WhatsOT/CY/Rti%20Brochure%20Oct%204%202011.pdf)

Accessed November 21, 2014.

American Occupational Therapy Association. Occupational therapy practice framework: Domain and process. 3<sup>rd</sup> ed. *American Journal of Occupational Therapy*. 2014;Suppl.1:S1-S48.

Americans With Disabilities Act of 1990, 42 U.S.C. 12101. Individuals with Disabilities Act 2004. U.S. Department of Education <http://idea.ed.gov/> Accessed December 16, 2014.

Atwater SW. Should the normal motor developmental sequence be used as a theoretical model in pediatric physical therapy? In: Lister MJ, ed. *Contemporary Management of Motor Control Problems: Proceedings of the II STEP Conference*. Alexandria, VA: Foundation for Physical Therapy; 1991;89-93.

Family Educational Rights and Privacy Act (FERPA).

<http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html?src=rn> Accessed November 21, 2014.

Frolek Clark G, Kingsley K. *Occupational Therapy Practice Guidelines for Early Childhood: Birth Through 5 Years*. Bethesda, MD: American Occupational Therapy Association Press; 2012.

Frolek Clark G, Polichino J. Response to Intervention and Early Intervening Services: Occupational Therapy Roles in General Education. Bethesda, MD. American Occupational Therapy Association. *OT Practice* CE1-8, 2010;15(1).

Frolek Clark G, Chandler BE, eds. *Best Practices for Occupational Therapy in Schools*. Bethesda, MD, American Occupational Therapy Association. 2013.

*Guide to Physical Therapist Practice 3.0*. Alexandria, VA: American Physical Therapy Association; 2014. Available at: <http://guidetoptpractice.apta.org/>. Accessed November 21, 2014.

Hanft BE, Pilkington KO. Therapy in Natural Environments: The Means or End Goal for Early Intervention? *Infants and Young Children*. 2010;12(4): 1-13.

Hanft BE, Rush, Sheldon MM. *Coaching Families and Colleagues in Early Childhood*. Baltimore, MD: Brooks Publishing; 2004.

Hanft BE, Shepherd J. *Collaborating for Student Success: A Guide for School-Based Occupational Therapy*. Bethesda, MD: American Occupational Therapy Association; 2008.

Hanft BE, Shepherd J, Read. Best Practices in Collaborating on School Teams. In: Frolek-Clark, Chandler, eds. *Best Practices in School Occupational Therapy*. Bethesda, MD: American Occupational Therapy Association; 2013.

Harris SR. Functional abilities in context. In: Lister MJ, ed. *Contemporary Management of Motor Control Problems: Proceedings of the II STEP Conference*. Alexandria, VA: Foundation for Physical Therapy; 1991;253-259.

Individuals With Disabilities Education Act Amendments. U.S. Department of Education <http://idea.ed.gov/> Accessed December 16, 2014.

Jackson LL, ed. *Occupational Therapy Services for Children and Youth Under IDEA*. 3<sup>rd</sup> Ed. Bethesda, MD: American Occupational Therapy Association; 2007.

Law M. (2000). Strategies for Implementing Evidence-Based Practice in Early Intervention. *Infants and Young Children*. 2000;13(2): 32-40.

McEwen I, ed. *Providing Physical Therapy Services Under Parts B & C of the Individuals with Disabilities Education Act (IDEA)*. Alexandria, VA: Section on Pediatrics, American Physical Therapy Association; 2009.

Minnesota Department of Education. <http://education.state.mn.us/mde/index.html> Accessed November 21, 2014.

Pacer Center, Inc. (2012) *A Guide for Minnesota Parents to the Individualized Education Program (IEP) - 2012 Edition*. Minneapolis, MN



Rush D, Sheldon MM. *The Early Childhood Coaching Handbook*. Baltimore, MD: Paul H. Brookes; 2001.

Rush D, Sheldon MM. *The Early Intervention Teaming Handbook: The Primary Service Provider Approach*. Baltimore, MD: Paul H. Brookes; 2013.

U.S. Department of Education. IDEA and FERPA Confidentiality Provisions. June, 2014. <http://www2.ed.gov/policy/gen/guid/ptac/pdf/idea-ferpa.pdf> Accessed October 31, 2014.

U.S. Department of Health and Human Services. Does the HIPPA Privacy Rule apply to an elementary or secondary school? [http://www.hhs.gov/ocr/privacy/hipaa/faq/ferpa\\_and\\_hipaa/513.html](http://www.hhs.gov/ocr/privacy/hipaa/faq/ferpa_and_hipaa/513.html) Accessed October 31, 2014.