# RECOMMENDED PRACTICES FOR OCCUPATIONAL AND PHYSICAL THERAPY SERVICES IN ILLINOIS SCHOOLS

**2019**
**OT & PT Coordinator Consortium of Northern Illinois**

**(Updated from 2003 document published by the ILLINOIS STATE BOARD OF EDUCATION )**

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# INTRODUCTION AND PURPOSE

The Illinois State Board of Education published the original version of the "*Recommended Practices for Occupational and Physical Therapy Services in Illinois Schools*" in 2003.[1] The educational system and approaches for all students as well as special education federal and State laws, rules, and regulations regarding students with disabilities have evolved since that time. Some of the recent changes include Multi-tiered System of Support (MTSS)/Response to Intervention (RtI), the need for a physician's referral, inclusion of functional skill goal areas along with academic goals and the requirement for transition services. In addition, service plans and proportionate share funding and obligations, guidelines for documentation, workload parameters, and the direction to provide integrated interventions have been more clearly defined. The concept of all students being educated in the least restrictive environment has been emphasized. This includes making sure that academic expectations are rigorous for students with disabilities.

The original purpose of the 2003 document was to present administrators, OT and/or PT personnel, educators, other professionals, and parents/guardians with information regarding the provision of OT and/or PT in educational environments. This updated document is intended to serve as guidance so that each Local Education Agency (LEA) employing Therapy Practitioners can establish or update agency procedures for providing OT and/or PT services within the educational setting. Supervisors of OT and PT departments and Therapy Practitioners should have access to and be knowledgeable of the most current resources. We hope this document will serve as one such resource in addition to the many resources shared. Another purpose is to provide Illinois school administrators and Therapy Practitioners with a sound source of information to follow when serving students with special needs in the school setting. It includes the most salient statutory provisions and best practices for Therapy Practitioners working in schools. This updated document is also intended to provide useful guidance to many other stakeholders of school-based OT and PT services, including but not limited to other school personnel, educators in university programs who prepare students to become Therapy Practitioners, and individuals studying to become Therapy Practitioners.

A consortium of OT and PT coordinators spearheaded a rigorous review of the 2003 document to revise this document with the most relevant and updated resources, changes to federal and State law, and current best practices in school-based OT and PT services. A committee was comprised of fifteen OTs and PTs in leadership positions from multiple school districts and special education cooperatives throughout Illinois as well as three professors in universities educating OT and PT students, who had formerly worked in school-based practice. The committee completed a thorough review of the 2003 document, which included comparing the document to other states' guidelines for OTs and PTs in schools, having subcommittees complete a review and revision of each section, second and third readings of the document by the whole committee, a review of the revised document by two tiers of professors with expertise in these areas, and additional review and editing by committee leaders and attorneys retained by the consortium.

Information provided herein is based upon standards of practice defined by the Illinois Occupational Therapy Practice Act, the Illinois Physical Therapy Act, the American Occupational Therapy Association (AOTA), and the American Physical Therapy Association (APTA), as well as the requirements set forth in various federal and State law governing LEAs. Please refer to the References and Legal References sections for detailed information about the resources used to update this document. Inherent in this document are the following assumptions:

- Students with disabilities must be served in the least restrictive environment appropriate to meet their individual needs.
- The educational needs of the student related to their participation in their educational program define the student's need for OT and/or PT services.
- The education environment is the setting where a student engages in his/her educational program activities. Therefore, therapeutic interventions should be implemented within the educational environment (including, but not limited to, classroom, lunchroom, bathroom, hallways, playground, vocational sites, etc.).
- While various aspects of student function may be assessed by professionals trained in various disciplines (e.g., occupational therapists, physical therapists, psychologists, general education and special education teachers, and physical education teachers), occupational therapists and physical therapists assess various aspects of functioning and adaptive abilities from their unique perspectives as described in this document.
- Even though OT and PT sometimes overlap, they are separate disciplines with distinct entry-level educational experiences and separate licensure laws.
- OT and PT services must both be available to students in the educational environment based on identified student need. Equal availability of both OT and PT service is assumed.[2]

**DISCLAIMER: This document is for informational purposes only and not for the purpose of providing legal advice, and it does not guarantee compliance with law or applicable standards of practice. While efforts have been made to provide only accurate and current information as of the date of publication, laws and best practices are constantly changing. Individuals using this document should contact the U.S. Department of Education, the Illinois State Board of Education, AOTA, APTA, and/or the LEA's attorney to obtain advice about a particular issue or problem.**

# TERMINOLOGY AND ABBREVIATIONS

The following terminology is used generally throughout this guidance:

**Episode of care** means the managed care provided for a specific problem or condition during a set time period and can be given either for a short period or on a continuous basis, or it may consist of a series of intervals marked by one or more brief separations from care.[3]

**Integrated practice** refers to the various activities conducted within the general education curriculum or the naturally occurring activities within the school day and school-related activities by Therapy Practitioners as part of school-based occupational therapy and physical therapy.

**Intervention** means services, strategies, supports, and other activities by Therapy Practitioners with or on behalf of students in the school setting. School-based intervention focuses on the ability of the student to access and participate in the activities or teaching that occurs in the school setting, rather than "treatment" (i.e., medical continuum of needs based on diagnosis and parent/patient concerns) commonly provided in a clinical setting.

**Local Education Agency or "LEA"** means a public school district, or any special education cooperative or other entity on behalf of a public school district, that is responsible for compliance with federal and/or State law. Note that local education agency is defined in the IDEA as "a public board of education or other public authority legally constituted within a State for either administrative control or direction of, or to perform a service function for, public elementary or secondary schools in a city, county, township, school district, or other political subdivision of a State, or for a combination of school districts or counties as are recognized in a State as an administrative agency for its public elementary schools or secondary schools."[4]

**Naturally occurring activities/environments** includes all activities or environments that a student engages in during regular school day and school-related activities.

The following abbreviations are used throughout this guidance:

- **ADA**: Americans with Disabilities Act of 1990
- **ADAAA**: Americans with Disabilities Act Amendments Act of 2008
- **AOTA**: American Occupational Therapy Association
- **APTA**: American Physical Therapy Association
- **CE**: Continuing Education
- **FAPE**: Free Appropriate Public Education
- **IDEA**: Individuals with Disabilities Education Act
- **IEP**: Individualized Education Program as provided in the IDEA
- **IFSP**: Individual Family Service Plan as provided in the IDEA
- **IDFPR**: Illinois Department of Financial & Professional Regulation
- **ISBE**: Illinois State Board of Education
- **ISP**: Individualized Service Plan
- **LEA**: Local Education Agency.
- **OT**: Occupational Therapy
- **OTA**: Occupational Therapy Assistant
- **OT Act**: Illinois Occupational Therapy Practice Act
- **OT Practitioners**: OTs and OTAs, collectively
- **PEAC**: ISBE Performance Evaluation Advisory Council
- **PERA**: Performance Evaluation Reform Act
- **PT**: Physical Therapy
- **PTA**: Physical Therapy Assistant
- **PT Act**: Illinois Physical Therapy Act
- **PT Practitioners**: PTs and PTAs, collectively
- **MTSS**: Multi-tiered System of Support
- **RtI**: Response to Intervention
- **Section 504**: Section 504 of the Rehabilitation Act of 1973
- **Therapy Practitioners**: OTs, OTAs, PTs and PTAs, collectively

# SECTION I:
# OVERVIEW OF OCCUPATIONAL THERAPY AND PHYSICAL THERAPY AS RELATED SERVICES

## A. INTRODUCTION

Section I provides a background on the laws and guidance which create a mandate for providing (OT) and (PT) services in the educational environment. It also addresses legal aspects of providing therapy services within the school setting and defines the training, certification, and licensure requirements for all Therapy Practitioners. This Section addresses the educational relevance of OT and PT, and common educational purposes for students to receive these therapies. In addition, this Section summarizes the legal requirements for maintaining school records and documentation of therapy services.

## B. LEGISLATIVE OVERVIEW

Legislation provides a legal framework to guide interventions provided during the school day. Laws, rules, and regulations from State and federal governments have built on each other to improve educational opportunities for students with disabilities.

Prior to 1969, students in Illinois with disabilities or health impairments primarily received their educational and therapeutic services in residential settings or community and private agencies. In 1969, Illinois enacted the first law that mandated services for students, essentially beginning formal special education services for children ages 3-21. Since then, State and federal legislation have continued to affect the services for children with disabilities in educational settings. Table 1 provides an overview of select federal legislation and regulations impacting special education. Table 2 provides an overview of State laws, rules, and policy impacting special education. Table 3 reviews Section 504 of the Rehabilitation Act of 1973 (Section 504) and Americans with Disabilities Act of 1990 (ADA).[5]

**Table 1. Federal Legislation/Regulations Impacting Special Education**

| Year | Law/ Regulation | Description |
|---|---|---|
| 1970 | The Elementary and Secondary Education Act (ESEA) Amendments of 1970 | Consolidated separate federal grants into one act serving children with disabilities. |
| 1975 | The Education of All Handicapped Children Act (EHA) | Mandated that states provide a free and appropriate education for children with disabilities, ages 5-18 in the least restrictive environment and that states seeking federal financial assistance serve students 3-5 and 18-22 years of age. Established PT and OT as a “related service” within the special education program. Provided for “due process” when complaints arose; and provided procedural protections. |

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| 1986 | EHA Amendments (P.L. 99-457) | Established a state grant program to fund early intervention services, expanding education to provide services to children with disabilities, ages 0-3. Established PT and OT as primary early intervention service providers based on need. |
| 1988 | The Catastrophic Medicare Coverage Act of 1988 | Allowed public schools to recover costs of providing medical services from Medicaid. |
| 1990 | EHA Amendments (P.L. 101-476) [Changed the name to Individuals with Disabilities Education Act (IDEA)] | Numerous additions to EHA. Offered expanded opportunities for PT and OT to provide input in the areas of assistive technology and transition. |
| 1997 | IDEA Amendments (P.L. 105-17) | Reauthorized the IDEA. Ensured that children with disabilities have available a free appropriate public education and protection of their rights. For more information, see "1997 IDEA Amendments" below or visit: https://www2.ed.gov/policy/speced/leg/idea/idea.pdf |
| 2001 | No Child Left Behind Act (NCLB) Public Law (P.L. 107-110) | Amended the ESEA. Ensured high quality education for all students, including the use of evidence-based instructional strategies. For more information, visit: http://www2.ed.gov/policy/elsec/leg/esea02/index.html |
| 2004 | IDEA Amendments (Individuals with Disabilities Improvement Act P.L.108-446) | Reauthorized the IDEA. Aligned IDEA with NCLB. For more information, visit: https://sites.ed.gov/idea/statute-chapter-33 |
| 2015 | Every Student Succeeds Act (ESSA) | Reauthorized the ESEA. The previous version of this law was NCLB. Advanced equity and high academic standards for disadvantaged and high-need students. For more information, visit: http://www.ed.gov/essa?src=rn |
| 2017 | IDEA Part B Regulations [34C.F.R. Part 300, as amended] | U.S. Department of Education amended the IDEA's implementing regulations in 2006 to implement the 2004 IDEA Amendments. The regulations were amended again in 2007, 2015, and 2017. For current version of the regulations, visit: https://sites.ed.gov/idea/statuteregulations/ |

**Table 2. State Law/Rules/Policy Impacting Special Education**

| Year | Law/Policy | Description |
|---|---|---|
| 1965 | Illinois House Bill 1407 passes first statute for providing special education in all school districts. | Requires all school districts provide special education for children with disabilities residing in their district. |
| 1978 | State Board Policy on Special Education endorsing EHA of 1975 | Policy on special education addressing both the State and federal intent up to that period: included the right to education at no cost to parent/guardian |

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| | | when placed by the school district, training for staff, and child find. |
| 2017 | Illinois special education rules [23 Ill. Admin. Code Part 226, as amended] | Provides the requirements for the treatment of children and the provision of special education and related services pursuant to the IDEA and its implementing regulations and Article 14 of the Illinois School Code. The rules are amended frequently. For more information, visit: http://www.ilga.gov/commission/jcar/admincode/023/02300226sections.html |
| 2018 | School Code of Illinois, Article 14 [105 ILCS 5/Art. 14, as amended] | Provides the requirements for the provision of special education and related services to eligible children with disabilities pursuant to the IDEA and its implementing regulations. Article 14 is amended frequently. For more information, visit: http://www.ilga.gov/legislation/ilcs/ilcs4.asp?DocName=010500050HArt%2E+14&ActID=1005&ChapterID=17&SeqStart=110500000&SeqEnd=116100000 |

**Table 3. Review of Section 504, ADA, Implementing Regulations, and Guidance[6]**

| Year | Federal Law/Regulation | Description |
|---|---|---|
| **Section 504 of the Rehabilitation Act of 1973** | | |
| 1973 | Section 504 of the Rehabilitation Act of 1973 (P.L.93-112) [29 U.S.C. §794, as amended] | Civil Rights Legislation: Defined "individual with a disability" and prohibited any program or activity receiving federal financial assistance from discriminating against otherwise qualified individuals with disabilities on the basis of their disability. |
| 1977 | Regulations passed for implementing Section 504 [34 C.F.R. Part 104, as amended] | Provided mandates for preschool, elementary, secondary, and adult education programs or activities that receive federal funding from the U.S. Department of Education. Provided mandate that a student defined as individual with a disability under Section 504 receives a free and appropriate public education as defined by Section 504. |
| **Americans with Disabilities Act** | | |
| 1990 | Americans with Disabilities Act of 1990 (ADA) (P.L.101-336) [42 U.S.C. §12101 *et seq*., as amended] | Civil rights law protecting persons with disabilities from discrimination by public entities and covered public accommodations. Provides a comprehensive definition of an individual with a disability. For more information, visit: http://www.ada.gov/ |
| 1991 | Regulations implementing ADA [28 C.F.R. Parts 35 and 36, as amended] | Implemented the requirements of ADA, and subsequently the ADAAA. For more information, visit: http://www.ada.gov/2010_regs.htm and https://www.ada.gov/regs2016/adaaa.html |

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| 2008 | Americans with Disabilities Act Amendments Act of 2008 (ADAAA) (P. L. 110-325) | Amendments to the ADA that broadened the definition of an individual with a disability. For more information, visit: https://www.gpo.gov/fdsys/pkg/PLAW-110publ325/pdf/PLAW-110publ325.pdf |
| **Guidance** | | |
| 2012 | U.S. Department of Education's Office for Civil Rights issues a "Dear Colleague" letter and Q&A on ADAAA for Students with Disabilities Attending Public Elementary and Secondary Schools | Guidance further clarified the definition of "individual with a disability" in Section 504 should be interpreted to allow for broad coverage. Students who, in the past, may not have been determined to have a disability under Section 504 may now in fact be found to have a disability under Section 504. Advised school districts to revise their policies and procedures to implement ADAAA's new legal standards. For more information, visit: https://www2.ed.gov/about/offices/list/ocr/docs/dcl-504faq-201109.html |
| 2013 | U.S. Department of Education's Office for Civil Rights issues "Dear Colleague" letter on Schools' Obligation to Provide Equal Opportunity to Students with Disabilities to Participate in Extracurricular Athletics | Guidance detailed the specific Section 504 regulations that require students with disabilities to have an equal opportunity for participation in nonacademic and extracurricular services and activities. Discussed the provision of separate or different athletic opportunities for students with disabilities. For more information, visit: https://www2.ed.gov/about/offices/list/ocr/letters/colleague-201301-504.pdf |
| 2016 | U.S. Department of Education's Office for Civil Rights issues Parent and Educator Resource Guide to Section 504 in Public Elementary and Secondary Schools | Guidance summarized key requirements of Section 504, provided answers to common questions, and explained how Section 504 applied in hypothetical situations within public schools. For more information, visit: https://www2.ed.gov/about/offices/list/ocr/docs/504-resource-guide-201612.pdf |
| 2018 | U.S. Department of Education's Office for Civil Rights updates its FAQ About Section 504 and the Education of Children with Disabilities | Guidance clarified the requirements of Section 504 by incorporating information about the ADAAA. For more information, visit: https://www2.ed.gov/about/offices/list/ocr/504faq.html |

## C. RECORDS OF STUDENT PERFORMANCE

### SCHOOL STUDENT RECORDS

School student records are created, used, and maintained to track student functioning and performance as well as to memorialize the provision of special education, related services, and other interventions. Within the educational system, procedures for the establishment and maintenance of school student records are developed by the LEA in

accordance with the mandates of federal and State law. These laws include, but are not limited to, the Family Educational Rights and Privacy Act (FERPA), the Illinois School Student Records Act, and their implementing regulations and rules.[7]

Under Illinois law, a school student record means any writing or other recorded information concerning a student and by which a student may be individually identified, maintained by a school or at its direction or by an employee of a school, regardless of how or where the information is stored.[8] This means that school student records may be in hard copy, electronic, or other format. However, writings or other recorded information maintained by a school employee or other person at the direction of a school for his/her exclusive use are not considered school student records, so long as all such writings and other recorded information are not released or disclosed to any person except a person designated by the school as a substitute and are destroyed no later than the student's graduation or permanent withdrawal from the school.[9]

In Illinois, two types of records exist:

A. Student permanent record means the minimum personal information necessary to a school in the education of the student and contained in a school student record, which includes only:
   - basic identifying information, including the student's name and address, birth date and place, and gender, and the names and addresses of the student's parents;
   - evidence required under Section (5)(b)(1) of the Missing Children's Records Act;
   - academic transcript;
   - attendance record;
   - health record, which is defined as medical documentation necessary for enrollment and proof of having certain examinations, as may be required under Section 27-8.1 of the Illinois School Code;
   - record of release of permanent record information;
   - scores received on all State assessment tests administered at the high school level; and
   - if not maintained in the temporary record, honors and awards received and information regarding participation in school-sponsored activities or athletics or offices held in school-sponsored organizations.[10]

B. Student temporary record means all information not required to be in the student permanent record, and may include:
   - health-related information, which is defined as current documentation of a student's health information, not otherwise governed by the Illinois Mental Health and Developmental Disabilities Confidentiality Act or other privacy laws, which includes identifying information, health history, results of mandated testing and screenings, medication dispensation records and logs (e.g., glucose readings), long-term medications administered during school hours, documentation regarding a student athlete's and his or her parents' acknowledgement of the LEA's concussion policy and other health-related information that is relevant to school participation (e.g., nursing services plan, failed screenings, yearly sports physical exams, interim health histories for sports);

- family background information;
- intelligence test scores;
- aptitude test scores;
- reports of psychological evaluations, including information on intelligence, personality and academic information obtained through test administration, observation and interviews;
- elementary and secondary achievement level test results;
- records associated with Section 504 plans;
- special education records, which are defined as school records that relate to identification, evaluation, or placement of, or the provision of a FAPE to, students with disabilities under the IDEA and Article 14 of the Illinois School Code, to include the report of the multidisciplinary staffing conference on which placement or nonplacement was based, and all records and audio recordings in any format relating to special education placement hearings and appeals;
- participation in extracurricular activities, including any offices held in school-sponsored clubs or organizations;
- awards and honors received;
- teacher anecdotal records;
- information regarding serious disciplinary infractions (i.e., those involving drugs, weapons, or bodily harm to another) that resulted in expulsion, suspension or the imposition of punishment or sanction, and other disciplinary information;
- records of release of information of temporary record information;
- scores received on the State assessment tests administered in the elementary grade levels;
- completed home language survey form;
- information provided under Section 8.6 of the Illinois Abused and Neglected Child Reporting Act (i.e., an indicated report of abuse/neglect);
- any collected biometric information;
- accident reports; and
- any verified reports or information from non-educational persons, agencies or organizations of clear relevance to the education of the student.[11]

The above list of student temporary records is not exhaustive and other information that is generated by the educational team, including Therapy Practitioners, may be a part of the student's temporary record. Student temporary records may include other information such as therapy logs and/or attendance records, plans of care, progress reports and supporting raw data, and communications with staff and/or parents/guardians (e.g., notes, e-mails, texts, phone logs). Also, Illinois law does not explicitly address test protocols and it is recommended that Therapy Practitioners consult with the LEA and/or the LEA's attorney concerning the maintenance of such protocols.

Student permanent records and the information contained in those records must be maintained by the LEA for not less than 60 years after the student has transferred, graduated, or otherwise withdrawn from the school.[12] Student temporary records and the information contained in those records must be maintained by the LEA for not less than 5 years after the student has transferred, graduated, or otherwise withdrawn from the school.[13] Illinois law provides specific requirements for destroying student records,

including but not limited to notifying students and parents/guardians prior to the destruction of these records.[14] Therapy Practitioners should consult with the LEA regarding the schedule and procedures for destroying student temporary records.

## GUIDELINES FOR DOCUMENTATION

Therapy Practitioners are required to document therapy services according to State and federal laws and standards of practice. Documentation facilitates effective intervention, provides communication among team members and the student's family, justifies reimbursement, reflects the Therapy Practitioner's reasoning, and stands as a legal record.[15] Poor documentation can have ethical, financial, and legal consequences. See references for documentation requirements in Table 4.

Documentation for reimbursement must follow the rules and regulations of the governing statutes and agency policies. IDEA allows for billing third-party payers, including Medicaid, for therapy services provided as part of a student's IEP. In fact, IDEA sets the expectation that LEAs will access Medicaid funds prior to using education funding for medical services:

> An identification of, or a method for defining, the financial responsibility of each agency for providing services described in subparagraph (B)(i) to ensure a free appropriate public education to children with disabilities, provided that the financial responsibility of each public agency described in subparagraph (B), including the State Medicaid agency and other public insurers of children with disabilities, shall precede the financial responsibility of the local educational agency (or the State agency responsible for developing the child's IEP).[16] (Emphasis added.)

See Section II.G (pg 63), *Referrals (Prescriptions), Documentation (Service Logs) and Medicaid Cost Recovery*, for more information about Medicaid cost recovery and related documentation requirements. Therapy Practitioners must account for intervention time as stated in a student's Section 504 Plan or IEP and document interventions and student progress. See Section II.F, *Formulation and Implementation of OT and PT Intervention*, for specific details and guidelines for effective documentation.

Each LEA may determine the documentation format to be used by Therapy Practitioners. The format used should reference and consider the guidelines established by national organizations (AOTA, APTA). Therapy Practitioners should maintain records for each student which include the goals being supported, the intervention plan, progress notes/attendance data, progress monitoring/data collection on goals, and other information as appropriate (e.g., positioning programs, sensory programs). State and federal laws ensure parents/guardians access to *all* files that fall within definition of a school student record. LEAs should consult with their legal counsel as to which documents are included in the student temporary record and the timeframe for maintaining different types of documents.

**Table 4. Legal References for Documentation Requirements**

| Legal Reference | Description |
|---|---|
| Illinois School Student Records Act and its implementing rules [105 ILCS 10/1 et seq.; 23 Ill. Admin. Code Part 375] | State law and rules governing maintenance and confidentiality of school student records. For more information, visit: http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=1006&ChapterID=17 and http://www.ilga.gov/commission/jcar/admincode/023/02300375sections.html |
| Illinois Mental Health and Developmental Disabilities Confidentiality Act [740 ILCS 110/1 et seq.] | State law governing the maintenance and confidentiality of therapist records containing mental health or developmental disability information. For more information, visit: http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=2043&ChapterID=57 |
| Illinois Local Records Act and its implementing rules [50 ILCS 205/1 et seq.; 44 Ill. Admin. Code Parts 4000 and 4500] | State law and rules governing the maintenance and destruction of public records of local governments (including but not limited to LEAs). For more information, visit: http://www.ilga.gov/legislation/ilcs/ilcs3.asp?ActID=699&ChapterID=11 and http://www.cyberdriveillinois.com/departments/archives/records_management/home.html |
| Family Educational Rights and Privacy Act (FERPA) and its implementing regulations [20 U.S.C. §1232g; 34 C.F.R. Part 99] | Federal law and regulations that protects the privacy of student educational records. For more information, visit: https://studentprivacy.ed.gov/ |
| Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations [P.L. 104-191; 45 C.F.R. Parts 160 and 164] | Federal law and regulations that establish standards for electronic health care transactions. Mandates security and privacy requirements for protected health information used by covered entities. For more information, visit: http://www.hhs.gov/ocr/privacy/index.html |
| U.S. Department of Health and Human Services and U.S. Department of Education Joint Guidance on the Application of FERPA and HIPAA to Student Health Records (2008) | This guidance document provided an overview of the relationship between FERPA and HIPAA in the school setting. Explains that many schools are not required to comply with the HIPAA Privacy Rule because the only health records maintained by the school are education/treatment records of students under FERPA, which are excluded from coverage under the HIPAA Privacy Rule. For more information, visit: http://www2.ed.gov/policy/gen/guid/fpco/doc/ferpa-hipaa-guidance.pdf |
| Individuals with Disabilities Education Act (IDEA) and its implementing regulations [20 U.S.C. §1400 et seq.; 34 C.F.R. Part 300] | Federal law and regulations that include requirements to protect the confidentiality of students' personally identifiable data, information and records collected or maintained by LEAs pursuant to the IDEA. For more |

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| | information, visit: http://sites.ed.gov/idea |
| American Occupational Therapy Association | National association provides guidelines for the requirements of documentation of OT services. For more information, visit: http://ajot.aota.org/article.aspx?articleid=1853060 |
| American Physical Therapy Association | National association provides guidelines for the requirements of documentation of PT services. For more information, visit: http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/BOD/Practice/DocumentationPatientClientMgmt.pdf |

## D. DESCRIPTION OF THERAPY PRACTITIONERS

Therapy Practitioners are licensed healthcare professionals trained and qualified to provide the unique services of OT and PT. The educational background for OT Practitioners is outlined in Table 6 and for PT Practitioners in Table 7. In Illinois, Therapy Practitioners must meet licensure requirements established by the Illinois Department of Financial and Professional Regulation (IDFPR). [17] Supervision of OTAs and PTAs is governed by State statutes and rules. See Section III.F, *Supervision and Management of Therapy Personnel*, for information regarding supervision for OTAs and PTAs.

### OCCUPATIONAL THERAPY

According to the Illinois Occupational Therapy Practice Act (OT Act):[18]

> "Occupational therapy" means the therapeutic use of purposeful and meaningful occupations or goal-directed activities to evaluate and provide interventions for individuals, groups, and populations who have a disease or disorder, an impairment, an activity limitation, or a participation restriction that interferes with their ability to function independently in their daily life roles, including activities of daily living (ADLs) and instrumental activities of daily living (IADLs). Occupational therapy services are provided for the purpose of habilitation, rehabilitation, and to promote health and wellness. Occupational therapy may be provided via technology or telecommunication methods, also known as telehealth, however the standard of care shall be the same whether a patient is seen in person, through telehealth, or other method of electronically enabled health care. Occupational therapy practice may include any of the following:
>
> (a) remediation or restoration of performance abilities that are limited due to impairment in biological, physiological, psychological, or neurological processes;
>
> (b) modification or adaptation of task, process, or the environment or the teaching of compensatory techniques in order to enhance performance;
>
> (c) disability prevention methods and techniques that facilitate the development or safe application of performance skills; and

(d) health and wellness promotion strategies, including self-management strategies, and practices that enhance performance abilities.

The licensed occupational therapist or licensed occupational therapy assistant may assume a variety of roles in his or her career including, but not limited to, practitioner, supervisor of professional students and volunteers, researcher, scholar, consultant, administrator, faculty, clinical instructor, fieldwork educator, and educator of consumers, peers, and family.

"Occupational therapist" means a person initially registered and licensed to practice occupational therapy as defined in this Act, and whose license is in good standing.

"Occupational therapy assistant" means a person initially registered and licensed to assist in the practice of occupational therapy under the supervision of a licensed occupational therapist, and to implement the occupational therapy treatment program as established by the licensed occupational therapist.

**Table 5. Educational Background of OT Practitioners[19]**

| **Educational Background** | | |
|---|---|---|
| | **Occupational Therapist** | **Occupational Therapy Assistant** |
| **Degree** | Bachelor's, master's, or doctoral level (entry level OTD; post-professional Ph.D., DrOT or OTD) professional educational program approved by the Accreditation Council for Occupational Therapy Education (ACOTE) or National Board for Certification in Occupational Therapy (NBCOT), or otherwise approved by the IDFPR. Currently entry-level OT programs are, at a minimum, at the master's level. | Granted a certificate or associate degree by an institution of higher education approved by ACOTE, NBCOT, or IDFPR. Currently, bachelor's standards are being developed for entry level OTA programs. |
| **Coursework** | Curriculum may include, but is not limited to natural, medical and human sciences including chemistry, physiology, human anatomy, kinesiology, orthopedics, medical and surgical conditions, and human growth and development, the behavioral sciences such as psychology, sociology, and anthropology, and occupational therapy theory, skills, and application. | Course work emphasizes technical principles and applications. |

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|---|---|---|
| **Overview of Fieldwork Instruction** | Six to nine months of fieldwork internship experience are required. OT students complete a minimum of 24 weeks full-time fieldwork education (Level II) in a variety of clinical settings working with clients across the lifespan. The goal is to develop competent, entry-level, generalist occupational therapists. | Two to four months of clinical fieldwork in different clinical settings working with clients across the lifespan. A minimum of 16 weeks of full-time (Level II) fieldwork education is required. |
| **Exam Following Completion of Academic Instruction** | Following graduation from an accredited OT program and completion of fieldwork, the individual is eligible to take the NBCOT exam. After passing the NBCOT exam and receiving confirmation, the Registered Occupational Therapist will use the initials "OTR" after the therapist's name. Continued use of the "R" credential requires renewal of NBCOT certification every 3 years. | Following graduation from an accredited OTA program and completion of fieldwork, the individual is eligible to take the NBCOT exam for OTAs and become certified through NBCOT. Upon registration with the NBCOT, the title "Certified Occupational Therapy Assistant," abbreviated "COTA," is used after the assistant's name. Continued use of the "C" credential requires renewal of NBCOT certification every 3 years. |
| **State Licensure** | Following successful completion of the NBCOT exam, the individual must apply for licensure in Illinois. In Illinois, the initials "OTR/L" signify the therapist is licensed appropriately by IDFPR. No person is permitted to practice occupational therapy or hold himself/herself out as an occupational therapist, or as being able to practice occupational therapy, or to render services designated as occupational therapy unless s/he is licensed, except if an exemption applies. | Following successful completion of the NBCOT exam, the individual must apply for licensure in Illinois. In Illinois, the initials "COTA/L" signify the assistant is licensed appropriately by IDFPR. No person is permitted to practice occupational therapy or hold himself/herself out as an OTA, or as being able to practice occupational therapy, or to render services designated as occupational therapy unless s/he is licensed, except if an exemption applies. |

## PHYSICAL THERAPY

According to the Illinois Physical Therapy Act (PT Act):[20]

> "Physical therapy" means all of the following: (A) Examining, evaluating, and testing individuals who may have mechanical, physiological, or developmental impairments, functional limitations, disabilities, or other health and movement-related conditions, classifying these disorders, determining a rehabilitation prognosis and plan of therapeutic intervention, and assessing the on-going effects of the intervention. (B) Alleviating impairments, functional limitations, or disabilities by designing, implementing, and modifying therapeutic interventions that may include, but are not limited to, the evaluation or treatment of a person through the

use of the effective properties of physical measures and heat, cold, light, water, radiant energy, electricity, sound, and air and use of therapeutic massage, therapeutic exercise, mobilization, and rehabilitative procedures, with or without assistive devices, for the purposes of preventing, correcting or alleviating a physical or mental impairment, functional limitation, or disability. (C) Reducing the risk of injury, impairment, functional limitation, or disability, including the promotion and maintenance of fitness, health, and wellness. (D) Engaging in administration, consultation, education, and research.

"Physical therapist" means a person who practices physical therapy and who has met all requirements as provided in this Act.

"Physical therapist assistant" means a person licensed to assist a physical therapist and who has met all requirements as provided in this Act and who works under the supervision of a licensed physical therapist to assist in implementing the physical therapy treatment program as established by the licensed physical therapist. The patient care activities provided by the physical therapist assistant shall not include the interpretation of referrals, evaluation procedures, or the planning or major modification of patient programs.

**Table 6. Educational Background of PT Practitioners[21]**

| **Educational Background** | | |
|---|---|---|
| | **Physical Therapist** | **Physical Therapist Assistant** |
| **Degree** | Baccalaureate, master's, or doctoral level professional educational program approved by The Commission on Accreditation in Physical Therapy Education (CAPTE), or otherwise approved by the IDFPR. As of 2015, all entry-level PT programs offer only the DPT degree. | Graduates of an entry-level physical therapist assistant program, accredited by CAPTE or otherwise approved by the IDFPR, receive an associate level degree. |
| **Coursework** | Curriculum may include, but is not limited to, biology/anatomy, cellular histology, physiology, exercise physiology, biomechanics, kinesiology, neuroscience, pharmacology, pathology, behavioral sciences, communication, ethics/values, management sciences, finance, sociology, clinical reasoning, evidence-based practice, cardiovascular and pulmonary, endocrine and metabolic, and musculoskeletal content. | Primary content areas in the curriculum may include, but are not limited to, anatomy & physiology, exercise physiology, biomechanics, kinesiology, neuroscience, clinical pathology, behavioral sciences, communication, and ethics/values. |

| | | |
|---|---|---|
| **Overview of Clinical Instruction** | Students complete 30+ weeks of clinical internships in a variety of settings including, hospitals, public schools, rehabilitation centers, private practice, or educational/community agencies. The goal is to develop competent, entry-level, generalist practitioners. (CAPTE Accreditation Handbook, 2016). For more information, visit: http://www.capteonline.org. | The physical therapist assistant completes approximately 16 weeks of full-time clinical internships. For more information, visit: www.apta.org/PTAEducation/Overview/. |
| **Exam Following Completion of Academic Instruction** | After successful completion of coursework and clinical internships, the individual must pass the National Physical Therapy Exam (NPTE) of the Federation of State Boards of Physical Therapy for physical therapists. | Following graduation from a PTA program, the individual must then pass the NPTE exam for PTAs. |
| **State Licensure** | Following successful completion of the NPTE exam, the individual must apply for licensure in Illinois. A person who is currently licensed as a PT in another state or U.S. territory may apply for licensure by endorsement. After the license is obtained, the individual can practice as a physical therapist in the Illinois. A licensed therapist may use the initials "PT" after his/her name.<br><br>The PT license must be renewed in August of each even-numbered year. The physical therapist must complete 40 hours of continuing education (CE) relevant to the practice of physical therapy during each prerenewal period as a condition of renewal. At least 3 hours of the 40 hours must include content related to the ethical practice of physical therapy. A prerenewal period is the 24 months preceding September 30 in the year of the renewal. A renewal applicant is not required to comply with CE requirements for the first renewal following the original issuance of the license. | Following successful completion of the NPTE exam, the individual must apply for licensure in Illinois. A person who is currently licensed as a PTA in another state or U.S. territory may apply for licensure by endorsement. After the license is obtained, the individual can practice as a physical therapist assistant in the Illinois. A licensed assistant may use the initials "PTA" after his/her name.<br><br>The PTA license must be renewed in August of each odd-numbered year. The assistant must complete 20 hours of CE relevant to the practice of physical therapy during each prerenewal period as a condition of renewal. At least 3 hours of the 20 hours must include content related to the ethical practice of physical therapy. A prerenewal period is the 24 months preceding September 30 in the year of the renewal. A renewal applicant is not required to comply with CE requirements for the first renewal following the original issuance of the license. |

## E. OT AND PT IN THE EDUCATIONAL ENVIRONMENT

OT and PT are integrated into the school's educational program as a means to enhance functioning and attain the student's individual educational objectives. Therapy Practitioners are members of collaborative teams, assisting in determining appropriate programs for students and supporting the total educational system. They can assist with problem solving to eliminate barriers that hinder access to educational environments and assist with modifications and accommodations to support students in their regular education or special education program. The role of occupational therapists and physical therapists in the team decision-making process involves collecting and analyzing the evaluation data and conveying to the team members its impact on the student's ability to access and participate in the educational environment and programs. The school system provides the programming, services, supports and interventions specified in a student's IEP or Section 504 plan, as deemed necessary by the team, for achievement of a student's identified educational goals and objectives/benchmarks, and participation in and progress through the general education curriculum.

Under the IDEA, OT and PT are considered related services and are provided to support the student's IEP.[22, 64, 65] In conjunction with the occupational therapist and/or physical therapist, the IEP team decides which services are necessary to meet the educational goals of the student.[23] Decisions regarding what type of service, how it is provided, and who is to provide it are based on data and directly tied to the student's overall educational program. All team members support the attainment of these educational goals. Thus, the specific expertise and/or licensure of Therapy Practitioners is not limited to OT and PT goals and objectives/benchmarks, rather they are valuable members of the team in deciding the necessary means or methods to attain all educational goals and objectives/benchmarks.

School-based OT and PT are not intended to meet all the therapy needs of a child but are intended to meet needs of the student to promote success in the educational environment.[24] This is an important distinction between therapies provided in schools and those provided in the clinical setting. Some students require only community-based therapy; some only need therapy at school; some need both. All IEP determinations must be individualized and based on data to meet each student's unique needs. Although OT and/or PT may be provided in both educational and clinical settings, the overall objectives and therapeutic interventions may be different.[25] Therapy in a school setting is part of a student's total educational program and is provided to assist students in accessing, participating in, increasing independence and engaging within their educational program. If a student needs OT and/or PT to address problems, but the problems do not prevent the student from participating in the educational program, school-based OT and PT should not be provided. For students receiving services in and out of the school setting, communication and collaboration between Therapy Practitioners are instrumental to student success.

Similarly, the Section 504 regulations provide that a FAPE for a qualified child with a disability is the provision of regular or special education and related aids and services

that are designed to meet the individual educational needs of disabled persons as adequately as the needs of nondisabled persons are met.[26] This may include providing OT and PT services to eligible students pursuant to their Section 504 plans. See Section II.H, *OT and PT as Part of the Section 504 Process*, for detailed information about the requirements of Section 504 and Section 504 plans.

Occupational therapists and physical therapists in schools need to identify the educational significance of therapy provided to students. Table 7 describes areas of educational relevance in which Therapy Practitioners work directly with the student, teacher, parent/guardian, and relevant staff members for the student to progress towards identified IEP goals. The most common educational purposes for students to receive OT and/or PT services within the school environment include, but are not limited to, those listed in Table 7.

**Table 7. Common Educational Services in School Practice**

| **OT** | **PT** |
|---|---|
| Enhancing independence and participation in educational programming | Enhancing the "capacity of individuals to do what is important to them in their daily activities and roles." - to "prevent, minimize, or eliminate impairments of body functions and structures, activity limitations, and participation restrictions." |
| ● Skill development, remediation of skill deficits, and ability to self-regulate<br>o Activities of daily living (self-care)<br>o Instrumental activities of daily living (safety awareness, shopping, meal preparation, and clean up, etc.)<br>o Educational activities (fine motor skills, pre-writing, written communication, technology, participation in academics, etc.)<br>o Work and volunteer (pre-vocational/vocational exploration and participation, employment interests and pursuits, etc.)<br>o Play/leisure (exploration and developmentally appropriate participation, identification of interests and pursuits, etc.)<br>o Social participation (promoting mental health, social behavior, social confidence, etc.) | ● Physical Access*<br>○ Safety for students and staff regarding the student's ability to physically access or participate within the school environment (i.e., posture and movement)<br>○ Mobility to negotiate the school environment (stairs, curbs, hallways, doors, etc.) via various means of mobility including assistive devices or wheelchairs in order to access materials and instructional tasks<br>○ Transfer between positions to participate in classroom activities<br>○ Posture and ability to maneuver to access and participate in the lunchroom, bathroom/self-care, playground, etc.<br>○ Body orientation to complete motor tasks typical of the daily routine<br>○ Fundamental movement skills for recreation and age level play/activities<br>○ Efficiency of participation, mobility and motor performance<br>○ Maximizing independence/ self-determination |

| | |
|---|---|
| ● Adaptations and modifications of educational environment and activities<br>o Physical and social environments/expectations<br>o Cultural, personal, and temporal contexts<br>o Habits and routines<br>o Equipment<br><br>(AOTA, 2014) | ● Health and Fitness*<br>○ Endurance, posture, and body mechanics needed for participation in PE/fitness activities, community activities, and work-related tasks.<br>○ Performance endurance (energy expenditure and breath support) to participate in academic and functional activities (single tasks and across the day)<br><br>*Intervention provided through enhancement of the student's physical capacity, use of assistive technology, and/or modification of the task or environment. (APTA, 2014) |

# SECTION II:
# DETERMINATION OF THE NEED FOR AND PROVISION OF THERAPY

## A. INTRODUCTION

Section II provides information on the evaluation process and presents information on how OT and PT are included in the educational setting. Students with disabilities may be identified as in need of OT and/or PT by the LEA through Section 504 or the IDEA. Eligibility and initiation of services under the IDEA and Section 504 include factors an occupational therapist or physical therapist should consider when making recommendations to the team, although the factors for each may be different. Topics in Section II include: systems level interventions; overview of FAPE; OT and PT as part of the special education process; the role of OT and PT Practitioners in the formulation of the IEP; formulation and implementation of OT and PT intervention; health care professional referral (prescriptions) and Medicaid cost recovery; OT and PT as part of the Section 504 process; and individual service plans and proportionate share funds.

## B. SYSTEMS LEVEL INTERVENTIONS

### THERAPISTS AS MEMBERS OF EDUCATIONAL TEAMS

As members of the educational team, occupational therapists and physical therapists may provide collaborative services that support the ability of all students to participate in the school setting.[27] The role of OTAs and PTAs is governed by the Illinois Occupational Therapy Practice Act (OT Act) and the Illinois Physical Therapy Act (PT Act), and they should be in direct consultation with their supervising occupational therapists and physical therapists if participating in this process.[28] It is the role of the supervising therapist to direct and oversee the activities that are included in systems level intervention. Supervision may be provided in person or through phone, electronic communication, or video consultation.[29]

In the educational setting, collaborative services may include systems-level collaboration, colleague collaboration, screenings, or student-specific collaboration. In a systems-level collaboration, Therapy Practitioners may provide consultation to schools to enable students with and without disabilities to fulfill their role as students by engaging in school activities.[30] Collaboration may address a variety of issues including, but not limited to:

- promoting universal design throughout district/school campuses (e.g., playgrounds, bathrooms, egress, play options);
- ensuring access to the physical environment (e.g., advising on specific accommodations that allow all students, including students with disabilities, to access parts of the school building such as the restroom, classroom, lunchroom, stage, or playground);

- developing new learning environments (e.g., advising on design or specialized equipment in new or remodeled areas to meet the needs of all students, including students with disabilities); and
- collaborating with school personnel to develop programs to meet the needs of all students, including students with disabilities (e.g., developing programs for social participation, self-help skills, physical or mental health, fitness, behavior, academics, recess, or prevocational participation).

With respect to colleague collaboration, Therapy Practitioners may consult with school personnel regarding groups of students with similar needs. Consultation may address a variety of issues relevant to OT or PT (e.g., safety, written communication, sensory processing, self-regulation, behavior, mental health, executive functioning, mobility, functional independence, safe transfer techniques for moving students with disabilities).[31] This type of consultation includes, but is not limited to, LEA or building-wide in-services, individualized staff training to facilitate knowledge of diagnoses, use of equipment, development of skills, etc. without students being present, or working with educators to develop small group intervention programs that apply common sense approaches to support skills.

In a screening, Therapy Practitioners may generally assess groups of students within a LEA, building, grade, or classroom. Screenings address common issues such as developmental skills, desk heights, or environmental accessibility. Under the IDEA regulations, the screening of a student by a teacher or specialist to determine appropriate instructional strategies for curriculum implementation is not considered an evaluation for eligibility for special education and related services.[32] As a result, parent/guardian consent is not required for a screening conducted to determine appropriate instructional strategies, though it is recommended that staff provide the parent/guardian with notice of any such screening.

In a student-specific collaboration which often occurs as part of the LEA's RtI/MTSS process, also called a case consultation or individual problem-solving, Therapy Practitioners may collaborate on individual students to provide recommendations to school personnel and parents/guardians. This type of consultation may include interviewing students, parents/guardians, and staff along with individual observation of the student's participation in the school environment. Therapy Practitioners must consider the nature and scope of their recommendations when the collaboration is not part of an evaluation or occurs prior to completion of an evaluation. Recommendations should guide school staff to use general, common-sense strategies rather than specific therapeutic strategies. Also, when engaging in this consultation, it is important for PT Practitioners to know the scope of practice for PTAs under the PT Act, including but not limited to that PTAs may not engage in activities such as interpretation of referrals, evaluation procedures, or planning or major modifications of patient programs.[33] Please see following subsections for specific information related to Therapy Practitioners' participation in the RtI/MTSS process (which includes but is not limited to case consultation).

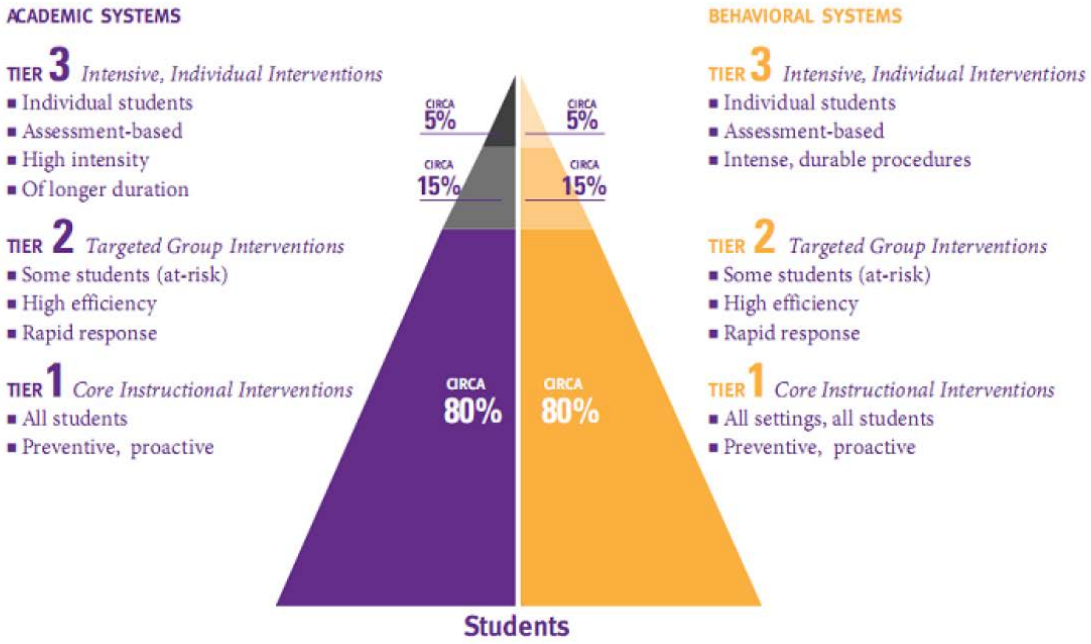
It is best practice for the educational team to inform the parent/guardian when a specialist (related service provider) is brought in to consult or to provide services through a MTSS/ RtI approach on an individual basis.

## MTSS/RtI AND EARLY INTERVENING INITIATIVES

MTSS "is a framework for continuous improvement that is systematic, prevention focused, and data informed, providing a coherent continuum of supports responsive to meet the needs of all learners."[34] See Figure 1 for a visual model that describes three tiers of supports provided in a school setting.

The MTSS/RtI framework enables educational teams to utilize evidence-based interventions (academic, behavioral and mental health, etc.) and access expertise to meet the needs of all students, without waiting for students to fail. This framework requires collaboration from all school personnel. It involves universal screenings, high quality, evidence-based instruction and interventions, data collection and data-based decision making, and progress monitoring. The intensity and types of services provided increase from school-wide interventions, to targeted small group instruction, to individually designed/targeted interventions. The goals of this model are to increase support for and performance of all students. This system addresses needs of students with different learning needs as well as those who may struggle due to transience, limited English proficiency, and/or social and economic disadvantages.[35]

**Figure 1. Three-Tier Model of School Supports**




*Source*: National Association of State Directors of Special Education, 2010.

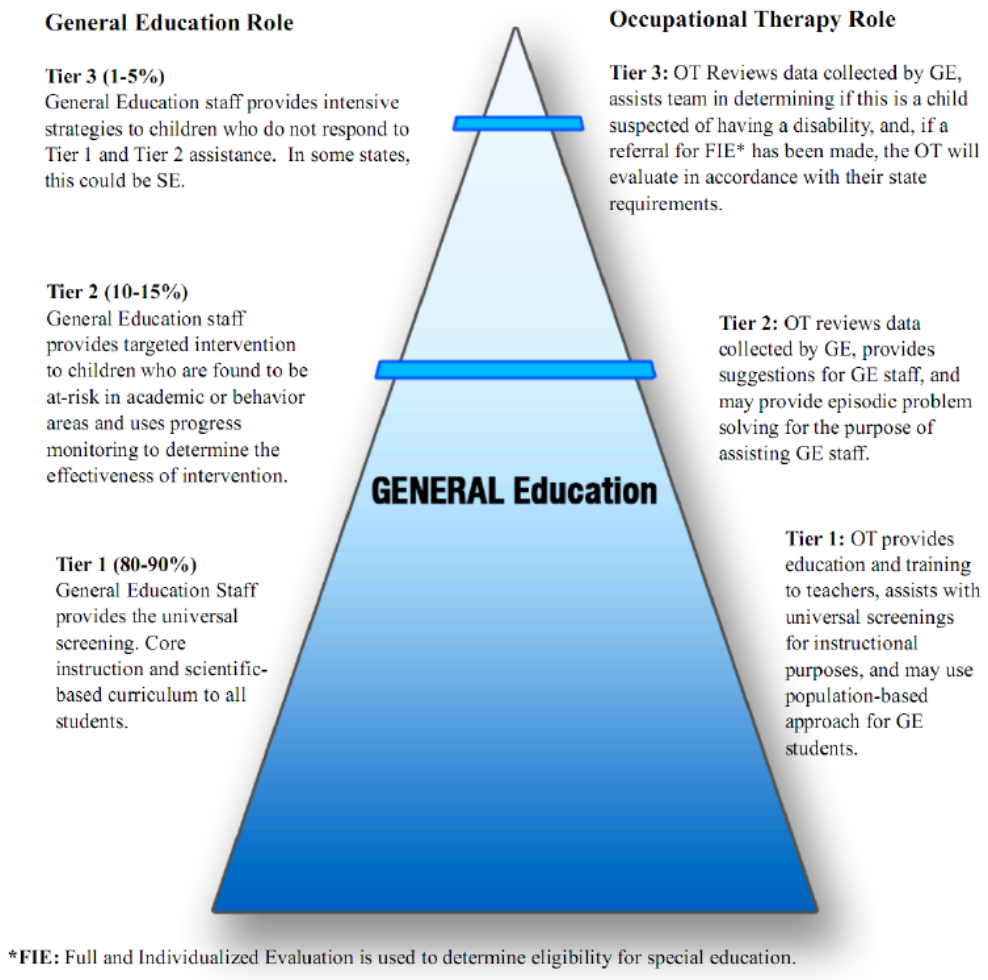
(Figure used with permission from National Association of State Directors of Special Education, 2010)

## ROLE OF OT AND PT IN MTSS/RtI

Therapy Practitioners have specific knowledge and skills that aid in facilitating successful environments, participation and learning for students. They are skilled in activity and environmental analysis and modifications that promote student performance in their educational roles.[36]

Occupational therapists and physical therapists may participate at every level of the MTSS/RtI framework as integral members of the problem-solving team. OTAs and PTAs may be able to contribute to some aspects of MTSS/RtI activities under supervision of the occupational therapist or physical therapist, respectively. It is the responsibility of all Therapy Practitioners to ensure that the MTSS/RtI activities in which they engage are consistent with the OT Act or PT Act.

**Figure 2. The Role of the Therapist in an MTSS/RtI Model.**




(Figure used with permission from G. Frolek Clark, 2010)

Tier 1 activities and interventions are universal, targeting all students in the general education and special education settings. Examples of Tier 1 activities include but are not limited to: in-service trainings for teachers and paraeducators, screenings for functional or developmental skills, implementing classroom-based curriculum/strategies, and assessment of general environmental barriers. Tier 2 focuses on targeted group instruction for students identified as "at risk" in the general education setting. Therapy Practitioners may collaborate with teachers to develop targeted group activities, co-teach, and/or participate in data collection and review. Tier 3 activities are related to individual intervention, progress monitoring, and data collection for specific students. When deemed necessary by the educational team and the parent/guardian provides written consent, a formal evaluation may be conducted by the occupational therapist and/or physical therapist.

Figure 2 provides a visual representation of support that can be provided through MTSS/RtI by an OT Practitioner; MTSS/RtI support by a PT Practitioner can be implemented in a similar manner. For instance, with knowledge in exercise methods and strategies, developmental motor patterns and skills, and seating and body alignment for effective work production for all students, PT Practitioners in school settings may play a role in early intervening and MTSS/RtI relative to health and wellness for all students. PT Practitioners may assist educational staff in operationalizing behavioral interventions, employing physical activity and/or movement strategies during instruction, developing effective data keeping systems, and interpreting information regarding medical conditions and rehabilitation strategies that are commonly utilized with specific diagnoses.

## IMPACT OF LICENSURE ON PROVISION OF OT SERVICES UNDER AN MTSS/RtI MODEL

In most circumstances, contact with a physician or other health care provider is not necessary for OT services in school, including services provided in an MTSS/RtI model. According to the Illinois Occupational Therapy Practice Act (OT Act), a "[r]eferral from a physician or other health care provider is not required for evaluation or intervention for children and youths if an occupational therapist or occupational therapy assistant provides services in a school-based or educational environment, including the child's home." [37]

Further evidence to support OT Practitioner involvement in MTSS/RtI can be found in the OT Act, which states that OT Practitioners may "consult with, educate, evaluate, and monitor services for individuals, groups, and populations concerning occupational therapy needs."[38] The OT Act further states that a referral is not needed for "the purpose of providing consultation, habilitation, screening, education, wellness, prevention, environmental assessments, and work-related ergonomic services to individuals, groups, or populations."[39] These sections of the OT Act reiterate and further support the ability of OT Practitioners to provide services within an MTSS/RtI model without a referral.

However, in circumstances when a student receiving MTSS/RtI services is presenting with signs or symptoms of a potential medical condition which may be outside the scope of early intervening services, the OT Practitioner must refer the student to a licensed

health care provider for medical guidance. This requirement is identified in the Occupational Therapy Code of Ethics and the OT Act: "An occupational therapist shall refer to a licensed physician, dentist, optometrist, advanced practice registered nurse, physician assistant, or podiatric physician any patient whose medical condition should, at the time of evaluation or treatment, be determined to be beyond the scope of practice of the occupational therapist."[40] If a student is being seen by a physician or other health care provider outside of school for a condition which is not related to the issues being addressed through MTTS/RtI, the student may continue to receive intervention by the OT Practitioner without the requirement of a referral. See Section II.G., *Referrals (Prescriptions), Documentation (Service Logs) and Medicaid Cost Recovery*, for additional information.

## IMPACT OF LICENSURE ON PROVISION OF PT SERVICES UNDER AN MTSS/RtI MODEL

PT Practitioners, like their OT Practitioner colleagues, function as collaborative team members in their LEAs, programs, and classrooms.[41] Collaboration with team members in the learning environment (system consultation) by PT Practitioners may involve issues related to safety, increased physical activity, transportation, architectural barriers, equipment, participation and program evaluation.[42] School-based PT Practitioners, along with physical education teachers, adapted physical education specialists, school nurses, and school dietary and nutritional experts, may also play a key role in program collaboration aimed at improving health and wellness for all students to manage the burgeoning epidemic of obesity in children and adolescents.[43]

The role of PT Practitioners in early intervening services, including MTSS/RtI is supported by the Academy of Pediatric Physical Therapy (formerly known as the Section on Pediatrics of the APTA). This Academy identifies pediatric PT Practitioners as "practitioners of choice" in selecting and applying strategies for all students related to health, physical activity, growth, development and health-related fitness and obesity management.[44] In addition, PT Practitioners working in schools have knowledge of musculoskeletal injury prevention that is beneficial for members of the school community with respect to lifting, body mechanics, and energy conservation.[45]

LEAs and schools within a given LEA vary with respect to implementation of early intervening practices. PT Practitioners play a key role in translating knowledge from research-based evidence related to supporting academic success with regular physical activity.[46] School-based PT Practitioners are in a unique position of being able to share their expertise with building teams in relation to the provision of universally designed and developmentally appropriate motor programs for students at all educational levels.[47] Physical therapists in some LEAs may participate in screening for deficits, especially at the early childhood or elementary level where movement skill deficits may impact school participation and/or performance of functional activities such as mobility, physical activity or self-care essential to the role as a student.

Despite the enhanced role of PT Practitioners as potential providers of early intervening services for all students in a school, there is a paucity of literature describing either models

or strategies that effectively utilize physical therapists in this manner. In a national survey of school-based PT practice conducted between October 2010 and January 2011, only the provision of PT services to students under IDEA was addressed.[48] At the time of this writing, the practice acts and licensure laws regarding direct access to PT vary widely with respect to the role PT Practitioners can play in implementing direct interventions.[49]

Provisions in the Illinois Physical Therapy Act (PT Act) related to referrals from health care providers were amended as of August 2018. Under the current PT Act, physical therapy includes, but is not limited to:

> (a) performance of specialized tests and measurements, (b) administration of specialized treatment procedures, (c) interpretation of referrals from physicians, dentists, advanced practice registered nurses, physician assistants, and podiatric physicians, (d) establishment, and modification of physical therapy treatment programs, (e) administration of topical medication used in generally accepted physical therapy procedures when such medication is either prescribed by the patient's physician, licensed to practice medicine in all its branches, the patient's physician licensed to practice podiatric medicine, the patient's advanced practice registered nurse, the patient's physician assistant, or the patient's dentist or used following the physician's orders or written instructions, (f) supervision or teaching of physical therapy, and (g) dry needling in accordance with [the Act].[50]

The PT Act provides the definition of a referral as a "written or oral authorization for physical therapy services for a patient by a physician, dentist, advanced practice registered nurse, physician assistant, or podiatric physician who maintains medical supervision of the patient and makes a diagnosis or verifies that the patient's condition is such that it may be treated by a physical therapist."[51] Per the 2018 amendments, the PT Act provides that a physical therapist may provide physical therapy services to a patient with or without a referral from such health care professional.[52]

However, the 2018 amendments to the PT Act provide that a physical therapist providing services without a referral from a health care professional must notify the patient's treating health care professional within 5 business days after the patient's first visit that the patient is receiving physical therapy.[53] This notice requirement does not apply to physical therapy services related to fitness or wellness, unless the patient presents with an ailment or injury.[54] Also, a physical therapist is required to refer a patient to a health care professional if: (1) the patient does not demonstrate measurable or functional improvement after 10 visits or 15 business days, whichever occurs first, and continued improvement thereafter; (2) the patient returns for services for the same or similar condition after 30 calendar days of being discharged by the physical therapist; or (3) the patient's condition, at the time of evaluation or services, is determined to be beyond the scope of practice of the physical therapist.[55]

Other limitations include that wound debridement services may only be provided with written authorization from a health care professional, and a physical therapist is required to promptly consult and collaborate with the appropriate health care professional anytime a patient's condition indicates that it may be related to temporomandibular disorder so

that a diagnosis can be made by that health care professional for an appropriate treatment plan.[56]

The PT Act states that the Illinois Department for Professional Regulation make take disciplinary action (e.g., revoke/suspend license) against a PT Practitioner for having treated ailments of human beings as a licensed physical therapist in violation of these new requirements.[57]

Based on the 2018 changes to the PT Act, PT Practitioners do not need to obtain a referral in order to provide school-based PT services. However, PT Practitioners must notify a student's treating health care professional that the student is receiving PT services, and may need to refer a patient to a health care professional under certain circumstances (after obtaining the parent/guardian's written consent to disclose information to such health care professional). Please refer to the PT Act for details on the circumstances in which a referral is not required. See Section II.G., *Referrals (Prescriptions), Documentation (Service Logs) and Medicaid Cost Recovery*, for additional information.

It is within the scope of practice for PT Practitioners within schools to assist the school team in providing program development, data collection strategies, and universal interventions that are developmentally appropriate for students of all ages or with a specific disability/diagnosis (e.g., Down syndrome, developmental delay). This allows PT Practitioners to participate with other team members in developing physical activity, movement and/or motor programs, movement breaks, or fitness standards for groups of children (Tier 1 and Tier 2 Interventions). PT Practitioners may also participate with other team members in providing targeted interventions to individual students (Tier 3 interventions). During Tier 3 Interventions, PT Practitioners provide interventions targeted to performance areas based on data obtained through the MTSS/RtI process. Unless a comprehensive evaluation is completed with the student, these interventions include tasks or exercise that addresses only the identified targeted need. PT Practitioners may have to refer the student to a health care professional if the student needs further intervention and/or fails to progress at an expected rate in the MTSS/RtI framework, or the student's condition is determined to be beyond the scope of physical therapy practice, as required by the PT Act. Also, a student with a need for further intervention by a PT Practitioner to address a recurring safety, mobility, fitness, or environmental access need in the school setting may be referred for an evaluation for special education and related services.

While administration of topical medication is within the scope of practice, administering topical medications to a student within the school setting should be considered only when these medication are required for the student to access or benefit from the curricular instruction within the school setting and there is appropriate supervision to monitor the student's reaction to the medication. Under Illinois law, the administration of medication to students during school hours and during school-related activities should be discouraged unless absolutely necessary for the critical health and well-being of the student.[58]

While the PT Act allows usage of various modalities by PT Practitioners, application of modalities should be based on whether the modality will address the educational need of the student. Modalities that do not have a direct correlation with supporting the student's participation in his/her educational program should not be provided within the school setting. As in all cases, usage of modalities depends on a student's unique and individual needs in the school setting, as determined by the IEP or Section 504 team.

## C. OVERVIEW OF FAPE

The Individual with Disabilities Education Act ("IDEA") and Section 504 of the Rehabilitation Act of 1973 ("Section 504") are federal laws, both of which require LEAs to identify eligible students with disabilities and provide them with a free appropriate public education ("FAPE"). IEPs and Section 504 plans are statements of an LEA's offer of FAPE to eligible students.[59]

Under the IDEA, FAPE means special education and related services that are provided at LEA expense under LEA supervision and discretion, and without charge; meet the standards of the ISBE and the IDEA; and are provided in conformity with an IEP that meets the IDEA requirements.[60] Special education is defined by the IDEA as specially designed instruction, at no cost to parents, to meet the unique needs of a student with a disability.[61] Specially designed instruction means "adapting, as appropriate to the needs of an eligible child…the content, methodology, or delivery of instruction (i) to address the unique needs of the child that result from the child's disability; and (ii) to ensure access of the child to the general curriculum, so that the child can meet the educational standards within the jurisdiction of the [LEA] that apply to all children."[62]

Related services under the IDEA means developmental, corrective, and other supportive services as are required to assist a student with a disability to benefit from special education, and the IDEA specifically states that related services include OT and PT.[63] The IDEA defines occupational therapy as 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; and preventing, through early intervention, initial or further impairment or loss of function.[64] Physical therapy is defined as services provided by a qualified physical therapist.[65]

Under Section 504, FAPE is the provision of regular or special education and related aids and services designed to meet the student's individual educational needs as adequately as the needs of nondisabled students are met, based upon adherence to procedures that satisfy the requirements in the Section 504 regulations, and at no cost to the student's parents/guardians.[66] An appropriate education under the Section 504 could consist of education in regular classrooms, education in regular classes with supplementary services, and/or special education and related services.[67] Students who are identified as having a disability and needing special education and/or related aids and services under Section 504 are entitled to a broad range of supplemental and related aids and services, as needed, such as OT or PT.[68]

The IDEA and Section 504 have different eligibility criteria. The IDEA provides that a student is eligible if: the student has one or more of the 14 disabilities defined under the IDEA; the disability adversely affects the student's educational performance; and as a result of that disability, the student needs special education and related services.[69] Section 504 provides that a student is eligible if: the student has a mental or physical impairment as defined under Section 504; that impairment substantially limits a major life activity; and the student needs special education or related aids and services.[70]

Students with disabilities who are eligible for an IEP are not required to also have a Section 504 plan even though they are protected under Section 504.[71] For these students, the IEP developed and implemented in accordance with the IDEA is sufficient.[72] Under the Section 504 regulations, one way to meet Section 504 requirements for a FAPE is to implement an IEP.[73] As a result, students with disabilities who need special education will receive IEPs (provided they meet all the IDEA's eligibility criteria) even though FAPE under Section 504 may include the provision of "special education" to eligible students. Students with disabilities who do not need special education, but who do need related aids and/or related services, are not IDEA-eligible but may receive such aids or services under Section 504 plans (provided they meet all of Section 504's eligibility criteria).

## D. OT AND PT AS PART OF THE SPECIAL EDUCATION PROCESS

### CHILD FIND

The State special education rules state the following about a LEA's "child find" obligations: "Each school district shall be responsible for actively seeking out and identifying all children from birth through age 21 within the district (and those parentally-placed private school children for whom the district is responsible under 34 C.F.R. §300.131) who may be eligible for special education and related services."[74] The child find responsibility requires LEAs to identify children with known or suspected disabilities who may be in need of special education and related services, evaluate those children, and determine their eligibility to receive special education and related services. In Illinois, procedures to fulfill this child find responsibility include: annual and ongoing screenings of children under the age of five for the purpose of identifying those who may need early intervention or special education and related services; ongoing review of each student's performance and progress by teachers and other professional personnel, in order to refer those children who exhibit problems that interfere with their educational progress and/or their adjustment to the educational setting, suggesting that they may be eligible for special education and related services; and ongoing coordination with early intervention programs to identify children from birth through two years of age who have or are suspected of having disabilities, in order to ensure provision of services in accordance with applicable timelines.[75]

Therapy Practitioners can be included in the child find process at different stages. The role of OTAs and PTAs is governed by the Illinois Occupational Therapy Practice Act (OT

Act), Illinois Physical Therapy Act (PT Act), and the Illinois special education rules. OTAs and PTAs should be in direct consultation with their supervising occupational therapist or physical therapist if participating in this process; especially given that this process relies upon assessment.[76] It is the role of the supervising occupational therapist or physical therapist to direct and oversee all activities during the child find process.[77] These stages include:

- Early Intervening Service/Problem-solving Process/MTSS/RtI
- Child Find/Section 504 (See Section 504 in Section III.H)
- Child Find/IDEA
- Response to parent/guardian request for evaluation

Procedures for child find must be well-known to school personnel, provided to the general public, and include the process by which the LEA considers a request for an evaluation. Including Therapy Practitioners in child find occurs through the team process. "The district refers a student for occupational therapy [and physical therapy] services when he or she demonstrates difficulties" in areas that may be supported by OT and PT.[78]

When a request for evaluation is made by a parent/guardian, staff member, or other agency, the LEA is responsible for processing the request, deciding what action should be taken, and initiating the necessary procedures.[79] The LEA must determine whether an evaluation of the student is warranted within 14 school days after receiving the request.[80] The LEA may utilize screening data and conduct preliminary procedures, such as observation of the student, assessment for instructional purposes, consultation with the teacher or other individual making the request, and a conference with the student.[81] The LEA may **not** conduct a partial evaluation with the student (i.e., individual assessments) without parent/guardian consent to assist the LEA with determining if a full and individual evaluation is warranted.

An occupational therapist or physical therapist may need to gather and/or obtain information as a part of this process, such as:

- basic student demographic information;
- student strengths and performance outcomes relative to educational setting;
- previously attempted strategies and the effectiveness of such strategies;
- pertinent, current medical information (may require an authorization for release of information from the parent/guardian);
- pertinent private therapy records (may require an authorization for release of information from the parent/guardian);
- existing educational records, including the most current IEP, evaluation reports, progress on goals, if applicable; and
- other relevant information (e.g., observations, parent/guardian or teacher concerns, performance in educational activities).

If the LEA determines that an evaluation is not warranted, the LEA must give prior written notice to the student's parent/guardian within 10 calendar days after receiving the request for evaluation.[82]

## NEEDS ASSESSMENT (DOMAIN)

If it is determined that an evaluation will be conducted, the IEP team and other qualified professionals, as appropriate, must review existing evaluation data on the student, including: evaluations and information provided by the parents/guardians; current classroom-based, LEA, or State assessments, and classroom-based observations; and observations by teachers and related services providers.[83] Based on that review and input from the student's parents/guardians, the IEP team and other qualified professionals must identify what additional data, if any, are needed to determine the following:

- whether the student is a child with a disability as defined by the IDEA, and the educational needs of the child (or in the case of a reevaluation, whether the student continues to have a disability and the educational needs of the child);
- the student's present levels of academic achievement and related developmental needs;
- whether the student needs special education and related services (or in the case of a reevaluation, whether the student 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 student to meet the measurable annual goals set out in the student's IEP and to participate, as appropriate, in the general education curriculum.[84]

There are eight (8) areas or "domains," that need to be considered for an evaluation:[85]

- Academic Achievement
- Functional Performance
- Cognitive Functioning
- Communication Status
- Health
- Hearing/Vision
- Motor Abilities
- Social/Emotional Status

Ideally, review of the domains is completed as a team at a "domain" meeting. The Illinois special education rules state, "The district shall convene a team of individuals (including the parent) having the knowledge and skills necessary to administer and interpret evaluation data. The composition of the team will vary depending upon the nature of the child's symptoms and other relevant factors."[86] However, the IDEA regulations permit school personnel to conduct this review without a meeting, provided that the personnel seek input from the student's parent/guardian.[87] See the Illinois School Code and the Illinois special education rules for additional information on required procedures.[88]

Therapy Practitioners may contribute information into multiple domains (such as educationally related self-care skills under Functional Performance, cardiovascular

performance under Health, and mental health issues under Social/Emotional Status) and their participation in the evaluation process is determined by LEA procedures. The team discusses each of the domains to determine which domains are relevant to the student's known or suspected disabilities, what information exists about student participation, what information is needed, and what sources (e.g., observation, data collection, assessment tools) will be used to gather this needed information. The team decides which personnel/disciplines will gather this information and/or complete the evaluation components according to the credentials required to administer the certain evaluations as provided in the Illinois special education rules. [89] See Section III.F, *Supervision and Management of Therapy Personnel*, for more information about the requirements for OT Practitioners and PT Practitioners to complete evaluations under the OT Act and PT Act, respectively.

The LEA must identify the assessments necessary for each domain to complete the evaluation and request parent/guardian consent to conduct the needed assessments within 14 school days after receiving the request for evaluation.[90] "School day" is defined as any day, including a partial day, that children with and without disabilities are in attendance for instructional purposes.[91] Written parent/guardian consent for an evaluation is required.[92]

Once parental/guardian written consent is obtained, the LEA has no more than 60 school days to complete the evaluation, convene a meeting to review the evaluation results and make an eligibility determination and, if the student is eligible, convene an IEP meeting to develop the student's IEP.[93] Additionally, once a student is determined eligible for special education and related services, an IEP meeting to develop the IEP must be conducted within 30 days of that eligibility determination.[94] This means that after receiving the parent's written consent, the LEA has a 60-school-day timeline to complete the process, *i.e.*, conduct the evaluation, convene a meeting to determine if the student is IDEA-eligible and, if eligible, develop an IEP. The LEA may hold separate meetings for the eligibility determination and developing the IEP for an IDEA-eligible student. However, once a student is determined eligible, the LEA has 30 calendar days or the remaining days within the 60-school-day timeline, whichever is less, to convene another meeting to develop the IEP. If fewer than 60 school days remain in a school year after the date of parental written consent, the eligibility determination must be made and the IEP meeting must be completed prior to the first day of the following school year.[95]

Therapy Practitioners need to consider appropriate evaluation methods that would obtain information identified in each assigned domain area. The assessment tools or methods used should provide an understanding of the relative strengths as well as challenges of the student and assist with developing an explanation of any discrepancy between student performance and the educational expectations of the teacher/curriculum (e.g., identifying performance components and skill deficits). When completing the domain form, the level of specificity for identifying particular assessment tools to be used during the evaluation is an individual LEA decision. Listing specific assessment tools or procedures on the domain form provides clear information to parents/guardians regarding what tools will be used to assess different areas. However, identifying just the category of tools to be used allows the occupational therapist and/or physical therapist the ability

to vary tests using professional judgement based on student behavior/response and additional issues that arise during the assessment process.

It is recommended that occupational therapists and physical therapists consult the OT Practice Framework[96] or Guide to Physical Therapy Practice 3.0[97] throughout the evaluation process.[98] These documents are aligned to the International Classification of Functioning, Disability, and Health (ICF) and identify all areas that could be evaluated or addressed by Therapy Practitioners. Occupational therapists and physical therapists should consider these areas to identify facilitators and barriers to student performance and participation. Using the ICF can facilitate the identification of appropriate supports (e.g., strategies, materials, and personnel) to enhance student independence and participation within the school environment.[99]

## OT AND PT AS PART OF THE EVALUATION PROCESS

The IDEA regulations define an evaluation as "procedures used in accordance with [the IDEA regulations] to determine whether a child has a disability and the nature and extent of the special education and related services that the child needs."[100] The OT and/or PT evaluation may be a part of an initial case study or a reevaluation.

For students who already have IEPs, the LEA must ensure that a reevaluation is conducted in accordance the IDEA regulations if the LEA determines that the student's educational or related services needs, including improved academic achievement and functional performance, warrant a reevaluation, or if the student's parent or teacher requests a reevaluation.[101] However, a reevaluation may not occur more than once a year unless the parent and the LEA agree otherwise.[102] Also, a reevaluation must occur at least once every 3 years (often referred to as a "triennial reevaluation"), unless the parent and the LEA agree that a reevaluation is unnecessary.[103]

An evaluation or reevaluation must assess all areas related to the student's suspected or known disability and must be sufficiently comprehensive to identify all of the student's special education and related services needs, whether or not commonly linked to the disability category in which the child has been classified.[104] The evaluation must be completed as stated on the parent/guardian consent for evaluation/domain sheet. The school staff, which may include an occupational therapist and/or physical therapist, determines the specific assessments unless the domain sheet lists specific assessment tools.

Before a student is given an evaluation, the LEA must determine the primary language of the student's home, general cultural identification, and mode of communication.[105] Each evaluation must be conducted so as to ensure that it is nondiscriminatory with respect to language, culture, race, and gender.[106] The LEA must ensure that assessments are administered in the student's native language or other mode of communication and the materials must be in the form most likely to yield accurate information on what the student knows and can do academically, developmentally, and functionally, unless it is clearly not feasible to do so. [107]

The school staff must use a variety of assessment tools and strategies to gather relevant functional, developmental, and academic information about the student, including information provided by the parents/guardians, that may assist in determining whether the student is eligible under the IDEA and the content of the student's IEP, including information related to enabling the student to be involved in and progress in the general education curriculum (or for a preschool child, to participate in appropriate activities).[108] The evaluators must use technically sound instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors.[109]

The assessments and other evaluation materials must be tailored to assess specific areas of educational need and not merely those that are designed to provide a single general intelligence quotient.[110] They must be selected and administered so as best to ensure that if an assessment is administered to a student with impaired skills, the assessment results accurately reflect the student's aptitude or achievement level or whatever other factors the test purports to measure, rather than reflecting the student's impaired sensory, manual, or speaking skills (unless those skills are the factors that the test purports to measure).[111] The evaluators must use assessment tools and strategies that provide relevant information that directly assists in determining the educational needs of the student.[112] Also, the LEA must ensure that assessments and other materials are used for the purposes for which the assessments or measures are valid and reliable, administered by trained and knowledgeable personnel, and administered in accordance with any instructions provided by the producer of the assessments.[113]

In addition to these requirements, setting, content, time of day and other factors may contribute to a student's performance during an evaluation. These should be considered and employed to elicit the best information for the eligibility determination and, if appropriate, developing the IEP.

During the evaluation process, it is the responsibility of the occupational and/or physical therapist to accurately convey the results of their assessments in order for the team to make an informed decision regarding the student's eligibility and needs. See Section III.F., *Supervision and Management of Therapy Personnel*, for additional information about the supervision, roles and responsibilities of OTs, OTAs, PTs, and PTAs relative to evaluations.

Evaluation involves a systematic and organized method of collecting data to understand student performance in relation to school district and grade level expectations. As part of this evaluation process, it is important to determine where the student is participating at the level of same-age, same-grade peers ("strengths") as well as where the student demonstrates challenges compared with such peers ("deficits"). A variety of methods can be used to identify strengths and deficits in participation, including standardized tests whenever possible. These can be categorized into two different evaluation types:

- Qualitative measures: qualitative methods may include **analysis of records** (medical and educational history, referral information, previous interventions, work samples, etc.), **interviews** (e.g., student, staff, parents/guardians, outside

providers, etc.), and **observations** (e.g., describing features of a student's performance in relevant settings/activities compared to peers, which may include motivation, posture, activity analysis, checklists, etc.).

- Quantitative measures: objective data assessing quantity, amount, frequency, and intensity of student performance on relevant school related tasks.[114]

If discrepancies are identified, then the barriers to the student's participation are examined. One model for this approach is to look at characteristics of the student (e.g., musculoskeletal, neuromuscular, sensorimotor, psychological), the environment (e.g., physical environment, social demands), and the task/activity.[115] Understanding the barriers and underlying factors that negatively impact student performance is critical to determining educational needs and appropriate intervention strategies/methods, including whether OT or PT support is required as a part of the student's educational program. Many of the same evaluation methods/tools can answer "why" the barrier exists. Occupational therapists and physical therapists use their professional expertise to determine which tools to use, and to synthesize and interpret the information obtained from such tools. The occupational therapist or physical therapist then identifies whether OT and/or PT interventions may potentially develop, enhance, or remediate the skill; and/or whether a student needs modification of expectations, the environment, or the activity.

Occupational therapists and physical therapists may gather information about the presence of a disability, any effect of a student's disability on present functional capabilities and, where applicable, any changes (e.g., medical, educational focus, family) that have occurred with the student or his/her environment, and any previous interventions or accommodations provided.

The LEA may not stop the evaluation process prior to its completion and discussion at an eligibility meeting, unless the parent/guardian revokes consent for the evaluation. [116]

## DOCUMENTATION OF EVALUATION RESULTS

School-based occupational therapists and physical therapists must base their decisions on objective evaluation data to be able to support the effectiveness of proposed intervention strategies.[117] Reports should be clear, concise, and in a format agreed upon by the LEA. Reports should contain the results of specific evaluation procedures as well as a summary of any identified educational needs. It is recommended that any therapist recommendations regarding OT or PT as part of the student's educational program should be made without reference to therapy levels, frequency, or duration. Specific recommendations for services within the report can be misinterpreted as "pre-determining" services prior to the meeting for the IEP team to make such decisions. Recommendations could include a statement such as: "The need for OT and PT services within the educational environment will be discussed and decided upon at the IEP meeting" in order to allow for IEP team discussion when deciding on eligibility and educational programming for the student.

The following should be included in a written report:

- student's identifying information;
- reason for and date of referral;
- pertinent medical/educational history;
- date(s) and location(s)/setting(s)/context of assessment(s);
- evaluation methods, including description of standardized and formalized assessment tools used and scores obtained, informal assessment methods used, and description of functional skills assessed;
- interpretation/synthesis of results, including identifying strengths and deficit areas as they relate to the student's participation in activities within the educational environment, and any underlying conditions or factors that negatively impact student performance;
- identification of environmental and adaptive equipment needs, adaptations/modifications of materials, instruction, and expectations, and key intervention strategies that support improved student participation (for skill development or remediation); and
- summary of any educational needs, with an explanation of how these needs impact the student in the educational environment.

If an assessment is conducted under nonstandard conditions, a description of the extent to which the assessment varied from standard conditions must be included in the evaluation report; this information is needed so that the team can assess the effects of these variances on the validity and reliability of the information reported and determine whether additional assessments are needed.[118] If any portion of the evaluation cannot be completed due to lack of parental involvement, religious convictions of the family, or inability of the student to participate in an evaluative procedure, the occupational therapist or physical therapist must note the missing portions in the evaluation report and state the reasons why those portions could not be completed.[119]

See Section III.F., *Supervision and Management of Therapy Personnel*, for additional information about the supervision, roles and responsibilities of OTs, OTAs, PTs, and PTAs relative to documentation of evaluations.

## ELIGIBILITY DETERMINATION

Once all evaluations are completed a meeting is required with a group of qualified professionals and the parents/guardians to discuss the evaluation results.[120] Ideally, the occupational therapist and/or physical therapist who completed evaluations of the student will attend the meeting and report the results of their assessments.

The purpose of this meeting is to interpret evaluation data to determine if the student is a child with a disability under the IDEA and, if so, to determine the educational needs of the student. In doing so, the school district must:

- establish a composite understanding of the student's learning characteristics, participation, behaviors, function, sensory and motor skills;
- draw upon information from a variety of sources, including aptitude and achievement tests, parent input, teacher recommendations, and information about

the student's physical condition, social or cultural background, and adaptive behavior; and
- ensure that information obtained from all of these sources is documented and carefully considered.[121]

The occupational therapist and/or physical therapist is responsible for clearly communicating the evaluation findings to the other team members. It is important that the team understands the connections between the therapist's interpretation of the results and a student's present needs at school. The occupational therapist and/or physical therapist provides input, substantiated by evaluation results (formal and informal), for the evaluation team to determine eligibility. The team must not use any single measure or assessment as the sole criterion for determining whether a student is IDEA-eligible and for determining an appropriate educational program for the student.[122]

The team determines whether: the student has one or more of the 14 disabilities defined under the IDEA; the disability adversely affects the student's educational performance; and as a result of that disability, the student needs special education and related services in order to receive an educational benefit. If the team finds all of the above, the student is a "child with a disability" eligible for services under the IDEA.

## E. THE ROLE OF OT and PT PRACTITIONERS IN THE FORMULATION OF THE IEP

### IEP TO OFFER A FAPE

The IEP is developed following determination by the team that the student is eligible under the IDEA. The IEP team collaboratively determines the special education program for the student through the development of the IEP. The IEP team is also responsible or determining if OT and/or PT services are necessary to assist the student to access or to participate in the educational environment in order to attain educational goals.[123] A description of the IEP development process is outlined next.

To provide a FAPE, the IEP must be reasonably calculated to enable a student to make progress appropriate in light of the student's unique circumstances.[124] For a student who participates fully in general education classes, the IEP should be "reasonably calculated to enable the child to achieve passing marks and advance from grade to grade."[125] For a student not fully integrated into the general education classroom, the programming provided should be "appropriately ambitious in light of his circumstances, just as advancement from grade to grade is appropriately ambitious for most children in the regular classroom."[126] Determinations of what is "appropriate" for the student must be made on a case-by-case basis by the IEP team.[127]

### IEP PLANNING AND DEVELOPMENT

Required members of the IEP team are delineated in the IDEA and Illinois special education rules and include: the parents/guardians 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 or, where appropriate, one

special education provider who works with the student; a representative of the LEA; an individual who can interpret the instructional implications of the evaluation results; at the discretion of the parent or LEA, other individuals who have knowledge or expertise regarding the student, including related service personnel as appropriate; and, whenever appropriate, the student with a disability.[128] The IEP team must include a qualified bilingual specialist or bilingual teacher if needed to assist the other participants in understanding the student's language or cultural factors as they relate to the student's instructional needs.[129] The IEP team must include a person knowledgeable about positive behavior strategies when a student's behavior impedes his or her learning or the learning of others.[130] Also, if transition planning is being discussed, the LEA must invite a representative from any agency likely to provide/pay for transition services [if the parent/guardian gives written consent] and the student with a disability.[131]

The LEA must ensure there is a proper IEP team for developing the student's IEP. A member of the IEP team may be excused from attending all or part of an IEP meeting under certain circumstances. If the team member's area of the curriculum or related services is not being modified or discussed in the IEP meeting, the LEA and parent may agree in writing to excuse the member's attendance.[132] When the IEP meeting involves modifying to or discussing the team member's area of the curriculum or related services, the team member may be excused from attending all or part of the IEP meeting only if the LEA and parent agree in writing to excuse that member's attendance and the member submits, in writing to the parent and the IEP team, input into the development of the IEP prior to the meeting.[133]

The IEP meeting must be arranged at a mutually agreeable time and place in order to afford one or both of the student's parents/guardians the opportunity for participation.[134] It is through the IEP meeting that the written, legally binding commitment of educational resources is developed to offer the student a FAPE.[135]

**IEP COMPONENTS**

A sample format of an IEP document is provided by ISBE and is frequently added to by LEAs. As a result, the written IEP format often varies among different school districts in the State although the contents are comparable. As delineated in the IDEA and Illinois special education rules, the required components of an IEP are:

- a statement of the student's **present levels of academic achievement and functional performance**, including how the student's disability affects his/her involvement and progress in the general education curriculum or, or preschool children, how the disability affects the student's participation in appropriate activities;
- a statement of **measurable annual goals**, as well as benchmarks or short-term objectives, developed in accordance with the student's present levels of academic and functional performance;
- a description of how the student's progress toward meeting the annual goals will be measured and when periodic reports on the student's progress will be provided

to the parents/guardians (such as through the use of quarterly or other periodic reports, concurrent with the issuance of report cards);

- 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 student or on behalf of the student and a **statement of the program modifications** or **supports for school personnel** that will be provided to enable the student to:
    - advance appropriately toward attaining the annual goals,
    - be involved in and make progress in the general education curriculum,
    - participate in extracurricular and other nonacademic activities, and
    - be educated and participate with other children with and without disabilities;
- an explanation of the extent, if any, to which the student will not participate with nondisabled students in the regular class and in extracurricular and other nonacademic activities (**placement**);
- a statement of any individual appropriate **accommodations** that are necessary to measure the student's academic achievement and functional performance on **State or district-wide assessments**; or if the IEP team determines that the student must take an alternate assessment instead of a particular State or district-wide assessment of student achievement, a statement of why the student cannot participate in the regular assessment, and the particular alternate assessment selected is appropriate for the student;
- the **projected date** for the beginning of the special education related services, supplementary aids and services and modifications, and the anticipated **frequency, location, and duration** of those services and modifications;
- beginning not later than the first IEP to be in effect when the child turns age 14½ (or younger, if determined appropriate by the IEP team) and updated annually: appropriate, measurable, **post-secondary goals** based upon age-appropriate assessments related to employment, continued education and independent living; **transition services** needed to assist the student in reaching those goals, including courses of study and any other needed services to be provided by entities other than the LEA; and additional information required by Section 14-8.03 of the Illinois School Code (See School Transitions and Transition Services subsection below);
- a statement as to the languages or modes of communication in which special education and related services will be provided, if other than or in addition to English;
- a statement as to whether the student requires extended school year services and, if so, a description of those services that includes their amount, frequency, duration, and location; and
- for a student who may, after reaching age 18, become eligible to participate in the home-based support services program for adults with intellectual disabilities that is authorized by the Illinois Developmental Disability and Mental Disability Services Act, specific plans related to that program that conform to the requirements of Section 14-8.02 of the Illinois School Code.[136]

As delineated in the IDEA regulations, when developing an IEP, the IEP team must consider:

- the student's strengths;
- the parent/guardian concerns for enhancing the student's education;
- the results of the student's initial or most recent evaluation;
- the academic, developmental, and functional needs of the student;
- in the case of a student whose behavior impedes his/her learning or that of others, 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, the student's language needs as those needs relate to the student's IEP;
- in the case of a student who is blind or visually impaired, instruction in Braille and the use of Braille;
- communication needs of the student, and in the case of a student who is deaf or hard of hearing, 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; and
- whether the student needs assistive technology devices and services.[137]

Also, an IEP for a child who has a disability on the autism spectrum must consider the factors specified in Section 14-8.02(b)(1) through (7) of the Illinois School Code.[138]

The IEP team collaboratively develops the IEP, including all of the components and special factors listed above. Therapy Practitioners, as members of this team, may contribute to many of these components regardless of whether the student requires OT or PT services.

## IEP GOAL DEVELOPMENT

The IEP team members are responsible for collaborating to develop annual goals, including academic and functional goals, designed to: meet the child's needs that result from the child's disability to enable the child to be involved in and make progress in the general education curriculum; and meet each of the child's other educational needs that result from the child's disability.[139] The goals must reflect consideration of the State Goals for Learning and the Illinois Learning Standards,[140] and other standards established by the LEA. To indicate such consideration, each IEP goal should reference the current standard(s) with which it is connected (e.g., Common Core, SEL, Health and Physical Development).

Team members need to be in agreement regarding the priority of identified goals, such that goal implementation will be an integrated approach in which several staff members may be responsible for working on set goals with the student (e.g., providing opportunities for practicing skills in natural settings, supporting therapeutic strategies across the student's school day, collecting data and monitoring progress throughout the school day).

IEP goals should be written to target access to the general education curriculum to the maximum extent possible, address function and performance, be discipline-free, chronologically age-appropriate, meaningful to both the student and the student's family, and aligned to Illinois Learning Standards and Common Core.[141]

IEP goals function to either address a performance deficit or a skill deficit. A performance deficit is a discrepancy in which a student has the skills needed to perform the desired skill, but is not demonstrating the skill within the educational setting either because of choice or because he/she cannot perform for reasons such as anxiety, anger, frustration, environmental factors, or a medical condition.[142] A skill deficit presents as a discrepancy in the ability to complete a task because the student does not know how or have the skill to do the task. The intervention approach may be different for a student with performance deficits than for a student with skill deficits.

Defining outcomes that are aligned to the general education curriculum may be more difficult when a student's present levels of performance vary significantly from that of same-age, same-grade peers. Collaboration of all team members, including the student's parents/guardians and the student as appropriate, is necessary to target relevant, age or grade level appropriate goals that are designed to meet the student's individual needs resulting from the his/her disability. The IEP team must align the student's outcomes with the Illinois Learning Standards for his/her grade level.

Additionally, the IEP team should refer to research-based evidence concerning the student's abilities, medical condition, development, etc. when developing the goals to ensure they are appropriate.

Both academic and functional goals may be developed within the IEP. While academic goals are specifically related to a learning standard, functional goals emphasize skills or a level of performance in activities/tasks that are necessary to engage in vocational/work and daily living activities, but are deficit areas for the student. Functional needs can include the student's need to develop skills in the areas of socialization, independent living, and orientation and mobility.[143] If there is no curricular emphasis on the skill, or the skill is not a prerequisite for a vocational or daily living task or lead to education/training for a future transition plan, the area(s) is not educationally relevant. Ideally, the student should have opportunities to practice the tasks, activities, or strategies that comprise the IEP goal on a daily basis and in more than one environment during the school day.

Best practices in goal development follow the SMART goal format: specific, measurable, attainable, relevant, and time-bound. Short-term objectives or benchmarks are used to provide a logical breakdown of the annual goal and should serve as milestones for measuring progress towards goal attainment.

The SMART [specific, measurable, attainable, relevant, and time-bound] goal format:

- aligns with Common Core/State Standards,

- includes statement of present level of academic achievement or functional performance (PLAAFP) for each goal,
- includes progress monitoring methods, schedule, criteria, and data tool used to monitor the student's progress,
- identifies how the student's parents/guardians will be regularly informed, at least as often as parents/guardians of students not receiving special education services are informed, and
- identifies implementers as part of team goals.

## DETERMINING THE NEED FOR OT AND/OR PT SERVICES

### Establishing Need

After the IEP team has developed a student's IEP annual goals and corresponding objectives/benchmarks, the IEP team determines the services and supports necessary for the student to achieve those goals, including:

- 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 student or on behalf of the student, and the program modifications or supports for school personnel that will be provided to enable the child to:
  - advance appropriately toward attaining the annual goals;
  - be involved in and make progress in the general education curriculum and to participate in extracurricular and other nonacademic activities; and
  - be educated and participate with other children with and without disabilities children in the activities;[144]
- the level of expertise required to implement the special education, related services, supplementary aids and services, or program modifications or supports for school personnel (here the decision is made whether or not to provide OT and/or PT services as part of the IEP); and
- the least restrictive environment in which OT and/or PT services, if any, will be delivered to the student.[145]

The IEP team determines which professionals are needed to implement services and supports to the student based on the developed IEP goals and objectives/benchmarks. In addition, the IEP team makes decisions on program modifications, supplementary aids, and supports for staff that may be necessary to allow the student access to and participation in the general education curriculum and environment. Supplementary aids and services are defined as 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.[146]

In determining the need for OT and/or PT services, the IEP team decides which team members have the expertise needed to assist the student and how much time will be required from that professional to enable the student to attain a particular goal.[147] The decision for a Therapy Practitioner to provide direct service is made by the IEP team after

a discussion about whether the expertise of a practitioner is required to implement and monitor services and/or supports in order for the student to make progress on the IEP goal(s).

Determining whether a student requires OT and/or PT services is solely based on the services and/or supports needed for the student to make progress appropriate in light of the child's circumstances as identified by the IEP team. The OT Practice Framework identifies areas of occupation, relevant client factors, performance patterns, contexts, and environments for which an OT Practitioner is qualified to provide services.[148] The Guide to Physical Therapist Practice 3.0 outlines the scope of physical therapy, including tests and measures used and interventions provided, across a variety of settings.[149] These resources are recommended to assist the IEP team in making decisions about the need for OT and PT services.

## ENTRANCE GUIDELINES

Based on discipline-specific frameworks and defined scopes of practice, it is recommended that all the following concepts and other relevant information be considered to determine if the student's needs require the expertise of a Therapy Practitioner:

- There is a at least one performance/skill deficit area that a Therapy Practitioner has the expertise to support.
- The deficit adversely affects the student's educational performance.
- The potential for student improvement over time through intervention appears likely (change is unrelated to maturity).
- The skilled expertise of a Therapy Practitioner is required to meet the student's identified needs or to assist other staff in providing the student's educational program.

While the final decision regarding the provision of OT and/or PT services is made by the whole IEP team at an IEP meeting, Therapy Practitioners are responsible for presenting intervention options to the team. "In order to provide best practice in educational settings, school-based PTs must use sound clinical reasoning to guide decisions on the dosage of recommended services for their students."[150] Sound clinical judgements are important to determining appropriate OT as well. A Therapy Practitioner should be prepared to discuss whether OT and/or PT services and supports are needed, the least restrictive environment in which such services and supports may be implemented with the student appropriate to meet his/her needs, as well as the advantages and disadvantages of each possible intervention plan. However, final decisions can only be made by the full IEP team.

## DETERMINATION OF MINUTES (FREQUENCY/DURATION/LOCATION)

The IEP must include a projected date for the beginning of the services and modifications, and the anticipated frequency, location, and duration of those services and modifications.[151] It is critical to consider the amount of time necessary to provide all

necessary OT and/or PT services for the student when determining IEP minutes. While there are tools that may assist Therapy Practitioners in recommending service minutes for the IEP, the IEP team must determine the specific number of minutes needed for the Therapy Practitioner to implement identified IEP goals/objectives and provide other supports identified during the IEP meeting. It may be helpful to review therapy logs and other relevant student data to determine how much time was spent with the student and on behalf of the student over the past year.

When determining direct services to be provided with the student, Therapy Practitioners should consider standards of practice regarding the effectiveness of interventions for particular diagnoses, standards and data on how much practice the individual student requires for acquiring the skill(s) to achieve an IEP goal, and how much time the Therapy Practitioner may need to work with the student on component skills and/or the generalization of those skills in natural environments. Intervention may be delivered within or outside the general education setting, to be specified in the student's IEP, and should be delivered flexibly enough to allow for working with and/or assessing the student's progress in a variety of settings or activities.

In addition to direct service minutes, Therapy Practitioners may need additional time to implement services on behalf of the student. This additional time may be reported on the IEP as consultation service minutes. See Section II.F, *Formulation and Implementation of OT and PT Intervention*, for detailed information about interventions with the student and interventions on behalf of the student. Strategies such as a 3:1 model (3 weeks of direct/1 week of support within a month) have been used successfully to address a variety of programming needs across environments.[152] The IEP team must determine all service minutes on an individual basis with the frequency, location, and duration.

## PARTICIPATION IN STATE ASSESSMENT (TESTING)

All students participate in State-mandated assessments, which can be a general education test or an alternative assessment for some students with more significant intellectual/cognitive disabilities as determined by the State. The IEP must include a statement of any individual appropriate accommodations that are necessary to measure the academic achievement and functional performance of the student on State and district-wide assessments.[153] If the IEP team determines that the student must take an alternate assessment instead of a particular regular State or district-wide assessment of student achievement, the IEP must include a statement of why the student cannot participate in the regular assessment and the particular alternate assessment selected is appropriate for the student.[154] Therapy Practitioners can assist the IEP team in determining which form of assessment is appropriate and necessary accommodations and modifications. These may include, for example, the use of adaptive equipment, alternate testing methods, specified positioning, mode of testing, adaptations, extended time, or breaks during testing.

## PLACEMENT

At the end of the IEP development process, the IEP team determines the appropriate placement for the student in accordance with the least restrictive environment (LRE) requirements under IDEA, the Illinois School Code, and their respective implementing rules and regulations. The LRE requirement means that an LEA must ensure that, to the maximum extent appropriate, students with disabilities are educated with children who are nondisabled; and special classes, separate schooling, or other removal of students with disabilities from the regular educational environment occurs only when the nature or severity of the disability of a student is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.[155] This decision is not 'all or nothing' and is made on an individualized basis by the IEP team.

Each LEA must ensure that a continuum of alternative placements is available to meet the needs of students with disabilities for special education and related services.[156] This continuum includes instruction in regular classes, supplementary services in conjunction with regular classes, special classes, special schools, home instruction and instruction in hospitals or institutions. [157]

**Placements Outside the LEA**

When an IEP team determines that no less restrictive setting will meet a student's needs, the IEP team may place the student outside the LEA in a State-operated or nonpublic special education facility that is appropriate to the student's individual situation.[158] Though the IEP team decides that an appropriate placement for the student is outside the LEA, the LEA remains responsible for the development and implementation of the student's IEP.[159]

Before placing a student, the LEA must determine that all educational programming and related services specified in the student's IEP will be provided to the student.[160] The LEA is responsible for ensuring that the student will receive all programming and related services required by the IEP, whether from one source or from multiple sources.[161] This includes any OT or PT services stated in the student's IEP. Also, the LEA is responsible for monitoring the facility to ensure implementation of the student's IEP.[162]

Therapy Practitioners may be part of the IEP team that determines an appropriate placement for a student, provides services at the facility as stated in the student's IEP, or monitors the facility's implementation of the services stated in the student's IEP.

**Home-Hospital (Homebound) Services**

An IEP team may determine that a placement in the LRE appropriate to meet the student's needs is the student's home.[163] In such cases, the IEP team determines the appropriate amount of special education and related services to be provided in the home, which may include OT or PT services and supports.

In addition, the Illinois School Code and Illinois special education rules require an LEA to provide services to a student who is at home or in the hospital for medical reasons. These

home or hospital services are commonly referred to as homebound services. In Illinois, a student (disabled or non-disabled) qualifies for homebound services if it is anticipated that, due to a medical condition, the student will be unable to attend school, and instead must be instructed at home or in the hospital, for a period of 2 or more consecutive weeks or on an ongoing intermittent basis.[164] "Ongoing intermittent basis" is defined as: the student's medical condition is of such a nature or severity that it is anticipated that the child will be absent from school due to the medical condition for periods of at least 2 days at a time, multiple times during the school year, totaling at least 10 or more days of absences.[165] There is no minimum number of days that a student must be absent before qualifying for homebound services.[166]

To establish eligibility for homebound services, the student's parent/guardian must submit to the LEA a written statement from a licensed physician, physician assistant, or advanced practice nurse stating: (a) the existence of a medical condition; (b) the impact on the student's ability to participate in education (the child's physical and mental level of tolerance for receiving educational services); and (c) the anticipated duration or nature of the student's absence from school.[167] The LEA must begin providing the student with homebound services no later than 5 school days after receiving this written statement.[168]

For students with IEPs or (Section 504 plans), the LEA must implement the special education, related services, and/or accommodations stated in the student's IEP as part of the homebound services, unless the student's IEP team determines that modifications to the IEP are necessary during the homebound services due to the student's condition.[169] This requirement includes any OT or PT services and supports stated in a student's IEP.

The Illinois special education rules state that when a student with a disability has a medical condition that will cause an absence for 2 or more consecutive weeks of school or ongoing intermittent absences, the student's IEP team is required to consider the need for homebound services based on a physician's written statement.[170] The amount of instructional or related service time provided to the students through homebound services must be determined in relation to the student's educational, physical, and mental health needs.[171] Therapy Practitioners may be part of the IEP team that reviews the relevant information and decides on what homebound services will be provided for the student based on these considerations. Therapy Practitioners' expertise may assist the IEP team in understanding the student's physical condition and ability to participate in instruction and/or related services.

For students with IEPs, the amount of instructional time must not be less than 5 hours per week unless the physician has certified in writing that the student should not receive as many as 5 hours of instruction in a school week.[172] If the student's illness or a teacher's absence reduces the number of hours in a given week, the LEA must work with the IEP team and the student's parents to provide the number of hours missed, as medically advisable for the student.[173] Also, instructional time must be scheduled only on days when school is regularly in session, unless otherwise agreed to by both the LEA and the student's parents. A student with disabilities whose homebound services are being provided by telephone or other technology must receive not less than 2 hours per week

of direct instructional services.[174] The instructors must be qualified to provide the homebound services as set forth in the State rules.[175]

## EXTENDED SCHOOL YEAR (ESY)

Extended school year (ESY) services must be provided only if the IEP team determines, on an individual basis, that the services are necessary for the provision of FAPE to the student.[176] Therapy Practitioners can help decide whether the student requires ESY and what types of services are needed during ESY. These services might be to the student (direct) and/or on behalf of the student (consultation/collaboration). It is important for Therapy Practitioners to consider staff training needs, equipment needs, management, and logistics, as well as carry-over of therapeutic strategies established during the school year.[177]

## SCHOOL TRANSITIONS AND TRANSITION SERVICES

Students experience many transitions during their school years as they move from classroom to classroom and one level of schooling to another. The first transition that some students undergo is moving from Early Intervention (EI) services (i.e., those covered under Part C of IDEA) to school-based services (i.e., those covered under Part B of IDEA). Each LEA must have procedures that include ongoing coordination with EI programs to identify children from birth through two years of age who have or are suspected of having disabilities, in order to ensure provision of services in accordance with applicable timelines.[178] For each student who has been found eligible under Part B and will be making the transition from an EI program into the special education program of a LEA at age three, the LEA must ensure that either an IEP or an IFSP (if the IFSP meets requirements under Part B) is in effect on the child's third birthday.[179] If a child's third birthday occurs during the summer, the IEP team determines when the LEA's services will begin for that child.[180] The LEA must have a representative participate in transition planning conferences arranged by the EI program in order to develop a transition plan enabling the LEA to implement an IFSP or IEP no later than the child's third birthday.[181]

Parents/guardians of children with an IFSP and receiving EI services must be provided with a school referral packet by their service coordinator by the time the child is 2 years 6 months old.[182] Between the time the child is 2 years 6 months old and 2 years 9 months old, the service coordinator should organize a transition planning conference with members from the LEA.[183] Often, school-based Therapy Practitioners are invited to attend a transition planning conference. As part of the transition planning conference, the team must develop a plan to ensure that the child goes through the eligibility process for special education and related services and that, if warranted, an IEP (or IFSP that meets requirements under Part B) is developed for the child by his or her third birthday.[184]

After this first transition, students continue to make transitions as they advance in grade levels and/or if they transfer schools. During these transition times, it is recommended that Therapy Practitioners prepare updated present levels of performance and progress on the student's IEP goals. In addition, Therapy Practitioners may contribute to a plan

that outlines the strategies and supports a student will receive to transition into the new educational environment. Such plans may or may not be part of the student's IEP and may include accommodations, modifications, and equipment recommendations. They might also include pertinent information about the student that Therapy Practitioners want to share with the new teacher or therapy provider. Therapy Practitioners and educational teams often develop such transition plans at the end of the school year for the following school year or earlier if a transition is planned during the school year.

Another significant time of transition occurs when the student matriculates from middle school to high school. Around this time, the IEP team begins required planning to facilitate the student's transition from school to post-school opportunities (e.g., post-secondary community college or university, work, and/or living arrangements). "Transition services" means a coordinated set of activities for a student with a disability that: (1) is designed to be within a results-oriented process that is focused on improving the academic and functional achievement of the student to facilitate the student'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; (2) is based on the individual student's needs, taking into account the student's strengths, preferences, and interests; and (3) includes instruction, related services, community experiences, the development of employment and other post-school adult living objectives, and, if appropriate, acquisition of daily living skills, benefits planning, work incentives education, and the provision of a functional vocational evaluation.[185]

In Illinois, beginning not later than the first IEP to be in effect when the student turns age 14½, and updated annually thereafter, the student's IEP must include: appropriate, measurable, postsecondary goals based upon age-appropriate assessments related to employment, education or training, and independent living; and the transition services that are needed to assist the student in reaching those goals, including courses of study and any other needed services to be provided by entities other than the LEA.[186] Transition services for a student with a disability may be special education, if provided as specially designed instruction, or a related service if required to assist the student to benefit from special education.[187] Transition planning must be conducted as part of the IEP process and must be governed by the procedures applicable to the development, review, and revision of the IEP.[188] To appropriately assess and develop transition goals and transition services, additional participants may be necessary and may be invited by the LEA, parent, or student to participate in the transition planning process.[189] Additional participants may include, without limitation, a representative from the Illinois Department of Human Services or another State agency, a case coordinator, or persons representing other public or community agencies or services, such as adult service providers or public community colleges.[190]

The IEP must identify each person responsible for coordinating and delivering the transition services.[191] If the IEP team determines that the student requires transition services from a public or private entity outside of the LEA, the IEP team must identify potential outside resources, assign one or more IEP team members to contact the appropriate outside entities, make the necessary referrals, provide any information and

documents necessary to complete the referral, follow up with the entity to ensure that the student has been successfully linked to the entity, and monitor the student's progress to determine if the student's IEP transition goals and benchmarks are being met.[192] The IEP must indicate one or more specific time periods during the school year when the IEP team will review the services provided by the outside entity and the student's progress in such activities.[193]

Therapy Practitioners have expertise that provides valuable contributions to transition planning and services. Using a results-oriented process, IEP teams should collaborate on improving the academic, vocational, and functional achievements of students with disabilities.[194] During this period of transition services, communication and specificity of planning between the student (and his/her parent/guardian, if applicable) and school/community intervention providers are key. Therapy Practitioners should collaborate with the IEP team to problem-solve any difficulties with the student's performance in the new environment(s), assess and employ strategies for intervention in these environments, and consult with staff, parents/guardians, and the student regarding concerns, suggestions, and expectations for the student in post-secondary and community environments.[195]

Another type of transition occurs when a student approaches age 18. When a student with a disability reaches 18 years old, all rights accorded to the student's parents transfer to the student, except in limited circumstances stated in the Illinois School Code.[196] During the school year in which the student turns 17 years old, the LEA must notify the student and the student's parents of the transfer of rights in writing at an IEP meeting and provide the student with a copy of a Delegation of Rights form.[197] The LEA must mail the notice and a copy of the Delegation of Rights form to the student and to the student's parents if they do not attend the IEP meeting.[198]

A FAPE must be available to all eligible students with disabilities between the ages of 3 and 21, inclusive (i.e., through the day before the student's 22nd birthday).[199] The provision of FAPE is not required for a student with a disability who has graduated with a regular high school diploma.[200] A student with a disability who has fulfilled the minimum State graduation requirements is eligible for a regular high school diploma.[201] However, if the student's IEP prescribes special education, transition planning, transition services, or related services beyond that point, issuance of a regular high school diploma must be deferred so that the student will continue to be eligible for those services.[202] In that case, the student continues to receive special education services until the IEP team determines otherwise or the student turns age 22.

## DISCHARGE/TERMINATION OF SCHOOL-BASED THERAPY SERVICES

Therapy Practitioners may feel that school-based OT and/or PT services are no longer warranted for a particular student for several reasons. Data from a reevaluation and/or progress reports on IEP goals may show:

- the student no longer exhibits a deficit in skills;

- the student's functioning and/or skills has advanced such that OT and/or PT services are no longer required for the student to benefit from special education;
- the student is able to compensate for his or her disability or is successful with using accommodations and modifications that can be carried out by school personnel without the skilled input of Therapy Practitioners; and/or
- the student is not making progress toward stated goals and objectives based on intervention data (after a range of interventions have been implemented), AND the student's level of function and/or developmental level are not likely to change as the result of therapeutic intervention based on evidence in therapy literature.[203]

Once a Therapy Practitioner is of the opinion that a student no longer requires OT and/or PT services, the therapist makes a recommendation to the IEP team for discharge/termination of services. An LEA may have procedures for discharge/termination of a related service, such as requesting consent for a reevaluation prior to termination, requiring data to support mastery of IEP goals, etc. In many cases, the Therapy Practitioner generates a discharge summary report to be included in the student's IEP. It is recommended that the discharge summary includes, at a minimum:

- a summary of the student's progress and current level of performance, including supporting data;
- the reason for recommending discharge from therapy services; and
- recommendations for accommodations, modifications, classroom routines, or equipment that should continue to be maintained as part of the student's educational program and included in the IEP regardless of the provision of therapy services.

It is also prudent for the Therapy Practitioner to explain to the student's parents/guardians and other members of the IEP team that if the student demonstrates a regression in skills or if a new academic problem arises, a request for a new therapy evaluation may be initiated to consider re-initiating OT and/or PT services.

## F. FORMULATION AND IMPLEMENTATION OF OT AND PT INTERVENTION

This subsection gives further details about the nature and types of services provided by Therapy Practitioners. OT and PT intervention in the school environment has two key elements: (a) intervention that is delivered with the student, commonly known as "direct intervention" and (b) intervention that is delivered on behalf of the student, commonly known as "consultation" or "collaboration" with the educational team and other indirect activities performed as part of Therapy Practitioners' workload.[204] Therapy Practitioners need to consider each element to determine the least intrusive support that will enhance a student's ability to access his or her educational program. Although direct intervention to the student is often the first (or only) strategy considered, intervention on behalf of the student may be sufficient on its own to meet a student's identified needs. Also, when providing direct intervention, intervention on behalf of the student may also be critical to

optimize the student's participation in her/his educational program. Understanding how both of these elements support student performance is essential.

## "INTERVENTIONS WITH THE STUDENT" OR DIRECT INTERVENTION

When the Therapy Practitioner provides intervention delivered with the student (i.e. direct intervention), he or she works with a student in or out of the classroom on a frequent, consistent basis. Direct intervention is used when the distinct and ongoing expertise of the Therapy Practitioner is required to implement strategies to help the student develop skills and/or enable the student to participate in the educational program. The Therapy Practitioner's distinct expertise may be needed until a student has adequate skills and/or until the implementation of therapeutic techniques and strategies (modifications/accommodations) used within the educational program can be safely or consistently incorporated within the daily routine by non-Therapy Practitioner personnel. One way the need for the Therapy Practitioner's expertise is identified in a student's IEP is through listing the Therapy Practitioner as an "implementer" on an IEP goal. A Therapy Practitioner may be identified as the main implementer for a specific goal/objective when providing direct intervention with a student or as a support service along with another implementer (e.g., teachers or other related service providers) when the Therapy Practitioner's expertise will be used to support staff or carryover of strategies.

Direct intervention may be provided within naturally occurring educational activities or outside such environments in individual or group therapy sessions. When intervention is provided outside of the naturally occurring educational activities, this decision must be grounded in solid clinical reasoning, evidence-based practice and supported by data on the student's individualized skill deficits and needs. In these cases, best practice is to also incorporate opportunities for generalization of the identified skills within the routines and activities of the school day. For direct intervention to be successful, collaborative intervention with the educational team is critical for carryover of intervention strategies, practice in context and generalization of skills. Intervention with the student should occur as much as possible within naturally occurring environments (e.g., classroom, gym, playground) and during activities that occur throughout school routines. Intervention provided with a student in isolated settings should be followed up with opportunities to generalize those skills in his/her school routines. The Therapy Practitioner using an "intervention with the student" model may:

- work with a student individually or with students in a small group on tasks in naturally occurring environments and activities that occur throughout the daily routine to increase or generalize skills; or
- work with a student individually or students in small groups on isolated skill development outside of the normal routines and activities due to safety, the need for instruction free from distraction, and/or the need for specialized equipment not found in the classroom setting.

Whether it is delivered in natural settings or in isolation, direct therapy is provided face-to-face with the student by the Therapy Practitioner and is considered "intervention with

the student." Direct services with the student are delineated on the educational services and placement page of the IEP. The IEP must specify the frequency, duration, and location (in special education or general education) of the services. If the needs of the student change or if the Therapy Practitioner needs to deliver services in a different setting than is identified on the IEP, the IEP must be amended prior to such change through an IEP meeting or written IEP amendment, as determined by the LEA.

The need for OT and/or PT intervention with the student and the frequency, duration and location of that intervention is determined by the IEP team, derived from the assessment by and recommendations of the occupational therapist or physical therapist as well as data and input from other IEP team members. One consideration is identifying critical learning periods where temporary increase in intervention with the student by the Therapy Practitioner is needed to address skill development and/or remediation. Sometimes, only a short interval of direct therapy is needed during a skill-building or skill-remediation period.

Data collection and progress monitoring should be a part of all intervention. Data collection can occur in multiple ways. Therapy Practitioners can collect information on underlying components based on the plan of care/intervention plan and/or measure progress toward specific IEP goals during therapy intervention. Progress toward IEP goals and objectives should also be taken within the natural contexts or during naturally occurring activities. This data may include observation of the student and/or information from the student, parents/guardians and instructional staff. Data collection for underlying skill components can assist the Therapy Practitioner in determining whether direct intervention should continue, whether intervention needs to be adjusted, and/or whether the student or staff have become more proficient and no longer require the unique and ongoing expertise of the Therapy Practitioner to directly implement strategies. Findings from the data, along with a summary of the student's performance and needs, are identified in the present levels of academic achievement and functional performance within the IEP. This summary may also include the Therapy Practitioner's recommendation related to the student's need for further assistance by the Therapy Practitioner and the therapeutic activities/strategies that can be carried out by other staff members.

## "INTERVENTIONS ON BEHALF OF THE STUDENT" OR CONSULTATIVE/ COLLABORATIVE INTERVENTION AND OTHER INDIRECT ACTIVITIES

When the Therapy Practitioner provides intervention on behalf of the student, he or she provides consultative/collaborative intervention and performs other indirect activities necessary to meet the student's needs in the educational setting. For consultative/collaborative intervention, the Therapy Practitioner identifies therapeutic materials and/or strategies to address the student's needs. The Therapy Practitioner then collaborates with the teacher, other staff, parents/guardians, and, when appropriate, the student, regarding use of those materials and/or strategies. While direct intervention with the student may be needed initially to develop and monitor an appropriate consultative program, consultation or collaboration is primarily problem solving with the educational team to determine appropriate expectations, environmental modifications, assistive

technology, and possible instructional or therapeutic strategies that can be used with the student in naturally occurring environments and activities. As part of consultative/collaborative intervention, the Therapy Practitioner may work directly with the student to determine appropriate strategies/techniques to be used by the student and/or educational team, or to model strategies for the student and/or team members within the naturally occurring setting.

The collaborative/consultative intervention may be documented within the student's IEP. The consultative/collaborative minutes are included in the student's IEP if those services are directly on behalf of the individual student and required to implement the IEP for the student to receive a FAPE, as determined by the IEP team. Places where this may be listed in the IEP include the educational services and placement page which may have "consult services" as an option, or in the support for school personnel section of the IEP as a summary statement. A Therapy Practitioner may provide consultative/collaborative intervention and perform other indirect activities, which are not student-specific or not required for implementation of a student's IEP; those interventions and activities should not be included as service minutes in a student's IEP. Whether or not collaboration/consultative interventions provided by the Therapy Practitioner is included in a student's IEP may require administrative judgment by the LEA.

Intervention on behalf of the student may also include other indirect activities that are best practices to implement a student's IEP. The Therapy Practitioner may develop a treatment or consultative plan to implement IEP goals or supplementary aids and services, collect data for revising a treatment/consultative plan or updating IEP goal progress reports, and perform other planning and monitoring activities based on the content of the student's IEP. These activities are not delineated in a student's IEP but are part of the Therapy Practitioner's workload.

Interventions on behalf of the student may include key activities that can be divided under four main categories:

1) Therapeutic Intervention/Strategies/Techniques for IEP Development and Implementation:

    a. Preparation for/At the IEP Meeting:
        - develop draft instructional programs (e.g., emergency evacuation plan, positioning and transfer protocols, sensory diet, analyzing tasks to teach) to be carried out by school personnel for consideration by the IEP team; and
        - prepare data on student functioning/performance, progress reports, and proposed goals/objectives for consideration by the IEP team.

    b. After the IEP Meeting:
        - identify and develop appropriate, evidence-based therapeutic strategies and techniques for implementing goals in the IEP;

- prepare an intervention plan or plan of care for implementing the student's IEP goals and/or supplementary aids and services safely and effectively and to use as a tool for data collection; and
- document time spent on interventions with, and on behalf of, students (intervention completed, student response, and plan for follow-up intervention).

2) Collaboration with school personnel:

- problem-solve barriers/challenges to the student accessing the educational environment;
- act as a resource to share information regarding physical, sensory, skill development, and medical issues;
- discuss issues and concerns related to student participation or performance and identify proposed strategies to address them for consideration by the IEP team;
- collaborate on adapting functional and meaningful activities typically occurring in the student's routine;
- create opportunities for the student to practice and/or generalize new skills;
- act as a liaison between outside agency and school personnel;
- promote optimal independence, autonomy and/or self-determination appropriate for an individual student;
- support the staff's holistic approach of all factors impacting the student in the school environment (e.g., lunchroom, playground, classrooms, art, music, physical education); and
- work with staff members to develop draft IEP goals and objectives/benchmarks that integrate therapeutic interventions within the general education curriculum for consideration by the IEP team.

3) Training/coaching:

- identify equipment needs, and provide instruction to staff in the use and care of the equipment;
- provide instruction to educators, school support personnel, etc. in the use of therapeutic strategies that support student independence and participation; and
- provide monitoring and feedback regarding staff implementation of techniques/support across environments.

4) Data collection/progress monitoring:

- work with the educational team to develop and implement data collection tools to monitor progress toward IEP goals;
- collect pertinent performance data;
- review data collected to prepare proposals for intervention decisions for consideration by the IEP team; and
- develop progress reports.

It is critical that Therapy Practitioners have sufficient time to complete interventions on behalf of students. There should be time allocated for intervention planning, collaboration,

training, and progress monitoring to ensure that strategies implemented are evidence-based, coordinated among staff, and effectively embedded across the student's school day.

## INTERVENTION STRATEGIES/TECHNIQUES FOR IEP DEVELOPMENT AND IMPLEMENTATION

To assist the IEP team in developing a student's IEP, the Therapy Practitioner is responsible for preparing data on the student's functioning/performance and proposing programs, IEP goals and objectives, and supplementary aids and services to address the student's needs. The Therapy Practitioner presents this information during IEP meetings to facilitate the IEP team's decision-making about the content of the IEP for that student to receive a FAPE.

After the IEP team has finalized a student's IEP, the Therapy Practitioner performs many tasks that are best practices to implement the IEP. While the specific IEP goals and objectives/benchmarks may or may not change within an IEP year, the techniques or strategies used to implement the IEP goals and objectives/benchmarks may vary based on student progress, the educational environment, and the expectation for the student's participation. The judgment of the Therapist Practitioner as to how best utilize his/her expertise during the school year may offer the opportunity for a variety of interactions between the Therapy Practitioner and student, Therapy Practitioner and staff, and the Therapy Practitioner and parent/guardian.

The Therapy Practitioner may create an intervention plan or plan of care to (a) implement the student's IEP goals and objectives/benchmarks, and/or (b) support school personnel in implementing the student's IEP. A plan of care or intervention plan is a way to document the strategies and techniques being used to implement the student's IEP. The plan maps out the Therapy Practitioner's rationale for decision making by documenting her/his clinical reasoning, planning, and adaptations needed to implement the IEP throughout the IEP cycle.

"The *Standards of Practice for Occupational Therapy*[205] state that the 'occupational therapist ensures that the intervention plan is documented' and 'modifies the intervention plan throughout the intervention process'. The *intervention plan* is separate from the IEP and provides information about OT service delivery."[206] The American Physical Therapy Association recommends that an intervention plan includes student information, therapy intervention goals (in measurable terms), intervention approaches, types of interventions used, mechanisms for service delivery (duration and frequency), anticipated outcomes, and professionals overseeing the plan.[207] The information included in the intervention plan must be in accordance to the goals, services and supports stated in the student's IEP.

Best practice is for Therapy Practitioners to develop and implement an intervention plan or plan of care for IEP implementation. The Therapy Practitioner uses an intervention plan to outline the need to work flexibly with a student, meet with the educational team, make adaptations to facilitate student function, implement strategies in the classroom at

different times and during a variety of content areas, and measure progress in the educational environment pursuant to the student's IEP. Regardless of the methodology/intervention method chosen, the intervention plan must be in accordance with the content of the student's IEP.

## COLLABORATION WITH TEAMS

Collaborative teaming is the dynamic process through which quality therapeutic interventions are designed, implemented, modified, and monitored/evaluated. Components of collaboration include mutual respect, cooperation, communication, sharing of expertise, coordination of intervention, and interagency cooperation. The Therapy Practitioner's ability to develop and sustain productive working relationships with the student, parent/guardian, teachers, other professionals, and school personnel is critical to student success.[208]

Therapy Practitioners who work in the educational environment participate in a variety of teams. Teams may take many forms (e.g., IEP team, classroom team, building team) and have varying membership depending on the team's purpose and building/LEA structure. The role of the Therapy Practitioner on any team is to collaborate. Collaboration occurs between and among team members, which may include the student and the student's parent/guardian. Collaborative teams prioritize a student's educational needs, and then develop a plan for meeting these needs. Therapy Practitioners collaboratively anticipate future educational outcomes, are a resource for the team regarding the educational significance of a student's disability, and assist with interagency coordination.

## COACHING AND TRAINING

Supporting student participation and growth in the educational setting requires school staff to be appropriately trained to carry-over therapeutic intervention strategies, provide appropriate level of assistance and effectively support and/or monitor student practice. Therapy Practitioners need to provide documentation showing that the training has occurred and that trained staff are competent with the implementation of the strategies or techniques. Common areas of training include:

- disability awareness (establishing appropriate expectations);
- transfers and transitional movements;
- posture and positioning;
- equipment use and care;
- instructional strategies and appropriate/individualized level of assistance to support student growth and skill development (e.g., daily living skills, self-regulation, organizational skills, motor skill performance); and
- monitoring student outcomes (e.g., how to collect progress monitoring data).

## DATA COLLECTION/PROGRESS MONITORING

### Measuring Student Progress

Using criteria established by the IEP team, Therapy Practitioners objectively measure student progress toward relevant IEP goals that their interventions support. The criteria for mastery can be time, distance, repetitions, percentages, accuracy, completion of trials and/or quantified assistance levels (such as the Functional Independence Measure - FIM or School Function Assessment - SFA), as stated in the student's IEP. The measurement strategy (assessment procedure) is also stated in the IEP and may include work samples, observation, checklists, charting, daily logs, and/or formal tests. Therapy Practitioners may choose additional methods to collect data for determining the effectiveness of the intervention when existing data indicates the student is not making adequate progress. Progress monitoring data can be taken by Therapy Practitioners and/or other educational team members, depending on the type and frequency of data needed to demonstrate mastery. There is a wide variety of progress monitoring methods to measure change in student performance. To measure behavioral performance, a method to convert qualitative performance into quantitative data is necessary. Goal Attainment Scaling can be an effective tool in these cases.[209]

Data collected may include examples of work, checklists, rubrics, observation of behavior/ performance toward a specific task, or photos or videos (prior written consent from the parent is strongly recommended, as directed by the LEA). Therapy Practitioners should regularly review the data collected, with the IEP team if necessary, to determine if the student is making sufficient progress to meet IEP goals and, based on data, make intervention adjustments for continued progress or to advance expectations. Therapy Practitioners who determine that a student is not making adequate progress on IEP goal objectives/benchmarks should communicate with other educational team members to decide if an IEP meeting is warranted to discuss if modifications to services, supports or strategies are warranted.

Defined behavior, baseline performance data, and ongoing data collection promote effective intervention and decision making for educational programming. The format for collecting progress data and where the data is maintained are within the discretion of the LEA, in accordance with federal and State student records and confidentiality laws.

The IEP must include a description of when periodic reports on the progress the child is making toward meeting the annual IEP goals (such as through the use of quarterly or other periodic reports, concurrent with the issuance of report cards) will be provided to parents/guardians.[210] Involving the student and his/her parent/guardian in review of the data can further engage some IEP teams as a whole. Therapy Practitioners and the educational team use data when considering goal revision. The educational team also uses objective data regarding student progress to determine personnel and adaptations needed for a student's success in her/his educational environments. Revisions in program strategies or goals/objectives should be made based on collected data. If data indicates that the student may not achieve an IEP goal, an IEP meeting should be convened to consider modifying services and/or revising goals and objectives/benchmarks.

**Review of Progress**

The IDEA requires the IEP team to review the student's IEP periodically, and at least annually, to determine whether the annual goals are being achieved and, as appropriate, to revise the IEP to address any lack of expected progress toward the annual goals and in the general education curriculum (if appropriate), the results of any reevaluation, information about the student provided to or by the parents, the student's anticipated needs, or other matters.[211]

A progress report is a written document summarizing student progress and student response to any interventions implemented over the course of the IEP. Annual reports of progress on IEP goals are included by members of the educational team who are responsible for implementing the goals as part of the student's annual IEP review. Therapy Practitioners may integrate their report of progress into the IEP, write a joint report with other team members, or write a separate report. The content may include a summary of the interventions used to meet the IEP goal(s) and objectives/benchmarks, the student's progress toward meeting the goal(s), whether the student achieved the goal(s), the student's present level of performance, and the student continued educational needs (if any) relative to OT and PT.

**Service Contact/Therapy Logs**

The service contact or therapy log is used to document various intervention activities (e.g., working directly with the student, contacting the student's physician, adapting equipment or the environment, or meeting with the IEP team). This is one way to verify the appropriate use and commitment of resources specified in a student's IEP. Documentation of training/instruction to paraprofessionals, other educational staff, and parents/guardians is also achieved through the therapy log. The frequency, format, and location for maintaining this documentation is decided by the LEA. It is recommended that the content includes:

- date of activity
- if direct contact, duration;
- type of contact; and
- brief description of the activity/goal area addressed.

Therapy logs may also include:

- attendance and participation;
- a checklist or brief statement of the activities, techniques, and modalities used by the Therapy Practitioner, including specifics such as type of cuing, manual input, level of assistance, etc.;
- equipment issued or fabricated and specific instructions for the use of the item;
- training, education, consultation provided or received;
- student's response to therapy, related back to the IEP; and
- plan for next steps, collaboration needs, follow up, recommendations for modifications or altered focus.

## G. REFERRALS (PRESCRIPTIONS), DOCUMENTATION (SERVICE LOGS) AND MEDICAID COST RECOVERY

The need for a referral (i.e., prescription) from a health care professional for an OT and/or PT evaluation and intervention is specified under the Illinois Occupational Therapy Practice Act (OT Act) and the Illinois Physical Therapy Act (PT Act), which are revised periodically. As of the writing of this document, a referral is not required for OT evaluation or services delivered in a school-based or educational environment.[212] A referral is not required for PT evaluation or services under certain circumstances specified in the PT Act. See Section II.B., *Systems Level Intervention*, for more information about referral requirements under the OT Act and PT Act.

While a physician's referral may not be required for school-based OT evaluation or services or certain PT evaluation or services, it is best practice for Therapy Practitioners to obtain a physician's referral when there is a change in type of intervention or following a student's medical or surgical procedure. Therapy Practitioners should consider a variety of factors in deciding when to communicate with a student's health care professional and/or obtain a new referral, such as the student's health and physical abilities, precautions and safety concerns, and new or recurring medical issues.

In addition, Therapy Practitioners may be required to obtain referrals according to LEA procedures for purposes of Medicaid cost recovery. LEAs are permitted to bill Medicaid to recover costs for eligible services, which include OT, PT, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.[213] The Illinois Department of Human Services (IDHS) is a State Medicaid agency and oversees the Fee-For-Service program responsible for the reimbursement of costs incurred by LEAs to provide eligible services. Therapy Practitioners often are required to document the services provided, dates of service, and duration of each session. The LEA is responsible for the actual billing mechanism.

There are varied issues and concerns regarding recovering the cost of therapy services provided in the school setting through public funding sources for medical services. Therapy Practitioners should be aware that Medicaid billing is continuously evolving in schools, and it is important that Therapy Practitioners continue to be educated regarding requirements and third-party funding in relation to each LEA's procedures.[214] In particular, currently an annual referral is required for Medicaid reimbursement of OT and PT services.

Illinois Department of Healthcare and Family Services (IDHFS) publishes handbooks, which are updated regularly and contain information about requirements and procedures related to Medicaid cost recovery.[215] For detailed information about requirements related to Medicaid reimbursement, refer to the IDHFS Handbook for Local Education Agencies, Chapter U-200 Policy and Procedures, Fee-for-Service Medical Services (February 2014) (as updated with replacement pages 17-20, effective 12/19/14) and the IDHFS Handbook

for Providers of Healthy Kids Services, Chapter HK-200 Policy and Procedures for Health Care for Children (March 2017).[216] As of the writing of these guidelines, the 2014 Handbook for LEAs states that for Medicaid reimbursement for PT services, "[p]hysical therapy services are required to be prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under the law. The prescription must be updated annually and be maintained in the student's health record."[217] Similarly, the 2014 Handbook for LEAs states that for Medicaid reimbursement for OT services, "[a]n order from a physician or other licensed practitioner of the healing arts within the scope of his or her practice under law is required for occupational therapy services. The order must be updated annually and be maintained in the student's health record."[218]

In addition to prescriptions, the 2014 Handbook for LEAs states that LEAs must document all services for which Medicaid reimbursement is claimed, and such documentation must be maintained for each student by each service practitioner.[219] The 2014 Handbook for LEAs explicitly states that an IEP/IFSP is not sufficient documentation of actual services provided for claiming reimbursement.[220] LEAs may use any format(s), such as case notes or service logs, that includes the following information: student's name; student's date of birth; school; service date; service description; duration of face-to-face service (time spent); type of service (OT, PT); medical diagnosis or prescription as required by service type; service practitioner's name, title, and written or electronic signature; and signature of the service practitioner's supervisor if required.[221] The 2014 Handbook for LEAs includes a sample activity log in an appendix.[222] Also, LEAs must maintain documentation of the student's response and progress resulting from the claim service no less than quarterly.[223]

Because an initial and annual renewal of a referral is required for Medicaid reimbursement, LEAs may establish procedures for obtaining initial and annual renewals. LEAs may decide to require annual referrals for <u>all</u> students receiving OT or PT services to avoid potential issues with a discriminatory effect on only Medicaid eligible students. Without an annual renewal of the prescription, OT and PT services may be provided but the LEA may not be reimbursed by Medicaid. To ensure compliance with Medicaid and LEA procedures, annual renewal of the referral is the responsibility of the Therapy Practitioner, which may be delegated to or assisted by clerical personnel.

## H. OT AND PT AS PART OF THE SECTION 504 PROCESS

School-based Therapy Practitioners may work with students with disabilities who are not eligible under the IDEA because they do not require special education services but are eligible for related aids and services under Section 504 of the Rehabilitation Act of 1973 ("Section 504"). Section 504 is a federal civil rights law that prohibits discrimination on the basis of disability in programs and activities that receive federal financial assistance from the U.S. Department of Education. Section 504 establishes a student's right to equal access and participation to education and all school-related activities and requires LEAs to provide appropriate services to meet the individual needs of qualified students.[224] The

U.S. Department of Education's Office for Civil Rights (OCR) enforces Section 504 and its regulations. OCR also enforces Title II of the ADA (Title II), which extends the prohibition against discrimination to the full range of state and local government services, programs, and activities (including public schools) regardless of whether they receive any federal financial assistance.[225] The Americans with Disabilities Act Amendments Act of 2008 (ADAAA) amended the ADA and included a conforming amendment to the Rehabilitation Act of 1973 that affects the meaning of "disability" in Section 504.[226] No additional federal funding is provided to LEAs under Section 504 to provide supports and services for eligible students.[227] A LEA is out of compliance when it violates any provision of Section 504 or its regulations, and a lack of compliance may result in the loss of federal funding from the U.S. Department of Education and/or legal proceedings.

As explained in Section II.C., *Overview of FAPE*, for students with disabilities found eligible under Section 504, LEAs are required to provide any special education and/or related aids and services necessary to ensure the student is receiving a FAPE.[228] Also, the Section 504 implementing regulations include general non-discrimination provisions based on disability that apply to programs and activities receiving federal financial assistance (including but not limited to public schools) as well as specific requirements for preschool, elementary and secondary education programs or activities that receive federal financial assistance.[229] To be protected under Section 504 from disability-based discrimination in the school setting, a student must be determined to: (1) have a physical or mental impairment that substantially limits one or more major life activities; or (2) having a record of such an impairment; or (3) being regarded as having such an impairment.[230] Section 504 requires that LEAs provide a FAPE to students who have a physical or mental impairment that substantially limits one or more major life activities.[231] In public elementary and secondary schools, unless a student actually has an impairment that substantially limits a major life activity, the mere fact that a student has a "record of" or is "regarded as" disabled is insufficient, in itself, to trigger those Section 504 protections that require the provision of a free appropriate public education (FAPE).[259]

Section 504 requires LEAs that receive federal financial assistance to conduct "child find" activities, which are similar to the child find obligations under the IDEA. A LEA must annually undertake to identify and locate every qualified student with a disability residing in the LEA's jurisdiction who is not receiving a public education, and take appropriate steps to notify students with disabilities and their parents/guardians of the LEA's duties under Section 504.[232] A LEA must conduct an evaluation of any student who, because of disability, needs or is believed to need special education or related services before taking any action with respect to the initial placement of the student in regular or special education, and any subsequent significant change in placement.[233]

LEAs may use the same process to evaluate the needs of students under Section 504 as they use to evaluate the needs of students under the IDEA. If LEAs choose to adopt a separate process for evaluating students under Section 504, they must follow the requirements for evaluation specified in the Section 504 regulations.[234] OCR has interpreted Section 504 to require LEAs to obtain parental permission for initial evaluations.[235] The Section 504 regulations provide that LEAs must establish evaluation

standards and procedures which ensure that: tests and other evaluation materials have been validated for the specific purpose for which they are used and are administered by trained personnel in conformance with the instructions provided by their producer; tests and other evaluation materials include those tailored to assess specific areas of educational need and not merely those which are designed to provide a single general intelligence quotient; and tests are selected and administered so as best to ensure that, when a test is administered to a student with impaired sensory, manual, or speaking skills, the test results accurately reflect the student's aptitude or achievement level or whatever other factor the test purports to measure, rather than reflecting the student's impaired skills (except where those skills are the factors that the test purports to measure).[236] LEAs are also required to establish procedures for periodic reevaluation of students who have been provided special education and related services; a reevaluation procedure consistent with the IDEA is one means of meeting this requirement.[237]

In addition, the Section 504 regulations provide that in interpreting evaluation data and in making placement decisions, a LEA must: draw upon information from a variety of sources, including aptitude and achievement tests, teacher recommendations, physical condition, social or cultural background, and adaptive behavior; establish procedures to ensure that information obtained from all such sources is documented and carefully considered; ensure that the placement decision is made by a group of persons, including persons knowledgeable about the student, the meaning of the evaluation data, and the placement options; and ensure that the placement decision is made in conformity with the LRE requirement provided of the Section 504 regulations.[238]

LEAs should consider information from multiple sources and tools that relate to the student's learning process and function in the school environment.[239] A group of individuals familiar with the student and Section 504 procedures should consider information including past grades, teacher reports, parent/guardian input, health records, adaptive behavior information, and observations. A single source of information cannot be the only information considered to determine a student's eligibility under Section 504.[240]

The determination of whether a student has a physical or mental impairment that substantially limits one or more major life activities and is in need of regular or special education or related aids or services must be made on a case-by-case basis.[241] The Section 504 regulations provide definitions of a physical or mental impairment and major life activities.[242] Also, the ADAAA broadened the interpretation of these definitions.[243] In general, major life activities include, but are not limited to, functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, eating, sleeping, breathing, standing, lifting, bending, speaking, learning, reading, concentrating, thinking, communicating, and working.[244] A major life activity also includes the operation of major bodily functions such as the functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.[245]

Substantial limitation is not defined under Section 504. However, in enacting the ADAAA, Congress rejected a number of U.S. Supreme Court decisions which narrowly construed the term "substantial limitation" and the definition of disability. [246] The ADAAA provides that an impairment need not severely or significantly restrict a major life activity to be considered substantially limiting. [247] Also, "substantially limits" must be interpreted without regard to the ameliorative effects of mitigating measures (e.g., medications, prosthetic devices, assistive devices, or learned behavioral or adaptive neurological modifications). [248] Examples of impairments that may substantially limit major life activities, even with the help of medication, aids, or devices, include, but not limited to: attention deficit hyperactivity disorder (ADHD), asthma, allergies, blindness or visual impairment, deafness or hearing impairment, diabetes, epilepsy, heart disease, and mental illness.[249] Although LEAs may no longer consider the ameliorative effects of mitigating measures when making a disability determination, they still remain relevant in evaluating the need of a student with a disability for special education or related services.[250]

With the passage of the ADAAA, Congress clarified that the definition of disability must be construed broadly and that the determination of whether an individual has a disability should not demand extensive analysis.[251] That said, OCR has explained that a LEA must evaluate the student, as described in the Section 504 regulations, to determine if the student has a disability and, if so, the LEA must determine whether, because of the disability, the student needs special education or related services.[252]

If a student is eligible to receive a FAPE under Section 504, the Section 504 team must determine the regular or special education and related aids and services (including, but not necessarily limited to, accommodations and modifications) individually based on a student's need. Accommodations may include, but are not limited to, highlighted text, extended time for tests and assignments, enlarged print, behavior intervention plans, preferred seating, oral tests, alternate seating, and extended passing periods between classes, etc. Modifications are "adjustments to a test or assignment that changes, lowers, or reduces what is measured or learned."[253] Modifications may also include, but are not limited to, partial completion of assignments, alternate assignments, and revisions to tests and assignments.

Unlike the IDEA, the Section 504 regulations do not provide required components that must be included in a Section 504 plan. The format of a Section 504 plan and related paperwork is determined by the LEA. The Section 504 team determines the specific content in the student's Section 504 plan. When a student's Section 504 plan includes OT or PT services, it is best practice for Therapy Practitioners to develop and maintain an intervention plan that outlines the plan and delivery of such services. The Section 504 regulations also include requirements with respect to placement, transportation, and an eligible student's participation in extracurricular activities.[254] LEAs must establish and implement a system of procedural safeguards; compliance with the IDEA's procedural safeguards is one means of meeting this requirement.[255] These procedural safeguards must include notice, an opportunity for students' parents/guardians to examine relevant records, an impartial hearing with the opportunity for participation by student's parents/guardians and representation by counsel, and a review procedure.[256] Section 504 requires LEAs to provide notice to parents explaining any evaluation and placement

decisions affecting their children and explaining the parents' right to review educational records and appeal any decision regarding evaluation and placement through an impartial hearing.[257]

If, as a result of a properly conducted evaluation, the LEA determines that the student does not need special education or related aid and services, the LEA is not required to provide aids or services. Neither the ADA nor Section 504 obligates a school district to provide aids or services that the student does not need.[258] LEAs are not required to provide a FAPE to students solely due to having a record of an impairment or are regarded as having an impairment.[259]

## I. INDIVIDUAL SERVICE PLANS AND PROPORTIONATE SHARE FUNDS

Under the IDEA, all LEAs must expend a "proportionate share" of federal IDEA funds on equitable services for students with disabilities whose parents have chosen to place them in nonpublic schools. [260] Each year, the LEAs must consult with representatives of the students who have been parentally placed in private schools, which include private schools, parochial schools, and home schools. The LEAs must determine the number of parentally placed private school children with disabilities who are attending schools located within the LEA. A formula is then used to determine the LEA's proportionate share funds. Proportionate share funds are calculated for students in private schools, but do not include students placed in private special education schools by the LEA, another public agency, or by the students' parents/guardians when FAPE is at issue (i.e., the LEA and parents have a disagreement regarding programming offered/provided by the LEA).[261]

Proportionate share funds are used to provide equitable services, which are special education and/or related services that the LEA has determined, after completion of an annual Timely and Meaningful Consultation (TMC) as defined by the IDEA, will be available to parentally-placed private school students with disabilities found eligible under the IDEA.[262] If the "proportionate share" funds are depleted during a school year, the LEA is not required to continue services for the rest of the year.[263]

Under the IDEA, LEAs have "child find" obligations concerning parentally-placed private school students. Each LEA is responsible for locating, identifying and evaluating all children with disabilities in private schools located in the boundaries served by the LEA. This means the LEAs complete the initial evaluations and reevaluations of private school students within their boundaries, whether or not the students are residents of the district.[264]

Each LEA must complete an annual TMC meeting to consult with nonpublic representatives regarding child find, use of proportionate share funds, and the provision of special education and related services.[265] During the TMC meeting, the LEA must provide, in part, information about how much funding has been allocated to private school students and the types of service that will be provided during the school year to those

students.[266] The types of service can vary and may or may not include OT and/or PT services.

An eligible parentally-placed private school student with disabilities does not have a right to receive some or all special education and related services that he/she would receive in public school through an IEP.[267] Rather, the LEA develops an Individual Service Plan (ISP) for the student that describes the special education and related services that the LEA will provide the student in light of the services made available to parentally-placed private school students.[268]

Therapy Practitioners may be a part of the team that develops and reviews a student's ISP. Therapy Practitioners may also provide OT or PT services to parentally-placed private school students according to their ISPs.

# SECTION III
# ADMINISTRATIVE CONSIDERATIONS

## A. INTRODUCTION

This Section includes information on additional administrative considerations including employment, retention and recruitment; orientation; space, equipment and materials; caseload; supervision and management; and continuing education.

## B. EMPLOYMENT, RETENTION, AND RECRUITMENT EMPLOYMENT ARRANGEMENTS AND AGENCIES

Many options exist for LEAs to arrange for Therapy Practitioners to provide services to students, such as through direct employment, a special education cooperative assignment, or contracted services. Direct employment occurs when the LEA employs a Therapy Practitioner. A special education cooperative assignment occurs when an LEA is a member of a special education joint agreement (commonly referred to as a cooperative) and the cooperative employs a Therapy Practitioner to provide services to students of one or more member LEAs. A Therapy Practitioner may also be arranged through a contract between the LEA and another educational agency, a local hospital, a rehabilitation facility, a service agency, or an individual Therapy Practitioner. For contracted services, a written agreement typically includes terms that specify the qualifications of Therapy Practitioners providing services, service and documentation requirements, supervision responsibilities, liability insurance, fees for service, length of the agreement, and terms of cancellation of the agreement by either party. These terms and conditions vary and are negotiated by the parties.

OT and PT staffing needs in educational settings can fluctuate dramatically within a school year due to long-term leaves, Therapy Practitioner shortages, number of students referred, number of students requiring therapeutic services and programmatic changes. LEAs may choose to develop alternative long-term plans that include options for filling short-term or unexpected staffing vacancies. This may include cultivating alternative arrangements with contracted service agencies or private clinics/hospitals that allow atypical service contracts, maintaining relationships with retired/former Therapy Practitioners, or having alternative plans for increasing OTA or PTA usage. Understanding the potential for unexpected vacancies or increased needs during the school year and developing alternative plans can help provide continuity of services for students.

### RECRUITMENT AND RETENTION METHODS

With recent and recurring years of staffing shortages, recruiting the most qualified Therapy Practitioners has become more challenging. LEAs may want to consider projecting out recruitment needs at least six months in advance, utilizing a variety of recruitment methods such as online recruiting, and developing networking systems. For example, Applitrack is a fee-based Statewide school-based recruitment site for all K-12

postings. Postings from this site can be automatically posted to K12jobspot.com, a national school-based recruitment site. In addition to using online recruitment sites, it may be beneficial for LEAs to maintain a current online presence through updated websites, Facebook pages, and Twitter accounts. LEAs may consider using these types of online platforms to make available to potential candidates relevant employment documents, such as a well-formed job description that includes essential job functions as well as the core competencies supported by the LEA.

In addition to school-based recruitment sites, general career recruitment sites such as Indeed.com, Careerbuilder.com, and Monster.com may be helpful options. Several recruitment sites are listed below (Please note that the provision of these resources is not an endorsement of any particular company):

- AppliTrack (https://www.applitrack.com/IASB/onlineapp/ )
- K12jobspot.com (https://www.k12jobspot.com/)
- Careerbuilder.com (http://www.careerbuilder.com/)
- Indeed.com (http://www.indeed.com/)
- Monster.com (http://www.monster.com/)

Networking options include linking with universities, colleges, and technical training programs in which the LEA staff may guest lecture about school-based therapy, offer opportunities for career mentorship programs to adult students, and offer affiliations/internships, fieldwork rotations, or professional shadowing opportunities. Networking with local OT/PT coordinator groups or surrounding educational agencies for staffing leads or shared contracts can be beneficial. LEAs may also consider providing continuing education workshops to develop an established contact list of therapists who are not currently employed by the LEA.

Other recruitment methods include advertising in national, State, and regional professional publications and websites; advertising in local publications; posting job announcements with university and technical training programs; and mailing notices to a purchased list of licensed Therapy Practitioners.[269] Also, recruiting at job fairs, universities, or at state and national conferences offers a forum to share job opportunities.

Recruitment and retention of Therapy Practitioners are of primary concern for administrators. Job security, good working conditions, competitive compensation, opportunity for career development, mentoring and peer support, interesting and challenging work, supportive and positive communication, autonomy, and the opportunity for collaboration and to develop specialized skills are some of the important employment values for Therapy Practitioners in the marketplace. These areas require attention from educational managers to foster positive working environments and to support the commitment and loyalty of Therapy Practitioners.

Specific considerations to increase retention include supplementary job package supports, administrative/job support, and working conditions. Each of these considerations are described in more detail below.

- Examples of supplementary job package supports include:
    - professional development monies (e.g., continuing education courses, related travel and per diem expenses, association dues);
    - tuition support and loan forgiveness programs;
    - opportunities for summer school employment;
    - paid time off (e.g., sick bank availability, vacation days, continuing education days, personal days, and holidays); and
    - benefits such as investment programs, retirement, insurance, and health care benefits, etc.

- Examples of administrative/job support include:
    - available equipment such as laptops, iPads, etc.;
    - access to Human Resources for employment-related information;
    - available equipment for student use/trials;
    - library of resources such as reference books, journals, assessments, etc.
    - technical staff to support/train on electronics/online requirements;
    - specialized training opportunities (e.g., assistive technology, certification programs, research opportunities, etc.); and
    - access to experienced OT and PT Practitioners for mentoring, supervision, etc.

- Examples of working conditions include:
    - caseload and workload distinction (see Workload Determination subsection below);
    - policies and procedures for workload review;
    - recognized hours of practice and limiting after-hours requirements;
    - opportunities for in-house professional development (e.g., in-service presentations, institute days, journal clubs); and
    - opportunities for clinical mentoring and leadership development (e.g., supervise Therapy Practitioners and fieldwork students, mentor new staff).

Also, an easy to use and accessible website with posted LEA policies and/or procedures increases transparency around areas such as salary scales, union guidelines, workload agreements, etc.

**INTERVIEW PROCESS**

Most LEAs utilize an online employment application form. This feature can be used to gather the candidate's professional information and to gauge intervention philosophy, therapeutic skill level, clinical reasoning, etc. Developing standard interview questions helps ensure the candidate’s philosophy and skills support the LEA’s philosophies and core competencies and provides a platform for standard decision-making around recruitment. A portfolio system can be used instead of or in addition to an online application format and can provide samples of organizational and writing skills. Standard questions can provide the opportunity to compare candidates equally. Using a team interview process allows LEA stakeholders to contribute to the hiring process and allows

a forum for the candidate to elicit information from a variety of perspectives as well as foreshadowing the collaborative requirements of a school-based position.

### ORIENTATION OF NEW STAFF

In order to provide services that are appropriate and consistent within the educational system, Therapy Practitioners must understand the policies and procedures of relevant entities (e.g., LEA, special education cooperative, or both) in addition to the requirements set forth in the Illinois Occupational Therapy Practice Act (OT Act), or the Illinois Physical Therapy Act (PT Act), and their respective implementing rules. A strong orientation and mentoring program is helpful for not only developing but also retaining qualified staff. This should include provision of thorough and organized orientation information in electronic and/or hard copy formats with opportunities for questions and discussion. The following key areas should be included in the orientation:

- basic philosophy of OT and PT in an educational environment, including the distinction between school-based and community, clinic or hospital-based therapy;
- skills specific to practice in the educational environment;
- applicable State and federal laws and regulations/rules;
- documentation requirements for evaluation reports, Section 504 plans, IEP documentation, intervention plans, and monitoring of student progress;
- introductions to administrative, educational, and support staff and resources (e.g., itinerant employment, policies, procedures, guidelines, and handbooks including those specific to the LEA and/or special education cooperative, and APTA and AOTA standards); and
- opportunities for observation of and mentoring from experienced staff.

### UNIONS

Therapy Practitioners should be aware of State and federal labor laws. Many LEAs may have unions, and Therapy Practitioners may or may not be part of a union's bargaining unit. In Illinois, LEA employees are represented by several unions, including the Illinois Education Association (IEA/NEA), the Illinois Federation of Teachers (IFT/AFT), and the Chicago Teachers Union. If Therapy Practitioners are part of a bargaining unit, their terms and conditions of employment will be provided in the collective bargaining agreement between the LEA and Union.

The relationship between the LEAs and the unions is governed by the Illinois Educational Labor Relations Act (IELRA),[270] which went into effect on January 1, 1984, and establishes the right of educational employees to organize and bargain collectively. [271] The Illinois Educational Labor Relations Board is the public body that is charged with administering the IELRA.

## C. CONTINUING EDUCATION

Lifelong learning and continuing competence are essential to optimal service provision and ongoing professional development. The OT Act and the PT Act require continuing

education (CE). Occupational therapists and OTAs are required to complete 24 contact hours of CE during each two year license renewal period; one contact hour must include a course in ethics.[272] Physical therapists and PTAs are required to complete 40 and 20 contact hours, respectively, are required every two years with three of those hours relating to ethical practice.[273] Activities that meet these requirements are specified within each Act and the respective implementing rules, and may include: CE courses, post-licensure academic courses, professional writing, and classroom/clinical teaching. Therapy Practitioners should regularly refer to the Acts and their implementing rules for updates regarding continuing education requirements. Paid release time and funding support for CE are benefits that can promote program improvement, staff development, recruitment, and retention. Existing standards of what constitutes quality CE can be useful when designing or evaluating CE programs.[274]

## D. SPACE, EQUIPMENT, AND PLANNING FOR SERVICE DELIVERY WORKSPACE STANDARDS AND GUIDELINES

Space allocation and office design standards contribute to the making of sound management decisions. Best practices in space management facilitate functional efficiency, provide appropriate work environments for staff, and motivate student learning.

The type of space needed to provide OT and PT services may be comprised of general office space, functional workspace, and/or special purpose space. The combination of types of space needed will be a unique function of student needs within a particular building, program, and/or learning environment. Although OT and PT services provided in context during typical activities of the school day do not require specialized accommodations, a combination of spaces is needed to address the varied needs of students within a particular building, program, or learning environment. The space available to any therapy service is derived from the usable space within the physical environment. Usable space does not include accessory areas such as washrooms, closets, public corridors, and lobbies.[275] Placing moveable furniture in corridors, stairways, or near exit doors can potentially restrict egress and may violate fire codes.

General office space can be shared or reallocated with minimal building modification or disruption to OT and PT services. Typically, office space is needed to sufficiently accommodate small group meetings with up to four students or two adults. These groups or meetings routinely consist of sensitive situations that require confidentiality, security, and visual and acoustical privacy. A standard allocation of general office space for these types of requirements is one hundred square feet.[276] This is sufficient to house a desk, chair, file cabinet, minimal storage unit, small table, and student work chairs.

Best practice includes planning not only for general office space, but for functional workspace. Functional workspace is the area needed to provide OT and PT interventions to address goals and student needs. Planning for functional workspace may require Therapy Practitioners to create a detailed statement that describes what is needed to perform job activities efficiently, safely, and comfortably for both staff and students. Therapy Practitioners have different functional requirements to promote student access

to and benefit from the general education curriculum. These differences may affect the type of functional workspace required for each therapy service.

Special purpose space involves non-standard areas that are unique and essential to service delivery. In schools, this is most often for the storage and retrieval of equipment and supplies used in the delivery of OT and PT services. Unique therapy provisions may include, but are not limited to, assessment tools and evaluation materials, assistive technology devices and supports, positioning and mobility equipment, sensory supports and apparatuses, consumable supplies, and additional materials to support activities of daily living, educational tasks, or pre-vocational/vocational tasks.

## THERAPEUTIC ADAPTIVE EQUIPMENT

Each LEA, independently or in cooperation with other LEAs, is required to provide a comprehensive special education program for its resident students with disabilities that includes, but is not limited to, appropriate and adequate facilities, equipment and materials.[277] This may include providing specific adaptive equipment, assistive technology devices, and other special equipment, aids, and materials identified a student's IEP, ISP or Section 504 Plan.[278] As a general rule, when equipment or supplies are listed as supplementary aids/accommodations on an IEP, ISP, or Section 504 Plan, the type of equipment is functionally described rather than listing a specific brand or piece of equipment. This allows the flexibility to accommodate new technologies and equipment availability within the identified time frame to best meet student needs.

Best practice also involves setting aside funds for the trial of specialized equipment and materials. Highly individualized student needs and rapidly changing technology may require the use of unique combinations of specialized therapeutic equipment and assistive technology. Time-limited trials offered by vendors may provide a cost-effective opportunity to determine purchasing needs before investing in expensive technology and equipment.

Therapy Practitioners should be involved in deciding the type of equipment to be ordered, and in providing staff training, monitoring use as needed, and providing guidelines for appropriate use of equipment. Many sensory supports, such as weighted materials or equipment that provides axial rotation (e.g., single point suspension equipment), should only be used through the direct service or supervision from a Therapy Practitioner to minimize the potential for negative student responses associated with atypical neurological functioning.

LEAs may place equipment and supplies in a private placement for the period of time needed to support the IEP or ISP. For parentally-placed private school students with ISPs, these materials must be retrieved when the student no longer has an identified need.[279] Equipment placed in private placements may not involve changes to the physical plant of the school. LEAs are required by the IDEA regulations to control and administer the funds used to provide special education and related services provided to parentally-placed private school students.[280] LEAs must hold title to and administer materials, equipment,

and property purchased with those funds for use with parentally-placed private school students.[281]

## FACILITIES PLANNING

The ADA is a comprehensive civil rights legislation that prohibits discrimination and guarantees the rights of adults and children with disabilities. Federal regulations have established the 2010 ADA Standards for Accessible Design, which set minimum requirements for newly designed, constructed or altered State and local government facilities, public accommodations, and commercial facilities to be usable by individuals with disabilities.[282] To this end, new construction increasingly follows the principles of universal design.

Universal design is "the design of products and environments to be usable by all people, to the greatest extent possible, without the need for adaptation or specialized design.".[283] According to The Center for Universal Design at North Carolina State University, the seven principles of universal design are:

1. Equitable use – accessible and appealing to all users.
2. Flexibility in use – accommodates a wide range of preferences and abilities.
3. Simple and intuitive use – eliminates avoidable complexity and provides feedback.
4. Perceptible information – communicates information effectively to all users.
5. Tolerance for error – minimizes hazards and unintended consequences.
6. Low physical effort – encourages efficiency and comfort with minimum fatigue.
7. Size and space for approach and use – appropriate for all body sizes and types.

Universal design in product planning encourages differentiated instruction for the general education population as well as for students with disabilities. Universal design in facilities planning encourages flexible use of space, multiple use environments, and access to programs for all users regardless of individual requirements and abilities.

Attention to disability-related needs during facilities planning can minimize cost and need for modification after construction and also enhances learning environments by reducing distractions and facilitating comfort and concentration. Therapy Practitioners have knowledge and expertise in these areas that can contribute to effective facilities planning. All students benefit from facility plans that provide high quality daylight, enhanced acoustics, healthy indoor air quality, and durable sustainable product selection. The reduction of glare and thermal discomfort through proper lighting enhances student learning and minimizes emotional and behavioral outbursts by students with visual sensitivity. Students with auditory sensitivity receive similar benefits from heating, ventilation, and air conditioning (HVAC) systems that use high-quality sound absorbing materials. Carpeted floors minimize noise from student activities and movement of furniture. Finally, more new schools are "going green" by paying attention to volatile organic compounds (VOCs) found in paint, carpet, adhesives, floor wax, cleaning products, and composite wood products. These VOCs evaporate at room temperature, giving off gases that may cause eye, nose, and throat irritation, headaches, allergic skin

reactions, dizziness, confusion, and other health concerns. Students with disabilities are often more susceptible than the general population to these compounds, though all individuals benefit when planning to reduce VOCs occurs.

## E. WORKLOAD DETERMINATION

LEAs are required to implement and maintain limits on the workload of its special educators so that all services required under students' IEPs, as well as all needed ancillary and support services, can be provided at the requisite level of intensity to provide those students with a FAPE.[284] Workload limits must be developed in cooperation with the affected employees or the employees' union, where applicable.[285] Workload limits must be based on an analysis of the activities for which the special educators are responsible and shall encompass, but need not be limited to: individualized instruction; consultative services and other collaboration among staff members; attendance at IEP meetings and other staff conferences; and paperwork and reporting.[286]

For school-based Therapy Practitioners, determining staffing needs requires consideration of many variables. Many LEAs have used the caseload model. **Caseload** is typically defined by the number of students or IEP minutes assigned to a Therapy Practitioner at any given time.[287] However, the traditional caseload model does not consider all the other responsibilities and activities required of Therapy Practitioners. **Workload** is defined as "all activities required to be performed by [related service providers] and addresses the range of demands on the OTs, PTs, and [speech-language pathologists]."[288]

The IDEA and Section 504 require school personnel, including but not limited to Therapy Practitioners, to address students' needs in the least restrictive settings appropriate to meet their needs. This often means that Therapy Practitioners provide services to students in their naturally occurring environments, which creates time constraints for providing services due to the students' school schedules (e.g., core academic instruction, lunch, recess, passing periods). Many LEAs also have MTSS in which Therapy Practitioners provide intervention and support to students within the general education setting. A Therapy Practitioner's responsibilities to provide services or supports according to IEPs, Section 504 plans, and/or MTSS impacts the Therapy Practitioner's workload because they have to coordinate schedules with these various student populations along with many other variables of the school day. The level and intensity of Therapy Practitioners' involvement will vary from LEA to LEA and school to school, as discussed in Section II.

Variables that affect the work load for Therapy Practitioners can be categorized into three distinct groups: (1) OT and/or PT service delivery; (2) participation in multi-tiered systems of support (MTSS)/response to intervention (RtI), child-find activities, school initiatives, and professional development; and (3) other responsibilities assigned to Therapy Practitioners by the LEA.[289] These variables are explained in further detail below.

## WORKLOAD VARIABLES

Workload variables related to service delivery may include, but are not necessarily limited to:

- Direct service delivery (intervention with the student)
    - Number of minutes that need to be provided individually or in groups
    - Emphasis of service delivery in general education environment (“push-in” services)
    - Population of students and intensity of needs in certain programs or buildings
    - Number of evaluations and re-evaluations scheduled

- Consultative/collaborative intervention and other indirect service delivery (interventions on behalf of the student)
    - Consultation/collaboration with teacher(s), other school personnel, parents/guardians, vendors, and outside agencies
    - Number of IEP teams requiring support and frequency of team meetings
    - Number of students requiring programs developed for self-regulation to be utilized throughout the day and training provided to classroom teacher and other personnel for daily carryover
    - Number of students requiring programs developed for positioning / mobility needs and proper training given to staff to be carried out by teacher and paraprofessionals within classroom to ensure student and staff safety
    - Providing trainings to classroom teachers/ school personnel on universal designs for learning to enhance student participation within the classroom (i.e. use of various assistive technology supports)
    - Development and revision of intervention plans/plans of care for IEP implementation

- Equipment management/ accommodation supports
    - Selection, ordering, obtaining and maintaining equipment for student needs
    - Training staff on use of equipment and accommodations used in the school environment

- Data collection/documentation
    - Daily: data collection, attendance, interventions, communications regarding the student (e.g., parents/guardians, faculty/staff, vendors, etc.) Progress reports on IEP goals throughout the school year
    - IEP and/or Section 504 plan annual review documentation

- Planning/preparation
    - Developing, adapting/modifying materials and equipment
    - Setting up the environment for therapeutic interventions

- Participation at IEP and Section 504 plan meetings
- Other meeting participation (e.g., parent/teacher conferences, transition planning)
- Communications with students' health care providers
- Medicaid cost recovery activities (e.g., obtaining referrals from health care providers, data entry)
- Number of school sites
    - Realistic travel times between schools
    - Other variables that impact transition time to and from each site: parking, set-up/take-down of materials and equipment, computer access, etc.
- Time for supervision of OTAs or PTAs

Workload variables related to participation in MTSS/RtI, child-find activities, school initiatives, and professional development:

- Participation in MTSS/RtI
    - Screening groups of students related to areas supported by OT or PT (Tier I)
    - Ensuring integrity of the implementation of a curriculum relevant to OT or PT intervention (Tier I)
    - Environmental Inventories/assess for environmental barriers (Tier I)
    - Supporting additional small group work led by other staff members (Tier II)
    - Student-specific problem-solving to address concerns with independence and participation within the classroom (Tier III)

- Initial Evaluations
    - Domain meetings
    - Completion of assessment in multiple settings, responding to referral concerns
    - Generating reports and draft goals
    - Eligibility meetings

- School-wide initiatives
    - Positive Behavioral Interventions and Supports (PBIS)
    - Environmental consultation and modifications
    - Universal Design for Learning

- Professional Development
    - Inservice presentations to school staff, parents/guardians, and colleagues regarding common medical conditions, skill development, ergonomics, therapeutic intervention strategies/techniques and use of equipment, data collection tools, etc.
    - Attendance at professional development seminars

Workload variables related to other assigned responsibilities:
- Attendance at school/ departmental staff meetings

- LEA committees and professional learning communities (PLCs) (e.g., Common Core, curriculum mapping, Performance Evaluation Reform Act (PERA), and professional development initiatives)
- Building-based responsibilities (e.g., bus duty, professional learning groups/ committees)

"Transforming caseload into workload requires thinking not only about caseload 'numbers' but also about what is the most effective 'work' that [Therapy Practitioners] can perform".[290] The amount of time devoted to each of these types of activities should be determined based on LEA needs and may change through the school year depending on building/program needs.

Historically, attempts have been made to use percentages as a means for determining a Therapy Practitioner's workload (for example, 65% of the therapist's workday to implement direct and/or consultation IEP minutes and 35% to complete all other tasks related to the therapist's position). With the addition of MTSS/RtI, professional learning requirements, cost recovery billing, and other changes in documentation, a percentage model for workload may not accurately reflect the actual time needed to complete the varied expectations that support students of varying needs. Each Therapy Practitioner's caseload may require a differing amount of time to complete tasks.

LEAs should realistically determine a Therapy Practitioner's workload to ensure the practitioner is most effective and can provide appropriate services. To do so, it is helpful for Therapy Practitioners to identify the amount of time spent on the variables. A workload analysis or time study can be effective tools to use.[291] LEAs may use various resources for analyzing a Therapy Practitioner's workload. When analyzing the information from the workload analysis, several factors should be considered, such as: direct intervention; new student assessment; limited hours that students are in attendance; each student's schedule; travel time between buildings; and MTSS activities. Understanding and addressing the workload needs of Therapy Practitioners assists with effectively supporting students and meeting LEA needs. Using a workload approach allows for increased collaboration and opportunities to support students to increase participation in their natural environments, thus impacting student outcomes. Addressing workload needs of staff may result in an increase in employee satisfaction, and ultimately retention, as well as recruitment.[292]

## F. SUPERVISION AND MANAGEMENT OF THERAPY PERSONNEL

The State special education rules provide that "[e]ach school district, or the special education cooperative of which it is a member, shall employ sufficient professional personnel and personnel not holding Illinois educator licensure to deliver and supervise...related services needed by the eligible students who reside in the district or districts served by the cooperative. The number and types of personnel employed shall be based on students' need rather than administrative convenience."[293] The Illinois School Code identifies occupational therapists and physical therapists under the category of "qualified worker," which is defined as "a trained specialist and includes a… registered therapist…who has the required special training in the understandings, techniques, and

special instructional strategies for children with disabilities and who delivers services to students with IEPs…."[294]

ISBE does not issue separate licensure for Therapy Practitioners who provide therapy in public schools. The IDFPR governs therapy practice to protect consumers and the general public. The OT Act and the PT Act direct the roles and responsibilities of Therapy Practitioners in all practice settings. Supervision and management of OT and PT services, therefore, must comply with the mandates and standards set forth by State law, IDFPR, ISBE, and LEAs. In addition, professional therapy practice is influenced by state and national agencies and organizations including IPTA, ILOTA, APTA, and AOTA. Administrative and supervisory roles should be consistent with licensure law and codes of ethics for Therapy Practitioners.

State laws and rules are revised periodically. For complete information regarding supervision and licensure of OT and PT staff including OTAs/PTAs, student therapists, and new graduates, consult the OT Act, the PT Act, and their respective implementing rules. Guidelines for the employment of foreign-trained therapists are maintained by IDFPR.

## PERFORMANCE EVALUATIONS

Performance evaluations vary throughout LEAs and within union contracts. The Performance Evaluation Reform Act (PERA) (effective in 2010) was written for teachers and principals. Staff who are not licensed teachers or principals, including Therapy Practitioners, are considered educational support personnel. The PERA does not require specific evaluation procedures for educational support personnel, although some LEAs use processes similar to teacher evaluations to evaluate educational support personnel. The ISBE Performance Evaluation Advisory Council (PEAC) has indicated that evaluations are to be done by trained and prequalified evaluators, and LEAs should "identify an instructional framework for use in the evaluation of teacher practice."[295]

Many LEAs evaluate teachers utilizing a rubric that results in an overall performance score. Such rubrics also have been developed to evaluate Therapy Practitioners. Additionally, several documents available from special interest groups of the AOTA and APTA can guide development of rubrics for Therapy Practitioners in the school setting.[296] These documents often focus on professional competencies of the Therapy Practitioner rather than student growth, although student growth is becoming more of a focus. Currently, demonstrating student growth (such as through student learning objectives [SLOs]) is not required by ISBE for Therapy Practitioners. Implementation of student growth measures in the evaluation process for Therapy Practitioners should consider how the Therapy Practitioner works collaboratively as part of the team "to promote student access to and participation in educational programming and activities."[297]

An evaluation of a Therapy Practitioner should encourage professional growth and serve to establish professional goals that support student performance within the school setting. Guidance from the AOTA states, "It is essential that the evaluation: considers occupational therapy's unique contribution to the educational process, incorporates the

roles and functions of an occupational therapist in meeting the diverse needs of students, and measures occupational therapist effectiveness in contributing to student success."[298] These same essential components of performance can be evaluated with PT Practitioners as well. The evaluation process may include self-evaluation, 1-2 formal observations, informal observations, and/or portfolio submissions. Formal observations may consist of a pre-conference, a set time of observation, and a post-observation conference. Informal observations can take place at any time. The evaluator should have adequate knowledge of the OT and/or PT profession and professional practice standards for the school setting.[299]

Due to the unique expertise and skills required to provide therapeutic intervention in the school setting, it is strongly recommended that if the evaluator is not an occupational therapist or physical therapist, the evaluation process be conducted in collaboration with qualified, licensed occupational therapist or physical therapist.[300] Technical assistance by a licensed occupational therapist or physical therapist may include review of appropriate assessment and documentation, use of appropriate student interventions, workload management, implementation of consultation, and professional development. "Physical therapists [and occupational therapists] should work closely with states and local education agencies to develop a valid, comprehensive, and fair performance evaluation system."[301]

**SUPERVISION OF OTAs AND PTAs**

Under the rules implementing the OT Act, supervision of an OTA is "a process in which two or more persons participate in a joint effort to establish, maintain and elevate a level of performance and shall include the following criteria:

1) To maintain high standards of practice based on professional principles, supervision shall connote the physical presence of the supervisors and the assistant at regularly scheduled supervision sessions.

2) Supervision shall be provided in varying patterns as determined by the demands of the areas of patient/client service and the competency of the individual assistant. Such supervision shall be structured according to the assistant's qualifications, position, level of preparation, depth of experience and the environment within which he/she functions.

3) The supervisors shall be responsible for the standard of work performed by the assistant and shall have knowledge of the patients/clients and the problems being discussed.

4) A minimum guideline of formal supervision is as follows:
   A) The occupational therapy assistant who has less than one year of work experience or who is entering new practice environments or developing new skills shall receive a minimum of 5% on-site face-to-face supervision from a registered occupational therapist per month. On-site supervision consists of

direct, face-to-face collaboration in which the supervisor must be on the premises. The remaining work hours must be supervised.

B) The occupational therapy assistant with more than one year of experience in his/her current practice shall have a minimum of 5% direct supervision from a registered occupational therapist per month. The 5% direct supervision shall consist of 2% direct, face-to-face collaboration. The remaining supervision shall be a combination of telephone or electronic communication or face-to-face consultation."[302]

The implementing rules also state: "It is the responsibility of the occupational therapy assistant to maintain on file at the jobsite signed documentation reflecting supervision activities. This supervision documentation shall contain the following: date of supervision, means of communication, information discussed and the outcomes of the interaction. Both the supervising occupational therapist and the occupational therapy assistant must sign each entry."[303]

The PT Act states that PTAs assist in "implementing the physical therapy treatment program as established by the licensed physical therapist."[304] The physical therapist "must maintain continual contact with the physical therapist assistant including periodic personal supervision and instruction to insure the safety and welfare of the patient."[305] Although no time specifications are given, APTA recommends that there "must be regularly scheduled and documented conferences."[306] APTA recommends:

> In those situations in which a physical therapist assistant is involved in the care of a patient/client, a supervisory visit by the physical therapist will be made:
>
> a. Upon the physical therapist assistant's request for a reexamination, when a change in the plan of care is needed, prior to any planned discharge, and in response to a change in the patient's/client's medical status.
> b. At least once a month, or at a higher frequency when established by the physical therapist, in accordance with the needs of the patient/client.
> c. A supervisory visit should include:
>  i. An on-site reexamination of the patient/client.
>  ii. On-site review of the plan of care with appropriate revision or termination.
>  iii. Evaluation of need and recommendation for utilization of outside resources.[307]

**Roles and Responsibilities of Occupational Therapists and Occupational Therapy Assistants**

"The Occupational Therapist is responsible for all aspects of screening, evaluation, and reevaluation; however, if the state practice act allows, the occupational therapy assistant may contribute by implementing delegated assessments and providing reports to the occupational therapist. The occupational therapist is responsible for the development of the occupational therapy intervention plan. Occupational therapy assistants provide interventions by selecting, implementing, and modifying the therapeutic interventions consistent with their demonstrated competency and delegated responsibilities."[308]

"Depending on the occupational therapy assistant's demonstrated competencies, he or she may assist by conducting delegated formal or informal assessments. The occupational therapist is responsible for analyzing and interpreting the data provided and determines how this information influences the decision-making process. The amount of information the occupational therapist asks the occupational therapy assistant to contribute is proportionate to his or her level of competence in this area of practice."[309]

"Depending upon the school district policy, occupational therapy assistants, under the supervision of the occupational therapist, may write progress reports describing the student's current performance toward his or her IEP goals … [B]est practice mandates that all documentation be co-signed by the supervising occupational therapist. This includes all written reports, progress notes, changes in treatment plans, and documentation of supervision."[310]

"The occupational therapy assistant may attend the individualized education program (IEP) meeting but cannot change the information prepared by the occupational therapist. Because decisions occur at the IEP meeting and questions or requests from teachers arise, both the occupational therapist and the occupational therapy assistant may consider attending IEP meetings."[311]

**Roles and Responsibilities of Physical Therapists and Physical Therapist Assistants**

"Generally, in the school setting, the physical therapist assistant is professionally responsible to and under supervision and direction of a licensed physical therapist for all delivery of service-related functions. The PTA is considered a team member and may provide input, along with the physical therapist, when establishing educational goals for a student that will be documented in the student's individual education program (IEP) ... The PT may delegate aspects of the student's physical therapy to a PTA that are appropriate for the student's needs and the PTA's experience, knowledge and skill...The physical therapist will design a plan to meet the IEP goals, and the PTA may follow through and assist with the physical therapy plan as delegated and directed by the physical therapist. A PTA may modify specific interventions established by the physical therapist in response to change in a student's status, but may not change the plan of care."[312]

"A physical therapist assistant may follow established administrative procedures, including keeping records and inventory, ordering supplies and equipment and scheduling, in conjunction with the supervising therapist. The physical therapist may ask the physical therapist assistant, if appropriately trained and knowledgeable and as permissible by state practice act/laws, to assist in screenings (such as for scoliosis), participate in school-wide education, perform selected measurement procedures, and care for braces, orthoses, prostheses, and adapted equipment...A school based physical therapist assistant should not interpret any student referrals, evaluate or reevaluate students, determine physical therapy diagnosis or prognosis, develop or modify a

student's physical therapy plan (educational program), determine utilization of the PTA, release or discharge a student from physical therapy services, recommend wheelchairs, orthoses, prostheses, or other assistive devices, or alterations to architectural barrier to persons other than physical therapist, or perform any skills or activities that are beyond the knowledge base of the physical therapist assistant."[313]

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# OTHER RESOURCES

U.S. Department of Education, Office of Special Education Programs (OSEP) and Office of Special Education and Rehabilitation Services (OSERS), https://sites.ed.gov/idea/

U.S. Department of Education, Office for Civil Rights (OCR), https://www2.ed.gov/about/offices/list/ocr/index.html

**PTA Supervision**

American Physical Therapy Association. Standards of Ethical Conduct for the Physical Therapist Assistant. Retrieved from http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/Ethics/StandardsEthicalConductPTA.pdf
*This document was developed by the APTA to outline ethical responsibilities of practicing PTs and PTAs.

The Federation of State Boards of Physical Therapy. Jurisdiction Licensure Reference Guide on PTA Supervision Requirements. Retrieved from https://www.fsbpt.org/download/JLRG_SupervisionRequirements_201006.pdf
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* This document was developed by the AOTA to provide guidance when making ethical decision in practice.

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- https://www.isbe.net/Documents/work_load_plans.pdf *-Work Load Plans for Special Educators: Navigating the Process Effectively - Adapted from the following: Work Load Plans: How to Navigate the Process Effectively, a presentation at the 2008 IAASE Spring*

*Conference by Dr. Judy Hackett, Dr. Tim Thomas, Bennett Rodick & Mike Loizzi, and Work Load Plans for Special Educators: "The Sequel," an NSSEO Workshop by Dr. Judy Hackett & Cathy Kostecki*

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[1] ISBE, 2003
[2] Lindner, 1996
[3] APTA Standards of Practice for Physical Therapy HOD S06-13-22-15
[4] 34 C.F.R. §300.28
[5] Also see Jackson, 2013a, pp. 266-267
[6] Also see Frolek Clark and Chandler 2013, pages 266-267
[7] 20 U.S.C. §1232g; 34 C.F.R. Part 99; 105 ILCS 10/1 et seq.; 23 Ill. Admin. Code Part 375
[8] 105 ILCS 10/2(d)
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[10] 23 Ill. Admin. Code §375.10
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[12] 105 ILCS 10/4(e)
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[14] 105 ILCS 10/4(f); 23 Ill. Admin. Code §375.40; 50 ILCS 205/1 et seq.; 44 Ill. Admin. Code Parts 4000 and 4500
[15] Frolek Clark & Chandler, 2013; McEwen, 2009
[16] 20 U.S.C. §1412(a)(12)(A)(i)
[17] For more information regarding licensure, visit http://www.idfpr.com
[18] 225 ILCS 75/2
[19] ACOTE, 2016; 225 ILCS 75/1 et seq.; 68 Ill. Admin. Code Part 1315
[20] 225 ILCS 90/1
[21] APTA, 2015a; APTA, 2015b; APTA, 2015c; CAPTE, 2015; CAPTE, 2016; 225 ILCS 90/1 et seq.; 68 Ill. Admin. Code Part 1340
[22] APTA Section on Pediatrics, 2009b
[23] McEwen, 2009
[24] Effgen, 2006
[25] McEwen, 2009
[26] 34 C.F.R. §104.33(b)
[27] AOTA, 2010a; APTA, n.d.a.
[28] AOTA, 2009; APTA 2012a, APTA 2009b, APTA 2012b
[29] AOTA, 2013a; APTA, 2009a
[30] AOTA, 2010a; AOTA 2012a
[31] AOTA, 2010a; AOTA, 2012b; AOTA, 2015a; APTA Section on Pediatrics, 2009b
[32] 34 C.F.R. 300.302
[33] 225 ILCS 90/1(9)
[34] ISBE, 2015a
[35] AOTA, 2012a; Illinois MTSS Network, n.d.
[36] AOTA, 2012a; APTA Section on Pediatrics, 2011
[37] 225 ILCS 75/3.1(c)
[38] 225 ILCS 75/3.1(a)
[39] 225 ILCS 75/3.1(b)
[40] 225 ILCS 75/3.1(d); AOTA, 2015b
[41] Effgen, 2006; APTA Section on Pediatrics, 2009b
[42] Effgen, 2006
[43] Shaya, Flores, Grabayor, & Wang, 2008
[44] APTA Section on Pediatrics, 2012
[45] APTA Section on Pediatrics, 2012
[46] APTA Section on Pediatrics, 2012
[47] APTA Section on Pediatrics, 2012
[48] Effgen & Kaminker, 2014
[49] Reeder, Arnold, Jeffries, & McEwen, 2011

[50] 225 ILCS 90/1(1)
[51] 225 ILCS 90/1(6)
[52] 225 ILCS 90/1(13), 1.2(a)
[53] 225 ILCS 90/1.2(b)
[54] 225 ILCS 90/1.2(b)
[55] 225 ILCS 90/1.2(c)
[56] 225 ILCS 90/1.2(d), (e)
[57] 225 ILCS 90/17(1)(V)
[58] 105 ILCS 5/10-22.21b
[59] Parent and Educator Resource Guide to Section 504 in Public Elementary and Secondary Schools (OCR December 2016)
[60] 34 C.F.R. §300.17
[61] 34 C.F.R. §300.39(a)(1)
[62] 34 C.F.R. §300.39(b)(3)
[63] 34 C.F.R. §300.34(a); 23 Ill. Admin. Code §226.310
[64] 34 C.F.R. §300.34(c)(6)
[65] 34 C.F.R. §300.34(c)(9)
[66] 34 C.F.R. §104.33; Protecting Students with Disabilities, Frequently Asked Questions About Section 504 and the Education of Children with Disabilities (OCR 2015)
[67] Protecting Students With Disabilities, Frequently Asked Questions About Section 504 and the Education of Children with Disabilities (OCR 2015)
[68] Parent and Educator Resource Guide to Section 504 in Public Elementary and Secondary Schools (OCR December 2016)
[69] 34 C.F.R. §300.8
[70] Parent and Educator Resource Guide to Section 504 in Public Elementary and Secondary Schools (OCR December 2016)
[71] Parent and Educator Resource Guide to Section 504 in Public Elementary and Secondary Schools (OCR December 2016)
[72] Parent and Educator Resource Guide to Section 504 in Public Elementary and Secondary Schools (OCR December 2016)
[73] Parent and Educator Resource Guide to Section 504 in Public Elementary and Secondary Schools (OCR December 2016)
[74] 34 C.F.R. §300.111; 23 Ill. Admin. Code §226.100(a)
[75] 23 Ill. Admin. Code §226.100(a)
[76] AOTA, 2009; APTA, 2009b; APTA, 2012a; APTA 2012b
[77] Frolek Clark & Chandler, 2013
[78] Polichino, Frolek Clark, Swinth, & Muhlenhaupt, 2007, p. 30
[79] 23 Ill. Admin. Code §226.110(c)
[80] 23 Ill. Admin. Code §226.110(c)
[81] 34 C.F.R. §300.302; 23 Ill. Admin. Code §226.110(c)(2)
[82] 34 C.F.R. §300.305(d), 300.503; 23 Ill. Admin. Code §226.110(c)(3), 226.520
[83] 34 C.F.R. §300.305(a)(1)
[84] 34 C.F.R. §300.305(a)(2)
[85] 34 C.F.R. §300.304(c)(4); 23 Ill. Admin. Code §226.75
[86] 23 Ill. Admin. Code §226.110(c)(3)(A)
[87] 34 C.F.R. §300.305(b)
[88] 105 ILCS 5/Art. 14; 23 Ill. Admin. Code Part 226
[89] 23 Ill. Admin. Code §226.840
[90] 23 Ill. Admin. Code §§226.110(c)(3)
[91] 34 C.F.R. §300.11(c)
[92] 34 C.F.R. §300.9, 300.300(a) and (c); 23 Ill. Admin. Code §226.110
[93] 34 C.F.R. §330.301(c)(1); 23 Ill. Admin. Code §226.110(d)
[94] 23 Ill. Admin. Code §226.110(j)
[95] 105 ILCS 5/14-8.02(b); 23 Ill. Admin. Code §226.110(d)
[96] AOTA, 2014
[97] APTA, 2014

[98] Polichino, Frolek Clark, Swinth, & Muhlenhaupt, 2007, p. 30
[99] Frolek Clark & Chandler, 2013; APTA, 2014
[100] 34 C.F.R. §300.15
[101] 34 C.F.R. §300.303(a)
[102] 34 C.F.R. §300.303(b)(1)
[103] 34 C.F.R. §300.303(b)(2)
[104] 34 C.F.R. §300.304(c)(6)
[105] 23 Ill. Admin. Code §226.140
[106] 23 Ill. Admin. Code §226.150; 34 C.F.R. §304(c)(1)
[107] 34 C.F.R. §300.304(c)(1)
[108] 34 C.F.R. §300.304(b)(1)
[109] 34 C.F.R. §300.304(b)(3)
[110] 34 C.F.R. §300.304(c)(2)
[111] 34 C.F.R. §300.304(c)(3)
[112] 34 C.F.R. §300.304(c)(7)
[113] 34 C.F.R. §300.304(c)(1)
[114] McEwen, 2009; Frolek Clark & Chandler, 2013
[115] Perry, 1998; Yancosek & Howell, 2010
[116] 23 Ill. Admin. Code §226.540
[117] Frolek Clark & Chandler, 2013
[118] 23 Ill. Admin. Code §226.110(h)
[119] 23 Ill. Admin. Code §226.110(i)
[120] 34 C.F.R. §300.306(a)(1)
[121] 34 C.F.R. §300.306(c)(1)
[122] 34 C.F.R. §300.304(b)(2)
[123] McEwen, 2009
[124] Endrew F. v. Douglas County School District Re-1, 137 S.Ct. 988 (3/22/17)
[125] Id.
[126] Id.
[127] Id.
[128] 34 C.F.R. §§300.321(a); 23 Ill. Admin. Code §226.210
[129] 23 Ill. Admin. Code §226.210(e)
[130] 23 Ill. Admin. Code §226.210(f)
[131] 34 C.F.R. §300.321(b)
[132] 34 C.F.R. §300.321(e)(1)
[133] 34 C.F.R. §300.321(e)(2)
[134] 34 C.F.R. §300.322(a)(2); 23 Ill. Admin. Code §226.530
[135] McEwen, 2009
[136] 34 C.F.R. §300.320; 23 Ill. Admin. Code §226.230; 105 ILCS 5/14-8.03
[137] 34 C.F.R. §300.324(a)
[138] 23 Ill. Admin. Code §226.220(c); 105 ILCS 5/14-8.02(b)(1)
[139] 34 C.F.R. §300.320(a)(2)
[140] 23 Ill. Admin. Code §226.230(a)(1)
[141] McEwen, 2009
[142] Center for Effective Collaboration and Practice, 2000
[143] U.S. Department of Education's Comments to IDEA regulations, 71 Fed. Reg. 46684 (2006).
[144] 34 CFR §300.320(e)(4)
[145] Frolek Clark & Chandler, 2013
[146] 34 CFR §300.42
[147] McEwen, 2009
[148] AOTA, 2014
[149] APTA, 2014
[150] APTA 2014
[151] 34 C.F.R. §300.320(a)(7)
[152] AOTA, APTA, & ASHA, 2014
[153] 34 C.F.R. §300.320(a)(6)

[154] 34 C.F.R. §300.320(a)(6)
[155] 20 U.S.C. §1412(a)(5), §1413(a)(1); 34 C.F.R. §300.114(a)(2); 23 Ill. Admin. Code §226.240
[156] 23 Ill. Admin. Code §226.300
[157] 34 C.F.R. §300.115(b)
[158] 23 Ill. Admin. Code §226.330
[159] 23 Ill. Admin. Code §226.330(b)
[160] 23 Ill. Admin. Code §226.330(c)
[161] 23 Ill. Admin. Code §226.330(c)
[162] 23 Ill. Admin. Code §226.330(c)
[163] See 34 C.F.R. §300.39(a)
[164] 105 ILCS 5/14-13.01(a); 23 Ill. Admin. Code §226.300(b)
[165] 105 ILCS 5/14-13.01(a)
[166] 105 ILCS 5/14-13.01(a)
[167] 105 ILCS 5/14-13.01(a); 23 Ill. Admin. Code §226.300(b)
[168] 105 ILCS 5/14-13.01(a); 23 Ill. Admin. Code §226.300(g)
[169] 105 ILCS 5/14-13.01(a); 23 Ill. Admin. Code 226.300(c)
[170] 23 Ill. Admin. Code §226.300(b)
[171] 23 Ill. Admin. Code §226.300(c)(1)
[172] 23 Ill. Admin. Code §226.300(c)(2)
[173] 23 Ill. Admin. Code §226.300
[174] 34 C.F.R. §300.304(c)(1)
[175] 23 Ill. Adm. Code §1.610, 226.300(f)
[176] 34 C.F.R. §300.106(a)(2)
[177] For more information on ESY services, see 34 C.F.R. §300.106 and Communication on Extended School Year Services for Students With Disabilities (ISBE November 2001)
[178] 23 Ill. Admin. Code §226.100(a)(3)
[179] 34 C.F.R. §300.124(b); 23 Ill. Admin. Code §226.260(a)
[180] 23 Ill. Admin. Code §226.260(c)
[181] 34 C.F.R. §300.124(c); 300.323(b); 23 Ill. Admin. Code §226.100(a)(3), 226.260(a)
[182] 34 C.F.R. §303.209; Early Intervention to Early Childhood Transition Frequently Asked Questions (Revised ISBE May 2017)
[183] 34 C.F.R. §303.209; Early Intervention to Early Childhood Transition Frequently Asked Questions (Revised ISBE May 2017)
[184] Memo 10-2, ISBE Guidance Relating to Transitioning from Early Intervention to Early Childhood Special Education Services when Children Turn Three (ISBE 10/04/10);Early Intervention to Early Childhood Transition Frequently Asked Questions(ISBE Revised May 2017)
[185] 34 C.F.R. §300.43(a); 105 ILCS 5/14-8.03(a)
[186] 105 ILCS 5/14-8.03(a-5); 23 Ill. Admin. Code §226.230(c); 34 C.F.R. 300.320(b)
[187] 34 C.F.R. §300.43(b); 105 ILCS 5/14-8.03(a)
[188] 105 ILCS 5/14-8.03(b)
[189] 105 ILCS 5/14-8.03(b)
[190] 105 ILCS 5/14-8.03(b)
[191] 105 ILCS 5/14-8.03(b)
[192] 105 ILCS 5/14-8.03(b)
[193] 105 ILCS 5/14-8.03(b)
[194] Bazyk & Cahill, 2015
[195] McEwen, 2009
[196] 105 ILCS 5/14-6.10(a) and (c)
[197] 105 ILCS 5/14-6.10(b)
[198] 105 ILCS 5/14-6.10(b)
[199] 34 C.F.R. §300.101(a); 23 Ill. Admin. Code §226.50(c)(1)
[200] 23 Ill. Admin. Code §226.50(c)(2)
[201] 23 Ill. Admin. Code §226.50(c)(3)
[202] 23 Ill. Admin. Code §226.50(c)(3)
[203] Kentucky Department of Education, 2012; Virginia Department of Education, 2011
[204] Frolek Clark & Chandler, 2013

[205] AOTA, 2010b
[206] Frolek Clark & Chandler 2013, p. 115
[207] APTA, 2005
[208] Hanft & Shepherd, 2008 & 2016
[209] Steenbeek, et al., 2007
[210] 34 C.F.R. §300.320(a)(3)(ii)
[211] 34 C.F.R. §300.324(b)
[212] 225 ILCS 75/3.1
[213] S. Bachman & S. Flanagan Medstat Group, 1999
[214] S. Bachman & S. Flanagan Medstat Group, 1999
[215] See https://www.illinois.gov/hfs/MedicalPrograms/sbhs/Pages/default.aspx.; https://www.illinois.gov/hfs/SiteCollectionDocuments/092818LEAHdbkPolicyAudiologyRefFinal.pdf; https://www.illinois.gov/hfs/sitecollectiondocuments/hk200.pdf
[216] Handbook for Local Agencies, Chapter U-200 Policy and Procedures Fee-forService Medical Services, Illinois Department of Healthcare and Family Services (IDHFS February 2014); Handbook for Providers of Healthy Kids Services, Chapter HK-200 Policy and Procedures for Health Care for Children (IDHFS March 2017)
[217] Handbook for Local Agencies, Chapter U-200 Policy and Procedures Fee-for-Service Medical Services, Illinois Department of Healthcare and Family Services (IDHFS February 2014)
[218] Id.
[219] Id.
[220] Id.
[221] Id.
[222] Id.
[223] Id.
[224] See https://www.isbe.net/Pages/Special-Education-Civil-Rights.aspx
[225] Protecting Students With Disabilities, Frequently Asked Questions About Section 504 and the Education of Children with Disabilities (OCR 2018)
[226] Protecting Students With Disabilities, Frequently Asked Questions About Section 504 and the Education of Children with Disabilities (OCR 2018)
[227] Protecting Students With Disabilities, Frequently Asked Questions About Section 504 and the Education of Children with Disabilities (OCR 2018)
[228] Disability Discrimination, Frequently Asked Questions (OCR 2016)
[229] 34 C.F.R. §104.2, 104.31
[230] 34 C.F.R. §104.3(j)
[231] 34 C.F.R. §104.33; and see Protecting Students With Disabilities, Frequently Asked Questions About Section 504 and the Education of Children with Disabilities (OCR 2018)
[232] 34 C.F.R. §104.32
[233] 34 C.F.R. §104.35(a)
[234] Protecting Students With Disabilities, Frequently Asked Questions About Section 504 and the Education of Children with Disabilities (OCR 2018)
[235] Protecting Students With Disabilities, Frequently Asked Questions About Section 504 and the Education of Children with Disabilities (OCR 2018)
[236] 34 C.F.R. §104.35(b)
[237] 34 C.F.R. §104.35(d)
[238] 34 C.F.R. §104.35(c)
[239] Jackson, 2013a
[240] Durheim, 2015; and see Protecting Students With Disabilities, Frequently Asked Questions About Section 504 and the Education of Children with Disabilities (OCR 2018)
[241] Protecting Students With Disabilities, Frequently Asked Questions About Section 504 and the Education of Children with Disabilities (OCR 2018)
[242] 34 C.F.R. §104.3(j)(2)
[243] Questions and Answers on the ADA Amendments Act of 2008 for Students with Disabilities Attending Public Elementary and Secondary Schools (OCR 2012)
[244] 34 C.F.R. §104.3(j)(2); ADAAA
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[246] Questions and Answers on the ADA Amendments Act of 2008 for Students with Disabilities Attending Public Elementary and Secondary Schools (OCR 2012)
[247] Questions and Answers on the ADA Amendments Act of 2008 for Students with Disabilities Attending Public Elementary and Secondary Schools (OCR 2012)
[248] Questions and Answers on the ADA Amendments Act of 2008 for Students with Disabilities Attending Public Elementary and Secondary Schools (OCR 2012)
[249] ADAAA
[250] Questions and Answers on the ADA Amendments Act of 2008 for Students with Disabilities Attending Public Elementary and Secondary Schools (OCR 2012)
[251] 42 U.S.C. §12102
[252] Questions and Answers on the ADA Amendments Act of 2008 for Students with Disabilities Attending Public Elementary and Secondary Schools (OCR 2012)
[253] Jackson, 2013a
[254] 34 C.F.R. §104.33, 104.34, 104.35, 104.37
[255] 34 C.F.R. §104.36
[256] 34 C.F.R. §104.36
[257] Protecting Students With Disabilities, Frequently Asked Questions About Section 504 and the Education of Children with Disabilities (OCR 2018)
[258] Questions and Answers on the ADA Amendments Act of 2008 for Students with Disabilities Attending Public Elementary and Secondary Schools (OCR 2012)
[259] Protecting Students With Disabilities, Frequently Asked Questions About Section 504 and the Education of Children with Disabilities (OCR 2018)
[260] Guidance Document 15-9, IDEA Proportionate Share Services for Parentally Placed Nonpublic Students with Disabilities (ISBE 2015)
[261] Guidance Document 15-9, IDEA Proportionate Share Services for Parentally Placed Nonpublic Students with Disabilities (ISBE 2015); Provisions Related to Children With Disabilities Enrolled by Their Parents in Private Schools (U.S, DOE 2011)
[262] 34 C.F.R. §300.134(d), 300.137
[263] ISBE, 2009a
[264] Guidance Document 15-9, IDEA Proportionate Share Services for Parentally Placed Nonpublic Students with Disabilities (ISBE 2015)
[265] Guidance Document 15-9, IDEA Proportionate Share Services for Parentally Placed Nonpublic Students with Disabilities (ISBE 2015)
[266] Guidance Document 15-9, IDEA Proportionate Share Services for Parentally Placed Nonpublic Students with Disabilities (ISBE 2015)
[267] 34 C.F.R. §300.137(a)
[268] 34 C.F.R. §300.132(b), 300.138(b)
[269] Purchased lists are available through the Illinois Department of Financial and Professional Regulation (at https://www.idfpr.com/). Listings of accredited professional schools may be obtained from the AOTA (http://www.aota.org/) and the APTA (https://www.apta.org/)
[270] 115 ILCS 5/
[271] 115 ILCS 5/
[272] 68 Ill. Admin. Code §1315.145(a)
[273] 68 Ill. Admin. Code §1340.61(a)
[274] AOTA State Affairs Group, 2016; APTA, 2011; APTA, 2012b
[275] General Services Administration, 2013
[276] National Institute of Building Sciences, 2009
[277] 23 Ill. Admin. Code §226.700(a)
[278] 105 ILCS 5/14-1.08; 34 C.F.R. §300.5, §300.6, §300.14, §300.42; 34 C.F.R. §104.33
[279] 34 C.F.R. §300.144
[280] 34 C.F.R. §300.144(a)
[281] 34 C.F.R. §300.144(a)

[282] See 2010 ADA Standards for Accessible Design, U.S. Department of Justice, 9/15/10 available at https://www.ada.gov/regs2010/2010ADAStandards/2010ADAstandards.htm
[283] Connell et al., 1997
[284] 23 Ill. Admin. Code §226.735
[285] 23 Ill. Admin. Code §226.735(a)
[286] 23 Ill. Admin. Code §226.735(b)
[287] Williams & Cecere, §2013
[288] AOTA, APTA, & ASHA, 2014
[289] American Speech-Language Hearing Association, 2002; Jackson, Polichino, & Potter, 2006; Ray, Holahan, & Flynn, 2009; Swinth, 2008; & Williams & Cecere, 2013
[290] Jackson, Polichino, & Potter, 2006
[291] Jackson, 2013b; Williams & Cecere, 2013
[292] AOTA, APTA, & ASHA, 2014
[293] 23 Ill. Admin. Code §226.800(a)(1)
[294] 105 ILCS 5/14-1.10
[295] ISBE, 2015c, p.1
[296] AOTA, 2013b; APTA Section on Pediatrics, 2013
[297] APTA Section on Pediatrics, 2013
[298] AOTA, 2013b
[299] AOTA, 2013b, APTA Section on Pediatrics, 2013
[300] AOTA, 2013b. APTA Section on Pediatrics, 2013
[301] APTA Section on Pediatrics, 2013
[302] 68 Ill. Admin. Code §1315.163(a)(4)
[303] 68 Ill. Admin. Code §1315.163(b)
[304] 225 ILCS 90/1(9)
[305] 225 ILCS 90/2(7)
[306] APTA, 2012a
[307] APTA, 2012a
[308] Frolek Clark and Chandler, 2013; p.36
[309] Frolek Clark and Chandler, 2013; p. 38
[310] Frolek Clark and Chandler, 2013; p. 38
[311] Frolek Clark and Chandler, 2013; p. 37
[312] McEwen 2009; p. 132
[313] McEwen 2009; p. 133