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Comparison of Pediatric Physical Therapy Service in the Educational versus Medical Setting with Special Focus on IEP Development

Nicki Christopherson

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COMPARISON OF PEDIATRIC PHYSICAL THERAPY SERVICE
IN THE EDUCATIONAL VERSUS MEDICAL SETTING
WITH SPECIAL FOCUS ON IEP DEVELOPMENT

By

Nicki Christopherson
Bachelor of Science in Physical Therapy
University of North Dakota, 1994

An Independent Study
Submitted to the Graduate Faculty of the
Department of Physical Therapy
School of Medicine
University of North Dakota
in partial fulfillment of the requirements
for the degree of
Master of Physical Therapy

Grand Forks, North Dakota
May
1995
This Independent Study, submitted by Nicki Christopherson in partial fulfillment of the requirements for the Degree of Master of Physical Therapy from the University of North Dakota, has been read by the Faculty Preceptor, Advisor, and Chairperson of Physical Therapy under whom the work has been done and is hereby approved.

Peggy M. Mohs
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Thomas Man
(Chairperson, Physical Therapy)
### PERMISSION

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ABSTRACT

The passage of Public Law 94-142, the Education for all Handicapped Children Act, in 1975, has created an increased demand for physical therapists to work with children in the educational setting. The intent of the law is that all individuals have the right to a free, appropriate public education. In order for an individual with a disability to receive an appropriate education, related services, including physical therapy, are provided.

Physical therapy has traditionally been a medical service. In accordance with the law, the services delivered by a physical therapist in the school setting must be educationally related. Service provisions including treatment methods, delivery of service, support network, administrative procedure, and reimbursement have differing qualities in the medical and educational setting.

The purpose of this study is to compare the services in medical and educational settings to make therapists aware of changing roles in the profession. The comparison will include a special focus on the development of an IEP as well as an outline of components of the law.
CHAPTER I
INTRODUCTION

The Education of All Handicapped Children Act (Public Law 94-142) was enacted in 1975. The law mandated a free, appropriate, public education, including any needed special education and related service, for children with disabilities age 3-21 years. In 1986, the Education for All Handicapped Children Act Amendments (Public Law 99-457) was passed by Congress. The law was enacted to provide early intervention services for children birth to two years who have, or are at risk for, developmental problems and their families. The acts were re-authorized and are now referred to as the Individuals with Disabilities Education Act (IDEA). The legislation has created an increased need for health services in the educational setting including physical therapy.

The physical therapy profession has been active in the United States for many years. Throughout this time, the role of the therapist has been constantly changing to adapt to the needs of the people. Physical therapy has traditionally been viewed as a medical service. Physical therapists have been employed in a variety of settings including acute care hospitals, rehabilitation hospitals, and outpatient clinics. The role of the therapist in these settings is to provide appropriate medical care to allow the patient to achieve a functional level
suited to their needs. Ottenbacher\textsuperscript{6} noted that therapists are trained in medically-oriented models of intervention in which they try to treat the underlying causes of a child's disability. Since the passage of Public Law 94-142, in which physical therapy was included as a related service, the need for therapists has increased in the educational environment.\textsuperscript{1,7} It was mandated that services delivered be \textit{educationally} related. Educational models commonly require therapists to help students succeed in school despite the limitations imposed by their disability.\textsuperscript{6} In order to maintain the professional standards, it is necessary to adapt to the situation by redefining the role of a physical therapist in this context. The focus of service provision is to support the educational progress of the child rather than focusing solely on medical issues.\textsuperscript{8} Service provision including treatment methods, delivery of service, support networks, administrative procedures, and reimbursement methods have differing qualities in the educational and medical settings. It is important for therapists to be aware of these differences in order to maintain effective communication and consistency throughout the profession. In later segments of this paper, a comparison of service provision in the medical versus educational setting will be discussed.

After discussing the differing qualities that exist between the educational and medical setting, additional areas that need to be expanded from the educational model for further understanding of the practice in the educational setting will be reviewed. One area that must be addressed is the legislation
itself. Many provisions in the educational setting occur as a result of Public Law 94-142. It is necessary to look at the components of this law in order to understand the nature of physical therapy practice. Public Law 99-457 was enacted to provide early intervention services for children birth to two years and their families. Physical therapy is considered a primary (rather than related) service for this age group. Although the discussion of Public Law 99-457 goes beyond the scope of this paper, it has been mentioned for the benefit of those working in early intervention. Therapists should also anticipate that the early intervention regulations will vary from state to state. The components of Public Law 94-142 will be described and the interpretations of several authors examined.

Another process unique to the educational setting is the development of Individualized Education Program (IEP). The IEP is one component of Public Law 94-142. An IEP is developed and implemented by members of the educational team to address the special education needs of the individual student. The IEP document is the organizing framework for therapy services in schools. Although the law stated that an IEP is required and gives general guidelines, the actual details of the development process are established by the education team putting them together. Many school districts and individual education teams have developed more specific guidelines that they follow. Several different components of IEP development will be addressed.
The final section of this paper will include this author's conclusion regarding the relevance of the information to the physical therapy profession. The need for the information in daily practice for all physical therapists will be reiterated.
CHAPTER II
OVERVIEW OF DIFFERENCES BETWEEN MEDICAL
AND EDUCATIONAL SETTING

Service provisions vary from setting to setting throughout all areas of physical therapy practice. Therapists need to be aware of provisions in order for consistency throughout the profession. Although differences occur in every setting, those occurring between the medical and educational setting are many. This chapter will include some differences that occur in the areas of treatment methods, delivery of service, support network, administrative procedure, and reimbursement.

Treatment Methods

Physical therapists use many different treatment techniques with patients in order to achieve the desired goal. With so many options available, it is the role of the therapist to determine the most effective treatment method for a given situation. In the medical setting, the therapist considers various aspects of the patient and situation in order to choose the appropriate treatment. Included in the decision are diagnosis of the patient, results form the subjective and objective portions of the evaluation, goals of the patient, availability of
equipment needed for treatment, preference of the therapist, and efficacy of
treatment(s) on similar patient population.9

When a patient is referred to physical therapy by a physician, the
diagnosis of the patient is often the initial consideration. With this diagnosis,
the therapist is able to examine the anatomical, physiological, psychological,
emotional, and social implications that may be present. The information from
the initial evaluation is very important in determining the specific needs of the
patient. While a diagnosis can give an idea of what may be seen in a specific
patient population, it is not a complete picture. Patients with the same
diagnosis can present with very unique problems and need to be addressed
individually. The subjective portion of the evaluation will lead to information
about onset, perception of progression, coping mechanisms (physical and
mental), and general personality and learning style of patient. The objective
portion of the evaluation gives specific information about joint range of motion,
muscle strength, sensory changes, and functional activity level.10 The treatment
chosen will also depend on the goals of the patient. Although availability of
resources may not be a desirable thing to consider, it is a realistic part of the
decision-making process. Not all departments will have the necessary
equipment to deliver a specific treatment. The preference of the therapist also
plays a role in the decision. A therapist may have special training in the
application of a treatment and, therefore, is more proficient in administering it.
The efficacy of a technique is also considered when determining the treatment. Current review of research of a treatment can be used to determine efficacy.

All of the above criteria are also used in the educational setting. Therapists also find the referral and the prescription from the physician helpful to orient themselves to the medical aspect of the child's condition. The primary diagnosis, precautions, and medications are highly informative in the evaluation and treatment of the child. There are also additional items that must be considered when determining treatment for students. The services delivered must be educationally related according to legislation. The specific mandates of this legislation will be discussed in chapter three. One such mandate that may alter treatment methods is that which stated services must be delivered in the "least restrictive environment." Least restrictive environment means that to the maximum extent appropriate, children with disabilities must be educated with children who are not identified as disabled. While in the medical model, the focus of care is on discovering and remediating the underlying cause; in the educational model, the approach may be to learn compensatory strategies. Within the school system, the child's ability to function in the educational environment, rather than the severity of the disability itself, is of primary importance. Another difference may occur due to the fact that a district or agency cannot use the excuse of unavailability of resources in order to deprive a child with a disability of the right to an appropriate education.
Giangreco\textsuperscript{14} discussed an integrated approach which referred to the incorporation of educational and therapeutic techniques to assess, plan, implement, evaluate, and report progress on goals. This model was based on the following basic assumptions. (1) Assessment should be conducted in the natural environments frequented by the learner. (2) Programs for the student should be jointly devised by educators, related service personnel, and parents. (3) Intervention should focus on the teaching of the clusters of behavior which constitute functional activities. (4) Therapy should be interwoven into a variety of activities continuously throughout the day in a naturalized manner. (5) Skills and activities should be taught within the context of the settings where they naturally occur.

The requirements that physical therapy be educationally related and delivered in the least restrictive environment necessitates that treatment methods be altered. A therapist may be working with a child in the classroom with other children and treatment needs to be compatible with the lesson that is being learned. Chandler\textsuperscript{15} stated this requires a therapist be "knowledgeable about schools, curriculum, teaching styles, materials, routines, schedules, and children." In addition, a therapist may not have direct contact for treatment, but instead will consult with others who will carry out the treatment. For example, a therapist may set up a positioning program that is used in the classroom throughout the day. Also, the focus of treatment is on the functional level. Functional independence demands an interactive relationship between the
person and the environment. Dr. Harry C. Webster stated, "Successful education uses many different systems in a child's body. It involves the child's central nervous system, musculoskeletal system, and sensory systems." Physical therapists need to remember the many areas involved with education when determining whether a child is eligible to receive services.

**Delivery of Service**

Developing methods of service delivery that effectively meet the needs of students who require therapy programs is a challenge physical therapists face. Some factors that may influence the decision are eligibility criteria, the therapist-to-student ratio, adequacy of space and equipment, and scheduling. Delivery of service is provided on a continuum basis from direct individual treatment to consultation only. The method of service delivery can and should be modified as the student's needs change. More than one method can be utilized at the same time depending on the needs of the child.

The direct services provided by the physical therapist include screening, evaluation, and direct therapy. Direct therapy can be divided into two categories: one-to-one contact between the therapist and the student and group therapy in which the therapist is actively involved in the treatment session with more than one student at a time. Direct individual therapy is often restricted in educational settings because of therapists' large caseload and need to provide services in more than one school. Direct therapy may also be affected by the "least restrictive environment" that restricts taking a child out of the classroom.
for treatment. Palisano\textsuperscript{18} stated that group therapy allows “more children to be served in less time compared to individual therapy; however, a lack of research on the effectiveness of different methods of service delivery limits the therapist’s ability to select a method based on the expected benefits for the students.”

Indirect services can be divided into several categories including management, monitoring, and consultation.\textsuperscript{19} Often consultation is considered to be a separate category.\textsuperscript{18,20} Consultation will be presented here for explanatory purposes. Management programs are physical techniques developed, taught, and supervised by a physical therapist, but administered by another person; for example, a positioning program to be used by the teacher for regular classroom work. Monitoring involves periodic contact by the physical therapist with at-risk students who are functioning appropriately at the present time. This may include students who have previously received therapy services or students who have not received therapy, but have risk factors that may cause concerns about further development to arise. Lindsey\textsuperscript{19} reported, “monitoring is often done annually, and usually at the beginning of the school year.”

Consultation is specific instruction by a physical therapist provided to enhance the student’s education by looking at overall needs in the school or home environment. The consultation role is part of a team process involving regular and special education teachers, parents, physical educators, bus drivers, guidance counselors, aides, volunteers, principals, psychologists,
nurses, physicians, social workers, occupational and speech therapists, transportation and maintenance personnel, and community health agencies. Consultative services are designed to enable many professionals to help meet the expressed goals for the child. Each of the individuals must communicate to the other professionals what their role is in serving the child. The other members of the team can then work more efficiently by having individuals available in other areas of expertise for gaining information.

Much of the delivery of service is similar in the medical setting. A therapist must determine which method of service delivery is most appropriate for the patient at that time. Direct therapy service is common in the medical setting. Scheduling of patients and the delivery of service to all patients in the same facility makes this possible. Although direct services are more common, indirect and consultative services are also important. Indirect services may include management programs that are carried out by others; for example, a range of motion program to be carried out by nursing staff or family members. Consultation is also important to provide consistent, appropriate care for the child. The physical therapist may consult with nurses, physicians, volunteers, parents, other medical staff, and personnel at the child's school, which may include another physical therapist. Methods of service delivery are similar between the educational setting and the medical setting. The difference occurs in how often and under what circumstances each is used in the various settings.
Support Network

Support network is an all inclusive term used to define any person who has a relationship to the child. This network is very important for the well-being of the child. Everyone involved plays an integral role in the child's development and maturation. Children learn from environment and, therefore, the environment needs to be conducive to appropriate learning. Kalscheur\textsuperscript{16} stated, "Functional independence demands an interactive relationship between the person and the environment." The child also needs social interaction in order for appropriate emotional development. The support network may consist of parents, physicians, nurses, teachers, other family members, and numerous others. A varying degree of involvement of these individuals is seen between the medical and educational setting.

In the medical setting, the child is directly involved with a variety of medical personnel including physicians, nurses, and therapists. The child may also be involved with teachers, psychologists, and social workers. The child's parents are usually involved with the treatment that the child is receiving. The parents are involved in gaining information for the subjective portion of the evaluation of the child. They are also sometimes involved in carrying out a home program. Although all of these people are involved with the children, the priority is focused on their medical needs.\textsuperscript{17,22}

The educational setting is different in that the priority is given to educational goals.\textsuperscript{22} Therefore, increased contact is made with the child's
teacher. Lawlor stated "partnerships between special educators and therapists are critical links in the educational system." In the schools, it is not uncommon for the therapist to only be in contact with the parent a few times throughout the school year at conferences or IEP meetings. Much of the information the therapist receives about the child is through the teacher rather than the parent. Parent participation is required under PL 94-142. Under the law, a parent must provide consent prior to conducting the initial evaluation of the child and have the opportunity to participate and contribute at the IEP meeting. Effgen and Klepper stated, "Sixty-nine percent [of therapists surveyed] report that parents are always or usually involved in the evaluation of their child, whereas 97% believe parents should participate in this process." One example which emphasizes the involvement of parents is the Cayuga-Onondaga Assessment for Children with Handicaps (COACH). This emphasis is based on five major assumptions. (1) Parents know their child better than anyone else. (2) Parents have the greatest vested interest in seeing their child learn. (3) Parents are likely to be the only adults involved with their child's education throughout the entire school career. (4) Parents have access to information about their child in home and community settings to which others have no access. (5) Parents have the ability to positively influence the quality of educational services provided in their community. Another factor showing the need for parental involvement is the knowledge that functional skills need to be carried into the home environment.
Another area that needs to be addressed when looking at networks is the relationship that professionals have with each other. There are many people working with a child throughout the day in either a medical or educational setting. The most efficient way to facilitate communication between professionals is by forming a team. The team approach is a practical way of using the time and talents of the members for the best results. The team service models include the multidisciplinary approach, the interdisciplinary approach, and the transdisciplinary approach.

The multidisciplinary team approach usually includes several specialists located in the same facility who act independently to provide evaluation information and recommendations. The team leader then shares the information with the parents. This model assumes that although various disciplines are necessary, they could function independently of one another. This is the model that is often used in the medical setting.

The interdisciplinary approach is characterized by cooperative interaction among specialists who evaluate the child, share the results, and by group consensus make recommendations, prescribe services, and delegate responsibility. This approach is often used in the educational setting and is the approach used in forming the IEP.

The transdisciplinary approach includes a team leader and a group of specialists. In this model, each team member trains others to use methods traditionally performed primarily by one discipline. One source reported the
transdisciplinary team model has been promoted as the most effective means to deliver the education and related services required by Public Law 94-142. One problem noted with this approach is the concern about one practitioner being able to provide a multiplicity of service.\textsuperscript{27}

Administrative Procedures

Administrative procedure is an important part of service delivery. The variance between the medical and educational setting is wide. Administrative procedure is a very in-depth topic. For the purposes of this paper, only a small portion of this will be discussed.

For a therapist working in the medical setting, the employment is usually through the facility in which they practice. The services are regulated by administrators who are trained to supervise medical professionals. They are, therefore, knowledgeable in the role that a physical therapist plays in the medical setting.

Physical therapists in the public school setting encounter a variety of employment arrangements.\textsuperscript{29} Some are hired by the school system under a teacher contract with the same pay scale and benefit package. Others work in an educational collective wherein several neighboring towns cooperate to hire specialists for children with special needs. Some school systems may choose to contract with individual therapists or with agencies such as Easter Seals or United Cerebral Palsy.
Services are regulated in a variety of ways. The majority of directors of physical therapy in school systems are not physical therapists or any type of therapist. According to Effgen, this has serious implications. To understand professional roles and responsibilities and how to nurture a professional, one must understand the profession. The administrators are often educational personnel and are unaware of what procedures the physical therapists are performing. The agency ultimately responsible for related services is neither the school system nor the medical sector, but rather the state. Fremont feels problems arise with this because there are inconsistencies in state guidelines and local interpretation of who should prescribe the amount and type of physical therapy. There are proposed regulations to mandate each state's lead agency to ensure the development of formal interagency agreements: (a) defining each agency's financial responsibility for payment of special instructional and related services, (b) including procedures for resolving disputes between agencies, and (c) incorporation of additional components to ensure interagency collaboration.

Reimbursement

Concern for reimbursement is great in the medical setting as well as the educational setting. In essence, receiving services comes down to one question, "Who will pay for the service?". The topic is extensive and will only be touched upon here. The medical sector receives payment from a variety of
Administrators in the educational environment have looked in many different directions to find payment for services. To cover the costs of physical therapy, some school systems are attempting to charge third-party payers.\(^30\) Private insurance carriers have generally declined to reimburse for therapies provided in the schools.\(^32\) Medicaid has approved procedures allowing school systems to bill Medicaid directly for physical therapy.\(^30\) Court rulings have generally mandated that therapies recommended in the IEP be reimbursed by the educational system.\(^36\text{-}38\) The federal law mandated that states would be eligible to receive grants to fund the special education and related services for children with disabilities.\(^1\) State grants were projected to cover 40% of the average per pupil expenditure each year in the school system.\(^1\) Actually, however, funding has never been higher than 9-10%.\(^39\) With mandated services and insufficient funding, the financial responsibility falls on the state and local districts.
CHAPTER III

A BRIEF DESCRIPTION OF PUBLIC LAW 94-142

The Education of All Handicapped Children Act was enacted in 1975. The legislation is often referred to as Public Law 94-142 (PL 94-142). In 1990, the law was re-authorized and is now referred to as the Individuals with Disabilities Education Act (IDEA). For the purposes of this paper, the legislation will be referred to as PL 94-142. The law is broken down into several sections that address issues facing the education of children with disabilities. The sections that will be addressed here are general information, services, and procedural safeguards. In addition to the law itself, Volume 34 of the Code of Federal Regulations (CFR) contains the regulations intended to supplement and further explain the legal requirements which are established in PL 94-142.23 In some cases, the regulations do not answer all the questions about the education of children with disabilities. In these situations, it is helpful to study court cases that have been filed. Some of the cases are published and become part of the law governing the education of children with disabilities.40 Key sections of PL 94-142 and CFR will be addressed in order for therapists to understand the implications that they have on practice in the educational setting. Several authors have given interpretations of the law and the
connection to physical therapy practice. The interpretations will be addressed throughout the chapter.

General Information

PL 94-142 begins by stating the purpose of the law which includes the following:¹

"(A) To insure that all children with disabilities have available to them a free appropriate public education which includes special education and related services to meet their unique needs.

(B) To insure that the rights of children with disabilities and their parents are protected.

(C) To assist states and localities to provide for the education of all children with disabilities, and

(D) To assess and insure the effectiveness of efforts to educate those children."

Several definitions of the terms used are also given within the law.¹ These definitions are necessary in order to further explain the intent of the law. The term "free appropriate public education" means special education and related services which "(a) have been provided at public expense, under public supervision and direction, and without charge, (b) meet the standards of the State educational agency, (c) include an appropriate preschool, elementary, or secondary school in the State involved, and (d) are provided in conformity with the individualized education program."²³ Purvis et al.²⁶ stated free appropriate
public education means "schools may not reject or exclude children with disabilities from their programs." The requirements must also coordinate with those of the "least restrictive environment," which will be addressed in the procedural safeguards section. Myers and Jenson suggested an appropriate education should be defined as "... one that enables a [child with a disability] to make measurable progress toward educational goals which are within his or her ability." The authors also suggested progress can be demonstrated if:

(a) the child's ability is assessed through the collection of baseline data,
(b) educational goals are then established and set some distance ahead of the child's present level of achievement, and (c) the child then makes progress toward his or her goals as demonstrated by objective measurements rather than by subjective observations or opinions.

Special education and related services also are defined by the law. "Special education" means specially designed instruction, at no cost to parents or guardians, to meet the unique needs of the child with a disability, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions. A child with a disability is not automatically eligible to receive special education. It must be determined if the child's condition adversely affects educational performance. If, however, access to regular education is arranged and educational progress is consistent with ability, the child may not be eligible for special education placement.
"Related services" means transportation and such development, corrective, and other supportive services (including speech pathology and audiology, psychological services, physical and occupational therapy, recreation, and medical and counseling services, except that such medical services shall be for diagnostic and evaluation purposes only) as may be required to assist a handicapped child to benefit from special education, and includes the early identification and assessment of disabling conditions in children. The terms that are used in the definition of related services are defined in the CFR and are presented in Appendix A. There has been much litigation concerned with defining the precise parameters of the specific related services defined in the regulations. Several states have developed criteria for eligibility of related services. According to Simunds, "the criteria for eligibility of related services should only augment the decision-making process for therapeutic services and that the final determination should actually occur through the IEP process."

"'Physical therapy' means services provided by a qualified physical therapist," according to the CFR. The definition leaves a wide range of question and freedom for what a physical therapist is to provide as a service. Martin provided additional descriptions of physical therapy services in schools. Services provided include:
(1) Screening for movement disorders/deficiencies/delays in infants, children, and young adults to determine need for further assessment.

(2) Evaluation and assessment of movement dysfunction in such areas as reflex integration, postural responses, motor development, joint range of motion, muscle strength, muscle tone, postural alignment, gait deviations, functional motor skills, adaptive equipment needs, orthotic/prosthetic needs, and respiratory function.

(3) Program planning for physical therapy or appropriate options for each individual educational program (IEP) as a member of the multidisciplinary educational team.

(4) Treatment/management of disability based upon results of evaluation, which may include direct and/or indirect therapy services.

(5) Consultation and education of paraprofessionals and parents regarding educational programming and disability information (to provide information and to upgrade/maintain one professional expertise).

(6) Administration of physical therapy services within the educational environment (documentation, record keeping, equipment, space requirements, supervision of physical therapist assistant and other personnel).
(7) Research and evaluation of school physical therapy services. These additions are helpful in defining the role of the physical therapist working in the schools but are not exclusive. Through the study of court decisions, White\textsuperscript{23} found schools "may be required to provide services which would ordinarily be considered to be medical services, if the services are directly necessary to enable a child to benefit from his or her education."

After the services to be provided by law are described, the children with disabilities receiving services must be identified. According to PL 94-142, the term children with disabilities means mentally retarded, hard of hearing, deaf, speech or language impaired, visually impaired, seriously emotionally disturbed, orthopedically impaired, or other health impaired children, or children with specific learning disabilities who by reason thereof require special education and related services. As with the definitions of related services, the items that describe the term children with disabilities are also defined by the CFR and are presented in Appendix B. If a child has a disability that falls into one of the categories, he/she is then eligible for special education. Each of the definitions includes a statement about the condition affecting the educational performance of the child. White\textsuperscript{48} added "minor ailments which do not affect educational performance do not entitle a child to the protections afford by [PL 94-142]."

Services

PL 94-142 mandated that children age 3-21 are to be included in the services. Some exceptions occur for children age 3-5 and 18-21. The
exceptions depend on the laws that occur at the state level. The state is not required to make free appropriate public education available if state law "does not authorize the expenditure of public funds to provide education to non-handicapped children in that age group." For example, Wyoming state law provides services for children age 5-21 inclusively. This is possible because no children age 3-5 are provided a public education. They are required to provide services if there is a court order or a public agency provides education to children without a disability of the same age. Therapists must check the laws in the state where they practice to determine requirements.

Priorities in the use of funds are also mandated in the law. First priority are children who are in an age group for which the state must provide services and are not receiving any education. Second priority are "handicapped children, within each disability, with the most severe handicaps who are receiving an inadequate education." Mullins cautioned that "one must not interpret the overall priorities too narrowly." A literal interpretation could result in allocating limited resources of physical therapy to severe or profoundly involved children whose ultimate situation may not be much different than their present one; that is, where goals are defined in terms of maintenance rather than improvement. This may take away from services that could allow for improvement of a less severe child. The word "appropriate" should be remembered by practitioners when it comes to delivery of service and question of priorities.
An Individualized Education Program (IEP) is a written statement for a handicapped child that is developed and implemented in accordance with regulations. Guidelines of how the document is to be written and who is to be involved are laid out in the law. Further detail about the guidelines and some components of the IEP are to be addressed in chapter three.

**Procedural Safeguards**

The first element that is included in procedural safeguards is due process procedure for parents and children. Included in this process are: the parents' opportunity to examine records, the right to obtain an independent educational evaluation, prior notice and parental consent for changes that occur, and the right to an impartial due process hearing. Each of these allows a parent and/or child to have complete involvement in the educational process. Lawlor stated, "Effective school system practice involves understanding the strengths and needs of families related to their children and providing opportunities for parents to become actively involved in all aspects of the special education process."

Parents have the right to view all educational records involving their child. These records include those that provide identification, evaluation, and educational placement of the child. They are also given the opportunity to view records that deal with the provision of a free appropriate public education.

The parents have the right to obtain an independent educational evaluation of the child and each public agency, in most cases the school
district, will provide the parents information on where the evaluation may be obtained. The evaluation must be conducted by a qualified examiner who is employed by the public agency responsible for the child. The evaluation will be provided at public expense and at no cost to the parent. The parent also has the right to obtain an evaluation at private expense that must be considered by the public agency as long as the evaluation is completed by a qualified examiner. A parent can then choose the examiner if they are uncomfortable with the evaluation or examiner that was provided by the public agency.

The parent must be notified in writing by the public agency before they propose to initiate or change the identification, evaluation, or educational placement of the child. The notice must contain an explanation understandable by the parents as to what is to occur. Parental consent must be obtained before conducting a preplacement evaluation and initial placement of a child in a program providing special education and related services. If any of the rights of the parent or child are violated, a parent or public agency may initiate a hearing to be conducted by the state.

In addition to the due process procedure, there is also protection in evaluation procedures. The CFR set the following criteria for evaluation procedures: (1) The tests are provided in the child's native language or other mode of communication. (2) The tests must be validated for the specific purpose for which they are used and must be administered by trained personnel. (3) The test that is chosen will accurately reflect the child's impaired
sensory, manual, or speaking skills (unless those are the skills it is intended to measure). (4) No single procedure is used as the sole criterion for determining the appropriate educational program for the child. The evaluation is made by a multidisciplinary team and includes all areas related to the child's suspected disability.

An area of procedural safeguards that has a big impact on the practice of a physical therapist is that of "least restrictive environment" (LRE). PL 94-142 mandated,

"To the maximum extent appropriate, children with disabilities, including children 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 disabilities from the regular educational environment occurs only when the nature or severity of the handicap is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily."

The least restrictive environment (LRE) ensures that all school districts have a continuum of alternative placements, including regular classrooms, special classrooms, special schools, and other alternatives. LRE further requires that
a child should not be removed from regular education environments unless the nature or severity of the disability precludes education in regular classes, although other services may be used. A school district or agency cannot use the excuse of unavailability of resources in order to deprive a child of the right to an appropriate education in the least restrictive environment. Little documentation on the placement of children has been provided. Palfrey et al suggests "the lack of specific data delineating which children receive services in which placement options is unfortunate because this makes it difficult to assess how well the schools are meeting the [intent of the law]." Schools must make decisions based on the best information available as to the types of special education and related services that meet the criteria of free appropriate public education and least restrictive environment.
CHAPTER IV

INDIVIDUALIZED EDUCATION PROGRAM

An individualized education program (IEP) is a written statement for a child with a disability that is developed and implemented in accordance with federal regulation.\(^1\) The state must ensure that each public agency develop and implement an IEP for each of its children with disabilities. There are several areas that are regulated in the IEP development including when the IEP must be in effect, meetings for development, participants of meetings, parent participation, content of the IEP, and accountability. The law gives general guidelines of what is to occur in each area. The actual implementation of the mandate will vary from state to state and district to district. Purvis et al.\(^2\) reported, “States vary in the format used for the development of the IEP and may add additional requirements, but all must respond to the ones set out in the regulations pursuant to PL 94-142 as amended.” Many schools have moved toward the use of computerized IEPs.\(^4\) With this change, providers must remember that the IEP is individualized. A preconceived list of goals and objectives applied indiscriminately is not consistent with each student’s unique needs.\(^4\)
The IEP must be in effect before any special education and related services are to be provided to a child.\textsuperscript{23} It is, therefore, necessary to have timely development of the IEP when it is suspected that the child may be eligible for services. The IEP must also be implemented as soon as possible following the meeting.\textsuperscript{23} It is expected that the IEP will be implemented immediately following the meeting with the exceptions that the meetings occur during a vacation period or where circumstances may require a short delay (e.g., working out transportation arrangements).

Each public agency is responsible for initiating and conducting meetings for the purpose of developing, reviewing, and revising a child's individualized education program.\textsuperscript{23} For children who are receiving services, the meeting must be held before the beginning of each school year. For children who have not received services, the meeting must be within thirty calendar days of a determination that the child needs special education and related service. A meeting must be held at least once a year to review a child's IEP and revise it if appropriate.\textsuperscript{25} Coutinho\textsuperscript{46} stated that an annual review of the IEP assures that "(a) Goals are not too high or too low, the educational relevance of related services is maintained. (b) The program is provided in the most integrated fashion possible and additional or different services are recommended as needed." Annual review also helps to conclude when special services are no longer needed.
The public agency must ensure that the following are participants in the IEP meeting:\(^\text{23}\)

(1) A representative of the public agency, other than the child's teacher, who is qualified to provide, or supervise the provision of, special education.

(2) The child's teacher.

(3) One or both of the child's parents.

(4) The child, where appropriate.

(5) Other individuals at the discretion of the parent or agency.

A physical therapist would fall under the "other individuals" category. It is not mandated that the physical therapist be at the IEP meeting, but as a team member, it is very beneficial. Greene\(^\text{45}\) reported that "the related services personnel need not attend the IEP meeting if they submit a written report with recommendations." A physical therapist may attend the meeting and it may be helpful to provide for better communication throughout the team.

Parent participation and its importance in a child's education has been mentioned previously. The section of the law which mandated parent participation in the IEP process is the cornerstone for further involvement of parents. The state must take steps to ensure that one or both of the parents of the child are present at each meeting or are afforded the opportunity to participate. The steps taken include notifying parents of the meeting early enough to ensure that they will have an opportunity to attend and scheduling the meeting at a mutually agreed upon time and place. The notice to the
parents must indicate the purpose, time, and location of the meeting and who will be in attendance. If the parent is unable or refuses to attend, the agency will use other methods to ensure participation including individual or conference telephone calls. The parent, in any case, will receive upon request a copy of the IEP document. The Protection and Advocacy System, Inc. of Wyoming has published an IEP checklist in order for parents to be aware of what should happen throughout the IEP process. This checklist is presented in Appendix C. Parents should also pay close attention to portions of the IEP which provide for parent training and counseling. The training will allow the use of specialized education techniques in the home as a supplement to the school program.

A general overview about the content of the IEP is given in the regulations. The IEP for each child must include the following:

(1) A statement of the child's present levels of educational performance.

(2) A statement of annual goals, including short-term, instructional objectives.

(3) A statement of the specific special education and related services to be provided to the child, and the extent to which the child will be able to participate in regular educational programs.

(4) The projected dates for initiation of services and the anticipated duration of the services.
(5) Appropriate objective criteria and evaluation procedures and schedules for determining, on at least an annual basis, whether the short-term instructional goals are being achieved.

One area that is included in the duration of service is if the services will be delivered for the regular 180-day school year or year-round services. This will be determined on an individual basis and will include evaluations before and after vacations from school. If the student's level of function decreases over long breaks, they may be eligible for year-long services.

The contents of the IEP are very important to a child's education and requires that a therapist be aware of how to write objectives. Mager provided four reasons for writing good objectives. “Objectives: (a) give educational team members an opportunity to think about and determine the most important skills and knowledge a particular student should acquire in the coming year; (b) provide a means for evaluating a particular student's progress; (c) help therapists and teachers determine the need for intervention from related services providers, the most logical types of service delivery, and the most effective intervention techniques and instructional methodology; and (d) harness everyone's efforts (including the student's) toward common important ends.”

To develop goals and objectives, desired outcomes must first be identified. Physical therapists who view students through different frames of reference than their educator colleagues may see a need for objectives that address self care or mobility; without their input, these areas might not be
addressed in the student’s IEP. One area that is often overlooked in the student’s IEP is his/her ability to assume the student role. The student role includes going from class to class, turning in papers on time, and finding things in the desk. These things are often done for children with disabilities instead of giving them the tools they need to achieve these things on their own.

Objectives determined by a physical therapist are an important part of the IEP document. Bates et al stated, “Specific objectives should be selected for each student’s IEP.” The objectives must reflect learning conditions, observable behavior, and a criterion for success. Because a particular skill is not educationally relevant for one student does not mean that it will not be educationally relevant for another student. Effgen and Klepper reported, “The objectives are not discipline specific, but describe functional skills the student will be able to perform in all appropriate environments.” Functional skills are those that are also relevant to the educational level. After the objectives are written, the physical therapist then writes specific physical and motor goals, based on evaluation results, which may be implemented through direct, individual or group therapy, indirect management programs, or consultation. Functional skills are those that are also relevant to the educational level. After the short-term instructional objectives are written, more detailed classroom instructional plans are developed. Lindsey et al stated, “the physical therapist then writes specific physical and motor goals, based on evaluation results,
which may be implemented through direct, individual or group therapy, indirect management programs, or consultation.\textsuperscript{11}

The law regulates that each public agency must provide special education and related services in accordance with an IEP. It does not, however, require that any agency, teacher, or other individual be held accountable if a child does not achieve the growth projected in the annual goals and objectives. Mullins\textsuperscript{5} added, "The agency, teacher, or other persons must make "good faith" efforts to achieve goals and objectives." Physical therapists need to put their best effort forward and maintain professional standards when developing the IEP.
CHAPTER V

CONCLUSION

The roles of physical therapists are constantly in a state of change. It is the responsibility of each individual therapist to keep up with the changes. One such change is the increase in the demand for physical therapists to work in the educational setting. Knowledge of what is occurring in physical therapy is important for even those therapists who are working in other settings. It was the author's intention to introduce some of the differences that may occur in the educational and medical settings. The introduction of the law and what mandates affect practice of physical therapists in this setting was also explored. Finally, the development and implication of the IEP were discussed. The challenges that physical therapists face working in the educational environment are numerous. Hopefully, this paper will give some background and explanations of what the role of a physical therapist is in the educational setting. Effgen stated the educational setting" is a rewarding and wonderful environment in which to work for those who are willing and able to adjust to its unique environment."
APPENDIX A
Related Services as defined in 34 Code of Federal Regulations

(1) “Audiology” includes:

(a) Identification of children with hearing loss;

(b) Determination of the range, nature, and degree of hearing loss, including referral for medical or other professional attention for the habilitation of hearing;

(c) Provision of habilitative activities, such as language habilitation, auditory training, speech reading (lip reading), hearing evaluation, and speech conservation;

(d) Creation and administration of programs for prevention of hearing loss;

(e) Counseling and guidance of pupils, parents, and teachers regarding hearing loss; and

(f) determination of the child’s need for group and individual amplification, selecting and fitting an appropriate aid, and evaluating the effectiveness of amplification.

(2) “Counseling services” means services provided by qualified social workers, psychologists, guidance counselors, or other qualified personnel.

(3) “Early identification” means the implementation of a formal plan for identifying a disability as early as possible in the child’s life.
(4) "Medical services" means services provided by a licensed physician to determine a child's medically related handicapping condition which results in the child's need for special education and related services.

(5) "Occupational therapy" includes:
(a) Improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation;
(b) Improving ability to perform tasks for independent functioning when functions are impaired or lost; and
(c) Preventing, through early intervention, initial or further impairment or loss of function.

(6) "Parent counseling and training" means assisting parents in understanding the special needs of their child and providing parents with information about child development.

(7) "Physical therapy" means services provided by a qualified physical therapist.

(8) "Psychological services" include:
(a) Administering psychological and educational tests, and other assessment procedures;
(b) Interpreting assessment results;
(c) Obtaining, integrating, and interpreting information about child behavior and conditions relating to learning;
(d) Consulting with other staff members in planning school programs to meet the special needs of children as indicated by psychological tests, interviews, and behavioral evaluations; and

(e) Planning and managing a program of psychological services, including psychological counseling for children and parents.

(9) "Recreation" includes:

(a) Assessment of leisure function;

(b) Therapeutic recreation services;

(c) Recreation programs in schools and community agencies; and

(d) Leisure education.

(10) "School health services" means services provided by a qualified school nurse or other qualified person.

(11) "Social work services in schools" include:

(a) Preparing a social or developmental history on a handicapped child;

(b) Group and individual counseling with the child and family;

(c) Working with those problems in a child's living situation (home, school, and community) that affect the child's adjustment in school; and

(d) Mobilizing school and community resources to enable the child to receive maximum benefit from his or her educational program.

(12) "Speech pathology" includes:

(a) Identification of children with speech or language disorders;
(b) diagnosis and appraisal of specific speech or language disorders;

(c) Referral of medical or other professional attention necessary for the habilitation of speech or language disorders;

(d) Provisions of speech and language services for the habilitation or prevention of communicative disorders; and

(e) Counseling and guidance of parents, children, and teachers regarding speech and language disorders.

(13) "Transportation" includes:

(a) Travel to and from schools and between schools;

(b) Travel in and around school buildings; and

(c) Specialized equipment (such as special or adapted buses, lifts, and ramps), if required to provide special transportation for a child with a disability.

From 34 Code of Federal Regulations Part 300
APPENDIX B
Children with Disabilities as defined in 34 Code of Federal Regulations

(1) "Deaf" means a hearing impairment which is so severe that the child is impaired in processing linguistic information through hearing, with or without amplification, which adversely affects educational performance.

(2) "Deaf-blind" means concomitant hearing and visual impairments, the combination of which causes such severe communication and other developmental and educational problems that they cannot be accommodated in special education programs solely for deaf or blind children.

(3) "Hard of Hearing" means a hearing impairment whether permanent or fluctuating, which adversely affects a child's educational performance but which is not included under the definition of "deaf" in this section.

(4) "Mentally retarded" means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period, which adversely affects a child's educational performance.

(5) "Multihandicapped" means concomitant impairments (such as mentally retarded-blind, mentally retarded-orthopedically impaired, etc.), the combination of which causes severe educational problems that they cannot be accommodated in special education programs solely for one of the impairments. The term does not include deaf-blind children.
(6) "Orthopedically impaired" means a severe orthopedic impairment which adversely affects a child's educational performance. The term includes impairments caused by congenital anomaly (e.g., clubfoot, absence of some member, etc.), impairments caused by disease (e.g., poliomyelitis, bone tuberculosis, etc.), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns which cause contractures).

(7) "Other health impaired" means

(a) having an autistic condition which is manifested by severe communication and other developmental and educational problems, or

(b) having limited strength, vitality, or alertness due to chronic or acute health problems such as heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anemia, hemophilia, epilepsy, lead poisoning, leukemia, or diabetes, which adversely affects a child's educational performance.

(8) " Seriously emotionally disturbed" is defined as follows:

(a) The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects a child's educational performance:

(I) An inability to learn which cannot be explained by intellectual, sensory, or health factors;
(ii) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;

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

(iv) A general pervasive mood of unhappiness or depression; or

(v) A tendency to develop physical symptoms or fears associated with personal or school problems.

(b) The term includes children who are schizophrenic.

The term does not include children who are socially maladjusted, unless it is determined that they are seriously emotionally disturbed.

(9) "Specific learning disability" means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not include children who have learning problems which are primarily the result of visual, hearing, or motor handicaps, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage.
(10) "Speech impaired" means a communication disorder such as stuttering, impaired articulation, a language impairment, or a voice impairment, which adversely affects a child's educational performance.

(11) "Visually handicapped" means a visual impairment which, even with correction, adversely affects a child's educational performance. The term includes both partially seeing and blind children.

From 34 Code of Federal Regulations Part 300
APPENDIX C
INDIVIDUALIZED EDUCATION PROGRAM (IEP) CHECKLIST

1. Have you had an opportunity to examine all relevant records concerning the identification, evaluation, and educational placement of the student?

2. Do you disagree with the results or interpretations of any tests or evaluations which have been administered to determine the nature and severity of the student's handicapping condition?

3. Do you feel that any testing or evaluation materials used to evaluate and place the student were selected or administered in a manner which is racially or culturally discriminatory?

4. Were the testing or evaluation materials provided or administered to the student in his or her native language or mode of communication?

5. Has one simple procedure or criterion been used to determine the educational placement of the student?

6. If you disagree with the evaluation conducted by the school district, have you been advised of your right to obtain an individual educational evaluation of the student?

7. Have you received prior written notice of the school's proposal to initiate or change or refusal to initiate or change the identification, evaluation, or placement of the student?

8. Have the notices which you have received from the school concerning the identification, evaluation, and placement of the student been written in your native language?
9. Do you fully understand the entire contents of and notices which you have received from the school concerning the identification, evaluation, and placement of the student?

10. Have you been advised that your giving consent in the identification, evaluation, and placement of the student is voluntary and you may revoke your consent at any time?

11. Have you been advised that no preplacement evaluation may be administered and no initial placement may be effected unless you have given your consent to such evaluation of placement?

12. Do you receive prior written notice of any and all meetings which are convened concerning the student's IEP?

13. Have the meetings conducted to discuss the student's IEP included the following participants: (1) representative of school, other than the student's teacher, who provides or supervises special education; (2) the student's teacher; (3) one or both of student's parents; and (4) where the student has been evaluated for the first time, a school representative or other person who is knowledgeable about the evaluation procedures and the results thereof?

14. Have you been advised of your right to be represented by an attorney at law or assisted by an advocate, counselor, or consultant at the IEP meeting?

15. Does the IEP contain, as a minimum, the following:
(a) a statement of the student's present levels of educational performance;
(b) a statement of annual goals, including short-term instructional objectives;
(c) a statement of the specific special education and related services to be provided to the student;
(d) a statement of the extent to which the student will be able to participate in regular educational programs;
(e) a statement of the projected date or dates for the initiation of services and the anticipated duration of services;
(f) a description of the objective criteria and evaluation procedures which will be used to determine at least on an annual basis whether instructional objectives are being met?

16. Do you fully understand the statement of the student's present levels of educational performances?

17. Do you believe that the student's handicapping condition has been adequately identified and evaluated?

18. Special education refers to specially designed instruction provided at no cost to the parent to meet the unique needs of a handicapped child, including classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions. The term includes speech pathology, vocational education, and other services which are
classified as special education under state education standards. Do you understand what special education services will be provided, when they will begin, and the anticipated length of time those services will occur?

19. Do you believe that other special education services would be more beneficial to the student?

20. Related services refers to transportation and such developmental, corrective, and other supportive services as are required to assist a handicapped child to benefit from special education. The term includes speech pathology and audiology, psychological services, physical and occupational therapy, counseling services, and medical services for diagnostic and evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training. Do you understand what related services will be provided, when they will begin, and the anticipated length of time those services will occur?

21. Do you believe that other related services would be more beneficial to the student?

22. Do you believe that the placement proposed by the school is either more restrictive or less restrictive than the placement which you feel would be beneficial for the student?

23. Has the school provided to you a continuum of alternative placements which are appropriate for the student?
24. Have you had an adequate opportunity to obtain information about alternative placements necessary to enable you to form an opinion as to the placement which you feel would be most beneficial for the student?

25. Are you aware of educational qualifications and experience of the special education teachers or related service providers who will be participating in the student's educational program?

26. Are you aware of the student-teacher ratio which will exist between the student and the various service providers who will participate in his/her educational program?

27. Are you aware of the age range of the other students in the programs in which your child is to be placed?

28. Does the IEP adequately address any discipline problems which the student may present at school?

29. On the whole, is the IEP reasonably calculated to confer an educational benefit upon the student?

30. Does any aspect of the IEP require you, as parents or guardians, to pay for all or any portion of the cost of the provision of special education and related services to the student?

31. Are you aware of the anticipated date of program completion; criteria to be used for graduation; and the type of diploma to be issued if the criteria are met?
32. Are you aware of the availability of vocational education, career education, work experience education, or independent living skills training to prepare your child for remunerative employment?

33. Have you been advised of your right to obtain a "due process" hearing with respect to any matter concerning the identification, evaluation, or placement of the student?

Checklist provided by Protection and Advocacy System, Inc., Cheyenne, Wyoming.
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