DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Office of Teaching and Learning

August 2016

SY 2016-17 Occupational and Physical Therapy Guidebook

Version 2.0

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Introduction

Capital Commitment

Better Schools for All Students by 2017

DCPS' five-year strategic plan, A Capital Commitment, provides a roadmap for building DCPS into a high-quality, vibrant school district that earns the confidence of our community. The plan defines an overarching purpose as well as five goals that will guide DCPS' work through 2017. Our stakeholder commitments reflect our promises to the community and underscore our dedication to improving the quality of education in the District.

Our Core Initiatives

The following are the core initiatives of DCPS:

- Build Neighborhood School Capacity
- Manage Non-Public Enrollment and Costs
- Expand Early Identification
- Provide Effective Student Supports
- Prioritize Academic Achievement
- Create a Culture of Inclusiveness

OUR PURPOSE is to ensure that every DCPS school provides a world-class education that prepares ALL of our students, regardless of background or circumstance, for success in college, career, and life.

OUR GOALS are ambitious. Based on the hopes and dreams of DCPS stakeholders, these goals will help us align our resources and measure our success.

GOAL 1: Improve Achievement Rates
At least 70% of our students will be proficient in reading and math, and we will double the number of advanced students in the district.

In 2011–12, DCPS launched a new, rigorous academic plan aligned to the Common Core State Standards. This plan is designed to prepare all students for success and to accelerate student achievement. To improve achievement rates, DCPS will:

- Continue to invest in high-quality instruction by rewarding our highly effective teachers and principals.
- Provide professional development driven by student performance data and teacher needs.
- Increase investments to improve In-Seat Attendance (ISA), decrease tardiness and truancy, reduce bullying, and improve student wellness.
- Invest in new gifted and talented programs and continued expansion of International Baccalaureate and Advanced Placement programs.

GOAL 2: Invest in Struggling Schools

Our 40 lowest-performing schools will increase proficiency rates by 40 percentage points. DCPS is committed to investing in our 40 lowest-performing schools, which serve large populations of students who need extra support, including low-income students, English language learners, and students with special needs. To help accelerate achievement, DCPS will:

- Offer the Proving What's Possible grant to low-performing schools that are improving instruction, extending learning time, and making targeted technology investments.
- Invest in the teachers, principals, and staff who interact with students every day. We will continue to recruit and retain highly effective educators with a focus on placing these educators in our 40 lowest-performing schools.

GOAL 3: Increase Graduation Rate

At least 75% of entering 9th graders will graduate from high school in four years. To ensure that more students graduate on time, DCPS will leverage technology and provide targeted support to secondary schools. For example, through an electronic portfolio, students in grades 6–12 will discover their interests, set goals, and create a thoughtful plan for high school and beyond. DCPS will also:

- Provide targeted resources to schools with low promotion rates for first-time 9th graders, including an intensive summer bridge program.
- Invest in an Early Warning Intervention system so we can identify students who need support to graduate on time.
- Explore new ways to make the high school experience vibrant and relevant.

GOAL 4: Improve Satisfaction

90% of students will say they like their school.

Academic achievement begins with engagement. DCPS is committed to ensuring that our students enjoy school and treasure their educational experiences. Our schools will:

- Employ dedicated staff who make meaningful connections with students.
- Provide a rich and varied educational experience that includes art, music, and physical education.
- Offer safe and modern facilities, quality meals, and current technology.
- Welcome families and encourage them to participate in their children's education.

GOAL 5: Increase Enrollment

DCPS will increase its enrollment over five years.

As enrollment increases, DCPS will be able to expand the range of courses and experiences offered at each school to make DCPS the system of choice for more residents. To expand enrollment in the coming years, DCPS will:

- Prepare to serve all students, including special education students who are returning to DCPS from non-public placements.
- Continue to use targeted recruitment to raise the profile of high-performing schools. As part of this effort, DCPS will continue to make school performance data easily accessible for families.
- Continually improve the quality of education at every school to attract new families to DCPS.

Division of Specialized Instruction

Our vision focuses on building the capacity of our schools to ensure that they have the systems, supports, tools, and well-trained staff to address the needs of our students with disabilities, allowing them to access education in their neighborhood schools alongside their typically developing peers. DSI's transition to OTL will increase collaboration and alignment with our partners within DCPS and throughout the District to develop clear policies and processes for delivering high-quality instruction and supports to improve the academic achievement of our students with disabilities.

DSI's core believe are:

- We believe that all children, regardless of background or circumstance, can achieve at the highest levels.
- We believe that achievement is a function of effort, not innate ability.
- We believe that we have the power and the responsibility to close the achievement gap.
- We believe that our schools must be caring and supportive environments.
- We believe that it is critical to engage our students' families and communities as valued partners.
- We believe that our decisions at all levels must be guided by data.

MISSION OF THE OFFICE OF TEACHING AND LEARNING

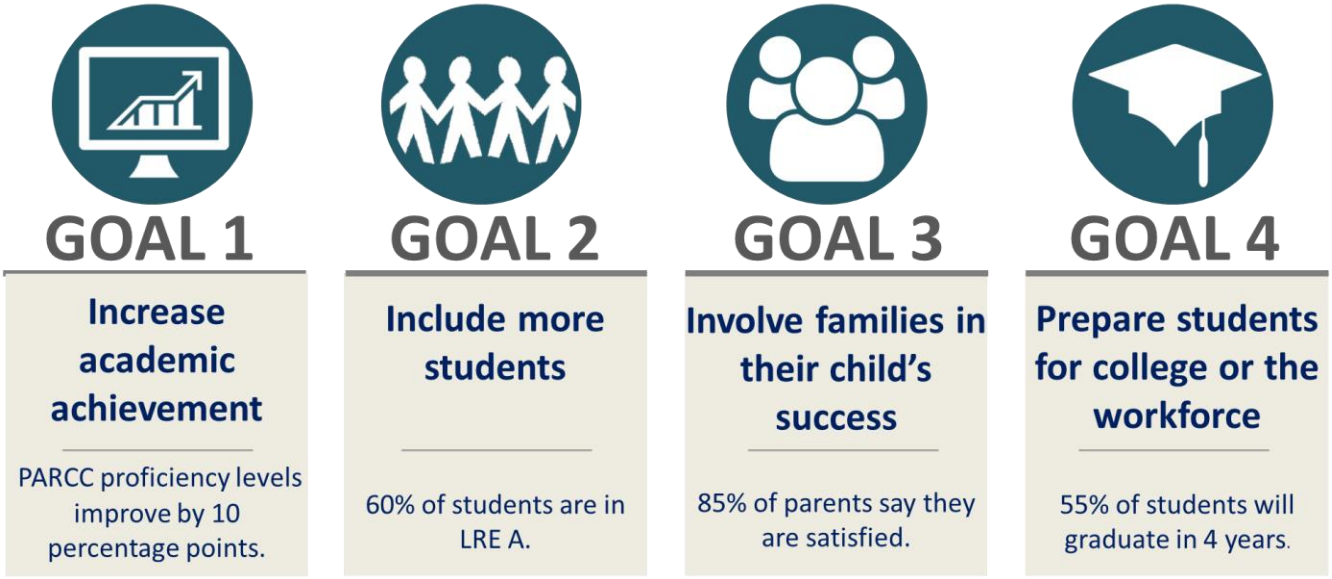
The mission of the Office of Teaching and Learning (OTL) is to deliver high-quality instructional resources, enhance classroom practice and scale effective programs to increase DCPS student achievement and prepare all students for success in college, career, and life. OTL spans four core competency areas:

1. Curriculum
2. Professional learning
3. Enrichments and interventions
4. Formative assessment

Special Education in DCPS

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

DCPS SY16-19 Special Education Strategic Plan
Vision: *dramatically improve academic outcomes for students with disabilities in DCPS.*



Related Services Team Vision

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

The related services team has THREE goals to achieve over the next three years:

1. 90% of providers achieve score of 3.0 on assessment quality section of IMPACT in three (3) years
2. Provide minimum of 80% of related services by showing evidence of due diligence efforts.
3. 100% of RSPs are trained and implementing evidence based interventions (RTI, inclusionary practices, EBTs, consultation)

Purpose and Structure of Guidebook

The purpose of this guidebook is to:

- Assist occupational therapy and physical therapy service providers as they support the educational goals of eligible students with disabilities in the District of Columbia Public Schools (DCPS).

- Ensure that all occupational therapists and physical therapists (OTs and PTs) in the District of Columbia Public Schools (DCPS) operate within the same premises, utilize the same procedures and guidelines, and are uniform in presentation.

This guidebook is written for special education administrators, school personnel responsible for 504 Plans, Individualized Service Plans (ISPs), and providers of occupational therapy and physical therapy services. In addition, it may benefit DCPS parents, teachers, and other school professionals. The procedures and best practices in this guidebook are designed to provide optimal school-based interventions as part of a Free Appropriate Public Education (FAPE) in the Least Restrictive Environment (LRE), following IDEA 2004 while simultaneously maximizing equal access to occupational therapists and physical therapists for all of the District of Columbia Public Schools students.

DCPS regulates the practice of occupational therapy and physical therapy services to the students in public schools of the District of Columbia while the Department of Health, Board of occupational therapy and Board of physical therapy regulates the practice of occupational therapists and physical therapists respectably. In this guidebook, providers will find guidelines, procedures, suggestions and ideas that should be used on a daily basis to guide them in assuring a high level of professional services for all students and invested stakeholders.

This guidebook replaces any guidebook introduced previously. Providers should expect to receive supplemental policy and procedure documents and training throughout the 2016-2017 school year.

Contact Information for the Occupational and Physical Therapy Department

Office of Teaching and Learning
Division of Specialized Instruction
1200 First Street, NE
8th Floor
Washington, DC 20002

Occupational and Physical Therapy Department Office
TBD

Dr. Yaritza Croussett, OTR/L
Program Manager
Cell (202) 480-3163
fax (202)535-2551
Office Hours: Fridays (By Appointment)

DCPS Employee Policies

Time and Attendance

Tours of Duty

ET-11 (12 month employees)

Occupational and Physical Therapists are to report to their schools for an eight and one-half (8.5) workday inclusive of a duty-free lunch period. Staff members should arrive at their assigned schools no later than the time of arrival expected for all school staff. An extended tour of duty may be inclusive of central office assignments, summer school assessments, compensatory education services, extended school year services, non-public assessment completions, HOD/SA specifications and extra duty cases which extend beyond the regular school day hours

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

ET-15* (10 month employees)

Service are to report to schools for a seven and one-half (7.5) workday inclusive of a duty-free lunch period. Staff members should arrive at their assigned schools no later than the time of arrival expected for all school staff. An extended tour of duty may be inclusive of extra duty team assignments, which extend beyond the regular school day.

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

Signing In and Out

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

*As stated in the WTU contract

Time and Attendance Procedures – Revised (January 31, 2008)
A memorandum from the Deputy Chancellor for Special Education stated that:
"It is vital that time and attendance is accurately reported by all personnel. The erroneous reporting of time is against DCPS policy and grounds for disciplinary action against the employee, his/her supervisor or his/her timekeeper….

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

School-based and Itinerant office of Specialized Instruction (DSI) Staff:

- All sign-in/sign-out sheets must be signed by you on a daily basis
- All request for leave must be approved by your Principal (school-based) or Manager (OSI)and submitted via PeopleSoft
- All annual leave must be approved prior to the leave period
- All administrative leave requests for seminars, conferences and official travel must be accompanied by appropriate documentation (registration, receipt, etc.)
- All requests for leave for over two weeks must be approved by your Principal, and your Manager must be informed.
- Itinerant staff should not plan to request leave during the two weeks prior to the start of the new school year. Emergencies will require APPROVAL by the Chief of Specialized Instruction
- All compensatory time or overtime must be approved by the Chief of Specialized Instruction prior to the work being performed and provide a copy to your timekeeper.
- Itinerant staff timesheets and leave requests must be submitted via PeopleSoft.
- If you have any questions or require additional clarification, please contact your Program Manager

Entering Time in PeopleSoft

How do I enter my own time?

1. Log into the PeopleSoft online system.
    - Inside of DC Network: https://pshcm.dc.gov
    - Outside of DC Network: https://ess.dc.gov
    - Login: Your DCPS email address without @dc.gov (generally firstname.lastname)
    - Use the "Forgot Your Password?" link if you do not know your password.
2. Click on "Self Service" in the blue box on the left side of the page.
3. Click on "Report Time" under the Time Reporting heading.
4. Click on "Timesheet" under the Report Time heading.
5. Enter the appropriate number of hours for each day of the current week.
    - You may need to change the Date field if you are entering time late.
    - After changing the date, click "Refresh" to enter time for a previous time period.

6. Select a Time Reporting Code from drop down menu. The most frequently used codes are:
    - Regular Pay – REG
    - Annual Leave Taken – ALT
    - Sick Leave Taken – SLT
    - Holiday Pay – HOL
    - Administrative Closing Pay – ACP
7. Click the "+" at the far right of the line if you will be entering more than one type of time.
    - Ex: 2 lines would be needed if you worked Monday-Thursday, but you were sick Friday.
    - Ex: 3 lines would be needed if the above were true except that Monday was a holiday.
8. Click "Submit."
    - Submitted time can be changed (prior to the end of the pay period) if needed.
    - Saved time cannot be approved. Please do not use the "Save for Later" button.
    - Only enter time for the current week, except prior to winter and spring breaks.

Time-Keeping FAQs

When do I need to enter my time?

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

How do I submit a leave request in PeopleSoft?

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

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

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

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

What if I need help?

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

Absence/ Leave Policies

Absence/ Leave Policies for ET-11

Refer to Council for School Officers (CSO) contract agreement for detailed information.

Annual

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

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

Officers may accumulate annual leave for later use up to a maximum of thirty (30) days.
Each supervisor in conjunction with the officer staff shall develop a tentative leave schedule for the use of annual leave, which shall be developed early in the leave year, which provides for vacations on a staggered basis throughout the year. On the basis of mutual agreement between employees and their supervisors, vacation periods should be scheduled in such a manner as to provide the least interruption to the work unit. These schedules may, of course, be revised from time to time. Employees should be given the opportunity for a planned period of extended vacation leave.

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

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

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

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

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

Restoration of Leave

- The Board is responsible for notifying the membership of, and providing the required form(s) for, the process to be followed in the restoration of annual leave in accordance with the annual "use or lose" leave protocol.
- The Board will provide the process for recording and utilization of restored annual leave to the membership and all responsible supervisors.
- If the Board fails to properly notify officers of the process to be followed and the forms to fill out for the restoration of annual leave, the restored leave the service provider would have been entitled to shall not be subject to the "use or lose" leave protocol timeline and will be restored.
- Requests to restore leave lost due to any of the three (3) conditions listed above should be submitted to the Department of Human Resources in writing and include the service provider's name and social security number, organizational code, amount of hours to be restored, reason(s) the scheduled leave could not be used and the date(s) the leave was scheduled for use, supported by documentation. Requests for restoration of leave must be submitted within thirty (30) days of the end of the leave year in which the leave was lost.
- Upon separation from service, an officer shall receive a lump-sum payment, at the rate of salary on the effective date of separation, for accumulated or restored annual leave.

Sick Leave

- Service providers shall earn thirteen (13) days sick leave, with pay, in any one calendar year.
- Sick leave, which is not used during the year it is earned, shall accumulate and be available for use in accordance with Board Rules.
- Upon arrival by the Board, an officer may use accumulated sick leave in addition to the maximum useable accumulation provide in 5 DCMR §1200.9 of the Board Rules.
- Permanent or probationary service providers may be advanced up to thirty (30) days leave by the Chancellor. Every application for advances leave shall by supported by a certificate signed by a registered practicing physician or other licensed practitioner certifying that the service provider is unable to perform regular duties. Any advance leave is paid back. Sick leave may be advanced irrespective of whether the officer has annual leave credit. If the employee voluntarily or involuntarily terminates their employment prior to the repayment of the advance sick leave, the employee will be required to repay, at their then current rate of pay, the amount remaining.

Court & Jury Leave

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

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

Family & Medical Leave

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

a. The birth of a child of the employee:
b. The placement of a child with the employee for adoption or foster care;
c. The placement of a child with the employee for whom the employee permanently assumes and discharges parental responsibility; or
d. The care of a family member of the employee who has a serious health condition.[1]
e. Family member means:
    i. A person to whom the employee is related by blood, legal custody, or marriage;
    ii. A child who lives with an employee and for whom the employee permanently assumes and discharges parental responsibility; or
    iii. A person with whom the employee shares or has shared, within the last year, a mutual residence and with whom the employee maintains a committed relationship.[2]

An employee who is unable to perform the functions of the employee's position because of a serious health condition shall be entitled to medical leave for as long as the employee is unable to perform the functions, except that the medical leave shall not exceed sixteen (16) work weeks during any twenty-four (24) month period.[3] The Board shall provide and implement Family and Medical Leave consistent with D.C. Law. The provision and implementation of Family and Medical Leave is based on D.C. Law.

Administrative Leave

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

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

Educational/Sabbatical Leave of Absence

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

[1] D.C. Official Code §32-502(a)
[2] D.C. Official Code §32-501 (4).
[3] D.C. Official Code §32-503 (a)

the school system.

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

- Standard: The total number of service providers granted sabbatical leave at the Chancellor's discretion in any leave year will not exceed one (1) percent of the total number of service providers.
- Eligibility: A service provider becomes eligible for sabbatical leave, for a minimum period of a full semester, up to a maximum of one full year after five (5) consecutive years of employment with the District of Columbia Public Schools, excluding periods of Family and Medical leave, military or exchange leave. Eligibility is reestablished seven years after the first sabbatical leave is completed.
- Salary Allowance: A service provider granted sabbatical leave shall receive a maximum of fifty (50) percent of his/her salary for the period of the sabbatical leave minus all required and/or elected deductions. Should the sabbatical leave be for participation in a program for which the officer is to receive remuneration, the total remuneration (DCPS salary and program assistance/compensation) shall not exceed the service provider's annual DCPS salary. In cases where the combined remuneration exceeds the service provider's annual DCPS salary, the service provider's DCPS salary shall be reduced accordingly.

Benefits during Sabbatical Leave

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

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

Contractual Agreement for Sabbatical Leave

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

termination pay upon agreement with the Officer.

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

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

Leave for Council Business

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

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

Return from Leave

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

Special Leave

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

Sick Leave Bank

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

Funeral/Bereavement Leave

Four (4) additional days of leave without loss of pay and benefits will be granted annually for the

occasion of the death of an employee's spouse/domestic partner, child, parent or sibling (whether adopted, natural, step, foster or in-law).The employee may be required to submit to the immediate supervisor a written statement specifying the date of funeral. This provision does not preclude the use of accrued sick leave if additional days are needed for the purpose of bereavement or attending a funeral. Funeral/bereavement leave shall not be cumulative and if not used during the school year, will not be carried over into the subsequent school year.

Liberal Leave During School Emergency Closures

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

Departmental Close-out Procedures for Providers Who are going on Extended/Maternity Leave, Resigning or Retiring

Below you will find a list of deliverables that are due to close-out your caseload prior to your transition and to assist with the continuity of services for your students upon your departure. These actions are required in order to leave DCPS and the Speech-Language department in "good-standing" and is part of your professional obligation (see Ethics section regarding abandonment). This is applicable to the following scenarios: 1) planned medical/family leave; 2.) maternity leave; 3.) retirement; and/or 4.) Resignation during the school year. Please review the below information and discuss with your assigned PM prior to your leave/departure.

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

- Submit formal letter of resignation to be submitted via the following link: https://octo.quickbase.com/db/main?a=SignIn&nexturl=https%3A%2F%2Focto.quickbase.com%2Fdb%2Fbgr42iqs8&rc=psi

Absence/ Leave Policies for ET-15

Refer to Washington Teacher's Union (WTU) contract for detailed information

Sick and Emergency Leave

- For the purposes of accruing and using sick leave, a day of leave is defined as eight (8) hours, regardless of the tour of duty. For leave purposes, one-half of the tour of duty is calculated as four hours. Twelve (12) days (96 hours) of sick leave are posted at the beginning of each school year for ten (10) month service providers. Four (4) sick leave days may be used for general leave and one (1) additional sick leave day may be used for "personal business leave" during each school year. General leave and personal business leave shall not be cumulative.
- Fifteen days (15) days (120 hours) of sick leave are posted at the beginning of each school year for twelve (12) month teachers (ET 15/12). Three (3) sick leave days may be used for general leave and one (1) additional sick leave day may be used for "personal business leave" during each school year. General leave and personal business leave shall not be cumulative. Unused sick leave shall be carried forward from year to year.
- A service provider who becomes sick or disabled to the point that he/she is unable to do his/her job, or has a scheduled medical or dental appointment, shall be permitted to use his/her accumulated leave in accordance with the Rules of the Board. **Leave requests for medical or dental appointments must be made by the service provider to his/her immediate supervisor as soon as the appointment is known to the employee**. **If a service provider cannot report for work due to illness, he/she shall notify the supervisor or designee as soon as possible, but in no case later than the first fifteen (15) minutes of the service provider's workday.**
- A service provider may be required to submit a doctor's certificate after three (3) or more consecutive days of absence due to illness, provided, however, that a service provider may be required to submit such a certificate in support of sick leave for any lesser period if the supervisor has reason to believe that the use of such leave has been abused.
- In cases of emergencies, service providers may be required to submit appropriate documentation in support of such absences.
- Service providers may be excused immediately from duties, with charge to leave, for pressing, urgent emergencies at any time upon oral explanation and notification to the supervisor or his/her designee. For the purpose of this ARTIcle, emergency shall be defined as any situation requiring immediate attention over which the employee has no control.

- Leave (sick and emergency), not to exceed thirty (30) days may be advanced to permanent and probationary service providers in cases of personal serious disability, illness or an emergency, which requires the service provider's personal attention. Service providers in a temporary status may be advanced sick leave in amounts equal to anticipated sick leave accruals during their temporary appointments. A request for advanced leave must be submitted and approved in writing at least five (5) days prior to the absence.
- A service provider may elect to return to the Board one half (1/2) of the sick leave days accrued but not taken during the current year at the current daily rate of pay. Un-purchased sick leave shall be credited each year to the service provider's sick leave balance and shall not be subject to the Sick Leave Buy-Back Plan.
- An employee sick leave bank shall be operated under the guidelines approved by the Board and the Union.
- An employee maternity/paternity leave bank may be established annually at the option of the Union. If established, it shall operate under the guidelines developed and approved by the Board and the Union.
- One day of "individual professional development leave" shall be posted at the beginning of each school year for all bargaining unit members. Such leave shall be cumulative and unused "individual professional development leave" shall be carried over from year to year as part of the cumulative sick leave. The Chancellor and the President of the WTU shall mutually agree on the parameters associated with the use of "individual professional development leave".

Extended Leaves of Absence

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

- Personal illness leave
- Family care leave
- Maternity leave
- Paternity leave
- Adoption leave
- Educational leave with pay
- Educational leave without pay
- Military service leave

A service provider who is granted an extended leave of absence for maternity/paternity purposes may elect to use her accrued sick leave at the time she begins the extended leave of absence from duty. A service provider returning from maternity/paternity, adoption or educational leave shall have the right to return to his/her former or comparable position. A service provider shall be permitted to return from maternity/paternity, adoption, or educational leave upon a thirty (30) day written notice of intent to return to work prior to the end of a semester. This shall not preclude a teacher from an earlier return at the discretion of the Board.

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

Court and Jury Leave

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

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

Family and Medical Leave

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

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

- The birth of a child of the employee:
- The placement of a child with the employee for adoption or foster care;
- The placement of a child with the employee for whom the employee permanently assumes and discharges parental responsibility; or
- The care of a family member of the employee who has a serious health condition.[4]
- Family member means:
  - A person to whom the employee is related by blood, legal custody, or marriage;
  - A child who lives with an employee and for whom the employee permanently assumes and discharges parental responsibility; or
  - A person with whom the employee shares or has shared, within the last year, a mutual residence and with whom the employee maintains a committed relationship.[5]

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

[4] D.C. Official Code § 32-502(a)
[5] D.C. Official Code § 32-501 (4)

functions, except that the medical leave shall not exceed sixteen (16) work weeks during any twenty-four (24) month period.[6]

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

Administrative Leave

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

Educational/Sabbatical Leave of Absence

- Educational/Sabbatical leave for academic study/professional improvement may be granted at the Chancellor's discretion and approval for academic study, research or other purposes that will increase or further the officer's professional growth and development and will contribute to the improvement of the school system.
- An outline of a planned program must be submitted with the application for leave, including what the officer intends to accomplish during the period of leave, how the leave would enhance the service provider's performance/career and benefit the school system, and a plan for monitoring progress during the term of leave. In addition, the service provider must obtain approval of the Chancellor or his/her designee who will monitor the plan, review progress reports submitted by the officer, and approve the documented completion of the approved program.
    a. Standard: The total number of service providers granted sabbatical leave at the Chancellor's discretion in any leave year will not exceed one (1) percent of the total number of service providers.
    b. Eligibility: A service provider becomes eligible for sabbatical leave, for a minimum period of a full semester, up to a maximum of one full year after five (5) consecutive years of employment with the District of Columbia Public Schools, excluding periods of Family and Medical leave, military or exchange leave. Eligibility is reestablished seven years after the first sabbatical leave is completed.
- Salary Allowance: A service provider granted sabbatical leave shall receive a maximum of fifty (50) percent of his/her salary for the period of the sabbatical leave minus all required and/or elected deductions. Should the sabbatical leave be for participation in a program for which the officer is to receive remuneration, the total remuneration (DCPS salary and program

[6] D.C. Official Code § 32-503 (a)

assistance/compensation) shall not exceed the service provider's annual DCPS salary. In cases where the combined remuneration exceeds the service provider's annual DCPS salary, the service provider's DCPS salary shall be reduced accordingly.

Benefits during Sabbatical Leave

- A service provider on sabbatical leave shall for all purposes be viewed as a full-time employee. The service provider's rights and privileges, length of service, and the right to receive salary increments as provided by the policies of the Board or this contract will be the same as if the service provider had remained in the position from which he/she took leave. However, annual or sick leave may not be used or earned while on sabbatical leave.
- During the period of sabbatical leave, the officer's contributions to his/her retirement plan will be continued.
- The service provider shall retain membership in the employee benefit plans, for which he/she shall be made for the period of leave; and the Board shall continue to make its contributions thereto.

Contractual Agreement for Sabbatical Leave

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

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

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

Leave for Council Business

Service providers elected to full time Council positions may be granted a leave of absence without pay for a period of one (1) year. Service providers granted leave of absence shall retain all rights to reinstatement and shall continue to accrue seniority. Service providers who are granted leave without pay for Council business may elect to receive retirement credit for such period of leave in accordance with the DC Official Code § 38-2021.01 (a).

Return from Leave

A service provider returning from Family and Medical leave or educational/sabbatical leave of absence shall have the right to return to his/her former position or to an equivalent position and the same salary

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

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

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

Funeral/Bereavement Leave

- Four (4) additional days of leave without loss of pay and benefits will be granted annually for the occasion of the death of an employee's spouse/domestic partner, child, parent or sibling (whether adopted, natural, step, foster or in-law).
- The employee may be required to submit to the immediate supervisor a written statement specifying the date of funeral.
- This provision does not preclude the use of accrued sick leave if additional days are needed for the purpose of bereavement or attending a funeral.
- Funeral/bereavement leave shall not be cumulative and if not used during the school year, will not be carried over into the subsequent school year.

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

Inclement Weather Policy

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

Inclement Weather Options

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

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

AM Radio:
WMAL (630), WOL (1450), Radio America, Spanish (1540), WTOP (1500)

FM Radio:
WAMU (88.5), WTOP (103.5), WHUR (96.3)

Television:
Channels 4, 5, 7, and 9 and Cable Channels 8, 16 and 28

Websites:
www.dc.gov/closures
www.dcps.dc.gov

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

Communications

E-mail

Each service provider has a dc.gov e-mail address. This is our primary means of communication***. Messages should be checked daily and returned promptly (within 24 hours)***. Failure to receive notification of job related information due to a lack of timely checking of one's e-mail is not an acceptable excuse for non-compliance to work responsibilities. Providers are required to use their dc.gov email address – no other email address should be used.

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

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

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

If you have any difficulty or questions in reference to using your dc.gov email, contact the Service Help Desk.

- (202)-671-1566 / (202)-442-5715 (DCPS)
- (202)-741-8832 (Fax)
- email: helpdesk.servus@dc.gov

Sample of E-mail Signatures

Jane Smith, MOT, OTR/L
Occupational Therapist

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

Out of the Office Messages

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

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

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

Mailbox and Route-Mail Service

Service providers are encouraged to check with school staff regarding correspondence.

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

Provider Management Application (PMA)

RSPs will be able to review their caseload, assigned assessments, document Tier II interventions, and review weekly email communication. The Provider's Management Application 2.0 is accessible through QuickBase by accessing the following website: https://www.octo.quickbase.com

Occupational and Physical Therapy Weekly Notices

OTs and PTs will receive weekly notices on Monday morning. It will include OT and PT timeliness rates for assessments and Random Moment in Time Study timeliness, documentation percentages, and tasks due for the week, and reminders on upcoming important dates or events in DSI and DCPS. This information will be received via the Provider Management Application 2.0, where the clinician will have that information on their dashboard.

CANVAS

This web application replaces the previous EdPortal. This site will house information and forms related to policy and procedure for related service providers will also be able to access template forms using this site.

1. CANVAS can be accessed via the following web address: https://dcps.instructure.com
2. Select "Portal" at the top of the page. You can access documents for Related Services in the following manner: Teaching and Learning → Specialized Instruction → OPSA → Occupational and Physical Therapy)

Equipment/IT Support

Laptop Computer Support

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

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

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

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

Stolen Computer/ Laptop

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

Test Materials

Assessment Test Materials

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

Sign-Out

Sign-out is required for all DCPS materials. Information will be cataloged and the provider assumes all responsibility for the equipment. If the equipment is loaned out between providers, some written verification should be obtained that the materials were loaned and that the materials have been returned. If materials are stolen, it is the providers' responsibility to file and submit police report verification as well as a property accountability form and present it to the appropriate DSI Supervisor.

Materials on Loans

Materials are on loan to you for DCPS work purposes only. Therefore, upon your resignation, your materials should be returned in good condition to your DSI Supervisor prior to your resignation date. Failure to return property will result in garnishing of wages. This includes laptops and other technology equipment provided by DCPS.

Dress Code Requirements

It is the providers' responsibility to find out the dress code requirements for the schools he/she services, and to wear the appropriate attire. Providers must be in compliance with the dress code for the school. Cleanliness, professionalism, good taste and safety are the primary considerations. The following is a non-exhaustive list of expectations. Please follow your school regulations.

- All clothing should be professional, clean, neat, and not stained.
- Clothing should not contain any suggestive or offensive pictures or messages.
- Appropriate leg and foot covering, as deemed by the school will be worn. Closed toe, low or no-heeled shoes should be worn for your personal safety.
- Clothing should fit appropriately. Tops should be of opaque fabric (not see-through), not too low cut, tight or loose, and long enough to remain tucked in with movement (i.e., no bare midriffs). Tops should allow for rising of hands above head without exposing skin. T-shirts that convey a casual appearance are not to be worn.
- Skirts or "skorts" may be worn, but should be no shorter than 2" above the knee and have no slits above the knee.

Additional Duties and Responsibilities

The Random Moment in Time Study (RMTS)

The Random Moment in Time Study is a mandatory study required by the Federal Centers for Medicare and Medicaid Services (CMS) to evaluate how school-based staff spend their time providing special education services. These snapshots are required to support claims for Medicaid reimbursement of school-based health services, which ultimately generates revenue for DCPS for products and services for special education programs. As a related service provider your participation in this study is crucial to securing these funds; if the response rate drops below 85% for all DCPS providers the federal government will deem the study invalid and penalize our district and DCPS' ability to claim for reimbursement. The terms RMTS and RMS are used interchangeably.

- Moment Timeline
- Each notification is sent in a separate e-mail and must be responded to individually
- Pre-notification 5 Business days before the moment
- Pre-notification 24 hours before the moment
- Notification 0-15 minutes before the moment
- If moment is not completed, reminders are sent 24 hours and 48 hours after the moment
- Moment expires 72 hours after the moment

If you have any questions about the Random Moment in Time Study you can contact Gloria Van Hook, Medicaid Analyst at **gloria.vanhook@dc.gov**

Performance Evaluations

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

- **Clarifying Expectations** - IMPACT outlines clear performance expectations for all school-based employees. Over the past year, we have worked to ensure that the performance metrics and supporting rubrics are clearer and more aligned to your specific responsibilities.
- **Providing Feedback** - Quality feedback is a key element of the improvement process. This is why, during each assessment cycle, you will have a conference to discuss your strengths as well as your growth areas. You can also view written comments about your performance by logging into your IMPACT account at http://impactdcps.dc.gov.
- **Facilitating Collaboration** - By providing a common language to discuss performance, IMPACT helps support the collaborative process. This is essential, as we know that communication and teamwork create the foundation for student success.
- **Driving Professional Development** - The information provided by IMPACT helps DCPS make strategic decisions about how to use our resources to best support you. We can also use this

information to differentiate our support programs by cluster, school, grade, job type, or any other category.

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

All related service providers in schools are in Group 12 and in Early Stages, Group 20. There are three IMPACT components for the members of Group 12. Those components include:

- Related Service Provider Standards (RSP)
- Assessment Timeliness (AT)
- Core Professionalism (CP)

Please refer to the DCPS Website to access additional information. You may also contact the IMPACT office at (202) 719-6553 or impactdcps@dc.gov.

NPI Requirement

As a result of the Affordable Care Act, the Centers for Medicare and Medicaid (CMS) issued a final rule[7] on April 12, 2012 requiring all providers of medical services to obtain a National Provider Identifier (NPI). The NPI acts as a unique provider identifier for Medicaid claims submitted to the Medicaid Agency. In order to conduct Medicaid claiming, all providers are rendering services on behalf of DCPS must obtain an NPI. Refer to the document "DSI Provider NPI Requirement for New Employees" in the appendix.

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

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

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

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

[7] 42 CFR Parts 424 and 431

Special Education Reference Information

Special Education Disability Classifications

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

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

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

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

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

Autism Spectrum Disorders (AUT)

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

Common Associated characteristics:

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

Traumatic Brain Injury (TBI)

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

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

Intellectually Deficient (ID)

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

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

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

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

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

Emotional Disturbance (ED)

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

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

Specific Learning Disability (SLD)

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

Speech Language Impairment (SLI)

To be eligible for SLI, a student must:

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

NOTE

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

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

Hearing Impairments including Deafness / Hard of Hearing (HI)

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

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

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

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

Visual Impairment (VI)

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

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

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

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

Orthopedic Impairment (OI)

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

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

Other Health Impaired (OHI)

Other health impairment means having limited strength, vitality or alertness, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that is due to chronic or acute health problems such as asthma, attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, an sickle cell anemia; and adversely affects a student's educational performance.

Multiple Disabilities (MD)

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

Developmental Delay (DD)

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

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

RTI and General Education Interventions

Pre-Referral Interventions

Before a student is referred for special education services, interventions in the general education setting may be implemented. This section describes the resources and tools used to provide these interventions and the processes to refer a student for special education services if further intervention is required.

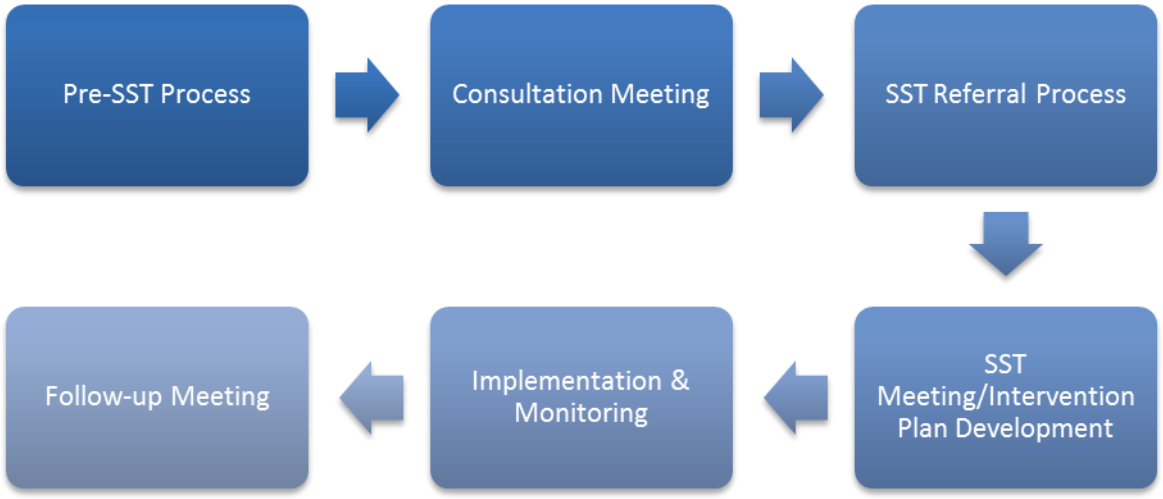
Pre-Referral Process

The Pre-referral process Team is a problem solving team consisting of school-based personnel. Parents are encouraged to participate as an active member of the team. The RTI Coordinator organizes and facilitates weekly meetings to address the academic and/or behavioral needs of students. The team:

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

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

Pre-Referral Process



This process is a vital part of the student referral process. The RTI/Pre-referral team includes three to five members, including, but not limited to, an administrator, a counselor, a regular education teacher, a special education teacher, a school social worker, a parent, with specialists or other central office persons as appropriate. In many schools, the social worker may be asked to chair this team or lead the team regarding behavior concerns. The RTI/Pre-Refferal process should be implemented over approximately six weeks, to determine if the recommendations are successful. If the strategies are not successful the team can meet again to modify the strategies. Students should be referred to Special Education if two important decision criteria are met:

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

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

Response to Intervention (RTI)

Introduction to Response to Intervention (RTI)

Prior to a referral being submitted for assessment for special education, response to intervention efforts should be employed. Pre-referral interventions are a part of the Response to Intervention (RTI) process. The RTI/Pre-referral team should meet to discuss the student and determine what interventions will be implemented to assist in meeting the individual needs of the student.

Response to Intervention (RTI) is a prevention-oriented approach to linking assessment and instruction that can inform educators' decisions about how best to teach their students. A goal of RTI is to minimize the risk for long-term negative learning outcomes by responding quickly and efficiently to documented learning or behavioral problems and ensuring appropriate identification of students with disabilities" (National Center on Response to Intervention 2010, 4). RTI is emerging nationally as an effective strategy to support every student. It is cited in the reauthorization of the Individuals with Disabilities Education Act (IDEA) of 2004 related to the determination of a specific learning disability and in 34 Code of Federal Regulations sections 300.307, 300.309, and 300.31.

Response to Instruction and Intervention (RTI) is a methodical, data-driven approach to instruction that benefits every child. RTI is intended to speak to the full range of instruction, from the general core curriculum, to supplemental or intensive instruction, to meet the academic and behavioral needs of children (34 CFR § 300.226).

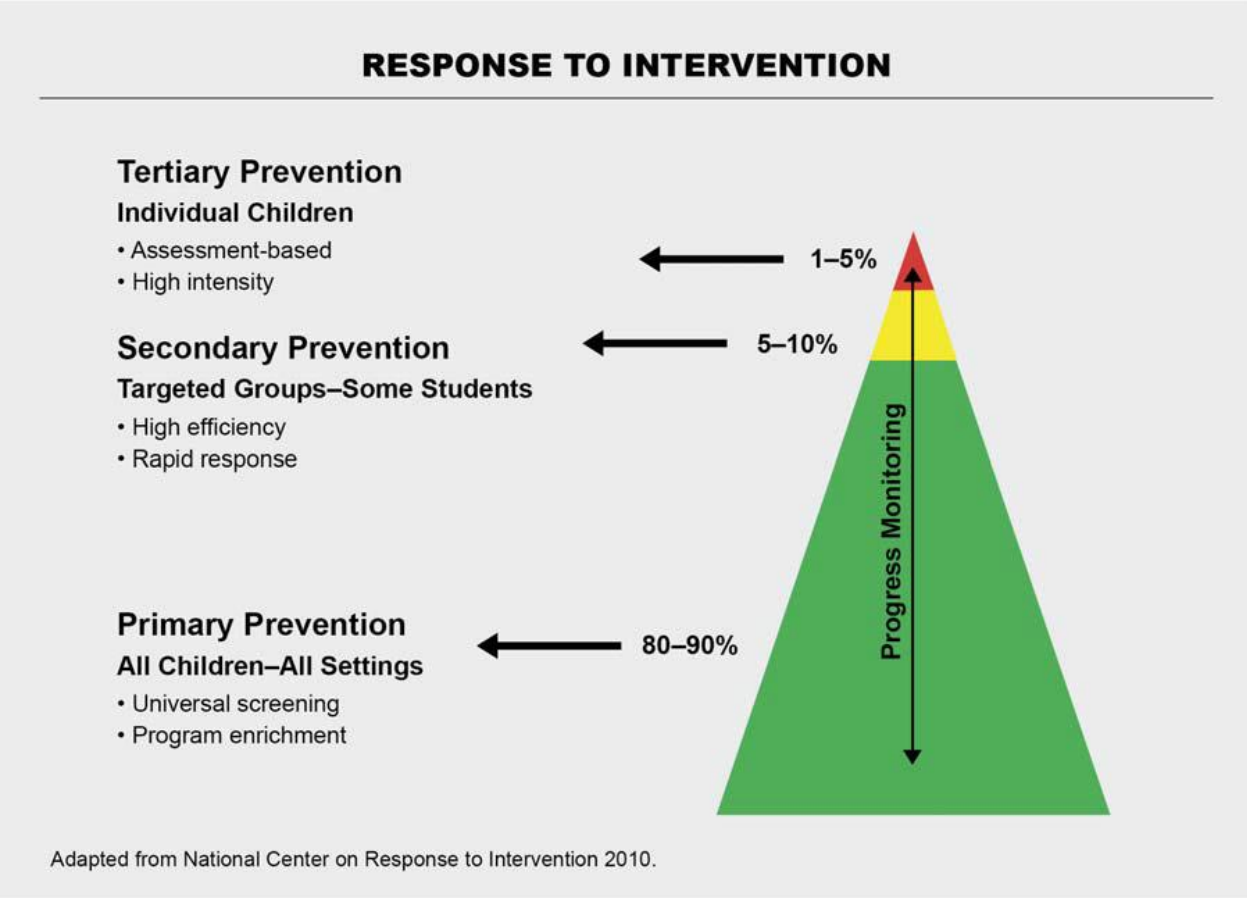
Documenting Pre-Referral Interventions

RSPs must document pre-referral interventions in the Provider Management Application (PMA). The PMA is accessible through Quickbase by accessing the following website:
https://octo.quickbase.com/db/main

The OT and PT Role in RTI and RTI strategies

Among the strategies used to prevent students from negative learning outcomes is one called Response to Intervention (RTI). OTs and PTs have emerging roles in the RTI process.

DCPS uses a three-tiered model (Figure 2): 1) Universal prevention and promotion, 2) Targeted or early intervention, and 3) Intensive intervention to implement mental health services across the continuum.



Response to Intervention Three Tier Model

Tier I: Universal screening and intervention:
In Tier I, the OT and PT collaborate with educational staff on curriculum enrichment providing universal, proactive, and preventive intervention strategies to support a high quality core instructional program and progress monitoring of all students in all settings. Program enrichment and accommodations are made in order to support the success of all children in the educational setting. The curriculum and activities become more accessible and meaningful. At this level of service, children have not been identified as requiring OT or PT as a related service to special education

Tier I Activities may include:

- In-service training sessions and provision of resources
- Accommodations for all children to gain access to the curriculum, classroom, and campus, including modifications of tools, tasks, materials, or the environment or all four
- Seating and/or positioning of the desk and chair for proper ergonomic fit
- Sensory-enriched classroom and curriculum design
- Adaptations to support fine and gross motor development
- Activity analysis and activity demonstration

- Universal design

For example, at Tier I the OT may make suggestions to the classroom teacher regarding different handwriting curriculum and strategies for fine motor and visual motor development; discuss appropriate ergonomic posture for desktop activities; make suggestions to facilitate improved core muscle strength; and illustrate the importance of children using an efficient pencil grasp and activities to improve hand strength and dexterity. Handwriting samples or a child's portfolio may be used to monitor progress toward meeting language arts state standards. After providing a universal screening of writing samples, the teacher and OT may identify a small group of children who need additional support in language arts for developing handwriting skills.

At Tier I, the PT may discuss gross motor skill development and milestones with the classroom teacher; identify specific motor skills needed to participate in the educational environment; pinpoint modified motor skills that children may use to accomplish the same activities with their peers; discuss sitting and standing posture and the importance of maintaining proper alignment for motor activities; or make suggestions for decreasing the level of difficulty of the motor skills required (e.g., use the ramp instead of the stairs). The PT may observe the children participating in natural opportunities (physical education, recess, free-play) using their motor skills and, based on this general observation, target a group of children for further screening if motor skills difficulty is noted.

Tier II: Targeted group intervention (strategic):
In Tier II, the role of the OT or PT may include an analysis of the screening of all children. The screening assists in forming highly structured groups of children with similar needs for appropriate evidence-based instructional strategies and interventions for success in the curriculum. Screenings are conducted in a natural environment conducive to eliciting a representative sample of a child's functional abilities in the school setting. Screenings must not involve any activity that removes a child from regular school activities. Screenings may include observation of a child in a peer group if the observation does not identify or single out a particular child (EC § 56301). A teacher or specialist may screen a child to determine appropriate instructional strategies for curriculum implementation. Screening is not considered an assessment for determining eligibility for special education and related services and therefore does not require parental consent (34 CFR § 300.302; EC § 56321(g)). Tier II intervention targets at-risk students and is short term in duration.

Tier II Activities may include:

- Review teacher data and the outcomes of Tier 1 classroom accommodations.
- Consult with parents, teachers, and other school staff to learn about their
- concerns regarding participation of various groups of children in the general education curriculum.
- Review group work samples identifying groups of children with specific needs.
- Review curriculum and propose modifications to meet targeted needs.
- Analyze ongoing curriculum data collected by the teacher and assist with disability identification.
- Assist in designing and implementing targeted group instruction.
- Review scientifically based data collected through the pre-referral process.

- Provide follow-up screening and intervention for a targeted group, as appropriate.

The following outcomes may result from the screening:

- Information to the teacher, school staff, or parent supports the determination that the child's abilities are adequate to gain access to educational opportunities.
- Targeted interventions, program accommodations, and data collection are recommended and implemented by the classroom teacher or parents or both.
- There is follow-up support in the form of a referral to the Student Success Team (RTI) or other general education process for RTI.

At Tier II, the OT may assist the teacher in developing a handwriting center in the classroom where children receive strategic instruction in targeted groups with ongoing monitoring and feedback from the teacher. The OT may suggest developmentally appropriate accommodations based on research, such as various handwriting programs, physical and sensory strategies, the use of a pencil grip, or paper with clear visual boundaries. If a child continues to demonstrate difficulties meeting state standards even with Tier II supports, more individualized attention may be suggested.

At Tier II, the teacher, parent, and school staff may discuss with the PT concerns about the child's gross motor skills. In turn, the PT analyzes the concerns and then may form a gross motor challenge (e.g., obstacle course) in which the entire class participates. This strategy allows the PT to note general performance patterns and to observe if any child demonstrates difficulties with these skills. From the general screening, the PT may discern that the majority of children demonstrate similar patterns or that more specific data are required to determine differences in performance. In addition, if the majority of the children demonstrate similar patterns, the PT may suggest skills for the children to practice and rescreen them in a given time frame to note any changes in the children's performances (National Center on Response to Intervention 2010).

Tier III: Intensive Intervention:

In Tier III, the OT and PT provide follow-up consultation to the classroom teacher, staff, and parents and support the collection of progress-monitoring data to help identify more effective individualized intervention strategies and accommodations. In collaboration with the teacher, the OT or PT develop a measurable goal and implement a specific, targeted intervention to address the area of concern. A systematic method of data collection is employed to monitor the child's progress toward the goal is. Upon review of the data, the RTI determines whether the intervention was successful and further intervention is necessary. If the child did not make adequate progress, the RTI modifies the intervention method and may refer the child for a special education assessment for all areas of a suspected disability.

Tier III Activities may also include**:**

- Participate on the RTI or other general education processes for RTI.
- Develop and monitor measurable goals.
- Assist the RTI in providing systematic monitoring of the child's progress by reviewing the data.

Throughout all of these phases, progress is continuously monitored. If a student continues to struggle after targeted interventions and accommodations are in place and documented for a reasonable amount of time (as determined by the RTI team), a referral for a special education evaluation should be made. If RTI activity is not successful in addressing the identified difficulties the student should be referred for an assessment.

Vision and Hearing

Vision and hearing screenings are completed by school personnel (i.e., school nurse). If either screening is failed, appropriate measures must be taken (parent notified, audiological assessment obtained, glasses prescribed, requests for vision / hearing assessments etc.) in an attempt to correct the problem before the student can be evaluated, in most cases. If it is ascertained that a vision or hearing impairment cannot be corrected or has been corrected to the extent that it can be, this information should be included and incorporated into the assessment report.

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

- Have the LEA order the Audiological Assessment in the Special Education Data System (SEDS)
- Contact the Audiology Department at (202) 698-8011 or send an email to DCPS.Audiology@dc.gov

Special Education Referral Process

Once strategies implemented through the RTI process have proved unsuccessful and an occupational therapy or physical therapy assessment is necessary, a referral for assessment will be initiated through the IEP team (See pg. 51-52). Once a referral for an occupational or physical therapy assessment has been made, the Analyzing Existing Data section in EasyIEP is completed.

Analyzing Existing Data

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

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

2. The IEP team should begin their review of the referral by analyzing as many of the following types of existing data as are available:

- Attendance
- Behavior or Incident reports
- Classroom observations
- Class work samples
- Current grades
- Discipline reports
- Documentation of academic and behavior interventions
- Evaluations and information provided by parents
- Health records and medical reports
- Report cards
- Standardized test scores

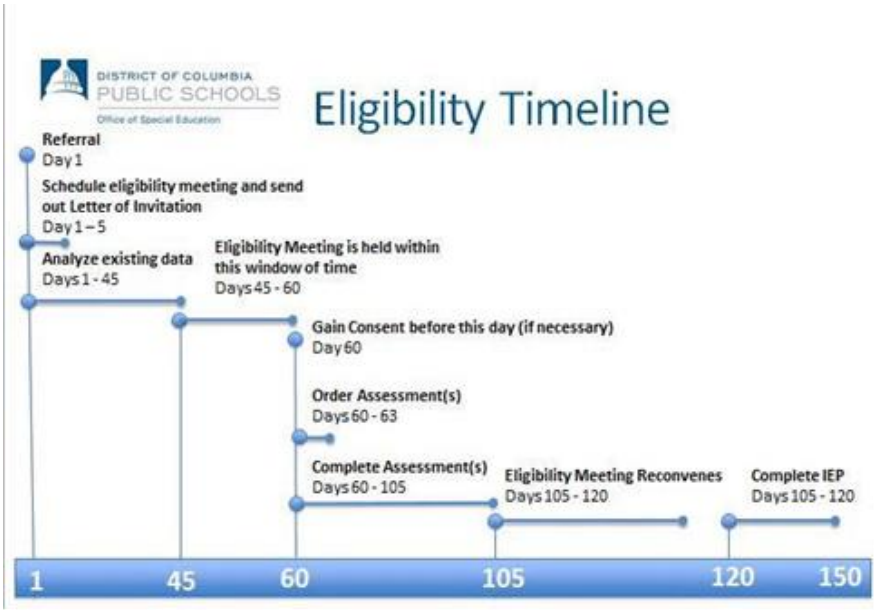
3. Identify the data that is needed to be determined
    - Category of disability
    - Present level of performance
    - Special education and related services
    - Modifications to allow child to meet IEP goals and participation in general education
    - The student's progress

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

OT/PT Services and the Special Education Process

Special Education Process

Eligibility refers to the meeting of specific criteria for receiving special education and related services. A student may not receive special education and related services as defined in IDEA unless they have been determined to be eligible by the MDT. The chart below illustrates how the identification and eligibility process which will trigger whether a student is eligible for special education and related services. This section will illustrate the steps required in this process:



If a student is found eligible for special education under IDEA, decisions about the need for related services are made by the IEP team taking into consideration the OT and PT assessment information provided. When a student is suspected of having a disability and initially referred for a comprehensive evaluation, the eligibility committee reviews the assessments and any pertinent information to determine if the child has a disability that requires special education. Once eligibility has been established, the IEP team determines if related services are needed to help the student benefit from his educational program or access the general curriculum. The IEP team makes this determination based on the current data in the child's education record, or by evaluating the child in accordance with applicable requirements.

Before a student may be assessed, the District must notify the parents in writing. This notice must describe any assessment procedure that the District proposes to use. Parents must give their informed consent in writing before their student may be evaluated/assessed. Once a meeting is held to determined if assessments should be ordered, parent consent is gained. Once consent is gained an assessment is ordered in EasyIEP and the respective provider begins the assessment process

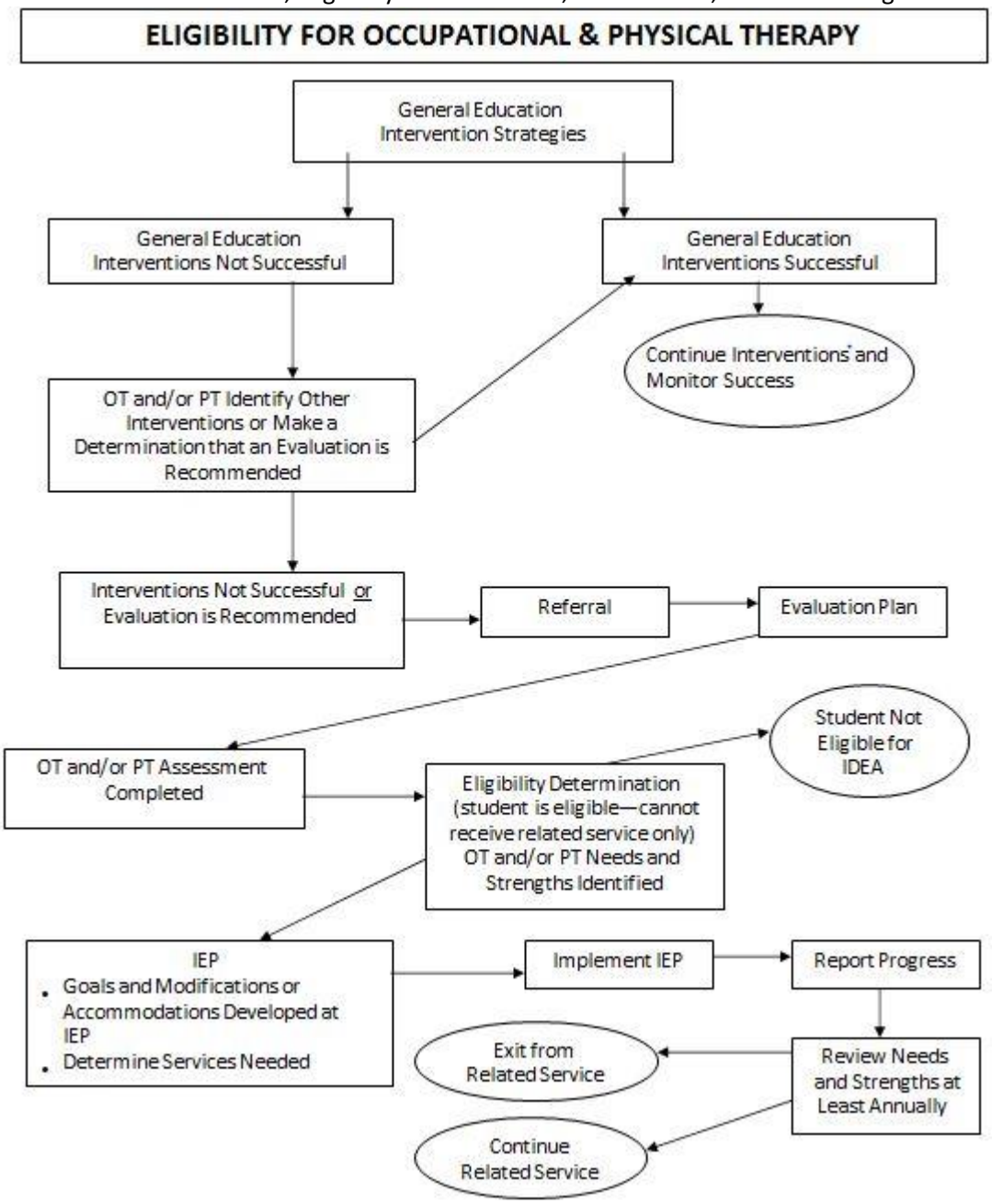
*****Per the DCPS guidelines, initial and reassessments must be completed within 45 days of parental consent.**

Once the evaluation process is complete a multi-disciplinary team will use data from these assessments to determine whether a student has a disability, the student's present levels of academic achievement and functional performance. If eligible for special education and related services, the MDT will then use this information to develop a student's IEP. The information will also be used to determine whether modifications are needed to enable the student to achieve his or her annual IEP goals, and to participate in the general education curriculum. For preschool students this information is used to help them participate in age-appropriate activities.

The multidisciplinary team is responsible for determining the need for an occupational or physical therapy assessment rests, while the service provider is responsible for choosing appropriate assessment methods,and intervention strategies.

Overview: Eligibility Process for OT and PT Services

The following flow-chart depicts the process for providing OT/ PT services at DCPS. The process is completed in the following stages of OT/PT service process: General Education Intervention and Referral, Evaluation and Assessment, Eligibility Determination, Intervention, and Monitoring.



Early Stages Eligibility and OT/PT Services

Students between the ages of 3 and 5 years, 10 months who are referred for an initial special education evaluation are assessed by the Early Stages team, not the special education team at the local school. Initial assessments for student's special education eligible 5 years, 11 months, are to be completed by the RSPs assigned to the school. Initial assessments for special education eligible students younger than this age are to be completed by Early Stages. This includes any bilingual assessments. Initial OT or PT assessments for students under 5 years, 10 months with an existing IEP, must be completed by the local school. Re-assessments for students between the ages of 3 years and 5 years, 10 months should be completed by the IEP team at the student's attending school.

Students referred to the Early Stages Center receive a full assessment at the center located at Walker Jones Education Center or Minnesota Avenue Center.

Early Stages Contact Information: (202) 698-8037 www.earlystagesdc.org

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

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

Student's transitioning from IFSPs to IEPs

Per court order, student's transitioning from an IFSP to IEP may not be re-evaluated by Early Stages providers. RSPs at Early Stages are only able to complete a review. Typically, hours on an IFSP are higher than an IEP secondary to the student not having any educational opportunities. Therefore, due to this process it may impact these student's IEPs as having greater hours than a typical IEP that has gone through the evaluation process.

Multidisciplinary Assessment Reports

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

Part C and Transition

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

Steps for a Smooth Transition

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

For toddlers who may be eligible for preschool services from the LEA under Part B (e.g., special education and related services), the transition must include the following steps:

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

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

The Collaborative Relationship between Providers in Schools and Early Stages

The assessments conducted at Early Stages plays an integral part in the shaping of the students receiving Occupational and/or Physical Therapy services within the schools. The early identification of students is intended to reduce future educational impact and adverse effects the student may experience throughout his/her educational career. In order to ensure that the needs of our students are adequately met, it is imperative that the Early Stages RSPs and School-based RSPs collaborate as it relates to identification, recommendations, and determination of services and service delivery.

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

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

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

Determination of Settings for Interventions

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

Service	Setting	Begin Date	End Date	Time Frequency
Occupational or Physical Therapy	Outside General Education Setting	2/27/2020	2/26/2020	60 min/month
Occupational or Physical Therapy	Inside General Education Setting	2/27/2020	2/26/2020	60 min/month

OR

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

Gold Collaboration

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

The Teaching Strategies GOLD assessment system blends ongoing, authentic observational assessment for all areas of development and learning with intentional, focused, performance-assessment tasks for selected predictors of school success in the areas of literacy and numeracy. This seamless system for children is designed for use as part of meaningful everyday experiences in the classroom or program setting.

It is inclusive of children with disabilities, children who are English-language or dual-language learners and children who demonstrate competencies beyond typical developmental expectations.
The assessment system may be used with any developmentally appropriate curriculum.

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

The Teaching Strategies GOLD goals in the area of Physical Development are as followings:

- **Objective 4 – Demonstrates traveling skills**
  - Moving purposefully from place to place without
  - Coordinates complex movements in play and games

- **Objective 5 – Demonstrates Balancing Skills**
  - Sustains balance during simple movement experiences
  - Sustains balance during complex movement experiences

- **Objective 6 – Demonstrates Gross-Motor Manipulatives skills**
  - Manipulates balls or similar objects with flexible body movements
  - Manipulates ball or similar objects with a full range of motion

- **Objective 7 – Demonstrates fine-motor strength and coordination manipulative skills**
  - Uses fingers and Hands

    - Uses refined wrists and finger movements
    - Uses small, precise finger and hand movements
- Uses writing and drawing tools

Early childhood teachers may reach out to the OT or PT to help collaborate on GOLD ratings.

Definition of Educational Impact For the Early Childhood Population

For occupational therapy educational impact is defined as decreased ability to apply, use, and generalized foundation fine motor, visual motor, and sensory processing skills towards academic and non-academic school tasks. These can include (but not be limited to) the following: written communication (pre-writing strokes, letter formation, organization of written work), multistep activities (arts and crafts, simple meal preparation, motor based activities [i.e. gym class, organized classroom games, etc.), gathering materials for school activities, keeping track of materials for school activities, etc.), efficient and *safe* manipulation of school tools (crayons, chalk, pencils, scissors), independence with age appropriate self-care tasks (clothing management, feeding, personal hygiene, tooth brushing), and establishing and maintaining functional and meaningful relationship(s)between peers and school staff (i.e. attending, expanding upon play schemes, etc.).

For physical therapy, educational impact is defined as decreased ability to safely and functionally access the school environment and accessing materials needed for academic and social success. *Short version—student demonstrates serious difficulty on effectively and safely accessing educational environment(s) and/or materials*

Occupational and Physical therapists should use these objectives to inform eligibility discussions, drive goals, gauge progress in treatment, and determine educational relevance and impact with the early childhood population. RSPs providing intervention services to early childhood students will provide input into the GOLD assessment tool for quarters 1 and 4 for the GOLD objectives related to their discipline. Each RSP assigned to an elementary school or educational campus should familiarize themselves with Teaching Strategy GOLD.

Parentally Placed/Self-Funded Students

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

- Day Care Center
- Private school
- Parochial school
- Non-Public School

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

In the event the parent elects to remain with the private school option, the parents reject the IEP and an ISP (Individual Service Plan) is developed. DCPS offers to provide the related services from the ISP during the school day at the student's location.

Documenting

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

Assessment Procedures

Assessments are crucial components of the special education evaluation process. Expert assessments can help the IEP team determineappropriate Occupational Therapy or Physical Therapy services for a student as necessary.

Comprehensive Occupational Therapy Evaluations

A Comprehensive Evaluation is an assessment completed to determine if areas of weaknesses or suspected disability are affecting a student academically, social/emotionally, and/or vocationally. The mandatory areas that must be assessed in an initial or re-evaluation for an evaluation to be considered comprehensive. A comprehensive Occupational or Physical Therapy Evaluation must include both quantitative and qualitative measures and components.

As outlined in *AOTA's Occupational Therapy Framework: Domain and Process, 3rd ed.*, Evaluation occurs during the initial and all subsequent interactions with a student. The evaluation consists of two steps: the occupational profile and an analysis of occupational performance.

1. **Create a Student's Occupational Profile:** The occupational profile is a summary of a student's occupational history and experiences, patterns of daily living, interests, values, and needs. Developing the occupational profile provides the occupational therapy practitioner with an understanding of a student's perspective and background. The evaluation process is focused on finding out what a student wants and needs to do; determining what a student can do and has done; and identifying supports and barriers to health, well-being, and participation.

   Using a student-centered approach, the practitioner gathers information to understand what is currently important and meaningful to the student (i.e., what he or she wants and needs to do) and to identify past experiences and interests that may assist in the understanding of current issues and problems. During the process of collecting this information, the student, with the assistance of the occupational therapy practitioner, identifies priorities and desired targeted outcomes that will lead to the student's engagement in occupations that support participation in life. Only students can identify the occupations that give meaning to their lives and select the goals and priorities that are important to them. By valuing and respecting students' input, practitioners help foster their involvement and can more efficiently guide interventions. This is why parents/guardian, teacher/educator and student interviews are so important.

2. **Create an Occupational Performance Profile:** Occupational performance is the accomplishment of the selected occupation resulting from the dynamic transaction among the student, the context and environment, and the activity or occupation. In the analysis of occupational performance, the student's assets and problems or potential problems are more specifically identified through assessment tools designed to observe, measure, and inquire about factors that support or hinder occupational performance. The analysis of occupational performance involves one or more of the following activities:
   - Synthesizing information from the occupational profile to focus on specific occupations and con-texts that need to be addressed

- Observing a student's performance during activities relevant to desired occupations, noting effectiveness of performance skills and performance patterns
- Selecting and using specific assessments to measure performance skills and performance patterns, as appropriate
- Selecting and administering assessments, as needed, to identify and measure more specifically the contexts or environments, activity demands, and student factors that influence performance skills and performance patterns
- Selecting outcome measures
- Interpreting the assessment data to identify supports and hindrances to performance
- Developing and refining hypotheses about the student's occupational performance strengths and limitations
- Creating goals in collaboration with the student that address the desired outcomes
- Determining procedures to measure the outcomes of intervention
- Delineating a potential intervention approach **or approaches based on best practices and available evidence.**

Multiple methods often are used during the evaluation process to assess student, environment or context, occupation or activity, and occupational performance. Methods include:

- An interview with the student and significant others
- Observation of performance and context
- Record review
- Direct assessment of specific aspects of performance.
- Formal and informal, structured and unstructured, and standardized criterion- or norm-referenced assessment tools can be used.

Note: Standardized assessments are preferred, when available, to provide objective data about various aspects of the domain influencing engagement and performance. The use of valid and reliable assessments for obtaining trustworthy information can also help support and justify the need for occupational therapy services.

Although testing in many areas is needed in a comprehensive OT evaluation, not all of these tests and measures are necessary for every child. Common child-specific areas assessed by OTs related to participation in school activities mayinclude:

- Activities of daily living
- Arousal, attention, adaptive behavior, and organizational skills
- Assistive and adaptive technology
- Community integration
- Environmental, home, and work (school/play/job) modifications
- Ergonomics and body mechanics
- Fine motor and gross motor function (motor control and motor learning)
- Habits, routines, and roles

- Leisure skills
- Neuromuscular functions
- Occupational profile, interests, values
- Play
- Praxis
- Rest and sleep
- Self-determination
- Social participation
- Tool use
- Visual motor integration
- Work and prevocational skills

Triennial Assessments/ Reevaluations

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

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

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

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

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

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

- Informed parental consent should be sought with due diligence by the school before any new assessments take place. The school division may proceed with new assessment if the school can show that it has taken reasonable measures to obtain this consent and the parents have failed to respond. These attempts must be documented in SEDS.
- A triennial assessment must include new assessments if the parent requests it.
- A triennial assessment should include new assessments, if:

1. Additional information is needed for continued placement and/or delivery of services.
2. The IEP committee is considering a change of placement, disability, or eligibility.
3. The evaluator determines that the previous assessment(s) is outdated, erroneous or inconsistent.

If the decision is to conduct new assessments, a comprehensive occupational or physical therapy evaluation must be conducted using the OT or PT re-assessment template.

*****All students must be re-assessed in order to exit occupational or physical therapy services**

Occupational Therapy Assessment Report Writing

After creating last two steps (assessment), these elements must be included in every assessment report which is the next step (please find a blank template in appendix as well as the CANVAS website: https://dcps.instructure.com/login/ldap).

Mandatory Occupational Therapy Assessment Report Elements
The following items are required in the Mandatory Occupational Therapy Assessment Report and their respective descriptions. Each section must include the mandatory elements with required information. Each section must include a summary of the test results using quantitative and qualitative information/data. In addition, the report should describe the specific skills and the student's ability to access the curriculum /grade level material. As school based providers, the written report must discuss the student deficits and its educational impact based on the test results, observations, teacher reports, etc. Below please find a description of all required elements.

DCPS LETTERHEAD

TITLE: Initial OT Assessment; OT Re-Assessment; OT Classroom Observation; OT Independent Assessment Review

SECTION I. STUDENT IDENTIFYING INFORMATION:

Name: Name of student
DOB: Date of Birth
SID#: Student id number
DOE: Date of Assessment
DOR: Date of Report/Review
Grade: The grade that the student is in

CA: Chronological age
Examiner: Name and credentials
School: Name of Attending school
Teacher: Name of student's teacher

SECTION II. BACKGROUND INFORMATION:

- Background History:
  - Birth history/Previous services/Medical history/Academic history:
- Student's current program and supports consist of:
- Progress on interventions (RTI or occupational therapy IEP goals)

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

SECTION III. ASSESSMENT TOOLS USED:

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

- Review of Records
- Interviews
- Clinical Observations and Clinical Assessment
- Analysis of Work Samples
- Standardized/Non-Standardized Testing

A. Interviews

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

B. Behavioral Observations:

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

C. Clinical Assessment:

- **Neuromotor/Musculoskeletal**: having to do with the brain, nerves, muscles and bones
- **Muscle Tone**: the stiffness or tension in the muscles at rest
- **Range of Motion** (AROM/PROM): amount of active or passive movement available at a joint and is necessary for movement
- **Muscle Strength**: the ability of a muscle to produce force, which may result in the production or prevention of movement

- **Endurance:** ability to maintain sustained involvement in activities when participating in physical education or other school-based physical activities
- **Motor Planning:** motor planning consists of the ability of students to imagine a mental strategy to carry out a movement or an action; for instance, how to get on top of a table, how to move from point A to point B and overcome some obstacle, how to execute a dance step, or learning how to skip
- **Postural Control:** the ability of the student to assume and maintain postures against gravity like pivoting on the stomach, lifting legs and head on his back and seating upright on the chair
- **Bilateral Coordination:** the ability to execute smooth, accurate, and controlled movements. It involves appropriate speed, spatial awareness, balance, and the ability to combine several movements into a sequence
- **Fine Motor Skills**: refined arm, hand and fingers movements needed for grasping, in-hand manipulation and visual motor integration
- **Sensory Processing**: the ability to organize and interpret information from the environment to produce an appropriate response and interact within the environment

D. Non-Standardized Tools/Results: (Qualitative Assessments)

*** All formal and informal assessments must include the following: a description of what the test and subtests measured; the interpretation of the scores; strengths and weaknesses must be identified and described as it relates to how it would look/manifest within the classroom setting. All standardized tests must include standardized scores, unless the clinician is unable to establish a baseline/basal. In those instances the provider must indicate that the test/subtest was attempted and describe (i.e., behaviors, etc…) that precluded the student from being able to complete the test tasks Providers should not include raw scores in their reports.***

E. Standardized Tools/Results: (Quantitative Assessments)

*** All formal and informal assessments must include the following: a description of what the test and subtests measured; the interpretation of the scores; strengths and weaknesses must be identified and described as it relates to how it would look/manifest within the classroom setting. All standardized tests must include standardized scores, unless the clinician is unable to establish a baseline/basal. In those instances the provider must indicate that the test/subtest was attempted and describe (i.e., behaviors, etc…) that precluded the student from being able to complete the test tasks Providers should not include raw scores in their reports.***

F. Equipment
Does the student use any equipment? Is equipment being recommended?

Standards for Quality Assessments

When writing assessment reports, service providers should include all the components ***necessary to support the MDT on its mission to determine eligibility for special education and related services,*** and adhere to the following criteria:

- The report should be devoid of educational/medical jargon and written with language that is understandable for all stakeholders involved.
- The language in the report should be sensitive in nature as it reflects the identified classification.
- The report should refrain from using absolute statements.
- The report should be gender specific throughout its entirety.
- The report should be grammatically correct and all data points should be sensitized in a way that answers the referral question(s) and incorporates all measures used via qualitative and/or quantitative.
- The report should consistently contain scores, a description of all the tools used and their results, and include a statement describing any concerns about validity.
- The report should be problem and/or issue focused, and should clearly state and substantiate the impact of the student's behavior on his/her ability to access grade-level material, acquisition of academic goals and overall educational experience.
- Raw evaluation data or completed questionnaires are not considered reports and should not be included. In all cases, merely collecting data without analyzing and reporting what the data means is of little benefit.
- The report should consistently make student specific and detailed recommendations as appropriate, and always be written in the proper format.
- Finally, the report should include, in accessible language, practical strategies that school staff and families can use to help improve the student's academic achievement.

*****Please remember that the decision of qualifying a student for special education, occupational or physical Services and any other related services relies on the Multidisciplinary IEP Team, and it also includes recommendations/approval for time, duration, and amount of therapy. The eligibility for provision of related services should never be a unilateral decision of the occupational or physical therapist or any singular IEP member.**

Validity Statements

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

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

Examples of Validity Statements
Example 1: The findings of this assessment should be reviewed with caution due to the student demonstrating non-compliance and work-refusal behaviors, therefore it may not be an accurate reflection of his abilities. Student required multiple redirection to tasks and additional repetition beyond that indicated in the assessment manual.

Example 2: The assessment procedures used throughout the testing sessions were valid for its intended purpose to assess the student's motor skills. Based on performance and observation, the procedures were valid and accurately reflected the student's current level of functioning. However, a French interpreter was used to read and translate the student's responses to increase the student's ability to comprehend information and answer questions to increase the validity of the results.

Example 3: The evaluation procedures included the use of (standardized measures, informal assessment, observation in a variety of settings, and interviews of student, teachers and/or parents). All tests were administered in the student's primary language or through an interpreter, and were administered by qualified personnel in accordance with the instructions provided by the test publishers. Tests were selected to provide results that accurately reflect the student's aptitude, achievement, and which are not influenced by impaired sensory, manual, or communication skills. Except where otherwise noted, the results of this assessment are believed to be valid.

What to do when a quantitative (Standardized) assessment is not warranted or recommended

There are two types of assessments that typically guide our evaluation process, Quantitative (which includes the administration of standardized tools) and Qualitative. In an attempt to script the best possible learning profile of a student it is optimal that a combination of quantitative and qualitative assessments be conducted. This practice allows the professionals administering these assessments to drill down numerical outcomes and conduct cross analysis with all descriptions and anecdotal data.

Rationale for Utilizing Qualitative Assessments

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

Quantitative Assessment Method:
A quantitative assessment includes methods that rely on numerical scores or ratings. A quantitative measurement uses values from an instrument based on a standardized system that intentionally limits data collection to a selected or predetermined set of possible responses. Quantitative assessment

approaches work by the numbers, collecting, analyzing, interpreting, and charting results, trends, and norms. As such, this type of assessment in the educational setting allows for objective data and the ability to compare student performance across ages, grades, peers and oneself.

Qualitative Assessment Method:
A qualitative assessment gathers data that does not lend itself to quantitative methods but rather to interpretive criteria. This can include methods that rely on descriptions/ anecdotal information as opposed to numeric values. This type of assessment is more concerned with detailed descriptions of situations or performance; therefore it can be much more subjective but can also be much more valuable when analyzed by an expert. This tends to be the case because it accounts for human behavior, emotions, needs, desires and routines, which naturally captures insight into the "why" not just the numerical outcome.

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

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

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

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

- Record review (birth, developmental, medical, social, previous assessment data and educational histories)

- Direct Observation of the student within the natural environment/setting to elicit a representation of classroom function
- Parent/Teacher Interview (probing to determine level of demands within the communicative environment;
- Questionnaires and/or inventories that provide information regarding the student's communication abilities within the home and school settings, such as making request, length of MLU, joint attention, etc…(to be completed by the parent and/or teacher)
- A criterion-referenced assessment which compare a student's performance on specific skills, to a previously determined performance level. The criterion is based on expectations of what the child should be able to do.
- Dynamic assessment places emphasis on a student's learning potential rather than test performance by capturing the potential change in a student's performance on a task in response to specific facilitation techniques
- Play-based assessment uses free and structured play opportunities to observe and document the student's behavior as he/she interacts with toys and people.

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

- Validity - This section should indicate why standardized tests were not used in the administration of the OT/PT assessment. It should also indicate that the findings of the assessment should be interpreted with caution secondary to issues indicated in the scenarios outlined in the "Determination of Appropriateness for Qualitative Assessment" section of this document. These are some of situations where there could be potential invalidation of the findings within the assessment report.
- The "Recommendation" section needs to indicate the type of follow-up recommended if necessary following the administration of the assessment, such as suggestions for future assessments (this could be to gain additional information needed to make determinations). An example of this is to rule-in/rule-out an impairment and the need for a re-evaluation following the outcome of any other assessment

Independent Evaluations (IEEs)

There are times when an outside assessment is submitted to the District of Columbia Public Schools - DCPS, for consideration for the eligibility of a student with a suspected disability for the purpose of seeking placement in education programs or accessing services. It should be understood by parents and private services providers alike that determining student eligibility for an exceptional education program is more than administering a battery of tests. As it relates to the District of Columbia Public Schools, a

multidisciplinary assessment team (MDT) is required to review all relevant documentation and decide if data is sufficient and/or additional information is needed. Among the procedures to produce additional information the reviewer could include parent conferences notes, student observations, current educational functioning, and interviews (including the student's educational staff, parents and other service providers) before eligibility is determined.

All available information, assessment results, and results from independent evaluations are used by the team in the decision-making process regarding the student's participation in special education and related services, including occupational therapy. Information from independent evaluations has no greater weight than any other team evaluation. **A strong independent evaluation (IEE) addresses the student's performance in the educational setting considering the least restrictive (LRE) mandate. A credible evaluation includes, at minimum, observation of the child at school, interview of relevant team members, and consideration of past and current services.**

- When completing an IEE providers must complete:
  - The Independent Assessment Review form
  - The Record Review Report
  - Once complete the practitioner will upload both documents into SEDS using an "OT assessment" or "miscellaneous" cover sheet and then change the label to "IEE Review Report-OT" Or "IEE Review Report – PT".

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

An assessment by a person not employed by The District of Columbia Public School does not eliminate the need to assure that all procedures are followed prior to eligibility determination.

Untimely Assessment Due Diligence

All reports that are late or are incomplete will be considered Untimely. In those cases, please adhere to the Untimely Assessment Guidelines developed in November 2009. Please see Appendix for the *Untimely Assessment Guidelines Due Diligence Guidelines*.

Alternative Assessment Report

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

- You have made at least 3 documented attempts to assess the student, and the student was uncooperative or absent each time.

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

This process should not be followed if:

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

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

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

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

- Work samples or notes from the student's classroom teacher
- Teacher's concerns/observed difficulties as they pertain to academics affected by the areas of concern
- Accommodations and adaptations the classroom teacher has made to mitigate/remediate deficits, and results.
- Information on the student's cooperation towards the implementation of those accommodations and adaptations.
- Previous assessment reports
- Progress reports by related service providers (where relevant)
- Classroom observation (if possible)

Your report must state that you or another DCPS provider may complete the full range of initially recommended testing if upon review of this report by the IEP team both of the following statements is true:

1. The team (or parent) still believes there is not enough data available to make an eligibility determination; AND
2. There is reason to think that the factors that previously inhibited you from completing the testing will be ameliorated.

Closing Out Assessments

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

Entering Assessments Results:

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

Submitting Assessment Reports

- There are two options for submitting assessment reports: fax or copy and paste. Please select the fax option.
- For the fax option, you will be able to create an EasyFax cover sheet by clicking the "Create Occupational Therapy or Physical Therapy Assessment Report Cover Sheet" button.
- The cover sheet will appear in a separate document table. Fax your assessment report into the system with this cover sheet.
- When the system receives the fax, a data will appear in the Fax Received column along with a link to the faxed document in the EasyFax column.
- To submit assessment results, click the "Submit Assessment Results" button.
- After you submit the results, you will no longer be able to edit the information on the page.

Emailing the Case Manager

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

- Click the "Save & Continue" button to send the email and return to the previous page.

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

Procedures: FAQ

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

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

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

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

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

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

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

https://osse.pcgeducation.com/dcdcps

Bilingual Assessments and Interpreter Request Process

The Individuals with Disabilities Education Act (IDEA) regulations require assessments and other evaluation materials to be provided and administered in the student's native language or other mode of communication.

When a student has gone through the referral process and it is concluded based on the results of the English Proficiency Test that he/she needs to be assessed in his/her native language, the Special Education Coordinator will forward a referral package for a bilingual assessment. It is still necessary for all of the pre-referral steps, including intervention, to be completed prior to the referral package being forwarded to the Bilingual Team.

Currently DCPS does not have an OT or PT as part of the Bilingual Team. OT and PT staff will need to request an interpreter.

DSI Related Services Interpreter Request Process

The Division of Specialized Instruction (DSI) Related Services Interpreter Request process allows Related Services providers (RSPs) to formally request interpreter/translation services. Interpreter/translation services may be requested to support RSPs while conducting student evaluations, and assist parents participating in student meetings. All requests for interpreter/translation services require the RSP to submit an Interpreter Request Form or filling out the form electronically via the google link (please see appendix).

An interpreter may be necessary to facilitate the bilingual assessment of ELL students. An interpreter may also be necessary to facilitate review meetings or other MDT meetings with non-English speaking parents. **Scheduling an interpreter for meeting is the responsibility of the LEA Representative. Scheduling for an interpreter for testing is the responsibility of the assigned provider or evaluator.**

Requests can be made for the following services:

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

The information below outlines the process to secure an interpreter for a interpreting for testing that must be completed by the provider or evaluator:

1. LEA orders the assessment in SEDs and assigns the assessment to the school's assigned provider
2. Provider completes the Interpreter Request form using the following link: https://docs.google.com/a/dc.gov/forms/d/1zC__1BLdGezxcSgn8SUZ58X510VP5aFYSrsMVzuMpV0/viewform
3. The DSI point of contact will identify a vendor to complete the interpreter services and provide confirmation of interpreter/translation services at least two days prior to the date of services
4. Upon completion of interpreter services, the provider send a follow-up email to ROBERT RICHARDSON (202)-384-7870 or JENNIFER FULLER (202) 480-0898 (EARLY STAGES), confirming

the services were rendered with attached evaluation form (interpreter should provide form for the provider to complete at the time of service). All evaluation forms should be sent within 2 days of completed interpreter services.

How to Use an Interpreter

Prepare the interpreter by using the Briefing, Interaction and Debriefing (BID) process:

1. **Briefing**
   - Establish Seating Arrangement;
   - Provide overview of assessment purpose, session and activities;
   - Review student behaviors and characteristics that may impact; Discuss plans in case the child is not cooperative;
   - Discuss issues of confidentiality and it's boundaries;
   - Provide protocols, interviews, materials in advance so that the interpreter can become familiar with them;
   - Discuss technical terms and vocabulary ahead of time so that the interpreter may ask questions to verify concepts;
   - Discuss cross-cultural perspectives. The interpreter may provide the OT or PT with rules consistent with the student's background
   - Explain that the interpreter will need to limit non-verbal cues, such as hand gestures or vocal variations that may impact assessment results
   - Remind the interpreter to take notes on the student's responses
2. **Interaction**
   - Develop an agenda for the assessment session and review it with the interpreter interaction
   - Welcome student, introduce participants and establish rapport
   - Inform the student of the role of the interpreter and the role of the OT or PT
   - Speak directly to the student avoiding darting eyes between the interpreter and student
   - Speak in short, concise sentences and allow time for the interpreter to translate everything precisely
   - Pause frequently to allow the interpreter to translate information
   - Avoid oversimplification of important explanations
   - Avoid use of idioms and slang

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

Translation of documents

According to DCPS policy, the Language Acquisition Division will provide translation of vital documents into any non-English language spoken by a limited or non-English proficient population that constitutes 3% or 500 individuals, whichever is less, of the population served or encountered. Vital documents are defined as document(s) which are for district-wide distribution and do not

include individual student records. For example, the Chancellor's Letter to Parents about the last day of school and DCPS Enrollment packets are considered vital documents. These are documents for all DCPS parents including ELL parents. Translation for the document will be provided for the language group that constitutes 500 or 3% of the total population of DCPS.

If you have additional questions about document translation, please contact Psychology Program Manager, Dr. Ramonia Rich, Ramonia.Rich@dc.gov, 202-369-2886.

Special Education Eligibility Meeting and Determination

OT/PT participation in an Eligibility Meeting Discussion

For an IEP team or related service provider to consider the need for services, a student must be experiencing difficulties that impede either the student's learning. The student's response to evidence-based, pre-referral interventions, and applicable outside reports should be reviewed in the process of making this determination. To avoid the inappropriate identification of students requiring OT or PT services, the IEP team must determine this needs and include the parents/guardians and either an occupational or physical therapist.

When considering occupational and physical therapists, the IEP team should start with the basic question, "What does the child need to do in order to be successful in his/her educational program?" The functional skills a student needs to perform in the educational setting are dependent on a variety of factors, including the student's diagnosis, present level of function, educational program, and overall developmental, cognitive, and academic abilities. Some skill deficits may not directly impact educational progress and may not constitute educational need. In order to receive services at school, the impairment must be linked to the student's inability to access the curriculum and to achieve educational goals and objectives on the IEP. Also, the student's needs must be met in the least restrictive environment.

The team may consider the following conditions when determining that a child needs OT or PT to benefit from the education program, progress in the education setting and/or access the curriculum:

- Student's educational performance in the general education or special education program is negatively impacted if needs are not addressed by OT or PT, and he/she is not functional within the educational environment.
- Student requires OT or PT as a related service in order to benefit from his or her special education program.
- Student does not consistently demonstrates behaviors that would inhibit participation in OT or PT, such as lack of cooperation, motivation, or chronic absenteeism. In those circumstances, the IEP team should consider the initial eligibility decisions since the behaviors may reflect social maladjustment, environmental, cultural, or economic factors rather than an actual disability. The IEP team may also explore alternative services or strategies to remedy the interfering behaviors or conditions.
- Student's needs cannot be served by an alternative program and/or service, as determined by the IEP team.
- Changes in medical or physical status do not make therapy contraindicated.
- Student graduates from high school with a diploma.
- Student reaches the age of twenty-two years.

- When the student's anticipated goals and expected outcomes related to OT or PT intervention have been met for a particular episode of care.
- When based upon the therapist's judgment it is determined that the student will no longer benefit from therapy

Providing Documents to Parents Before and After Eligibility and IEP Meetings

D.C. Municipal Regulations require schools to provide parents with all related documents before Eligibility and IEP meetings. Please pay close attention to action items for OT/PT providers (i.e. make sure that all of their reports are available to be sent to parents by the appropriate dates and following up with LEA Rep to make sure that their reports were included and Communications log entry was made).

At least ten (10) business days before scheduled meeting, schools must:

1. Send parents all documents that will be discussed during that meeting must be sent home to parents and the Pre-Meeting Packet letter that explains the information should be sent with packet (can be found in Canvas and in Appendix).
2. After all documents have been provided to parents, Pre-Meeting Checklist must be completed and faxed into SEDS. Use "Miscellaneous Cover Sheet" and rename "Pre-Meeting Materials Checklist".
3. A Communications Log entry must be completed after providing parents with documents.

The following chart describes the most common documents that must be sent home prior to Eligibility/ IEP Meeting:

Documents to Provide Before an Eligibility Meeting	**Documents to Provide Before an IEP Meeting**
Analyzing Existing Data Report	Draft IEP
Copies/ results of any formal or informal assessments and/or evaluations (educational, FBA, OT/PT speech, psychological, etc.)	ESY Criteria Worksheet
Any other additional relevant documents that will be discussed at the meeting.	Post- secondary transition plans and any informal vocational assessments or surveys (students 14+)
If any of the IDEA required IEP team members will be unable to attend or participate by phone, a Mandatory IEP Meeting Excusal Form is also required.	LRE observation reports (if applicable
	Transportation forms (if applicable)
	Dedicated aide observation reports (if applicable)
	Any data/documents related to possible change of service hours

	Any other documents that will be discussed in the meeting.
	If any of the IDEA required IEP team members will be unable to attend or participate by phone, a Mandatory IEP Meeting Excusal Form is required.

Within 2 business days after an Eligibility or an IEP meeting, the school must:

1. Send the **finalized documents to parents, including:**
    - Finalized Eligibility or IEP
    - Signed Eligibility or IEP signature page
    - Eligibility or IEP PWN
2. A Communications log entry must be completed after providing parents with documents.

IEP Process

Once student's eligibility for special education and related services have been determined, the team must consider the following while developing the IEP:

Present Levels of Achievement and Functional Performance (PLAAFP)

Traditionally, IEPs have focused on helping students develop basic academic and functional skills with little connection to a specific academic area or grade-level expectations. In contrast, standards-based IEPs are directly tied to content standards; both the student's present level of performance and annual academic IEP goals are aligned with and based on the Common Core State Standards (CCSS,) creating a program that will assist the student in reaching greater academic proficiency.

Writing PLAAFP and Goals for IEP (also referred to as PLOP)

The first main element of an IEP is a statement of the student's present levels of academic achievement and functional performance (PLAAFP). The purpose of the PLAAFP is to describe the problems that interfere with the student's progress in the general education classroom and with the general education curriculum. The PLAAFP is the foundation to develop the student's IEP and measure the student's short-term and long-term success. From the PLAAFP, the IEP team develops an IEP that identifies the student's appropriate goals, related services, supplementary aids and supports, accommodations, and placement. The IEP team should include goals as well as any necessary accommodations and/or modifications, related service, or supplementary aides and supports to address any identified area of weakness.

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

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

Data Sources

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

- Most recent special education evaluation
- Student performance on DC-CAS/DC-CAS Alt
- Teacher reports

- Classroom observations
- Parental input
- Cumulative records: grades, attendance, retentions
- Discipline records

Three Components in Writing a PLAAFP statement

Component 1	A description of the student's strengths and weaknesses.
Component 2	A statement of needs that prioritizes the student's relative weaknesses to highlight what should be the primary focus of instructional support. Information should be included as to why these needs should be prioritized and how addressing these particular needs will improve the student's ability to access grade level content.
Component 3	An explanation of how the disability impacts academic achievement and functional performance in the general education setting. A brief description of specific recommended modifications and/or accommodations that directly relate to the impact of the student's disability on academic achievement and functional performance should be included.

PLAAFP Linked to Goals

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

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

Writing IEP Goals

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

DCPS requires goals and objectives are written in a S.M.A.R.T. format:

S Specific
M Measurable
A Achievable
R Realistic and relevant
T Time-limited

Specific goals and objectives "target areas of academic achievement and functional performance. They include clear descriptions of the knowledge and skills that will be taught and how the child's progress will be measured." To write specific goals and objectives the Social Worker should ask themselves the questions, "who, what, when, where and how?"
Measurable means that the goal can be measured by counting occurrences or by observation. "Measurable goals allow parents and teachers to know how much progress the child has made since the performance was last measured. With measurable goals, you will know when the child reaches the goal." The Social Worker should ask the question, "How can I measure this goal?"

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

Achievable (attainable) goals which respond to the questions; "Can the student meet the goal? Is the goal too difficult to be met, considering the student's physical, cognitive, social and environmental barriers?"

Realistic and Relevant goals and objectives "address the child's unique needs that result from the disability. SMART IEP goals are not based on district curricula, state or district tests, or other external standards". The Social Worker should ask the question "Is this goal meaningful to the student?"

Time-limited goals enable you to monitor progress at regular intervals. The Social Worker should ask the question, "What kind of time frame should be used?"

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

In addition to writing goals that fit the S.M.A.R.T format, the provider must also learn to use the data provided by the educational team and progress monitoring tools employed by the Social Worker (per e.g. Ohio Scales, CPSS,SDQ) which can provide very valuable help in formulating goals. This data can include test results, assessments; benchmark tests and studies conducted on, with or for the student,

which are available in Easy/IEP for review and can be provided to the provider by the student's school or by the caregiver[8].

All DCPS goals should be linked to Common Core State Standards (CCSS)

- CCSS DCPS Link
  - Elementary - http://dcps.dc.gov/page/elementary-school-academic-standards
  - Middle - http://dcps.dc.gov/page/middle-school-academic-standards
  - High - http://dcps.dc.gov/page/high-school-academic-standards
- Goal book Link – To assist you in learning how to develop SMART goals
  - The sign in page is **https://goalbookapp.com/accounts/users/sign_in**
  - Here's a link to a recorded webinar for related service providers: https://goo.gl/3AiYUX
- For a user account, email your DCPS program manager.

Extended School Year (ESY)

Definition of ESY

- ESY services are specialized instruction and/or related services provided to a student with a disability beyond the regular school year
- Features of ESY:
  - Ensures students with disabilities can access FAPE
  - Provided in accordance with student's IEP
  - Provided at no cost to parents
  - Must be individualized to the unique needs of each student
  - Provided in accordance with OSSE standards

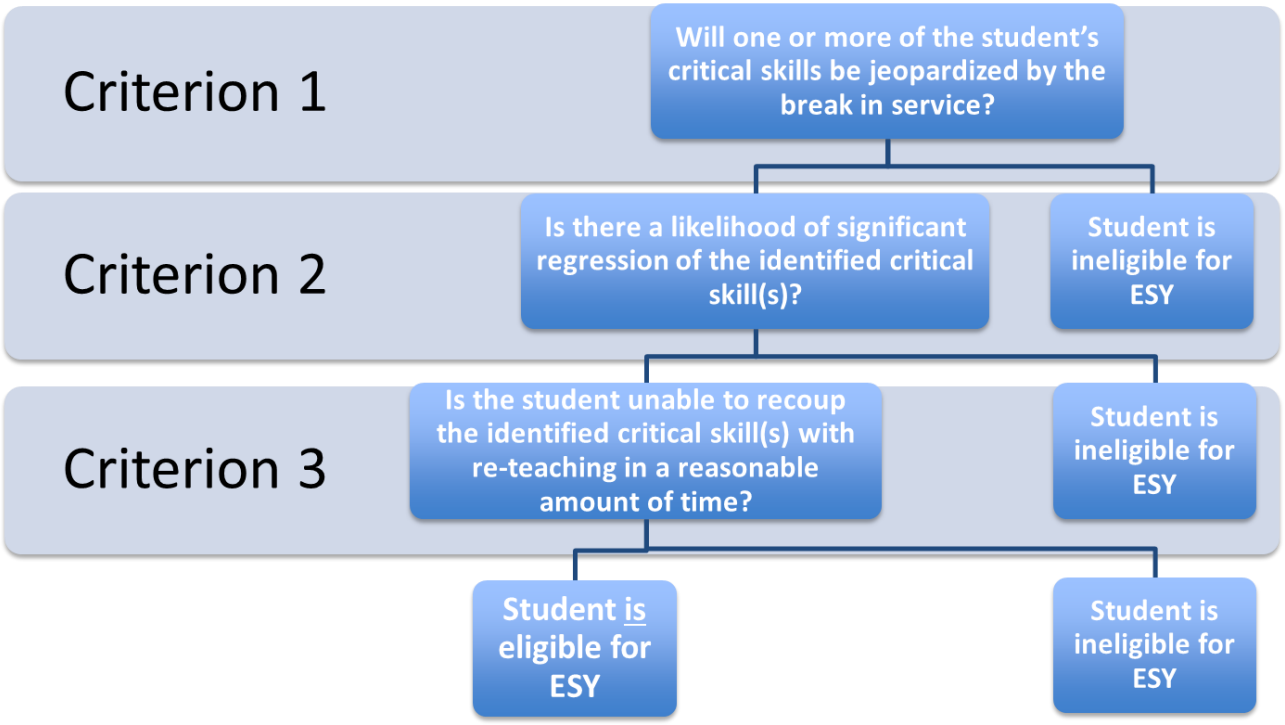
ESY Determination Timeline

- **All** ESY decisions must be made between **DECEMBER 1st and APRIL 1st.**
- If a student has an IEP date *after* April 1st and you think s/he may be a candidate for ESY, please plan accordingly and **hold the annual meeting early** to fall within this timeframe.
- If an ESY eligibility decision needs to be reconsidered due to new data, you should hold an amendment meeting between **DECEMBER 1st and APRIL 1st** to amend the IEP.

If you amend an IEP, please also be sure to follow the *full* IEP amendment process in SEDS to change the actual IEP document

[8] Parenting Special Needs Magazine, July/August Issue, Copyright [2009] by Parenting Special Needs LLC. www.parentingspecialneeds.org
Setting "SMART" Seating Goals, by Linda M. Lambert and Angie Maidment - Health Sciences Centre – Winnipeg, Manitoba

Analysis of Existing Data ESY Eligibility Determination Criteria Decision Tree



** For more information regarding ESY Related Services, please refer to the DCPS ESY Guidelines.*

Dismissal Guidelines for OT and PT Services

IDEA requires that the IEP service provision system be driven by the child's individual needs. Changes in service delivery (such as changes in frequency, duration, location, or discontinuation of services) must therefore be determined on an individual basis.

Prior to a reduction or exit recommendation for services you need to prepare your IEP team, parents and teachers to support. You can do this by obtaining:

- Teacher buy in
  - Provide specific strategies to support the carryover and generalization of the targeted skills
  - Use the morning grade-level collaborative blocks to train teachers on specific techniques
  - Email the teachers to check in on how the student is performing on their off therapy week.
  - Provide teachers data sampling forms to support your consultation sessions.

- Parent buy in
  - Send carryover activities to the parents on a regular basis.
  - Invite the parent to observe your session.
  - Send progress notes home. Ex. Note from the OT

Required steps for reducing students

If a student meets one or more of these criteria, you may want to consider a reduction or dismissal from services. It's time to develop a transition plan:

- Alter service delivery:
  - Increase group size
  - Modify the location of the services
  - Modify the frequency (i.e. 120 mins per month, 30 mins per week, and 60 mins every other week)
  - Check with classroom teacher on the off therapy week for signs of regression.
- Have student complete class work rather than clinician created activities to align learned skills with CCSS and educational curriculum

Required documentation to reduce services

- Service tracker notes
- Quarterly progress notes
- Teacher report
- Student work samples if applicable

Dismissal Criteria for Exiting Students from OT and PT Services

The team may consider the following conditions when determining that a child no longer needs OT or PT or either one to benefit from the education program when the:

- Student's needs being addressed by OT or PT no longer negatively affect his/her educational performance in the general education or special education program, is functional within the educational environment, and therapy services are no longer indicated.
- Student no longer requires OT or PT as a related service in order to benefit from his or her special education program.
- Student consistently demonstrates behaviors that inhibit progress in OT or PT, such as lack of cooperation, motivation, or chronic absenteeism. In those circumstances, the IEP team should consider the initial eligibility decisions since the behaviors may reflect social maladjustment, environmental, cultural, or economic factors rather than an actual disability. The IEP team may also explore alternative services or strategies to remedy the interfering behaviors or conditions.
- Student's needs are better served by an alternative program and/or service, as determined by the IEP team.
- Therapy is contraindicated because of the change in medical or physical status.
- Student graduates from high school with a diploma.
- Student reaches the age of twenty-two years.

- When the student's anticipated goals and expected outcomes related to OT or PT intervention have been met for a particular episode of care.
- When based upon the therapist's judgment it is determined that the student will no longer benefit from therapy.
- The educational setting has changed and the student is functional within this setting.
- The student has learned appropriate compensatory strategies.

Required steps and documentation for exiting students

1. Complete OT or PT Re- Assessment Report
2. Hold IEP meeting.
3. Complete completion of services form.
4. Parent and IEP team approve changes during IEP meeting.

Intervention

Intervention Process

School based OTs and PTs base their intervention with a child with a disability on several principles from IDEA and occupational and Physical therapy practice. These include the following:

- The child has access to the general curriculum in order to meet the educational standards that apply to all children in the school district. (34 CFR s. 300.39(b)(3) (ii))
- The child is educated with children who are nondisabled to the maximum extent appropriate. (34 CFR s. 300.114(a)(2)(i))
- Special education and related services are designed to meet the unique needs of the child and prepare him or her for further education, employment, and independent living. (34 CFR s.300.1(a))
- Related services to be provided to the child or on behalf of the child are based on peer-reviewed research to the extent practicable. (34 CFR s. 300.320(a)(4))

IEP Mandated Services- Minutes/ Month Services

Monthly IEP Services

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

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

- **All IEPs for related services must include a frequency of <u>monthly</u>, NOT weekly or yearly service delivery prescriptions**.
- Make monthly selection in SEDS.
- Benefits of monthly services:
- Flexibility in providing services
- Accommodating student and classroom needs
- Increased opportunities to integrate services in the classroom or during school events
- Allows rescheduling of sessions to accommodate provider unavailability
- Scheduling options that can change to meet the student's needs
- Increased opportunities to make up missed sessions

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

Occupational Therapy Intervention

AOTA's Practice Framework: Domain and process 3rd ed. states that the intervention process consists of the skilled services provided by occupational therapy practitioners in collaboration with students to facilitate engagement in occupation related to health, well-being, and participation. Occupational therapy practitioners analyze the demands of an activity or occupation to understand the specific performance skills, and performance patterns that are required and to determine the demands the activity or occupation makes on the student.

Activity and occupational demands include the following:

- The tools and resources needed to engage in the activity—What specific objects are used in the activity? What are their properties, and what transportation, money, or other resources are needed to participate in the activity?
- Where and with whom the activity takes place— What are the physical space requirements of the activity, and what are the social interaction demands?
- How the activity is accomplished—What process is used in carrying out the activity, including the sequence and timing of the steps and necessary procedures and rules?
- How the activity challenges the student's capacities— What actions, performance skills, body functions, and body structures are the individual, group, or population required to use during the performance of the activity?
- The meaning the student derives from the activity—What potential symbolic, unconscious, and metaphorical meanings does the individual attach to the activity (e.g., driving a car equates with independence, preparing a holiday meal connects with family tradition, voting is a rite of passage to adulthood)?

Targeting Outcomes

Outcomes are the end result of the occupational therapy process; they describe what students can achieve through occupational therapy intervention.

Implementation of the outcomes process includes the following steps:

1. Selecting types of outcomes and measures. Outcome measures are:
    - Selected early in the intervention process (see "Evaluation Process" section);
    - Valid, reliable, and appropriately sensitive to change in student's occupational performance
    - Consistent with targeted outcomes
    - Congruent with student academic goals
    - Selected on the basis of their actual or purported ability to predict future outcomes.

2. Using outcomes to measure progress and adjust goals and interventions by
    - Comparing progress toward goal achievement to outcomes throughout the intervention process

- Assessing outcome use and results to make decisions about the future direction of intervention (e.g., continue intervention, modify intervention, discontinue intervention, provide follow-up, and refer for other services).

Occupational Therapy Intervention[9]

Evaluation		Intervention			Targeting of Outcomes
Occupational Profile ⟷ Analysis of Occupational Performance		Intervention Plan	Intervention Implementation	Intervention Review	Outcomes

[9] AOTA- Practice Framework: Domain and Process, 3rd Ed.

Identify the following: 3. Why is the client seeking service, and what are the client's current concerns relative to engaging in activities and occupations? 4. In what occupations does the client feel successful, and what barriers are affecting his or her success? 5. What aspects of the contexts or environ- mints does the client see as supporting and as inhibiting en- gagmen in desired occupations? 6. What is the Client's occupational history? 7. What are the client's values and interests? 8. What are the client's daily life roles? 9. What the client's patterns are of engage- mint in occupations, and how have they changed over time? 10. What are the client's priorities And desired targeted outcomes related to occupational perform- mince, prevention, participation, role competence, health and wellness, quality	• Synthesize information from the occupational profile to focus on specific occupations and contexts. • Observe the client's performance during activities relevant to desired occupations. • Select and use specific assessments to identify and measure contexts or environments, ac- trinity and occupational demands, client face- tors, and performance skills and patterns. • Select outcome measures. • Interpret assessment data to identify sup- ports for and hindrance-is to performance. • Develop and refine hypotheses about the client's occupational performance strengths and limitations. • Create goals in collar- oration with the client that address desired outcomes. • Determine procedures to measure the out- comes of intervention. • Delineate a potential intervention based on best practices and available evidence.	1. Develop the plan, which involves selecting • Objective and mea- suable occupation- focused goals and related time frames; • Occupational therapy intervention approach or ape- preaches, such as create or promote, establish or restore, maintain, modify, or prevent; and • Methods for service delivery, including who will provide the intervention, types of intervention, and service delivery models. 2. Consider potential discharge needs and plans. 3. Recommend or refer to other professionals as needed.	1. Determine and carry out occupational therapy intervention or interventions, which may include the following: • Therapeutic use of occupations and activities • Preparatory meth- odds and tasks • Education and training • Advocacy • Group interventions 2. Monitor the client's Response through ongoing evaluation and reevaluation.	1. Reevaluate the plan and implementation relative to achieving outcomes. 2. Modify the plan as needed. 3. Determine the need for continuation or discontinuation of occupational therapy services and for referral.	1. Early in the intervention process, select outcomes and measures that are • Valid, reliable, sensitive to change, and consistent with outcomes • Congruent with client goals • Based on their ac- teal or purported ability to predict future outcomes 2. Apply outcomes to measure progress and adjust goals and interventions. • Compare progress toward goal achievement to outcomes throughout the intervention process. • Assess outcome use and results to make decisions about the future direction of inter- venation.

←————————Continue to renegotiate intervention plans and targeted outcomes.————————→

←————————————Ongoing interaction among evaluation, intervention, and outcomes occurs throughout the process.————————————→

Physical Therapy Intervention

Intervention is the purposeful interaction of the physical therapist with an individual—and, when appropriate, with other people involved in that individual's care—to produce changes in the condition that are consistent with the diagnosis and prognosis.

Decisions about the physical therapy interventions selected are based on the physical therapist's assessment of the individual's current condition and are contingent on the timely monitoring of the individual's response and the progress made toward achieving the goals. In prescribing interventions for an individual, the physical therapist includes parameters for each intervention (egg, method, mode, or device; intensity, load, or tempo; duration and frequency; and progression).

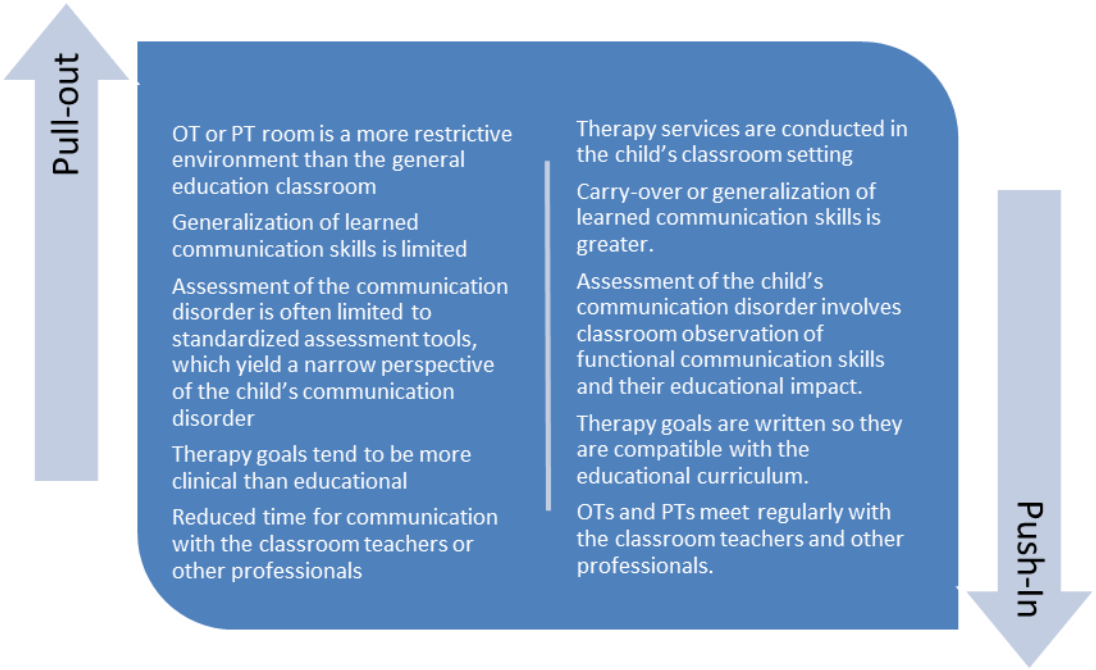
Choosing Interventions

- School-based PTs use activity-focused motor interventions for children in preschool and school-based settings. Activity-focused interventions involve structured practice and repetition of functional actions and are directed toward the learning of motor tasks that will increase the student's participation in daily routines. Activity-focused motor interventions are integrated in everyday classroom and school activities. (Rapport 2009) The PT chooses interventions based upon
- IDEA, which emphasizes functional performance.
- Peer-reviewed research and evidence-based practice.
- Contemporary research on motor control, motor learning, and motor development.
- Preferred practice patterns (*Guide to Physical Therapist Practice*).
- Enablement models, which emphasize function, participation, and community integration.

Service Delivery Models

Occupational and physical therapy services are provided to students using a variety of service delivery models to address skills across a wide context of the academic setting based on individualized needs. The type of service delivery model selected must reflect the student's individual level of severity and prognosis. Services should be provided on a continuum from most to least restrictive depending of the student's level of dependence. Providers should be mindful that the purpose of services is to assist the student with generalizing his/her skills to the classroom setting. These service delivery models can be implemented separately and/or in combination.

Traditional ("Pull-out" or "Outside of General Education Setting") vs. Inclusion ("Push-in" or "Inside General Education Setting") Models of Service Delivery



Advantages to Inclusion-based Interventions

- Increased communication between the disciplines
- Improved knowledge about the relationship between language and academics
- Learning new techniques that support academic achievement
- Access to specialists and resources to help all children in the classroom
- Implementation of Educationally-relevant therapy
- Generalization of therapy & therapy materials (Textbooks, Class assignments, Workbooks)
- Staff members are able to determine where the student is struggling and collaborate to appropriately modify class assignments and tests.
- Provides strategies/techniques for better access/understanding of the curriculum
- Additional support within the classroom for the teacher and the students
- Exposes strategies and techniques regarding memory and organization for other students not on the speech/language caseload
- Clinician can provide feedback and/or suggestions regarding the classroom environment to increase engagement/participation

Services Inside the General Education Setting (Inclusion)

Models of Inclusion – Service Delivery Options

1. Co-Teaching

- Involves at least two credentialed professionals – indicating that co-teachers are peers having equivalent credentials
- Both professionals coordinate and deliver substantive instruction and have active roles
- Responding effectively to diverse needs students
- Instruction occurs in the same physical space

What Co-Teaching Is NOT?

- Doesn't involve a teacher and a classroom volunteer or paraprofessional
- Doesn't mean that two adults are merely present in a classroom at the same time
- Doesn't include separating or grouping students with special needs in one part of the classroom
- Doesn't include teaching teams that plan together and then group and instruct students in separate classrooms

Lead Role

- Lecturing
- Giving instructions orally
- Checking for understanding with large heterogeneous group of students
- Circulating providing one-on-one support as needed
- Prepping half of the class for one side of a debate
- Facilitating a silent activity
- Re-teaching or pre-teaching with a small group

- Facilitating sustained silent reading
- Reading a test aloud to a group of students
- Creating basic lesson plans for standards, objectives, and content curriculum
- Facilitating stations or groups
- Explaining new concepts
- Considering modification needs

Support Role

- Modeling note-taking on the board/overhead.
- Writing down instructions on board.
- Checking for understanding with small heterogeneous group of students.
- Providing direct instruction to whole class.
- Prepping the other half of the class for the opposing side of the debate
- Circulating, checking for comprehension
- Monitoring large group as they work on practice materials
- Reading aloud quietly with a small group.
- Proctoring a test silently with a group of students
- Providing suggestions for notifications, accommodations, and activities for diverse learners
- Also facilitating stations or groups
- Conducting role playing or modeling concept.
- Considering enrichment opportunities.

2. Parallel Teaching
   - This collaborative model divides the classroom in half and the RSP and the classroom teacher subsequently each instructs one half of the class on the same instructional material.
   - The classroom teacher may use a standard format for instruction while the RSP may modify the lesson for the group so that the students will be able to master the material. The groups of students may change to accommodate individual strengths and weaknesses (Capilouto & Elksnin, 1994).

3. Complementary Teaching
   - Role of the RSP in this model is a tutor, with the classroom teacher as primary instructor
   - Classroom teacher presents the majority of the curriculum content & the RSP assists students with their work. The RSP floats around the room and intervenes when children encounter difficulty.

4. Supportive Teaching
   - Combination of pullout services and direct teaching in the classroom setting.
   - RSP teaches information related to the curriculum while also addressing IEP goals.

5. Station Teaching

- In this model the RSP and the classroom teacher divide the instructional content into two parts with each professional teaching one group of students
- Once the instruction is completed, the two groups switch adults so that each group receives instruction from the classroom teacher and the RSP (Capilouto & Elksnin, 1994).

6. Consultation
- The RSP works outside the classroom to analyze, adapt, modify, or create appropriate materials composed of strategies.
- Regular, ongoing classroom observations and meetings with teachers take place so as to assist the teacher with planning and monitoring student progress.

7. Team Teaching
- The classroom teacher and the SLP, occupational therapist, physical therapist, or other professional teach a class or lesson together with each professional addressing his or her area of expertise.
- The classroom teacher may present the curriculum content while the SLP assists with a communication system. Similarly, the occupational therapist may work on handwriting while the physical therapist assists with positioning (ASHA, n.d.).

Related Services Provider Weekly Building and Intervention Schedule

By the first day of school, LEA Representatives must identify all students who require related services as per their IEP. This identification process includes:
- Type of service and the Related Service Provider assigned to the student
- Beginning date of service
- Intensity of service (e.g., 120 minutes per month, etc.)

During the first two weeks of school, Related Service Providers must:
- Check with the LEA Representatives at each of their assigned schools to ensure they have all of the students on their caseload assigned to them in SEDS.
- Add students to their caseload using their EasyIEP access.
- If the OT or PT provider has difficulty engaging their LEA Representatives in this process, they should contact the OSSE SEDS (EasyIEP) Call Center (202-719-6500 - Monday – Friday, 7:30am – 6:00pm) for assistance in appropriately assigning students to their caseload and immediately notify their program manager via email.
- Identify any program manager Supervisor immediately to ensure they are aware of the capacity issue at that school.
- **By second Friday of the school year** - Complete and submit a copy of the intervention schedule to:
  - Their LEA Representatives and Principal(s).
  - Program Manager
- Note:
  - All submitted copies of the original schedule and updated schedules must be signed by the principal at the assigned school(s).

- All submitted schedules must contain the complete name of the student and the length of the session
- When changes are made to the schedule, an updated schedule must be submitted to the appropriate school administrator and OSI Supervisor immediately

Elements to Include When Creating Your Intervention Schedule

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

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

Refer to appendices for Weekly Intervention Schedule Template.

Start Date for Occupational and Physical Therapy Services

Occupational and physical therapists begin service delivery on **First student day.** Please make up any missed services from that date forward.

Intervention Communication

Parent/ Guardian Introductory Letter

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

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

Please refer to appendices for a template.

Classroom Staff Introductory Letter

Each occupational and physical therapist is required to send or hand-deliver an introductory letter to each teacher of the students on his/her caseload no later than the second **Friday of the school year**. The correspondence should contain the following information:

- Your name
- Days assigned to School
- Day student is scheduled for OT or PT services
- Your contact information (ex. Email or school phone number)

The OT and PT must then document this action in the communications log of each student in SEDS.

Collaboration/Consultation with Classroom Staff/Teachers

All OTs and PTs are required to attend collaborative session at their assigned schools outside of IEP meetings.

Documentation

DSI's goal for all related service providers is to achieve 95% monthly documentation and more than 80% service delivery rates each of their student's on their caseload each month. Newly hired providers/contractors must register and complete SEDS training.

Progress Notes / Medicaid

Each intervention or consultation service listed on the IEP that is provided to a student must be documented in the Special Education Data System (SEDS) EasyIEP. This includes services to students with in the local schools, services private religious students, missed services, and home-hospital instruction program (HHIP).

Per OSSE guidelines, RSPs should not document services that are not included on the IEP. This includes consultation with parent or teacher, teacher or parent training, or information reported during an IEP meeting. To capture consultations, the RSP should enter the information (date, with whom, and type of contact) in the Communication section in SEDS. **Assessments and consultations should never be listed as a direct service in the service tracker notes.**

Service Trackers

Each service tracker note must include the following information:

- Identification of the intervention activity / activities
- Description of the student's response to the intervention (quantitative and qualitative information)
    - Quantitative includes – accuracy percentage, number of trials/opportunities, etc…
    - Qualitative includes – level of prompting/dependence (i.e., moderate verbal prompts, tactile cues, hand-over-hand etc...), behaviors impacting/contributing to progress, etc….
    - Alignment and relevance to the OT or PT IEP goals
- Explanation of the relevance of the activity to the IEP goal

DCPS, the Centers for Medicare and Medicaid (CMS), and the Office of the State Superintendent for Education (OSSE) have established a best practice service delivery documentation system. Related Service Providers should document the services they provide or attempt to provide pursuant to the IEP within the same school day those services were scheduled to occur.

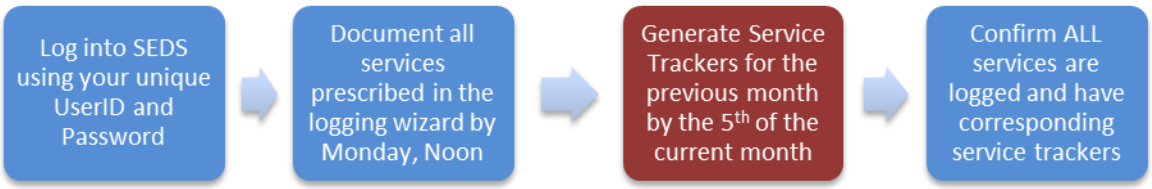
Definitive Due Date for Documenting Services Logs: All services provided in a school week **must** be documented by **noon on the Monday of the following school week**. If school is closed on Monday then documentation is due by noon of the next school day. For example, 60 minutes of speech/language services provided on Friday from 2 to 3 p.m. should be documented by noon that upcoming Monday. Refer to the Documenting Services Guidance memorandum dated November 2009 in the Appendix.

Email your program manager if barriers exist for daily documentation of services. We recognize there may be challenges (e.g. incorporating time to collaborate with teachers and parents) that could prevent you from providing daily documentation 100% of the time. Therefore, DCPS has established a definitive due date for documenting services provided during a school week.

Definitive due date for documenting service trackers. Service tracker must be generated or **finalized no later than the fifth (5th) of the following month**. For example, September notes must be generated or finalized by October 5th. If the fifth of the month falls on a weekend or holiday, the deadline moves to the next workday.

DCPS obtains Medicaid reimbursement for direct related services provided to students. The finalized service trackers are submitted monthly for reimbursement. A physical signature on the finalized service trackers is not required. By logging into SEDS, the provider understands and accepts that his electronic signature will be created with a unique combination of his/her network login username and secure password. The unique combination is necessary to ensure that only the provider has completed all documentation submitted into SEDS under this unique combination.

To document services per DSI guidelines, please adhere to the following steps:



Quarterly IEP Progress Reports

Quarterly IEP progress reports must be completed in EasyIEP/SEDS for each student on the occupational and physical therapist's caseload. This IEP report must be printed and provided to the parent at the end of each advisory period. Please refer to the school calendar to obtain DCPS' IEP Progress Reports due dates; and also consult your schools' LEA's to know the specific due dates for you to complete these reports.

Each IEP Progress Report must include the following information:

- Baseline data on all IEP goals
- Current performance on all IEP goals. In measurable terms
- Information on each goal must be noted on the IEP progress report
- Special Factors important to treatment/instruction sessions (Examples: cooperative, student often refuses to participate and requires a lot of encouragement from teacher and therapist to attend therapy sessions, etc.)
- General therapeutic/instructional interventions used in therapy sessions
- Feedback gathered from the student's classroom teacher on progress the student has experienced towards achieving his/her goals.
- Feedback gathered from the student's caregiver on progress the student has experienced towards achieving his goals
- If an IEP goal was not addressed during the quarter, state that the goal was not addressed during the reporting period and inform why it was not so.

The website for EasyIEP is: https://osse.pcgeducation.com/dcdcps

Consultative (Indirect) Services

Consultation is a service provided indirectly to the student consisting of regular review of student progress, student observation, accommodations and modifications or core material, developing and modeling of instructional practices through communication between the general education teacher, the

special education teacher, parent and/or related service provider. Consultation is not the provision of direct therapy services to a student. The focus of consultation is to ensure the generalization of the addressed goals are generalized across the academic setting and to assist the student with being independent of the skill outside of the therapy setting.

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

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

Documenting Missed and Make Up Services

Documenting Missed Services

Follow the *DCPS Missed Related Services Sessions, Truancy and Due Diligence Guidelines* dated July 2016. See Appendix.

Documentation for Winter and Spring Breaks

The RSP must document "Schools Closed" in SEDS for the dates that correspond with winter and Spring Breaks.

Missed Services Versus Compensatory Education

On occasions, related service providers are unavailable due to absences, MDT meetings, etc. When the missed sessions are a significant disruption of occupational or physical therapy and not attributable to the student or student's parents, it must be made up. Missed services are made up in school during the student's school day by the occupational or physical therapist.

If there are too many missed service hours to be made up during the school day, compensatory education hours may be awarded. Compensatory Education hours are provided after the student's school day at a mutually agreed upon location and time between the service providers and parent.

OT/ PT Services Through Home and Hospital Instruction Program (HHIP)

Students who are unable to attend school secondary to medical issues, continue to receive instruction and related services through the home-hospital instruction program. An assigned OT and/or PT goes into the home or hospital setting to deliver Occupational or Physical therapy services per the student's IEP. Parents must enroll and submit supporting medical documentation to acceptance into HHIP. If there is a HHIP student showing on your SEDS caseload, document the scheduled services as student absent. Email hip.dcps@dc.gov and copy DCPS manager to determine if the student has been accepted to HHIP.

OT/PT Services at Youth Service Center (YSC)

Background and Overview:

The documentation of all related services provided to students attending Youth Services Center (YSC) is required by District of Columbia Public Schools, (DCPS), and the Office of the State Superintendent for Education (OSSE), and the *Jerry M*. Consent Decree. In accordance with applicable federal and state requirements, documentation of related services is analyzed and monitored by the Office of Specialized Instruction (OSI) to ensure services are delivered as set forth in the students' individualized education programs (IEPs). The lack of service documentation confirms services have not been provided and/or a potential interruption of services has occurred. Accordingly, related Service Providers must document all services delivered, or attempts to deliver services, pursuant to the student's IEP.

Process/Procedure:

Step	*Action*	*Description*
1	**Dedicated Service Delivery Time**	YSC must provide all related service providers with 3-4 hours of dedicated time for service delivery daily. YSC must provide a minimum of 1 hour daily to document services. Full-time providers will create an intervention and testing schedule and provider to administration and teachers.
2	**Notification of students with related services**	DYRS notifies YSC registrars immediately of new students.
3	**Recording of Service**	All related service providers will document their services, or attempt to render services, on the YSC service logs. The related service provider will note the type, of service, the duration of service, and whether the service is a make-up session. The related service provider will also note if the student is unavailable or refuses services and the reason therefore. Documentation of services rendered or attempted service delivery will be contemporaneous with the delivery or attempted delivery of those services. Providers must document school closure on the YSC service logs including extended breaks such as winter and spring break.
4	**District-Wide SEDS Access**	All related service providers assigned to YSC will be granted district-wide SEDS access. If a provider cannot log for a student, the provider should email dcps.relatedservices@dc.gov to request SEDS access to the student.
5	**Service Trackers are Placed in Student Files**	All related service providers will provide the YSC service logs to YSC administrative staff upon completion of the service. YSC staff will place each service log in the student's folder within 24

		hours of service delivery or attempted delivery.
6	**All Files are in SEDS**	Related service providers will services provided during the week into the SEDS caseload logging wizard copy by Monday at 12:00 of the following week.
7	**SEDS-Generated Service Trackers**	Related service providers will finalize SEDS-generated service logs by the last day of each month. If the student transfers from YSC before the end of the month, the provider will finalize any outstanding SEDS service logs once notified of the transfer.
8	**File Auditing**	DCPS and DYRS will conduct regular audits of students' paper and SEDS files to ensure that all related services were appropriately provided and documents. These audits will take place on the 2nd and 4th Mondays, with that audit data submitted to the Related Services Supervisors. The audit will include: review of sample of YSC files for each discipline and SEDS analysis of documentation, delivery and missed services for the current month. YSC file audit and SEDS audit will be completed by RS Analyst. Results will be given to the RS supervisors to follow up with the providers. Related Service Providers will have until Wednesday of that week to complete outstanding documentation.
9	**Exit from YSC**	LEA will print student history page from SEDS to add to the file.

Assistive Technology

Assistive Technology Considerations

Assistive technology devices and services enable students to accomplish IEP goals and objectives and make progress in the general curriculum. AT provides alternative ways for children to gain access to educational technology and the curriculum that is in place for the child. AT may include instructional strategies; low or no-tech and mid- and high-tech equipment but differs from educational technology. Educational technology supports the teaching of a skill or concept, most commonly in the form of software.

The law defines "assistive technology service" as any service that directly assists individuals with a disability in the selection, acquisition, or use of an assistive technology device (20 USC § 1401(1)). Assistive technology (AT) services provide children who have disabilities with access to participation in school tasks and the least restrictive environment. AT devices range from simple to complex and include adaptation, fabrication, and customization of materials, which are activities that OTs and PTs engage in as part of their domains of practice. Therapists working in the school setting play an integral role in all aspects of the AT process.

What is the DCPS Assistive Technology (AT) Team?
The Assistive Technology Team of District of Columbia Public Schools is comprised of a multi-disciplinary team. The team provides collaborative assistance to schools, students, and members of the IEP team.

The DCPS' Assistive Technology Team functions as part of the Division of Specialized Instruction. Assistive Technology (AT) is federally mandated for all students with an Individualized Education Plan (IEP) by requiring that IEP teams ***consider*** the student's needs for assistive technology devices and services in order to ensure a Free Appropriate Public Education (FAPE).

The Assistive Technology Team works to integrate with other services that the student receives training and support to ensure that AT services are effectively integrated into the student's curriculum may be provided by any member of the IEP team.

How is Assistive Technology considered within the IEP?
The consideration for Assistive Technology is discussed at every IEP meeting when the IEP team reflects on what accommodations are necessary to ensure that the student receives FAPE. Within the Special Considerations section of the IEP, the need for Assistive Technology devices and services is determined through one of the following:

- Accommodations documented in the IEP reflect consideration

- No assistive technology is necessary to ensure FAPE.

What does the continuum of supports by the DCPS Assistive Technology Team include?

District-Wide Supports:
These supports, provided countywide in accordance with the principles of the Universal Design for Learning Framework, offer options in educating and training students, staff, and parents for integrating tools and strategies presently available within the school environment to meet educational goals.

Classroom Supports
These supports are classroom specific. Examples include collaboration with educators, conducting classroom evaluations, and training of students and staff. Collaborating with the AT Specialists can occur in person, by phone, or through digital means (email, etc.). The AT Specialist may recommend a classroom evaluation to provide strategies, equipment, and/or classroom modifications for use in the classroom.

Individual Supports
These supports identify potential strategies and tools to assist individual students who demonstrate difficulty achieving specific educational goals. This includes students receiving special education services and students receiving accommodations outlined within a 504 plan. The educational team (i.e. IEP team/504 committee, etc.) must consider whether the strategies, accommodations, and modifications that are currently in place to support the student are meeting the student's educational needs or if the student may need other supports.

Collaborating with the AT Specialist during AT Consideration results in one of the following:
Written recommendations for customizing and integrating tools and strategies presently available within the school environment to support the student in meeting individual educational goals. **The educational needs of the majority of students receiving individual supports are met through resources already available within the learning environment (approx. 75%). *_RTI Tier 1 & 2_**

The occupational and physical therapist's role in the AT process
In order for the LEA representative to make appropriate requests for information and equipment needs for a student, the OT and PT can provide information to the AT department and school team to assist with making determinations for AT devices. The OT and PT should guide the team in asking these questions:

- Is the child currently able to independently complete expected educationally related tasks with current strategies or accommodations? If so, AT may not be indicated.
- If the current strategies and accommodations are not sufficient, what task(s) is the child unable to do at a level that reflects the child's skills and abilities?
- Has a form of AT (e.g., strategies, devices, tools, hardware, software, etc.) been used to address this task? How successful is/was it?
- Would the use of new or different AT help the child perform this task more easily or efficiently.

- Below is a table with a summary of the roles each team member has in the AT process[10]:

Team Member	Roles
Child and/or Family	Communicates needs/concerns regarding access to the educational environment; the family also provides support in implementation and carryover to the home environment.
OT	Determines occupational and educational relevance and physical motor access; Recommends AT equipment to team. Provides ongoing training to staff on use of recommended equipment. Provides equipment information regarding functional need for equipment. Addresses modifications of materials and equipment. Provides training to staff.
PT	Determines relevance and physical motor access; addresses positioning of the child and modifications of materials and equipment. Recommends AT equipment to team. Provides ongoing training to staff on use of recommended equipment. Provides equipment information regarding functional need for equipment Provides training to staff
Speech Pathologist	Addresses communication needs; determines the communication system/device; provides equipment training on AAC devices
Classroom Teacher	Identifies academic concerns; incorporates assistive technology (AT) into the curriculum.
LEA Representative	Coordinates and lead the IEP team in the request process. Inputs relevant information provided by the team into the AT portal.
AT Personnel	Determines equipment needs to address academic areas; consults with classroom teacher and RSPs on equipment training. Helps identify funding; and orders equipment. Also provides technical support in installation, repair, and maintenance of equipment.

Areas an occupational therapists and physical therapists should analyze when considering what AT device to recommend:

- SENSORY—auditory, tactile, and visual (functional vision and visual perception)

[10] Adapted from Guidelines for occupational therapy and physical therapy in California publics schools, 2012

- PHYSICAL—SEATING and positioning needs to identify potential anatomical access sites for control and selecting and testing control interfaces

- COGNITIVE—attention, memory, ability to follow directions, understanding of cause and effect, and the degree of motivation

- LANGUAGE—expressive and receptive skills, including categorization, sequencing, matching, the degree of interaction, recognition of words and symbols, understanding simple commands, and motor and pragmatic skills associated with speech.

- SOCIAL PARTICIPATION—relating to others, initiating interactive play, sharing, and taking turns

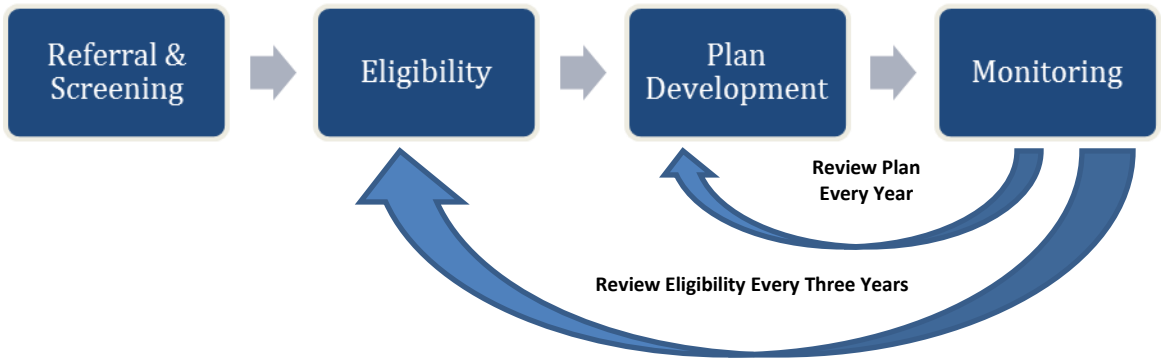
IEP Goals for Occupational and Physical Therapy and Assistive Technology
When formulating IEP goals for occupational and physical therapy, providers should not indicate specific names of equipment or devices. However, they may indicate a description of the type of device the student requires to access the academic curriculum. Please refer to the Assistive Technology Guidebook for more information on the AT Process.

If you have any questions or concerns related to the AT process, you can contact Lisa Brodjieski, SLP and Assistive Technology Manager at (202) 360-1680 or lisa.brodjieski@dc.gov. You can also contact Todd Metzler, Specialist, Assistive Technology at todd.metzler@dc.gov

504 Plan OT/PT Services

It is the intent of the district to ensure that students who are disabled within the definition of Section 504 of the Rehabilitation Act of 1973 are identified, assessed, and provided with appropriate educational services. Under this policy, a student with a disability is one who (a) has a physical or mental impairment that substantially limits one or more major life activities, (b) has a record of such impairment, or (c) is regarded as having such an impairment. Students may be disabled under Section 504 even though they do not require services pursuant to the Individuals with Disabilities Education Act (IDEA). Due process rights of students with disabilities and their parents under Section 504 will be enforced.

The Section 504 Process in DCPS



What are the eligibility requirements for Section 504 accommodations?

For a student to be eligible for accommodations under Section 504, s/he must have a physical or mental impairment that "substantially limits one or more major life activities," as determined by the "504 team." Important terms are defined as follows:

- *Physical or mental impairment* can be any physiological condition that affects a body system, such as the respiratory, musculoskeletal, or neurological systems; any mental or psychological disorders, such as emotional or mental illness and intellectual disabilities; or specific learning disabilities. The definition does not limit the impairments that can qualify a student for Section 504 services.
- *Major life activities* means functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. Again, this list does not limit what kind of activities can qualify a student as having a disability.

- *Substantially limits* means that the impairment results in considerable impairment with a permanent or long-term impact. A substantial impairment prevents or severely restricts a person from performing major life activities. Determining whether a child has a substantial impairment is based on a child's disability without any assistive measures other than ordinary eyeglasses or contact lenses. Eligibility will be reviewed at least annually.

If a student qualifies for services under the 504 Plan the OT or PT will do the following:

- Provide accommodations/modifications to the classroom and/or special education teacher
- Provide direct, indirect and/or consultative services
- Conduct ongoing periodic monitoring of progress and/or concerns with the educational team to ensure accommodations/modifications are being implemented
- Collect data regarding performance given strategies
- Document communication with educational team and outside resources
- Participate in the 504 meetings to provide relevant information and updates

If you have any questions regarding the 504 Process, you may contact the identified 504 Coordinator at your school or Colin Bishop, 504 Specialist at 202-904-8862 (cell)/ 202- 442-5485 or Colin.Bishop@dc.gov.

Documenting 504 interventions:
Documentation for students receiving direct or indirect services via a 504 Plan is entered into the PMA

Providers OT or PT services to students with 504 Plans must complete the 504 -Service Tracker. At the end of the school year each provider will print all OT or PT services trackers for the year turn them in to their respective 504 coordinators. Documentation on 504 Plan interventions follows DCPS guidelines for content and timelines.

Evidence-Based Practice

Evidence-based Practice Research

Education systems nationwide, including DCPS, endorse the need for an evidence-based education approach and "the integration of professional wisdom with the best available empirical evidence in making decisions about how to deliver instruction". [11]Federal education statutes and regulations, including IDEA 2004 and NCLB 2002, stress accountability as measured by the "use of effective methods and instructional strategies that are based on evidence-based practice".[12] Those federal education laws, requiring scientifically based research, make it clear that evidence-based practice is the standard for accountability and must be utilized by school-based OTs and PTs. Evidence-based practice is the "integration of best research evidence with clinical expertise and [child] values". [13]The laws, as well as AOTA and APTA professional documents, recognize that evidence-based practice is a continuous, dynamic integration of research evidence, professional expertise, and child factors. In addition to using evidence to inform practice, education professionals collect data to review intervention effectiveness in order to comply with the mandate for systematic and quantitative monitoring of the child's progress. Data can be collected through various methods during both general education, including early intervening services and Response to Intervention, and special education in order to document whether intervention strategies, including environmental adaptations and modifications, are effective at increasing the child's ability to gain access to the general curriculum and make progress.

The Steps of Evidence-Based Practice[14]

Evidence-based practice follows a five-step process designed to gather quality research evidence[15]:

- Step 1: Ask a relevant practice question
- Step 2: Gather the best available research evidence
- Step 3: Critically appraise the research
- Step 4: Integrate research evidence
- Step 5: Evaluate the outcomes

[11] Whitehurst 2002
[12] 20 USC §§ 1401 and 6301
[13] Sackett et al. 2000, 1
[14] Adapted from the guidelines for occupational therapy and physical therapy in California public schools, 2012
[15] Lin, Murphy, and Robinson 2010; Rappolt 2003; Sackett et al. 2000; Salmond 2007; Sarracino 2002; Tickle-Degnen 1999, 2000a, 2000b

Step 1: Ask a Relevant Practice Question
Relevant practice questions directly relate to a child's educational needs. Well structured questions will assist the therapist in developing key search words and finding research on how to improve the effectiveness and efficiency of treatment. In school-based practice, relevant practice questions can directly incorporate the intent of therapy as reflected in a child's IEP goals/objectives.

Step 2: Gather the Best Available Research Evidence A combination of research evidence, professional expertise, and consensus views should be used to answer the relevant practice question. Research evidence can be gathered from a variety of resources

Step 3: Critically Appraise the Research
The appraisal process guides the OT and PT in evaluating the study's findings, deciding whether a research study is of sufficient quality with results that are applicable to school-based therapy.[16] This step may be difficult, and many factors need to be considered for this process to be constructive. To begin, the OT or PT determines if the study is quantitative or qualitative. If the study is quantitative, the study must be categorized according to its research design and level of evidence. If the study is qualitative, it uses different research designs to examine the subjective views, experiences, and values of individuals and does not follow hierarchical quantitative levels of evidence. During the appraisal process, it is imperative to remember that the evidence-based practice philosophy utilizes the best available external research applicable to the situation. If no high level quantitative research is found, the practitioner should consider the next level of best available research.[17]

Step 4: Integrate Research Evidence
Therapists use their professional expertise coupled with knowledge of the child's functional needs to determine how to best integrate research evidence into service delivery. Well-informed collaborative decisions are made with the IEP team regarding when, where, and how often the intervention will be implemented to achieve the highest probability of desired outcomes.

Step 5: Evaluate the Outcomes
It is essential to evaluate whether the intervention used has research evidence for its effects on child progress.[18] The evaluation process documents the outcomes of intervention and can uncover new areas of educational concern.[19] Outcomes can be evaluated through observations, data collection, interviews, standardized and criterion-referenced tools, work samples, ratings, goal attainment scaling, and treatment notes. If evaluation of the outcomes
indicates that the child is not improving, the therapist can go back to the results of the current search to see if there are other viable resources or interventions to consider based upon the child and the context of the relevant practice question.

[16] Kellegrew 2005
[17] Sackett et al. 1996
[18] Tickle-Degnen 2000b
[19] Rappolt 2003

Training and Support

Related Service Provider Training Overview

DCPS seeks to create a culture in which all school-based personnel have a clear understanding of what defines excellence in their work, are provided with constructive and data-based feedback about their performance, and receive support to increase their effectiveness. The objectives of these efforts are:

- Clarify and outline clear performance expectations.
- Define your specific roles and responsibilities.
- Provide clear and concise feedback to enhance performance.
- Facilitate collaboration among service providers, school staff and parents to create the foundation for student success.
- Delivering professional development to supply service providers with the necessary evidence-based resources and support to enhance their role.
- Retain excellent service providers that can work with DCPS on increasing student achievement.

Related Service Provider Training Goal

- The RSD will implement trainings that promote high standards and "best practices" according to processes and procedures that support continuous quality improvement efforts and ensure compliance with court mandates, federal, local and discipline specific national organizations. As illustrated in IMPACT and the discipline specific procedural reference guides, which is allied to enhanced performance, increased collaboration and improved educational outcomes for students.
- The RSD will develop training programs that are evidenced-based, empirically driven and results-focused. These initiatives will be implemented through strategic planning aimed to identify effective strategies for improving the performance of related service provider in ways that enhance the quality of service delivery, mastery of student's goals for exiting services, quality assessments, appropriate educational planning, academic achievement, secondary transition outcomes as well as functional skills that improve educational outcomes of students with disabilities.

Types of Trainings and Professional Development

Professional Development Days (PD)

Reserve professional development dates on your calendar. Attendance on professional development days is MANDATORY. Program Managers reserve the right to request a doctor's note when calling out and able to document as unexcused

Community of Practice and Professional Development

Communities	Targeted Providers
Early Childhood	Providers who work with students ages 3-5 years old
School-Aged	Providers who primarily provide services to students who are in general education setting in grades k-7
Secondary and transition services	Providers who primarily provide services to students who are in grade 8-12 and ages 14 – 22 and/or transition ready
ASD	Providers who primarily provide services to students who are on the autism spectrum and/or have limited communication and/or cognitive skills
Medically Fragile	Providers who primarily provide services to students who are medically fragile and/or have moderate to severe cognitive delays

Optional Trainings

DCPS and the OT/PT Department offer several free trainings after the workday. These trainings include, workshops, webinars, case conferences, peer reviews, and lecture sessions. The OT/PT department offerings will be sent via email in the SLP weekly. All interested employees and contractors must register using SchoolNet.

The training course calendar and registration are available by accessing DCPS' SchoolNet website at https://dcps.schoolnet.com. If you have difficulties accessing the SchoolNet website, please contact the help desk at 866-MY-SN-HELP (866-697-6435) or helpdesk@schoolnet.com.

Appendices

Glossary

A. Abbreviations

APE	Adapted Physical Education
AUD	Audiologists
BIP	Behavioral Intervention Plan
DCMR	District of Columbia Municipal Regulations
DCPS	District of Columbia Public Schools
DHS	Department of Human Services
DOB	Date of Birth
ED	Emotionally Disturbed
ESL	English as a Second Language
ESY	Extended School Year
FAPE	Free Appropriate Public Education
FBA	Functional Behavioral Assessment
HI	Hearing Impairment
HOD	Hearing Office Determination
ID	Intellectual Disability (Also known as Mental Retardation MR)
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Program
IFSP	Individualized Family Service Plan
ISP	Individualized Service Plan
LD	Learning Disability

LEA	Local Education Agency
LEP	Limited English Proficiency
LRE	Least Restrictive Environment
MD	Multiple Disabilities
MDT	Multidisciplinary Team
OHI	Other Health Impairment
DSI	Division of Specialized Instruction
OSSE	Office of the State Superintendent of Education
OT	Occupational Therapy
PT	Physical Therapy
SA	Settlement Agreement
SEA	State Education Agency
SLD	Specific Learning Disability
SLI	Speech Language Impairment
SLP	Speech Language Pathologist
SSI	Supplemental Security Income
SW	Social Worker
TBI	Traumatic Brain Injury
VI	Visual Impairment
VIS	Visiting Instruction Services

B. Key Terms

The key terms outlined below have specific meanings assigned by IDEA (34 C.F.R §300.34, and/or DCMR 5-3001. This is not an exhaustive list of the developmental, corrective and supportive services that an individual child with disabilities may require. However, all related services must be required to assist a child with disabilities to benefit from special education. To provide clarity on the various types of related services, the individual definitions are provided below.

- Audiology. Audiology services include (i) the identification of children with hearing loss, (ii) determination of the range, nature, and degree of hearing loss, including referral for medical or other professional attention for the habilitation of hearing, (iii) provision of habilitative activities, such as language habilitation, auditory training, speech reading (lip-reading), hearing assessment, and speech conservation, (iv) creation and administration of programs for prevention of hearing loss, (v) counseling and guidance of children, parents, and teachers regarding hearing loss; and (vi) determination of children's needs for group and individual amplification, selecting and fitting an appropriate aid, and evaluating the effectiveness of amplification.

- Counseling. Counseling services means services provided by qualified social worker, psychologist, guidance counselors, or other qualified personnel.

- Early identification and assessment of disabilities in children. Early identification and assessment means the implementation of a formal plan for identifying a disability as early as possible in a child's life.

- Interpreting services. When used with respect to children who are deaf or hard of hearing, this includes (i) oral transliteration services, cued language transliteration services, sign language transliteration and interpreting services, and transcription services, such as communication access real-time translation (CART), C-Print, and TypeWell and (ii) special interpreting services for children who are deaf-blind.

- Medical services. This service is for diagnostic or assessment purposes provided by a licensed physician to determine a child's medically related disability that results in the child's need for special
- Occupational therapy. Occupational therapy means services provided by a qualified occupational therapist and (ii) include (a) improving, developing, or restoring functions impaired or lost through illness, injury, or deprivation, (b) improving ability to perform tasks for independent functioning if functions are impaired or lost, and (c) preventing, through early intervention, initial or further impairment or loss of function.
- Orientation and mobility. Orientation and mobility services means services: (i) provided to blind or visually impaired children by qualified personnel to enable those students to attain systematic orientation to and safe movement within their environments in school, home, and community, and (ii) includes teaching children the following, as appropriate: (a) spatial and environmental concepts and use of information received by the senses (such as sound, temperature and vibrations) to establish, maintain, or regain orientation and line of travel (e.g.,

using sound at a traffic light to cross the street), (b) to use the long cane or a service animal to supplement visual travel skills or as a tool for safely negotiating the environment for children with no available travel vision, (c) to understand and use remaining vision and distance low vision aids, and (d) other concepts, techniques, and tools.

- Parent counseling and training. Includes (i) assisting parents in understanding the special needs of their child, (ii) providing parents with information about child development, and (iii) helping parents to acquire the necessary skills that will allow them to support the implementation of their child's IEP or IFSP.
- Physical therapy. Physical therapy means services provided by a qualified physical therapist.

- Psychological. Psychological services includes (i) administering psychological and educational tests, and other assessment procedures, (ii) interpreting assessment results, (iii) obtaining, integrating, and interpreting information about child behavior and conditions relating to learning, (iv) consulting with other staff members in planning school programs to meet the special educational needs of children as indicated by psychological tests, interviews, direct observation, and behavioral assessments, (v) planning and managing a program of psychological services, including psychological counseling for children and parents, and (vi) assisting in developing positive behavioral intervention strategies. .

- Recreation. This service includes (i) assessment of leisure function, (ii) therapeutic recreation services, (iii) recreation programs in schools and community agencies, and (iv) leisure education.

- Rehabilitation counseling. Rehabilitation services means services provided by qualified personnel in individual or group sessions that focus specifically on career development, employment preparation, achieving independence, and integration in the workplace and community of a student with a disability.[20]

- School health and school nurse. These health services that are designed to enable a child with a disability to receive FAPE as described in the child's IEP. School nurse services are services provided by a qualified school nurse. School health services are services that may be provided by either a qualified school nurse or other qualified person.
  .
- Social work. Social work in schools including (i) preparing a social or developmental history on a child with a disability, (ii) group and individual counseling with the child and family, (iii) working in partnership with parents and others on those problems in a child's living situation (home, school, and community) that affect the child's adjustment in school, (iv) mobilizing school and community resources to enable the child to learn as effectively as possible in his or her educational program, and (v) assisting in developing positive behavioral intervention strategies.

- Speech-language pathology Services. Speech-language services include (i) identification of children with speech or language impairments, (ii) diagnosis and appraisal of specific speech or language impairments, (iii) referral for medical or other professional attention necessary for the habilitation of speech or language impairments, (iv) provision of speech and language services for the habilitation or prevention of communicative impairments, and (v) counseling and guidance of parents, children, and teachers regarding speech and language impairments.

- Transportation. Transportation includes (i) travel to and from school and between schools, (ii) travel in and around school buildings, and (iii) specialized equipment (such as special or adapted buses, lifts, and ramps), if required to provide special transportation for a child with a disability.

Employment Information Form

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

SCHOOL YEAR _____

EMPLOYMENT INFORMATION FORM
(Please type or print information)

_____
_____

Name (LAST, FIRST, MI)

_____
_____

Address (Include City, State and Zip Code)

_____
_____

Home Telephone

Cellular Telephone

_____
_____

Date of Birth (Month and day)

Email Address

DCPS Employee ☐
Contract Staff ☐

Name of Contract Company

_____

Do you have a dc.gov email address? ☐Yes ☐No

Any ailment(s) you would like on record, or would like for us to consider if so please list:

_____
_____
_____
_____
_____

_____
_____
_____
_____
_____
_____

In case of emergency contact:

_____
_____
Name Relationship

_____
_____
Contact Number (work) Contact Number (cell)

Related Service Provider Weekly Building Intervention Schedule

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Related Service Provider Weekly Building Intervention/Assessment Schedule
School Year 2015-2016

Discipline: **Employee:**

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
	School: Contact#:	School: Contact#:	School: Contact#:	School: Contact#:	School: Contact#:
A.M.					
8:00					
8:30					
9:00					
9:30					
10:00					
10:30					
11:00					
11:30					
P.M.					
12:30					
1:00					
1:30					
2:00					
2:30					

3:00					
3:30					
4:00 (ET 11)					

Principal Signature

_____

Occupational Therapy Initial Parent Letter

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

SAMPLE INTRODUCTION PARENT LETTER

Dear Parent,

I am excited about the opportunity to work with your child on addressing his/her occupational therapy (OT) goals.

As a parent, you also serve as a crucial partner in the success of the child. At times, I will send home strategies or suggestions on activities you can implement to help with the reinforcement of the skills he/she is working on in occupational therapy (OT). If you should have any questions about any of the activities sent home, please don't hesitate to contact me.

I am the new provider assigned to _____ school on _____, _____, and _____. You can reach me by phone at the school on my assigned days or via email at _____.
In closing I want to invite you to observe your child in his/her occupational therapy (OT) session at any time during the year.

Once again, welcome to a new School Year. Let's work together to make this a productive school year for your child.

Sincerely,

_____
Name and Credentials, Date

Occupational Therapy Checklist

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

CONFIDENTIAL

OCCUPATIONAL THERAPY (OT) CHECKLIST – FOR THE CLASSROOM TEACHER

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

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

INSTRUCTIONS

- Place a check mark **(√)** by areas of difficulty.
- Place an **(*)** by areas of prominent difficulty.
- Items in italics are RED FLAG indicators for OT assessment.
- Complete all sections.
- Provide completed form to the Occupational Therapist assigned to screen/assess the student

- SELF-HELP SKILLS

  Preschool:

  _____ Is unable to use eating utensils to feed self by age 3

  School Age:

  _____ Has trouble with self-help skills beyond kindergarten.

- FINE MOTOR ACTIVITIES

  Preschool:

  _____ Unable to stack 4-5 small blocks
  _____ Unable to string 2-3 large beads
  _____ Uses whole palm to grasp small objects instead of fingers
  _____ Unable to complete simple inset puzzle (circle, square/triangle)
  _____ Does not turn pages in a board book
  _____ *Awkward pencil grip which interferes with handwriting legibility*
  _____ Complains of fatigue/hand hurting when writing
  _____ Pencil lines are tight, wobbly, too faint/too dark; pencil point often breaks when writing
  _____ Difficulty coloring within the lines (after kindergarten)

_____ *Hand dominance not well established (after age 6)*
_____ *Awkward cutting skills*

- **PRE-WRITING / HANDWRITING

Preschool:
_____ Does not scribble on paper
_____ Does not copy basic strokes
_____ Does not trace shapes or letters

Kindergarten:
_____ *Difficulty imitating simple geometric shapes*
_____ Difficulty writing first name

First Grade:
_____ *Difficulty forming upper/lower case letters and numbers*
_____ *Decreased handwriting legibility that impacts student's success in the classroom*

After First Grade:
_____ Difficulty copying from the board
_____ *Decreased handwriting legibility that impacts student's success in the classroom*
_____ *Difficulty completing assignments (slow writer)*

- VISUAL PERCEPTION:

_____ Difficulty completing wood inset puzzles by kindergarten

**also indicated above with legibility

- SENSORY MOTOR ORGANIZATION:

Preschool/School Age:
_____ Resists being held or cuddled
_____ Becomes very upset if own clothing, hands, and/or face are messy
_____ Exhibits odd, ritualistic, or self-stimulatory behavior
_____ *Avoids putting hands in various textured substances (glue, putty, sand, paint)*
_____ Seems overly sensitive to loud noises
_____ *Constantly seeks movement opportunities*
_____ *Flat affect, requiring constant instruction to engage in activities*
_____ *Unable to hold head up and/or frequently falls out of chair, is clumsy*

Specialized equipment: _____
Medical equipment: _____

- INTERVENTIONS/PROGRESS

Please complete the following table, which contains the strategies/interventions that have been implemented to address the student's difficulties you identified above, and also a summary of the progress demonstrated.

Difficulty	Strategy/Intervention	Length of Implementation (weeks)	Results/Progress

I would like training on: _____

_____

Teacher signature Date

Occupational Therapy Screening Report Template

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

CONFIDENTIAL

OCCUPATIONAL THERAPY SCREENING REPORT

SECTION I - STUDENT IDENTIFYING INFORMATION:

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

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

SECTION II

a. General Information:
b. Medical and Education History (birth history, developmental history, surgical procedures, previous and current therapeutic/medical interventions):
c. Reason for Referral/Presenting Academic Concern:

SECTION III – SCREENING TOOLS AND RESULTS

a. Clinical Observation:
b. Classroom Teacher Interview/The Occupational Therapy Checklist, completed by classroom teacher:
c. Parental interview:
d. Analysis of work samples:
e. Sensory processing:

SECTION IV. SUMMARY AND RECOMMENDATIONS

The results achieved from this screening are felt to be a true representation of _____'s skills in the areas observed.

a. Strengths:
b. Areas needing support:
c. Impact on learning and participation in academic activities:
d. Recommendations for the classroom staff:

The results of this screening will be used by the MDT to determine if further Occupational Therapy assessment is needed.

_____

Examiner Signature and credentials

Occupational Therapy Assessment Report Template

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

CONFIDENTIAL
OCCUPATIONAL THERAPY ASSESSMENT REPORT

SECTION I. STUDENT IDENTIFYING INFORMATION:

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

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

SECTION II. BACKGROUND INFORMATION:

- Background History and Record Review:
  - Birth history
  - Medical history
  - Academic history:
  - Previous Services
- Student's current program and supports consist of:
- Progress on intervention (RTI or Occupational Therapy IEP goals)
- Reason for Referral:

SECTION III. ASSESSMENT TOOLS USED:

- Record Review
- Interviews
- Clinical Observations and Clinical Assessment
- Analysis of Work Samples
- Standardized/Non-Standardized Testing

A. Interviews

- Classroom Teacher Interview:
- Special Education Teacher Interview:
- Parental Interview:
- Other Related-Service Provider Interview:
- Student Interview:

B. Behavioral Observations:

C. Clinical Assessment:

- Neuromotor/Musculoskeletal:
- Muscle Tone:
- Range of Motion (AROM/PROM):
- Muscle Strength:
- Motor Planning:
- Postural Control:
- Fine Motor Skills:
- Bilateral Coordination:
- Functional Mobility:
- Sensory Processing

D. Non-Standardized Tools/Results

E. Standardized Tools/Results:

F. Equipment

SECTION IV. SUMMARY AND RECOMMENDATIONS:

Validity Statement:

Strengths:

Areas of Growth:

Impact on Learning and Participation:

Recommendations for the educational staff:

Recommendations for the caregiver:

The results of this assessment will be used by the MDT to determine if school-based occupational therapy services are needed to help _____ achieve educational goals.

It has been a pleasure working/assessing_____. Please do not hesitate to contact me at_____@dc.gov in case you have any question about this report

_____

Examiner's signature and credentials DATE

Occupational Therapy Re-Assessment Report Template

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

CONFIDENTIAL
OCCUPATIONAL THERAPY RE-ASSESSMENT REPORT

SECTION I. STUDENT IDENTIFYING INFORMATION:

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

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

SECTION II. BACKGROUND INFORMATION:

- Background History and Record Review:
  - Birth history
  - Medical history
  - Academic history:
  - Previous Services
- Student's current program and supports consist of:
- Progress on intervention (RTI or Occupational Therapy IEP goals)
- Reason for Referral:

SECTION III. ASSESSMENT TOOLS USED:

- Record Review
- Interviews
- Clinical Observations and Clinical Assessment
- Analysis of Work Samples
- Standardized/Non-Standardized Testing

A. Interviews

- Classroom Teacher Interview:
- Special Education Teacher Interview:
- Parental Interview:
- Other Related-Service Provider Interview:
- Student Interview:

B. Behavioral Observations:

C. Clinical Assessment:

- Neuromotor/Musculoskeletal:
- Muscle Tone:
- Range of Motion (AROM/PROM):
- Muscle Strength:
- Motor Planning:
- Postural Control:
- Fine Motor Skills:
- Bilateral Coordination:
- Functional Mobility:
- Sensory Processing

D. Non-Standardized Tools/Results

E. Standardized Tools/Results:

F. Equipment

SECTION IV. SUMMARY AND RECOMMENDATIONS:

Validity Statement:

PROGRESS TOWARDS GOALS

LEVEL OF FUNCTIONAL PERFORMANCE AT INITIAL ASSESSMENT

LEVEL OF FUNCTIONAL PERFORMANCE AT RE-ASSESSMENT

Impact on Learning and Participation:

Recommendations for the educational staff:

Recommendations for the caregiver:

The results of this assessment will be used by the MDT to determine if school-based occupational therapy services are needed to help _____ achieve educational goals.

It has been a pleasure working/assessing_____. Please do not hesitate to contact me at_____@dc.gov in case you have any question about this report

_____

Examiner's signature and credentials DATE

Physical Therapy Initial Parent Letter

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

SAMPLE INTRODUCTION PARENT LETTER

Dear Parent,

Welcome to School Year 20XX-20XX! I am excited about the opportunity to work with your child on addressing his/her physical therapy (PT) goals.

As the parent, you also serve as a crucial partner in the success of the child. At times, I will send home strategies or suggestions on activities you can implement to help with the reinforcement of the skills he/she is working on in physical therapy (PT). If you should have any questions about any of the activities sent home, please don't hesitate to contact me.

I am assigned to _____ school on _____, _____, and _____. You can reach me by phone at the school on my assigned days or via email at _____.
In closing I want to invite you to observe your child in his/her physical therapy (PT) session at any time during the year.

Once again, welcome to a new School Year. Let's work together to make this a productive school year for your child.

Sincerely,

_____
Name and Credentials Date

Physical Therapy Screening Report Template

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

CONFIDENTIAL

PHYSICAL THERAPY SCREENING REPORT

SECTION I - STUDENT IDENTIFYING INFORMATION:

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

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

SECTION II -
GENERAL INFORMATION:
MEDICAL AND EDUCATIONAL HISTORY (birth history, developmental history, surgical procedures, previous and current therapeutic/medical interventions):
REASON FOR REFERRAL/PRESENTING ACADEMIC CONCERN:

SECTION III – SCREENING TOOLS AND RESULTS
a. Record Review:
b. Clinical Observation:
c. Classroom Teacher Interview/The Physical Therapy Checklist, completed by classroom teacher:
d. Parental interview:
e. Analysis of Balance, Bilateral Coordination, and Upper Extremity Coordination - Results

- Balance:
- Bilateral Coordination:
- Upper Extremity Coordination:

Summary of Gross Motor Screening			
Skill	Grade	Screening Test	Pass/Fail/NA
Balance	K	Balance on each foot for 5 seconds	
Balance	1-2	Balance on each foot for 10 seconds	
Balance	3	Balance on each foot for 12 seconds	
Bilateral Coordination	K-2	Jumping up and down on two feet and landing on both feet while clapping hands five times	
Bilateral Coordination	3	Jumping in the air and touching both heels with both hands during two out of three trials	
Upper	K-1	Toss an 8 ½ -inch playground ball in the air and catch it	

Extremity Coordination		five consecutive times (ball may be trapped in the body)	
Upper Extremity Coordination	2-3	Toss a 4- to 5-inch ball into the air and catch it with hands, five times consecutively, with hands only	

SECTION IV. SUMMARY AND RECOMMENDATIONS

The results achieved from this screening are felt to be a true representation of _____'s skills in the areas observed.

Strengths:

Areas Needing Support:

Impact on Learning and Participation:

Recommendations:

The results of this screening will be used by the MDT to determine if further Physical Therapy assessment is needed.

_____

Physical Therapist' Signature and Date

Physical therapy Assessment Report Template

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

CONFIDENTIAL
PHYSICAL THERAPY ASSESSMENT REPORT

SECTION I. STUDENT IDENTIFYING INFORMATION:

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

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

SECTION II. BACKGROUND INFORMATION:

- Background History and Record Review:
  - Birth history
  - Medical history
  - Academic history:
  - Previous Services
- Student's current program and supports consist of:
- Progress on intervention (RTI or Occupational Therapy IEP goals)
- Reason for Referral:

SECTION III. ASSESSMENT TOOLS USED:

- Record Review
- Interviews
- Clinical Observations and Clinical Assessment
- Analysis of Work Samples
- Standardized/Non-Standardized Testing

A. Interviews

- Classroom Teacher Interview:
- Special Education Teacher Interview:
- Parental Interview:
- Other Related-Service Provider Interview:
- Student Interview:

B. Behavioral Observations:

C. Clinical Assessment:

- Neuromotor/Musculoskeletal:
- Muscle Tone:
- Range of Motion (AROM/PROM):
- Muscle Strength:
- Endurance:
- Motor Planning:
- Postural Control:
- Coordination:
- Gross Motor Skills:
- Functional Level in the School Setting:
    - Ambulation/Mobility:
    - Transfers/Transitions:
    - Cafeteria Skills:
    - Participation in Physical Education:
    - Arrival and Dismissal:
    - Fire Drills/Evacuation:
    - Bus accessibility:
    - Participation in Playground Activities:
    - Participation in field trips:

D. Non-Standardized Tools/Results

E. Standardized Tools/Results:

F. Equipment

SECTION IV. SUMMARY AND RECOMMENDATIONS

Validity Statement:

Strengths:

Areas of Growth:

Impact on Learning and Participation:

Recommendations for the educational staff:

Recommendations for the caregiver:

The results of this assessment will be used by the MDT to determine if school-based physical therapy services are needed to help _____achieve educational goals.

It has been a pleasure working/assessing _____. Please do not hesitate to contact me at _____@dc.gov in case you have any question about this report

_____

Examiner's signature and credentials DATE

Physical Therapy Re-Assessment Report Template

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

CONFIDENTIAL
PHYSICAL THERAPY RE-ASSESSMENT REPORT

SECTION I. STUDENT IDENTIFYING INFORMATION:

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

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

SECTION II. BACKGROUND INFORMATION:

- Background History and Record Review:
  - Birth history
  - Medical history
  - Academic history:
  - Previous Services
- Student's current program and supports consist of:
- Progress on intervention (RTI or Occupational Therapy IEP goals)
- Reason for Referral:

SECTION III. ASSESSMENT TOOLS USED:

- Record Review
- Interviews
- Clinical Observations and Clinical Assessment
- Analysis of Work Samples
- Standardized/Non-Standardized Testing

A. Interviews

- Classroom Teacher Interview:
- Special Education Teacher Interview:
- Parental Interview:
- Other Related-Service Provider Interview:
- Student Interview:

B. Behavioral Observations:

C. Clinical Assessment:

- Neuromotor/Musculoskeletal:
- Muscle Tone:
- Range of Motion (AROM/PROM):
- Muscle Strength:
- Endurance:
- Motor Planning:
- Postural Control:
- Coordination:
- Gross Motor Skills:
- Functional Level in the School Setting:
    - Ambulation/Mobility:
    - Transfers/Transitions:
    - Cafeteria Skills:
    - Participation in Physical Education:
    - Arrival and Dismissal:
    - Fire Drills/Evacuation:
    - Bus accessibility:
    - Participation in Playground Activities:
    - Participation in field trips:

D. Non-Standardized Tools/Results

E. Standardized Tools/Results:

F. Equipment

SECTION IV. SUMMARY AND RECOMMENDATIONS

Validity Statement:

PROGRESS TOWARDS GOALS

LEVEL OF FUNCTIONAL PERFORMANCE AT INITIAL ASSESSMENT

LEVEL OF FUNCTIONAL PERFORMANCE AT RE-ASSESSMENT

Impact on Learning and Participation:

Recommendations for the educational staff:

Recommendations for the caregiver:

The results of this assessment will be used by the MDT to determine if school-based physical therapy services are needed to help _____achieve educational goals.

It has been a pleasure working/assessing _____. Please do not hesitate to contact me at _____@dc.gov in case you have any question about this report

_____

Examiner's signature and credentials DATE

Completion of Services Form

COMPLETION OF SERVICES FORM

STUDENT: _____ DATE:_____

ADDRESS: _____SCHOOL:_____
Street# Street Name Apartment # ADDRESS:_____

_____
City State Zip Code TELEPHONE: _____
TELEPHONE: _____

ID#: _____ DOB: _____ GRADE: _____

A multidisciplinary team meeting is required in order to determine whether a student has completed special education and related services identified on the IEP, including the consideration of information from the evaluation (for which you provided consent) in the area(s) to be considered. Complete the sections below identifying the services.

COMPLETION OF SERVICES(S) (Check all service that are being considered)

SERVICE	Goals/ Obj. Completed	Results of Evaluation	Date
☐ Speech-Language Therapy	☐Y ☐N		
☐ Orientation & Mobility	☐Y ☐N		
☐ Occupational Therapy	☐Y ☐N		
☐ Physical Therapy	☐Y ☐N		
☐ Counseling	☐Y ☐N		
☐ Adaptive PE	☐Y ☐N		
☐ Audiology	☐Y ☐N		
☐ Transportation	☐Y ☐N		
☐ Other (specify)	☐Y ☐N		
☐ Specialized Instruction	☐Y ☐N		
	☐Y ☐N		
	☐Y ☐N		
	☐Y ☐N		

REASON FOR COMPLETION OF SERVICES:

☐ Graduated ☐ Completed Services ☐Aged Out ☐Transferred Out of District ☐ Dropped Out
☐ Other:

_____

☐ I agree with the proposed termination of the special education and related service(s) identified above.
☐ I have been provided with my procedural safeguards and questions answered. I understand that my consent is voluntary, and that I have the right to appeal the decision of the multidisciplinary team (MDT).

Signature: _____ Date: _____

Parent/Eligible Student
(Student if age of majority has been reached and the transfer of rights has been officially documented)

IEE Review Form

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

INDEPENDENT ASSESSMENT REVIEW

Student's Name _____ Student ID Number _____

School _____ Grade ___ Date of Birth ___/___/___ Age _____

Date of Assessment ___/___/___ Date of Review ___/___/___

Type of Independent Assessment (Check One)

Adapted PE ____ Audiological ____ Clinical_____ Educational ____ Neuropsychological ____
Occupational Therapy ____ Physical Therapy ____ Psychiatric_____ Psychological____
Speech/Language _____ Other ____

Part I: Review by Qualified Personnel

Name and title of DCPS qualified personnel reviewing assessment: _____

Name and title of person who completed the independent assessment/and name and title of supervisor (if applicable)
_____

If the person who completed the assessment is an audiologist, occupational therapist, physical therapist, psychologist, physician, or speech-language therapist, is the person licensed? _____ Yes _____ No

The report is written, dated, and signed by the individual examiner who conducted the assessment or appropriate designee and appears on agency/company letterhead? _____ Yes _____ No

Testing and assessment materials and procedures used to assess the student's need for special education and related services are:

- Valid and reliable? _____ Yes _____ No
- Current version of assessment (newer version that is more than 2 years old does not exist)? _____ Yes _____ No
- Provided and administered in the student's native language, unless it is clearly not feasible to do so? _____ Yes _____ No
- Valid for the specific purpose for which they are used? _____ Yes_____ No

Part II: Review, Considerations, and Conclusions ori

The report includes the following:

- A review of relevant background information (including observation, teacher/parent interview)? _____ Yes _____ No
- A description of the student's performance on the assessment? _____ Yes _____ No
- A description of the student's performance in the current school environment (including educational impact)? _____ Yes _____ No
- A variety of assessment tools and strategies to directly assist in determining if the student has an educational handicapping condition as defined by IDEA and Chapter 30? _____ Yes _____ No

Are there additional data available to the school, which suggests that there are other factors, which significantly impact the student, such as health, attendance, social, or other issues?
_____ Yes _____ No
If yes, please specify _____
Are conclusions supported by the data provided? _____ Yes _____ No
Is additional information needed? _____ Yes _____ No
If yes, please specify _____
Reviewer has had direct contact with student? _____ Yes _____ No

The MDT concludes that a DCPS assessment is waived. _____ Yes _____ No ____ Yes, with reservations (attach note)

Independent Assessment Review Report Template

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

INDEPENDENT OCCUPATIONAL/PHYSICAL THERAPY ASSESSMENT REVIEW REPORT

SECTION I. STUDENT IDENTIFYING INFORMATION:

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

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

Caregivers/Legal Guardian Telephone Number:

Record Reviewed (please select as it applies):

□Independent Assessment □DCPS Assessment □IEP □Progress Report
□Service Log □Other (please list):

Date of Document Reviewed:

Name of Independent Assessor: (Name, Title and Company/Organization):

Date of Review:

DCPS Reviewer's Name and Credentials:

SECTION II. FINDINGS AND RECOMMENDATION OF THE INDEPENDENT ASSESSOR:

SECTION III. DCPS STUDENT'S OBSERVATION AND INTERVIEWS:

SECTION IV. DCPS CONSIDERATIONS AND RECOMMENDATIONS:

_____
Reviewer Signature, Title and Date

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

November 2009

Untimely Assessments and Due Diligence Guidelines

Pending official promulgation of policy

Version 1.0
Developed by: Erica Fener, Program Director, Related Services
Jennifer Parker, Program Manager, Policy Development

Purpose

The purpose of these Guidelines is to provide guidance when assessments are not conducted in a timely manner due to the student's absence, truancy, or refusal to participate or attend, lack of or withdrawal of parental consent for evaluation/reevaluation, or incomplete assessment.

Guidelines for Untimely Assessments and Due Diligence

Untimely Assessment Scenarios

Parent/Guardian Consent is Granted but the Student is Frequently Absent, Truant, and/or Refuses to Participate or Attend

When 2-3 attempts to assess are unsuccessful because the student is absent, truant and/or refuses to participate or attend:

- The Related Service Provider (RSP) assigned to complete the assessment must:
  - Contact the teacher, attendance monitor, and parent/guardian to determine the reason for the student's absence for each failed attempt;
  - Document contacts, attempted contacts, and outcomes in the SEDS communication log;
  - Call the parent/guardian to reschedule the assessment and document in the SEDS communication log; and
  - Inform the Special Education Coordinator (SEC) via email that the student was absent or refused to participate and that the information has been documented.
- The SEC must:
  - Contact the parent/guardian at least three times using multiple modalities (e.g., written, phone, email, visit). One contact must be written correspondence sent by certified mail with a return receipt;
  - Notify the related service provider via email when the attempts to contact the parent are made; and
  - Document contacts with parent/guardian, attempted contacts, and outcomes in the SEDS communication log.
- The IEP Team must convene within 15 school days of the second failed attempt to assess. The Team will:
  - Review the student's attendance history since consent was obtained;
  - Consider the reason(s) for the student's absence, truancy, and/or refusal to participate or attend; and
  - Determine if an alternate assessment or schedule for the assessment may be warranted.

The parent/guardian and DCPS can agree in writing that the attendance of certain IEP Team members is not necessary for this meeting depending on the member's area of curriculum or related services; allowing a partial team to meet to address this particular situation. **However, the related service provider assigned to that assessment MUST be in attendance.** If the parent/guardian cannot physically attend the IEP meeting an alternative means of participation may be used (e.g., individual or conference telephone calls).
The SEC will send a letter by certified mail with a return receipt to the parent/guardian within five business days of the IEP meeting if the parent/guardian does not want to attend the IEP meeting or fails to respond to the *IEP Meeting Invitation/Notice*.

No Parent/Guardian Consent for Initial Evaluation

If the parent/guardian refuses to consent to an initial evaluation or fails to respond to the *Parent/Guardian Consent to Initial Evaluation/Reevaluation* within 15 school days the SEC must:

- Contact the parent/guardian at least three times using multiple modalities (e.g., written, phone, email, visit). One contact must be written correspondence sent by certified mail with a return receipt;
- Document contacts, attempted contacts, and outcomes in the SEDS communication log;
- Send a Prior Written Notice (PWN) by certified mail with a return receipt to the parent/guardian indicating that the special education process has stopped. At this point, DCPS is no longer obligated to pursue consent or conduct assessments; and
- Contact the cluster supervisor via email if he/she feels it is necessary to pursue the consent to evaluate. DCPS may elect to proceed to mediation and/or a due process hearing in order to override the lack of consent for assessment.

No Parent/Guardian Consent for Reevaluation

If the parent/guardian refuses to consent to a reevaluation or fails to respond to the *Parent/Guardian Consent to Initial Evaluation/Reevaluation* within 15 school days the SEC must:

- Contact the parent/guardian at least three times using multiple modalities (e.g., written, phone, email, visit). One contact must be written correspondence sent by certified mail with a return receipt;
- Document contacts, attempted contacts, and outcomes in the SEDS communication log;
- Send a PWN by certified mail with a return receipt to the parent/guardian indicating that the special education process has stopped. At this point, DCPS is no longer obligated to pursue consent or conduct assessments; and
- Contact the cluster supervisor via email if he/she feels it is necessary to pursue the consent to reevaluate. DCPS may elect to proceed to mediation and/or a due process hearing in order to override the lack of consent for assessment.

Parent/Guardian Consent Provided but Assessment Not Completed in Timely Manner (Exception: student absent, truant, and/or refuses to participate or attend)

If the parent/guardian has provided consent to evaluate/reevaluate but the assessment may not be completed within the required timeline the SEC must:

- Contact the program manager of the specific discipline via email immediately (e.g., if the SEC suspects the speech/language evaluation will not be completed within the required timeline); and
- Mail written correspondence to the parent/guardian identifying the incomplete assessment(s) and requesting agreement on a new timeline for completion. This correspondence should be sent by certified mail with a return receipt on the same day as the program manager is contacted.

Parent/Guardian Withdraws Consent to Evaluate/Reevaluate

If the parent/guardian verbally withdraws consent to evaluate/reevaluate the case manager must:

- Document the conversation in the SEDS communication log; and
- Send a PWN by certified mail with a return receipt to the parent/guardian documenting that the consent to evaluate/reevaluate has been withdrawn.

July 2016

Missed Related Service Sessions, Truancy and Due Diligence Guidelines

Executive Summary

Introduction

The District of Columbia Public Schools (DCPS) provides related services as illustrated in student's Individualized Education Plan (IEP) in accordance with federal and local law. DCPS seeks to provide consistent service delivery to meet the needs of its students and legal obligations. For this reason, **related service providers** (RSPs) must provide consistent service delivery to help students function with greater independence. Related service providers are also responsible for creating supporting documentation and acting to ensure student access to needed services. When delivery of a service is impeded, the RSP is responsible for documenting due diligence consistent with these guidelines. This document delivers the procedures necessary when a student or provider misses service session. Bolded terms will be defined in the glossary at the end of the document. For further information regarding these guidelines, please direct your question to Office of Teaching and Learning.

Purpose

The purpose of this document is to provide guidance to related service providers (RSPs) regarding required actions for missed service sessions. These guidelines clarify the roles and obligations of RSPs, identify when and by when missed related service sessions must be made up, and explain how to document missed, make-up, and attempted make-up service sessions.

Truancy is an agency-wide problem in DC Public Schools. **Truancy** is the unexcused absence from school by a minor (5-17 years of age), either with or without parental knowledge, approval, or consent. Since regular school attendance is critical to academic success, chronic truancy must be addressed[21]. Absences impact the number of instructional hours that a student receives and may result in failing grades, disengagement from the school environment, and ultimately, increase the likelihood of students dropping out of school. Since truant students often miss related service sessions, RSPs are uniquely situated to assist in increasing attendance and reducing truancy for special education students.

These guidelines address due diligence for service delivery to truant students and instruct RSPs on how to support truancy prevention. The guidelines provide necessary information for monitoring student engagement through service delivery, engaging parents in problem solving, and adhering to district reporting requirements for student attendance. RSP providers in every discipline should adhere to these guidelines and all other specialized instruction policies.

[21] 61 DCR 222

Missed Related Service Sessions Scenarios and Due Diligence Procedures

Provider Unavailable

Provider not available for schedule service session(s) (e.g., sick leave, annual leave, attending an IEP meeting)

When a service session(s) is missed because the provider is unavailable to deliver the service, DCPS has the following two options:

1. The RSP will schedule a make-up service session for the missed service session(s) during the quarter in which the missed service session(s) occurred. If the missed service session(s) occurred during the last week of the quarter, it must be made up within the first week of the following quarter. This policy ensures that all relevant information will be provided in the quarterly progress report. In most cases, this is the option that should be utilized. If the RSP cannot make up the session(s) by the following quarter, he/she must notify the program manager.
2. When the RSP absolutely cannot make up the session(s), and notifies the program manager, the program manager must assign a substitute provider to make up the missed service session(s) during the quarter in which the missed service session(s) occurred or develop an alternative option with the RSP and LEA. If the missed service session(s) occurred during the last week of the quarter, it must be made up within the first week of the following quarter.

Student Unavailable

Student in school, but not able to attend session

Student Attendance at School-Related Activities (e.g., field trip, assemblies):
If a service session is missed because of student attendance at a school-related activity the RSP must:

1. Consider the impact of the missed service session on the child's progress and performance and determine next steps to ensure the provision of FAPE. Determine whether missed session must be made up according to the following criteria:

- If the missed service session due to the student's unavailability has caused a negative impact on the student's progress or performance, the missed session must be made up.
- If the missed service session due to the student's unavailability has not caused a negative impact on the student's progress or performance, the missed session does not need to be made up.

2. Document this determination in the **Service Log** in SEDS for that missed service session due to student unavailability.

For additional information regarding documentation see *Procedures for Documentation* below.

Student Refuses to Participate or Attend (e.g., verbal refusal, student is unable to be located)
When a student misses 3 service sessions because the **student refuses to participate or attend,** the RSP must:

1. Document each missed service session (see *Procedures for Documentation*); and
2. Notify the LEA or case manager via email within 24 hours of the last missed service session. This notification prompts an **IEP meeting**. The LEA or case manager must convene the IEP meeting within 15 school days of the 3rd missed service session to consider the impact of the missed session on the student's progress and performance and determine how to ensure the continued provision of a **free and appropriate public education (FAPE)**. Student attendance records should be reviewed at the meeting when making the determination.

The parent/guardian can agree in writing that the attendance of certain IEP Team members is not necessary for this meeting depending on the member's area of curriculum or related services. In this case an *IEP Team Member Excusal Form* must be completed in SEDS. **However, the RSP for the service sessions in question must be in attendance and cannot be excused from this meeting.** If the parent/guardian cannot physically attend the IEP meeting an alternative means of participation may be used (e.g., individual or conference telephone calls). The parent's/guardian's signature must be obtained on the IEP and/or the Prior Written Notice (PWN) before the delivery of services can be modified. The LEA or case manager is responsible for obtaining the parent's/guardian's signature on the amended IEP within 5 days of a telephone conference.

While there is no requirement to make up missed service sessions due to student absence or refusal to participate, DCPS seeks to ensure that related services are delivered despite the reason for missed service sessions. Therefore, the IEP team should consider alternative service delivery options or a change in services when a student's absence or refusal is significantly impacting service implementation as outlined above. Examples of alternative service delivery options include: service delivery in the classroom, a consultation delivery model, or transition out of the current service type and replacement with different services (e.g., exit from speech/language services and increase research-based reading intervention). Appropriate alternative service delivery does not include inclusionary delivery of services (e.g., RSP attends assembly with student as part of his/her service session).

Multiple Student Absences/Truancy and Suspension

Student absent from school and scheduled service sessions

ruancy with or without approval, parental knowledge, or consent) The District of Columbia Compulsory School Attendance Law 8-247[22] and DC Municipal Regulations Title V Ch. 21[23] govern mandatory school attendance and the ways schools must respond when students are truant. The Compulsory School Attendance Law states that parents/guardians who fail to have their children attend school are subject to the following:

- Truancy charges may be filed against the parent or student;

[22] D.C. Law 8-247, § 2(a), 38 DCR 376, D.C. Law 20-17, § 303(a), 60 DCR 9839
[23] 5-A DCMR § 2103

- Neglect charges may be filed against the parent;
- The parents may be fined or jailed;
- School-aged students may be picked up by law enforcement officers during school hours for suspected truancy;
- Students may be referred to Court Diversion and other community based interventions; and
- Parents and students may be assigned community service and placed under court supervision/probation.

When a student misses a related services session because of an excused or unexcused student absence the RSP must:

1. Speak with the teacher and Attendance Counselor / Attendance Designee to determine reason for the student's absence;
2. Check ASPEN to provide information regarding the student's absence;
3. Contact the student's parent, make a home phone call ***(if the absence is excused, there is no need to contact the student's parent)****;*
4. Document the contact with the student's guardian in the SEDS **Communication Log**;
5. Document each missed session in an entry the Service Log in SEDS (see examples below);
   - "Attempted to provide (state related service), however (name of student) is absent per report of classroom teacher (name teacher). Per ASPEN the student's absence is excused/unexcused."
   - You may also add information received following phone call with parent/guardian. For example "Per telephone conversation with parent (name the parent/guardian), (student's name) is absent from local school because (state the provided excuse)"; and
6. Notify the LEA or case manager via email within 24 hours of the missed service session.

hen a student misses five (5) related service sessions because of unexcused student absences the RSP must:

1. Contact the student's parent or guardian by making a home phone call;
2. Inform the teacher, Attendance Counselor / Attendance Designee to determine what staff has already done to address attendance concerns;
3. Inform the LEA/Case Manager of the absences and attempts to contact the student's parent or guardian; and
4. Document the attempts to service the student and contact the student's guardian in the SEDS Communication Log **and** in the Service Log.

Per DCPS' Attendance Intervention Protocol, after five (5) unexcused absences:

1. The Attendance Counselor / Attendance Designee will mail an Unexcused Absences ASPEN letter to the student's home requesting an attendance conference;
2. Student is referred to the Student Support Team (SST);

3. Student, parent or guardian and appropriate school officials develop Student Attendance Support Plan to connect the family to in-school or community resources and city agencies, and to make recommendations for next steps;
4. Follow up within 10-days to track student's progress on next steps identified in attendance conference. The SST Team will follow up with programs/resources identified for support during attendance conference to determine if student/family is participating; and
5. A home visit must be conducted by the SST Team if parent is not responsive to meeting request.

The Attendance Counselor / Attendance Designee or SST chair will request RSP attendance in the SST meeting. RSPs should be prepared to contribute to the development of the Student Attendance Support Plan. A decision to reduce or remove a related service from a student's IEP due to truancy should not be made without consideration from the MDT to determine whether the student's non-attendance of service sessions is a manifestation of his/her disability. Refer to the *DCPS Attendance Intervention Protocol* provided below for the detailed protocol.

Student Suspension from School

Suspensions lasting ten (10) days or less

IDEA allows school administrators to apply short-term disciplinary removals of students with disabilities and students suspected of having disabilities for up to ten consecutive school days or ten accumulated school days throughout the course of the school year.

If a service session is missed due to a short-term disciplinary removal from school the RSP must:

1. Consider impact of the missed service session(s) on the child's progress and performance and determine next steps to ensure the provision of FAPE. Determine whether missed session must be made up according to the following criteria:

- If the missed service session due to short-term suspension has caused a negative impact on the student's progress or performance, the missed session must be made up.
- If the missed service session due to short-term suspension has not caused a negative impact on the student's progress or performance, the missed session does not need to be made up.

2. Document this consideration in the Service Log for the missed service session(s).

Suspensions beyond ten (10) consecutive or accumulated school days

Any additional removal beyond ten consecutive school days or ten accumulated school days constitutes a change in placement for the student. Under these circumstances, the IEP team must meet to determine:

- The setting for the Individual Alternative Educational Setting (IAES);
- The services that will be provided to the student at the IAES in order for the student to meet the student's IEP goals;
- If additional services are necessary to ensure the misbehavior does not continue into the IAES; and
- How the student will continue to participate in the general education curriculum.

On the 11th day of a student's removal from school, educational services must begin at the IAES. The IDEA's procedural safeguards require that all students with disabilities who have been suspended or expelled from school still must receive a free and appropriate education, which includes services provided to the student at the IAES in order for the student to meet his or her IEP goals. RSPs must provide services in the IAES regardless of whether the incident leading to suspension was a manifestation of the student's disability.

Administrative Circumstances

Student Withdrawn from ASPEN but showing in SEDS

If the school registrar has completed the steps to withdraw a student from ASPEN but the student is still showing in SEDS, the RSP must:

1. Document the missed service session (see *Procedures for Documentation*); and
2. Document as "student unavailable".

   The Service Log entry must include:

   - Date student was withdrawn in ASPEN;
   - Reason for withdrawal (noted in ASPEN); and
   - Attending school if known.
3. Continue to document the missed services until the student is no longer showing in SEDS.

School Closure: School closed for holiday or emergency.

When school is not in session due to a scheduled holiday, delayed opening, or complete closure due to poor weather there is no requirement to make up the missed service session(s).

Procedures for Documentation

Missed Service Sessions

For all missed service sessions, the RSP must complete the SEDS Service Log as follows:

1. Include detailed information to identify the missed service section and the student's progress:
   - Date of missed service session;
   - Service type (e.g., student absent, student unavailable, provider unavailable, school closure);
   - Duration of service scheduled (service duration must be documented even if a student is absent; if the student receives only partial service, document the altered duration.);
   - Group size; and
   - "Progress Report" (e.g., just introduced, mastered, no progress, not introduced, progressing, regressing).
2. Complete the "Comments" box in the SEDS Service Log:
   - Document why the service session was missed (e.g., student unavailable, student absent, provider unavailable, school closure); and
   - List action taken to ensure service delivery (e.g., contacted the parent/guardian, talked with the teacher, contacted the student).

Documenting Missed Services if Student is Unavailable

As mentioned above, in certain cases of "student unavailable," consider and document the impact of the missed session on the child's progress and performance. If the missed session has impacted the student's progress or performance, indicate that services will be made up and include the make-up plan dates. If the missed session has not impacted the student's progress or performance, please indicate and provide supporting data.

Make-Up Service Sessions

The RSP must log all delivered or attempted make-up service sessions in the SEDS Service Log as follows:

1. Include detailed information to identify the missed service section and the student's progress:
   - Date and time of make-up service provided;
   - Service type (e.g., student absent, student unavailable, provider unavailable, school closure);
   - Duration of the service provided (if the student receives only partial service, document the altered duration);
   - Group size;
   - "Progress Report" (e.g., just introduced, mastered, no progress, not introduced, progressing, regressing).
2. Complete the "Comments" box in the SEDS Service Log:
   - Describe the session (i.e. "MAKE UP SERVICE SESSION for Missed Session on XX/XX/XXXX";
   - Record progress note standards for service sessions delivered; and

- List action taken to ensure service delivery (e.g., notified the parent/guardian of the make-up service session dates(s)).

Make-Up Service Session Attempts

The RSP is required to attempt to make up a service session three times. All attempts at attempting make-up service sessions should be documented in SEDS as follows:

1. Any failed attempt prior to the third scheduled make-up session should be logged in the SEDS Communication Log, including:

- Attempted date and time of service session; and
- Which attempt it was (e.g., first, second, third, etc.).

2. Upon the third failed attempt the scheduled missed make-up service session should be logged in the SEDS Service Log indicating:
   - Attempted date and time of service session;
   - Service type (e.g., student absent, student unavailable, provider unavailable, school closure);
   - Which attempt it was (e.g., first, second, third);
   - Duration of service attempted (number of minutes or zero minutes);
   - Group size; and
   - "Progress Report" (e.g., just introduced, mastered, no progress, not introduced, progressing, regressing).
3. When documenting the third failed attempt, complete the "Comments" box in the SEDS Service Log:
   - Describe the session (i.e. "MAKE UP SERVICE SESSION for Missed Session on XX/XX/XXXX"); and
   - List action taken to ensure service delivery (e.g., contacted parent/guardian, talked with the teacher, contacted the student.
4. After three attempts have been made and documented in an effort to make up the missed service session(s) and DCPS has exercised due diligence, attempts to implement a make-up session for the missed session(s) can be discontinued.

Appendices

Appendix I: DC Public Schools Attendance Intervention Protocol

Connect-Ed calls to absent students occurs daily ONLY when absence is recorded the same day as absence*

# OF ABSENCES	SCHOOL ACTION	DISTRICT ACTION	LEGAL ACTION
1 & 2 (Total)	a. Teacher calls home ➢ *Teachers should inform Attendance Counselor (AC)/ Designee (AD) of any contact attempted/made with parent and on non-working phone numbers.*	a. **Connect-Ed calls to absent students (occurs daily)**	
3 (Unexcused)	a. AC/AD mails **3-Day Unexcused Absences** Attendance Notice STARS letter and **mails** to student's home **(elementary and middle school and educational center students only).**	a. Connect-Ed call from Chancellor	
5 (Total)	a. AC/AD mails **5-Day Total Absences** Attendance Notice STARS letter and mails to student's home. ➢ AC/AD submits 5-day letter to nurse to: ✓ Check for the Universal Health Form ✓ Contact family ✓ Develop Individual Health Plan for students (i.e. Asthma Action Plan)		
5 (Unexcused) & MPD Pick-ups	a. AC/AD **mails 5-Day Unexcused Absences** STARS letter to the student's home requesting an attendance **conference** b. Student is **referred to the Student Support Team (SST)** c. Determine and document **root cause** of absences and intervention in STARS ➢ Student, parent/guardian and appropriate school officials develop **Student Attendance Support Plan** to connect the family to in-school or community resources and city agencies, and to make recommendations for next steps ***Follow up within 10-days** to track student's progress on next steps identified in attendance conference. Follow up with programs/resources identified for support during attendance conference to determine if student/family is participating*** d. Home visit must be conducted, if parent is not responsive to meeting request	a. OYE will monitor 5-day meeting compliance rate b. OYE will review root causes to identify common themes in need of system wide action.	✔
7 (Unexcused)	a. AC/AD mails **MPD warning** letter		
10 (Total)	a. AC/AD mails **10-Day Total Absences** STARS letter to the student's home arranging an attendance conference; ➢ *Student, parent/guardian and appropriate school officials meet to develop or modify **Student Attendance Support Plan** to connect the family to in-school or community resources and city agencies, and to make recommendations for next steps* b. If parent is non-responsive to meeting request, student is referred to SST		

1

Connect-Ed calls to absent students occurs daily ONLY when absence is recorded the same day as absence*

# OF ABSENCES	SCHOOL ACTION	DISTRICT ACTION	LEGAL ACTION
10 (Unexcused) Student becomes "chronically truant"	***Elementary and middle schools and educational centers (ages 5 – 13):*** a. If attendance interventions have been executed and documented in STARS,; ➢ AC/AD will complete CFSA educational neglect referral form and email to CFSA.EdNeglect@dc.gov and include Attendance Specialist on email b. Document referral in STARS adhoc field ***High school students (ages 14 and up)***: c. AC/AD refers student to SST for follow-up. SST meets to review student's progress and revise the Student Attendance Support Plan d. SST will notify administrators of **all** students reaching 10 unexcused absences	a. OYE will monitor CFSA referral compliance rate b. OYE will notify MPD & OSSE of all students with 10+ unexcused absences	✔
15 (Unexcused)	a. If all interventions have been executed and documented in DC STARS, AC/AD, in conjunction with their attendance specialist, will refer student/family to court in conjunction with Attendance Specialist **(students ages 5-17 only)** b. Document submission to OYE in STARS adhoc field	a. OYE will approve and send court referral to OAG/CSS b. OYE will monitor court referral compliance rate	✔
16+ (Unexcused)	a. Continue to monitor student's progress and modify Student Support Plan		
20* (Unexcused Consecutive)	b. AC/AD mails letter to student's home to notify parent/guardian that the student is eligible to be withdrawn from school ➢ School must have executed all the above interventions before withdrawal	a. Attendance Specialists will review list of students that have been withdrawn and will refer dropped students to Student Placement Team	✔

Additional Instructions for MPD Drop-offs

1. Student goes to designated office to sign in
2. AC/AD documents time of entry in adhoc MPD field in STARS
3. AC/AD contacts student's parent/guardian to inform them of MPD pick up
    a. Print and send STARS MPD Pick Up letter requesting a meeting within 5 days of pick up
4. AC/AD convenes **Attendance Conference** with parent/guardian to develop Student Support Plan

Appendix II: Glossary

Communication Log

Tab in in SEDS where all communications with parents should be documented in detail. Log entries should include date, mode of outreach (i.e. phone call, e-mail), summary of communication, and parent response.

FAPE (Free Appropriate Public Education)

Public education special education and related services that a) are provided at public expense, under public supervision and direction, and without charge; b) meet the standards of the SEA, including the requirements of this part; c) include an appropriate preschool, elementary school, or secondary school education in the State involved; and d) are provided in conformity with an individualized education program (IEP)" (34 CFR 300.17).

IEP Meeting

A written statement for each child with a disability that is developed, reviewed, and revised in a meeting that includes a) a statement of the child's present level of academic achievement and functional performance; b) a statement of measurable annual goals, including academic and functional goals; c) a description of how the child's progress toward meeting the annual goals will be measured; d) a statement of the special education and related services and supplementary aids and services to be provided to the child and a statement of the program modifications or supports or school personnel that will be provided to the child; e) a statement of any individual appropriate accommodations that are necessary to measure the academic achievement and functional performance of the child on assessments; and f) the projected date for the beginning of the services and modifications and the anticipated frequency, location, and duration of those services and modifications.

Related Service Providers (RSPs)

Related Service Providers (RSPs) provide wrap-around services for students. These positions include speech-language pathologists, social workers, school psychologists, and school counselors, etc.

Service Log

Tool in SEDS where all services (including those provided, missed, attempted, and made-up) should be documented in detail. Log entries should include date, duration of session, and summary of session.

Truancy

The unexcused absence from school by a minor (5-17 years of age), either with or without parental knowledge, approval, or consent.

Plan To Make Up Missed Services

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

MISSED SERVICES MAKE-UP PLAN

Student:
Date of Birth:
Service:
Date:

Student ID Number:
School:
Provider Name

Instructions:
(1) Follow DCPS guidelines regarding Missed Related Service Sessions and Due Diligence Guidelines (2) Notify the student's parent and teacher of make-up plan, and document in Communications Log in SEDS (3) Work with teachers to determine best times for providing make-up services (4) Submit a copy of this form to the Physical Supports Program Manager by the end of the month (fax to 202-535 2137)

Reason for Missed Service	Options for Making-Up Services
Select: T1T – Provider unavailable due to student/district/building meetings T2 – Provider – illness; personal; professional development T3 – Not provider to cover school S1 – Student unavailable for scheduled service (field trip, assembly, school closing) S2 – Student refusal	***Select:*** 1. Add time before or after the student's scheduled session 2. Add a session another day 3. Incorporate the student into other students' sessions 4. Integrate service into classroom activities 5. Schedule before/after school if permissible by the district

Dates of missed sessions	Amount of time missed (in minutes)	Reason	Option selected for make-up services	Dates services will be made up	Estimated completion date	Make up plan confirmed with teacher	Date make-up was completed and documented

Equitable Services Forms

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Related Service Log – Equitable Services

Student Name:

Student DOB:

Student ID#: Student's Location/Site: _____ Related Service:

ISP Goals:

1. The Student will
2. The Student will
3. The Student will
4. The Instructional Staff will
5. The Instructional Staff will
6. The Parent or Guardian will

Service Log:

Date	***Type of Contact**	**Duration**	**Goals/Objective(s) Addressed #**

***Type of Contact: G** = Group, **SA** = Student Absent, **SU** = Student Unavailable, **PU** = Provider Unavailable, **CP** = Consult/Communication with Parent, **CS**=Consult/communication with Instructional Staff **DC**=Direct Consultation/Observation

Comments:

_____
_____
_____
_____
_____

Name of Provider: _____ **Signature**: _____ **Date**: _____

Complete this form after each service. By the **5th** of the following month, upload/fax into SEDS using a Miscellaneous Cover Sheet labeled: "Equitable Services Log---Discipline---Month, Year"

Occupational Therapy Practice Framework: Domain & Process

OCCUPATIONAL THERAPY PRACTICE
FRAMEWORK:
Domain & Process
3rd Edition

Contents

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PREFACE

The *Occupational Therapy Practice Framework: Domain and Process,* 3rd edi- tion (hereinafter referred to as "the *Framework*"), is an official document of the American Occupational Therapy Association (AOTA). Intended for oc- cupational therapy practitioners and students, other health care professionals, educators, researchers, payers, and consumers, the *Framework* presents a sum- mary of interrelated constructs that describe occupational therapy practice.

Definitions

Within the *Framework, occupational therapy* is defined as

> the therapeutic use of everyday life activities (occupations) with individ- uals or groups for the purpose of enhancing or enabling participation in roles, habits, and routines in home, school, workplace, community, and other settings. Occupational therapy practitioners use their knowl- edge of the transactional relationship among the person, his or her en- gagement in valuable occupations, and the context to design occupa- tion-based intervention plans that facilitate change or growth in client factors (body functions, body structures, values, beliefs, and spirituality) and skills (motor, process, and social interaction) needed for successful participation. Occupational therapy practitioners are concerned with the end result of participation and thus enable engagement through ad- aptations and modifications to the environment or objects within the environment when needed. Occupational therapy services are provided for habilitation, rehabilitation, and promotion of health and wellness for clients with disability- and non-disability-related needs. These services include acquisition and preservation of occupational identity for those who have or are at risk for developing an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restriction. (adapted from AOTA, 2011; see Appendix A for additional definitions in a glossary)

When the term *occupational therapy practitioner* is used in this document, it refers to both occupational therapists and occupational therapy assistants (AOTA, 2006). Occupational therapists are responsible for all aspects of oc- cupational therapy service delivery and are accountable for the safety and ef- fectiveness of the occupational therapy service delivery process. Occupational therapy assistants deliver occupational therapy services under the supervision of and in partnership with an occupational therapist (AOTA, 2009). Addi- tional information about the preparation and qualifications of occupational therapists and occupational therapy assistants can be found in Appendix B.

Evolution of This Document

The *Framework* was originally developed to articulate occupational therapy's distinct perspective and contri- bution to promoting the health and participation of per- sons, groups, and populations through engagement in occupation. The first edition of the *Framework* emerged from an examination of documents related to the *Occu- pational Therapy Product Output Reporting System and Uniform Terminology for Reporting Occupational Therapy Services* (AOTA, 1979). Originally a document that re- sponded to a federal requirement to develop a uniform reporting system, the text gradually shifted to describing and outlining the domains of concern of occupational therapy.

The second edition of *Uniform Terminology for Oc- cupational Therapy* (AOTA, 1989) was adopted by the AOTA Representative Assembly (RA) and published in 1989. The document focused on delineating and defining only the occupational performance areas and occupational performance components that are addressed in occupa- tional therapy direct services. The third and final revision of *Uniform Terminology for Occupational Therapy* (AOTA, 1994) was adopted by the RA in 1994 and was "expanded to reflect current practice and to incorporate contextual as- pects of performance" (p. 1047). Each revision reflected changes in practice and provided consistent terminology for use by the profession.

In Fall 1998, the AOTA Commission on Practice (COP) embarked on the journey that culminated in the *Occupational Therapy Practice Framework: Domain and Process* (AOTA, 2002b). At that time, AOTA also published *The Guide to Occupational Therapy Practice* (Moyers, 1999), which outlined contemporary practice for the profession. Using this document and the feedback received during the review process for the third edition of *Uniform Terminology for Occupational Therapy,* the COP proceeded to develop a document that more fully articu- lated occupational therapy.

The *Framework* is an ever-evolving document. As an official AOTA document, it is reviewed on a 5-year cycle for usefulness and the potential need for further refinements or changes. During the review period, the COP collects feedback from members, scholars, authors, practitioners, and other stakeholders. The revision pro- cess ensures that the *Framework* maintains its integrity while responding to internal and external influences that should be reflected in emerging concepts and advances in occupational therapy.

The *Framework* was first revised and approved by the RA in 2008. Changes to the document included

refinement of the writing and the addition of emerging concepts and changes in occupational therapy. The ra- tionale for specific changes can be found in Table 11 of the second edition of the *Framework* (AOTA, 2008, pp. 665 - 667).

In 2012, the process of review and revision of the *Framework* was initiated again. Following member re- view and feedback, several modifications were made to improve flow, usability, and parallelism of concepts within the document. The following major revisions were made and approved by the RA in the Fall 2013 meeting:

- The overarching statement describing occupa- tional therapy's domain is now stated as "achiev- ing health, well-being, and participation in life through engagement in occupation" to encom- pass both domain and process.
- *Clients* are now defined as persons, groups, and populations.
- The relationship of occupational therapy to orga- nizations has been further defined.
- *Activity demands* has been removed from the do- main and placed in the overview of the process to augment the discussion of the occupational ther- apy practitioner's basic skill of activity analysis.
- *Areas of occupation* are now called *occupations*.
- *Performance skills* have been redefined, and Table 3 has been revised accordingly.
- The following changes have been made to the in- terventions table (Table 6):
  - *Consultation* has been removed and has been in- fused throughout the document as a method of service delivery.

- Additional intervention methods used in prac- tice have been added, and a clearer distinction is made among the interventions of *occupations, activities,* and *preparatory methods and tasks*.
- *Self-advocacy* and *group interventions* have been added.
- *Therapeutic use of self* has been moved to the process overview to ensure the understanding that use of the self as a therapeutic agent is inte- gral to the practice of occupational therapy and is used in all interactions with all clients.

- Several additional, yet minor, changes have been made, including the creation of a preface, reorga- nization for flow of content, and modifications to several definitions. These changes reflect feedback received from AOTA members, educators, and other stakeholders.

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Vision for This Work

Although this revision of the *Framework* represents the latest in the profession's efforts to clearly articulate the occupational therapy domain and process, it builds on a set of values that the profession has held since its found- ing in 1917. This founding vision had at its center a profound belief in the value of therapeutic occupations as a way to remediate illness and maintain health (Sla- gle, 1924). The founders emphasized the importance of

establishing a therapeutic relationship with each client and designing a treatment plan based on knowledge about the client's environment, values, goals, and de- sires (Meyer, 1922). They advocated for scientific prac- tice based on systematic observation and treatment (Dunton, 1934). Paraphrased using today's lexicon, the founders proposed a vision that was occupation based, client centered, contextual, and evidence based—the vi- sion articulated in the *Framework*.

INTRODUCTION

The purpose of a *framework* is to provide a structure or base on which to build a system or a concept (*American Heritage Dictionary of the English Language,* 2003). The *Occupational Therapy Practice Framework: Domain and Process* describes the central concepts that ground occu- pational therapy practice and builds a common under- standing of the basic tenets and vision of the profession. The *Framework* does not serve as a taxonomy, theory, or model of occupational therapy.

By design, the *Framework* must be used to guide occupational therapy practice in conjunction with the knowledge and evidence relevant to occupation and oc- cupational therapy within the identified areas of prac- tice and with the appropriate clients. Embedded in this document is the profession's core belief in the positive relationship between occupation and health and its view of people as occupational beings. Occupational therapy practice emphasizes the occupational nature of humans and the importance of occupational identity (Unruh, 2004) to healthful, productive, and satisfying living. As Hooper and Wood (2014) stated,

A core philosophical assumption of the profes-

> sion, therefore, is that by virtue of our biological endowment, people of all ages and abilities require occupation to grow and thrive; in pursuing occu- pation, humans express the totality of their being, a mind - body - spirit union. Because human exis- tence could not otherwise be, humankind is, in essence, occupational by nature. (p. 38)

The clients of occupational therapy are typically classified as *persons* (including those involved in care of a client), *groups* (collectives of individuals, e.g., families, workers, students, communities), and *populations* (col- lectives of groups of individuals living in a similar lo- cale—e.g., city, state, or country—or sharing the same or like characteristics or concerns). Services are pro-

vided directly to clients using a collaborative approach or indirectly on behalf of clients through advocacy or consultation processes.

Organization- or systems-level practice is a valid and important part of occupational therapy for several reasons. First, organizations serve as a mechanism through which occupational therapy practitioners provide interventions to support participation of those who are members of or served by the organization (e.g., falls prevention program- ming in a skilled nursing facility, ergonomic changes to an assembly line to reduce cumulative trauma disorders). Sec- ond, organizations support occupational therapy practice and occupational therapy practitioners as stakeholders in carrying out the mission of the organization. It is the fidu- ciary responsibility of practitioners to ensure that services provided to organizational stakeholders (e.g., third-party payers, employers) are of high quality and delivered in an efficient and efficacious manner. Finally, organizations em- ploy occupational therapy practitioners in roles in which they use their knowledge of occupation and the profession of occupational therapy indirectly. For example, practi- tioners can serve in positions such as dean, administrator, and corporate leader; in these positions, practitioners sup- port and enhance the organization but do not provide cli- ent care in the traditional sense.

The *Framework* is divided into two major sections:
(1) the *domain,* which outlines the profession's purview and the areas in which its members have an established body of knowledge and expertise, and (2) the *process,* which describes the actions practitioners take when providing services that are client centered and focused on engagement in occupations. The profession's under- standing of the domain and process of occupational therapy guides practitioners as they seek to support cli- ents' participation in daily living that results from the dynamic intersection of clients, their desired engage- ments, and the context and environment (Christiansen

& Baum, 1997; Christiansen, Baum, & Bass-Haugen, 2005; Law, Baum, & Dunn, 2005).

Although the domain and process are described sepa- rately, in actuality they are linked inextricably in a transac- tional relationship. The aspects that constitute the domain and those that constitute the process exist in constant inter- action with one another during the delivery of occupational therapy services. In other words, it is through simultane- ous attention to the client's body functions and structures, skills, roles, habits, routines, and context—combined with a focus on the client as an occupational being and the practitioner's knowledge of the health- and performance- enhancing effects of occupational engagements—that out- comes such as occupational performance, role competence, and participation in daily life are produced.

Achieving health, well-being, and participation in life through engagement in occupation is the overarching statement that describes the domain and process of oc- cupational therapy in its fullest sense. This statement

acknowledges the profession's belief that active engage- ment in occupation promotes, facilitates, supports, and maintains health and participation. These interrelated concepts include

- *Health*—"a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity" (World Health Organiza- tion [WHO], 2006, p. 1).
- *Well-being*—"a general term encompassing the total universe of human life domains, including physical, mental, and social aspects" (WHO, 2006, p. 211).
- *Participation*—"involvement in a life situation" (WHO, 2001, p. 10). Participation naturally oc- curs when clients are actively involved in carrying out occupations or daily life activities they find pur- poseful and meaningful. More specific outcomes of

  occupational therapy intervention are multidimen- sional and support the end result of participation.
- *Engagement in occupation*—performance of oc- cupations as the result of choice, motivation, and meaning within a supportive context and environ- ment. Engagement includes objective and subjec- tive aspects of clients' experiences and involves the transactional interaction of the mind, body, and spirit. Occupational therapy intervention focuses on creating or facilitating opportunities to engage in occupations that lead to participation in desired life situations (AOTA, 2008).

Domain

Exhibit 1 identifies the aspects of the domain, and Fig- ure 1 illustrates the dynamic interrelatedness among them. All aspects of the domain, including occupations, client factors, performance skills, performance patterns, and context and environment, are of equal value, and together they interact to affect the client's occupational identity, health, well-being, and participation in life.

Occupational therapists are skilled in evaluating all aspects of the domain, their interrelationships, and the client within his or her contexts and environments. In ad- dition, occupational therapy practitioners recognize the importance and impact of the mind-body-spirit con- nection as the client participates in daily life. Knowledge of the transactional relationship and the significance of meaningful and productive occupations form the basis for the use of occupations as both the means and the ends of interventions (Trombly, 1995). This knowledge sets occupational therapy apart as a distinct and valuable ser- vice (Hildenbrand & Lamb, 2013) for which a focus on the whole is considered stronger than a focus on isolated aspects of human function.

OCCUPATIONS	CLIENT FACTORS	PERFORMANCE SKILLS	PERFORMANCE PATTERNS	CONTEXTS AND ENVIRONMENTS
Activities of daily living (ADLs)*	Values, beliefs, and spirituality	Motor skills	Habits	Cultural
Instrumental activi- ties of daily living (IADLs)	Body functions	Process skills	Routines	Personal
Rest and sleep	Body structures	Social interaction skills	Rituals	Physical
Education			Roles	Social
Work				Temporal
Play				Virtual
Leisure				
Social participation				

*Also referred to as *basic activities of daily living (BADLs)* or *personal activities of daily living (PADLs).*

Exhibit 1. Aspects of the domain of occupational therapy. All aspects of the domain transact to support engagement, participation, and health. This exhibit does not imply a hierarchy.

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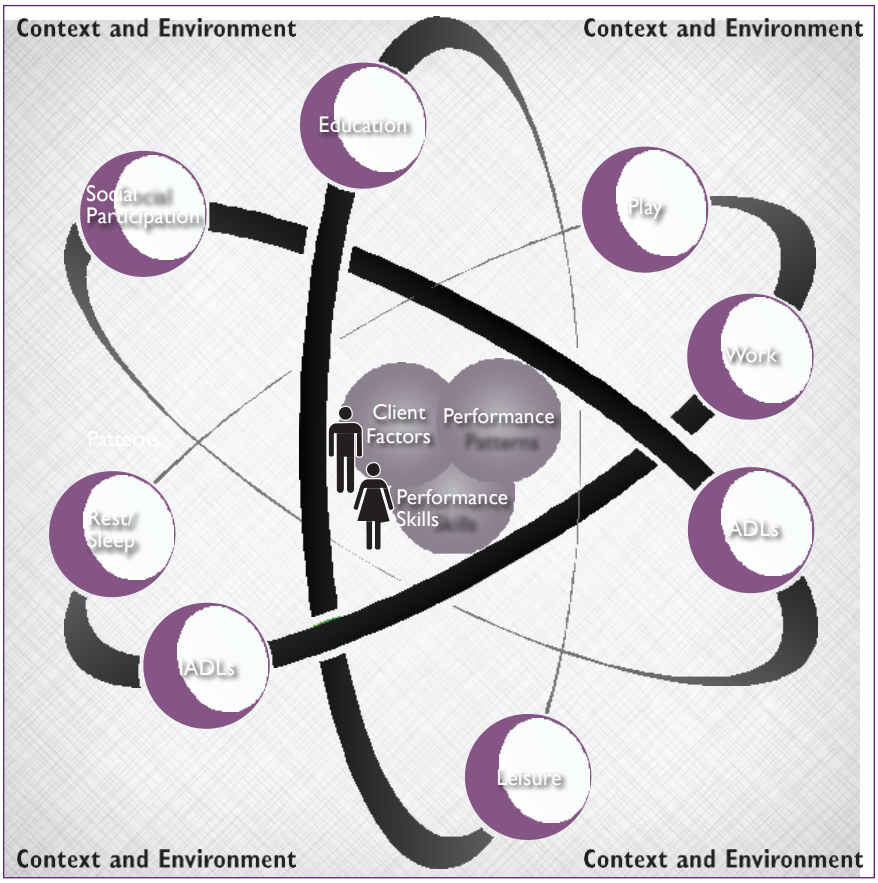

Figure 1. Occupational therapy's domain.
Note. ADLs = activities of daily living; IADLs = instrumental activities of daily living.

The discussion that follows provides a brief expla- nation of each aspect of the domain. Tables included at the end of the document provide full descriptions and definitions of terms.

Occupations

Occupations are central to a client's (person's, group's, or population's) identity and sense of competence and have particular meaning and value to that client. Several definitions of *occupation* are described in the literature and can add to an understanding of this core concept:

- "Goal-directed pursuits that typically extend over time, have meaning to the performance, and in- volve multiple tasks" (Christiansen et al., 2005, p. 548).
- "The things that people do that occupy their time and attention; meaningful, purposeful activity; the personal activities that individuals choose or need to engage in and the ways in which each in- dividual actually experiences them" (Boyt Schell, Gillen, & Scaffa, 2014a, p. 1237).
- "When a person engages in purposeful activities out of personal choice and they are valued, these clusters of purposeful activities form occupations

(Hinojosa, Kramer, Royeen, & Luebben, 2003). Thus, occupations are unique to each individual and provide personal satisfaction and fulfillment as a result of engaging in them (AOTA, 2002b; Pierce, 2001)" (Hinojosa & Blount, 2009, pp. 1–2).

- "In occupational therapy, occupations refer to the everyday activities that people do as individuals, in families and with communities to occupy time and bring meaning and purpose to life. Occupations include things people need to, want to and are ex- pected to do" (World Federation of Occupational Therapists, 2012).
- "Activities . . . of everyday life, named, organized, and given value and meaning by individuals and a culture. Occupation is everything people do to occupy themselves, including looking after them- selves . . . enjoying life . . . and contributing to the social and economic fabric of their communities" (Law, Polatajko, Baptiste, & Townsend, 1997, p. 32).
- "A dynamic relationship among an occupational form, a person with a unique developmental struc- ture, subjective meanings and purpose, and the

resulting occupational performance" (Nelson & Jepson-Thomas, 2003, p. 90).

- "Occupation is used to mean all the things peo- ple want, need, or have to do, whether of physical, mental, social, sexual, political, or spiritual nature and is inclusive of sleep and rest. It refers to all aspects of actual human doing, being, becoming, and belonging. The practical, everyday medium of self-expression or of making or experiencing meaning, occupation is the activist element of hu- man existence whether occupations are contem- plative, reflective, and meditative or action based" (Wilcock & Townsend, 2014, p. 542).

The term *occupation,* as it is used in the *Framework,* refers to the daily life activities in which people engage. Occupations occur in context and are influenced by the interplay among client factors, performance skills, and performance patterns. Occupations occur over time; have purpose, meaning, and perceived utility to the cli- ent; and can be observed by others (e.g., preparing a meal) or be known only to the person involved (e.g., learning through reading a textbook). Occupations can involve the execution of multiple activities for comple- tion and can result in various outcomes. The *Framework* identifies a broad range of occupations categorized as activities of daily living (ADLs), instrumental activities of daily living (IADLs), rest and sleep, education, work, play, leisure, and social participation (Table 1).

When occupational therapy practitioners work with clients, they identify the many types of occupations clients engage in while alone or with others. Differences among persons and the occupations they engage in are complex and multidimensional. The client's perspective on how an occu- pation is categorized varies depending on that client's needs and interests as well as the context. For example, one person may perceive doing laundry as work, whereas another may consider it

an IADL. One group may engage in a quiz game and view their participation as play, but another group may engage in the same quiz game and view it as education.

The ways in which clients prioritize engagement in selected occupations may vary at different times. For example, clients in a community psychiatric rehabilitation setting may prioritize registering to vote during an elec- tion season and food preparation during holidays. The unique features of occupations are noted and analyzed by occupational therapy practitioners, who consider all components of the engagement and use them effectively as both a therapeutic tool and a way to achieve the tar- geted outcomes of intervention.

The extent to which a person is involved in a particular occupational engagement is also important. Occupations

can contribute to a well-balanced and fully functional life- style or to a lifestyle that is out of balance and characterized by occupational dysfunction. For example, excessive work without sufficient regard for other aspects of life, such as sleep or relationships, places clients at risk for health prob- lems (Hakansson, Dahlin-Ivanoff, & Sonn, 2006).

Sometimes occupational therapy practitioners use the terms *occupation* and *activity* interchangeably to de- scribe participation in daily life pursuits. Some scholars have proposed that the two terms are different (Chris- tiansen & Townsend, 2010; Pierce, 2001; Reed, 2005). In the *Framework,* the term *occupation* denotes life en- gagements that are constructed of multiple activities. Both occupations and activities are used as interventions by practitioners. Participation in occupations is consid- ered the end result of interventions, and practitioners use occupations during the intervention process as the means to the end.

Occupations often are shared and done with others. Those that implicitly involve two or more individuals may be termed *co-occupations* (Zemke & Clark, 1996). Care- giving is a co-occupation that involves active participation on the part of both the caregiver and the recipient of care. For example, the co-occupations required during parent- ing, such as the socially interactive routines of eating, feed- ing, and comforting, may involve the parent, a partner, the child, and significant others (Olson, 2004); the activities inherent in this social interaction are reciprocal, interac- tive, and nested co-occupations (Dunlea, 1996; Esdaile & Olson, 2004). Consideration of co-occupations supports an integrated view of the client's engagement in context in relationship to significant others.

Occupational participation occurs individually or with others. It is important to acknowledge that clients can be independent in living regardless of the amount of assistance they receive while completing activities. Clients may be considered independent when they perform or di- rect the actions necessary to participate, regardless of the amount or kind of assistance required, if they are satisfied with their performance. In contrast with definitions of independence that imply a level of physical interaction with the environment or objects within the environment, occupational therapy practitioners consider clients to be independent whether they perform the component activ- ities by themselves, perform the occupation in an adapted or modified environment, use various devices or alterna- tive strategies, or oversee activity completion by others (AOTA, 2002a). For example, people with a spinal cord injury who direct a personal care assistant to assist them with their ADLs are demonstrating independence in this essential aspect of their lives.

Occupational therapy practitioners recognize that health is supported and maintained when clients are able to engage in home, school, workplace, and com- munity life. Thus, practitioners are concerned not only with

occupations but also with the variety of factors that empower and make possible clients' engagement and participation in positive health-promoting occupa- tions (Wilcock & Townsend, 2014).

Client Factors

Client factors are specific capacities, characteristics, or beliefs that reside within the person and that influence performance in occupations (Table 2). Client factors are affected by the presence or absence of illness, disease, deprivation, disability, and life experiences. Although cli- ent factors are not to be confused with performance skills, client factors can affect performance skills. Thus, client factors may need to be present in whole or in part for a person to complete an action (skill) used in the execution of an occupation. In addition, client factors are affected by performance skills, performance patterns, contexts and environments, and performance and participation in activities and occupations. It is through this cyclical rela- tionship that preparatory methods, activities, and occu- pations can be used to affect client factors and vice versa. Values, beliefs, and spirituality influence a person's motivation to engage in occupations and give his or her life meaning. *Values* are principles, standards, or qualities considered worthwhile by the client who holds them. *Be- liefs* are cognitive content held as true (Moyers & Dale, 2007). *Spirituality* is "the aspect of humanity that refers to the way individuals seek and express meaning and pur- pose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred" (Puchalski et al., 2009, p. 887).

Body functions and *body structures* refer to the "phys- iological function of body systems (including psycho- logical functions) and anatomical parts of the body such as organs, limbs, and their components," respec- tively (WHO, 2001, p. 10). Examples of body functions include sensory, musculoskeletal, mental (affective, cog- nitive, perceptual), cardiovascular, respiratory, and en- docrine functions. Examples of body structures include the heart and blood vessels that support cardiovascular function (for additional examples, see Table 2). Body structures and body functions are interrelated, and oc- cupational therapy practitioners must consider them when seeking to promote clients' ability to engage in desired occupations.

Moreover, occupational therapy practitioners un- derstand that, despite their importance, the presence, absence, or limitation of specific body functions and body structures does not necessarily ensure a client's success or difficulty with daily life occupations. Occu- pational performance and various types of client fac- tors may benefit from supports in the physical or so- cial environment that enhance or allow participation. It is through the process of observing clients engaging in occupations and activities that occupational therapy practitioners are able to determine the transaction be- tween client factors and performance and to then create adaptations and modifications and select activities that best promote enhanced participation.

Client factors can also be understood as pertaining to individuals at the group and population level. Al- though client factors may be described differently when applied to a group or population, the underlying tenets do not change substantively.

Performance Skills

Various approaches have been used to describe and catego- rize performance skills. The occupational therapy literature from research and practice offers multiple perspectives on the complexity and types of skills used during performance. *Performance skills* are goal-directed actions that are observable as small units of engagement in daily life oc- cupations. They are learned and developed over time and are situated in specific contexts and environments (Fisher & Griswold, 2014). Fisher and Griswold (2014) categorized performance skills as motor skills, process skills, and social interaction skills

(Table 3). Various body structures, as well as personal and environmen- tal contexts, converge and emerge as occupational per- formance skills. In addition, body functions, such as mental, sensory, neuromuscular, and movement-related functions, are identified as the capacities that reside within the person and also converge with structures and environmental contexts to emerge as performance skills. This description is consistent with WHO's (2001) *In- ternational Classification of Functioning, Disability and Health.*

Performance skills are the client's demonstrated abilities. For example, praxis capacities, such as imitat- ing, sequencing, and constructing, affect a client's mo- tor performance skills. Cognitive capacities, such as per- ception, affect a client's process performance skills and ability to organize actions in a timely and safe manner. Emotional regulation capacities can affect a client's abil- ity to effectively respond to the demands of occupation with a range of emotions. It is important to remember that many body functions underlie each performance skill.

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Performance skills are also closely linked and are used in combination with one another as a client en- gages in an occupation. A change in one performance skill can affect other performance skills. Occupational therapy practitioners observe and analyze performance skills to understand the transactions among client fac- tors, context and environment, and activity or occupa- tional demands, which support or hinder performance skills and occupational performance (Chisholm & Boyt Schell, 2014; Hagedorn, 2000).

In practice and in some literature, underlying body functions are labeled as *performance skills* and are seen in various combinations such as perceptual - motor skills and social - emotional skills. Although practitioners may focus on underlying capacities such as cognition, body structures, and emotional regulation, the *Framework* defines performance skills as those that are observable and that are key aspects of successful occupational par- ticipation. Table 3 provides definitions of the various skills in each category.

Resources informing occupational therapy practice related to performance skills include Fisher (2006); Po- latajko, Mandich, and Martini (2000); and Fisher and Griswold (2014). Detailed information about the ways performance skills are used in occupational therapy prac- tice may be found in the literature on specific theories and models such as the Model of Human Occupation (Kielhofner, 2008), the Cognitive Orientation to Daily Occupational Performance (Polatajko & Mandich, 2004), the Occupational Therapy Intervention Process Model (Fisher, 2009), sensory integration theory (Ayres, 1972, 2005), and motor learning and motor control the- ory (Shumway-Cook & Woollacott, 2007).

Performance Patterns

Performance patterns are the habits, routines, roles, and rituals used in the process of engaging in occupations or activities that can support or hinder occupational per- formance. *Habits* refers to specific, automatic behaviors; they may be useful, dominating, or impoverished (Boyt Schell, Gillen, & Scaffa, 2014b; Clark, 2000; Dunn, 2000). *Routines* are established sequences of occupations or activities that provide a structure for daily life; rou- tines also can promote or damage health (Fiese, 2007; Koome, Hocking, & Sutton, 2012; Segal, 2004).

Roles are sets of behaviors expected by society and shaped by culture and context; they may be further con- ceptualized and defined by a client (person, group, or population). Roles can provide guidance in selecting oc- cupations or can be used to identify activities connected with certain occupations in which a client engages.

When considering roles, occupational therapy practi- tioners are concerned with how clients construct their occupations to fulfill their perceived roles and identity and whether their roles reinforce their values and beliefs. Some roles lead to stereotyping and restricted engage- ment patterns. Jackson (1998a, 1998b) cautioned that describing people by their roles can be limiting and can promote segmented rather than enfolded occupations.

Rituals are symbolic actions with spiritual, cultural, or social meaning. Rituals contribute to a client's iden- tity and reinforce the client's values and beliefs (Fiese, 2007; Segal, 2004).

Performance patterns develop over time and are in- fluenced by all other aspects of the occupational therapy domain. Practitioners who consider clients' performance patterns are better able to understand the frequency and manner in which performance skills and occupations are integrated into clients' lives. Although clients may have the ability to engage in skilled performance, if they do not embed essential skills in a productive set of engagement patterns, their health, well-being, and participation may be negatively affected. For example, a client who has the skills and resources to engage in appropriate grooming, bathing, and meal preparation but does not embed them into a consistent routine may struggle with poor nutrition and social isolation. Table 4 provides examples of performance patterns for persons and groups or populations.

Context and Environment

Engagement and participation in occupation take place within the social and physical environment situated within context. In the literature, the terms *environ- ment* and *context* often are used interchangeably. In the *Framework,* both terms are used to reflect the impor- tance of considering the wide array of interrelated vari- ables that influence performance. Understanding the environments and contexts in which occupations can and do occur provides practitioners with insights into their overarching, underlying, and embedded influences on engagement.

The *physical environment* refers to the natural (e.g., geographic terrain, plants) and built (e.g., buildings, furniture) surroundings in which daily life occupa- tions occur. Physical environments can either sup- port or present barriers to participation in meaningful occupations. Examples of barriers include doorway widths that do not allow for wheelchair passage or absence of healthy social opportunities for people ab- staining from alcohol use. Conversely, environments can provide supports and resources for service delivery

(e.g., community, health care facility, home). The *so- cial environment* consists of the presence of, relation- ships with, and expectations of persons, groups, and populations with whom clients have contact (e.g., availability and expectations of significant individuals, such as spouse, friends, and caregivers).

The term *context* refers to elements within and sur- rounding a client that are often less tangible than physical and social environments but nonetheless exert a strong influence on performance. Contexts, as described in the *Framework,* are cultural, personal, temporal, and virtual. The *cultural context* includes customs, beliefs, activity patterns, behavioral standards, and expectations accepted by the society of which a client is a member. The cul- tural context influences the client's identity and activity choices, and practitioners must be aware, for example, of norms related to eating or deference to medical profes- sionals when working with someone from another cul- ture and of socioeconomic status when providing a dis- charge plan for a young child and family. *Personal context* refers to demographic features of the

individual, such as age, gender, socioeconomic status, and educational level, that are not part of a health condition (WHO, 2001). *Temporal context* includes stage of life, time of day or year, duration or rhythm of activity, and history.

Finally, *virtual context* refers to interactions that occur in simulated, real-time, or near-time situations absent of physical contact. The virtual context is be- coming increasingly important for clients as well as oc- cupational therapy practitioners and other health care providers. Clients may require access to and the ability to use technology such as cell or smartphones, comput- ers or tablets, and videogame consoles to carry out their daily routines and occupations.

Contexts and environments affect a client's access to occupations and influence the quality of and satis- faction with performance. A client who has difficulty performing effectively in one environment or context may be successful when the environment or context is changed. The context within which the engagement in occupations occurs is specific for each client. Some contexts are external to clients (e.g., virtual), some are internal to clients (e.g., personal), and some have both external features and internalized beliefs and values (e.g., cultural).

Occupational therapy practitioners recognize that for clients to truly achieve an existence of full partic- ipation, meaning, and purpose, clients must not only function but also engage comfortably with their world, which consists of a unique combination of contexts and environments (Table 5).

Interwoven throughout all contexts and environ- ments is the concept of *occupational justice,* defined as "a justice that recognizes occupational rights to inclusive participation in everyday occupations for all persons in society, regardless of age, ability, gender, social class, or other differences" (Nilsson & Townsend, 2010, p. 58). Occupational justice describes the concern that occu- pational therapy practitioners have with the ethical, moral, and civic aspects of clients' environments and contexts. As part of the occupational therapy domain, practitioners consider how these aspects can affect the implementation of occupational therapy and the target outcome of participation.

Several environments and contexts can present occu- pational justice issues. For example, an alternative school placement for children with psychiatric disabilities could provide academic support and counseling but limit op- portunity for participation in sports, music programs, and organized social activities. A residential facility could offer safety and medical support but provide little opportunity for engagement in the role-related activities that were once a source of meaning for residents. Poor communities that lack accessibility and resources make participation espe- cially difficult and dangerous for people with disabilities. Occupational therapy practitioners may recognize areas of occupational injustice and work to support policies, ac- tions, and laws that allow people to engage in occupations that provide purpose and meaning in their lives.

By understanding and addressing the specific justice issues within a client's discharge environment, occupa- tional therapy practitioners promote therapy outcomes that address empowerment and self-advocacy. Occupa- tional therapy's focus on engagement in occupations and occupational justice complements WHO's (2001) perspective on health. In an effort to broaden the un- derstanding of the effects of disease and disability on health, WHO recognized that health can be affected by the inability to carry out activities and participate in life situations caused both by environmental barriers and by problems that exist in body structures and body functions. The *Framework* identifies occupational jus- tice as both an aspect of contexts and environments and an outcome of intervention.

Process

This section operationalizes the process undertaken by occupational therapy practitioners when providing ser- vices to clients. Exhibit 2 identifies the aspects of the process, and Figure 2 illustrates the dynamic interrelat- edness among them. The *occupational therapy process* is

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Evaluation

Occupational profile—The initial step in the evaluation process, which provides an understanding of the client's occupational history and experiences, patterns of daily living, interests, values, and needs. The client's reasons for seeking services, strengths and concerns in relation to performing occupations and daily life activities, areas of potential occupational disruption, supports and barriers, and priorities are also identified.

Analysis of occupational performance—The step in the evaluation process during which the client's assets and problems or potential problems are more specifically identified. Actual performance is often observed in context to identify supports for and barriers to the client's performance. Performance skills, performance patterns, context or environment, client factors, and activity demands are all considered, but only selected aspects may be specifically assessed. Targeted outcomes are identified.

Intervention

Intervention plan—The plan that will guide actions taken and that is developed in collaboration with the client. It is based on selected theories, frames of reference, and evidence. Outcomes to be targeted are confirmed.

Intervention implementation—Ongoing actions taken to influence and support improved client performance and participation. Interventions are directed at identified outcomes. The client's response is monitored and documented.

Intervention review—Review of the intervention plan and progress toward targeted outcomes.

Targeting of Outcomes

Outcomes—Determinants of success in reaching the desired end result of the occupational therapy process. Outcome assessment information is used to plan future actions with the client and to evaluate the service program (i.e., program evaluation).

Exhibit 2. Process of occupational therapy service delivery.
The process of service delivery is applied within the profession's domain to support the client's health and participation.

the client-centered delivery of occupational therapy ser- vices. The process includes evaluation and intervention to achieve targeted outcomes, occurs within the purview of the occupational therapy domain, and is facilitated by the distinct perspective of occupational therapy practi- tioners when engaging in clinical reasoning, analyzing activities and occupations, and collaborating with cli- ents. This section is organized into four broad areas: (1)

an overview of the process as it is applied within the profession's domain, (2) the evaluation process, (3) the intervention process, and (4) the process of targeting outcomes.

Overview of the Occupational Therapy Process

Many professions use a similar process of evaluating, in- tervening, and targeting intervention outcomes. However,

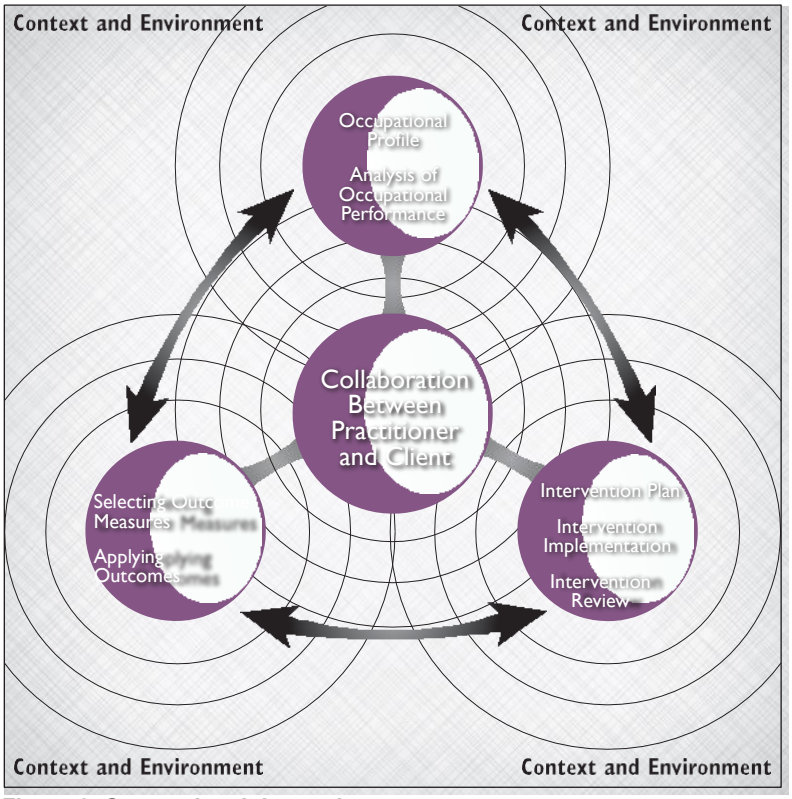

Figure 2. Occupational therapy's process.

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only occupational therapy practitioners focus on the use of occupations to promote health, well-being, and partici- pation in life. Occupational therapy practitioners use ther- apeutically selected occupations and activities as primary methods of intervention throughout the process (Table 6). To help clients achieve desired outcomes, occupa- tional therapy practitioners facilitate interactions among the client, his or her environments and contexts, and the occupations in which he or she engages. This perspective is based on the theories, knowledge, and skills generated and used by the profession and informed by available evidence (Clark et al., 2012; Davidson, Shahar, Lawless, Sells, & Tondora, 2006; Glass, de Leon, Marottoli, & Berkman, 1999; Jackson, Carlson, Mandel, Zemke, & Clark, 1998; Sandqvist, Akesson, & Eklund, 2005).

Analyzing occupational performance requires an understanding of the complex and dynamic interaction among client factors, performance skills, performance patterns, and contexts and environments, along with the activity demands of the occupation being performed. Occupational therapy practitioners attend to each as- pect and gauge the influence of each on the others, in- dividually and collectively. By understanding how these aspects influence each other, practitioners can better evaluate how each aspect contributes to clients' perfor- mance-related concerns and potentially contributes to interventions that support occupational performance.

For ease of explanation, the *Framework* describes the occupational therapy process as being linear. In reality, the process does not occur in a sequenced, step-by-step fashion. Rather, it is fluid and dynamic, allowing occu-

pational therapy practitioners and clients to maintain their focus on the identified outcomes while continually reflecting on and changing the overall plan to accom- modate new developments and insights along the way.

The broader definition of *client* included in this doc- ument is indicative of the profession's increasing involve- ment in providing services not only to a person but also to groups and populations. When working with a group or population, occupational therapy practitioners consider the collective occupational performance abilities of the members. Whether the client is a person, group, or popula- tion, information about the client's wants, needs, strengths, limitations, and occupational risks is gathered, synthesized, and framed from an occupational perspective.

Service Delivery Models

Occupational therapy practitioners provide services to clients directly, in settings such as hospitals, clinics, industry, schools, homes, and communities, and indi-

rectly on behalf of clients through consultation. Direct services include interventions completed when in direct contact with the individual or group of clients. These interventions are completed through various mecha- nisms such as meeting in person with a client, leading a group session, or interacting with clients and families through telehealth systems (AOTA, 2013c).

When providing services to clients indirectly on their behalf, practitioners provide consultation to en- tities such as teachers, multidisciplinary teams, and community planning agencies. Occupational therapy practitioners also provide consultation to community organizations such as park districts and civic organiza- tions that may or may not include people with disabil- ities. In addition, practitioners consult with businesses regarding the work environment, ergonomic modifica- tions, and compliance with the Americans With Dis- abilities Act of 1990 (Pub. L. 101‐336).

Occupational therapy practitioners can indirectly affect the lives of clients through advocacy. Common examples of advocacy include talking to legislators about improving transportation for older adults or improving services for people with mental or physical disabilities to support their living and working in the community of their choice.

Regardless of the service delivery model, the indi- vidual client may not be the exclusive focus of the inter- vention. For example, the needs of an at-risk infant may be the initial impetus for intervention, but the concerns and priorities of the parents, extended family, and fund- ing agencies are also considered. Occupational therapy practitioners understand and focus intervention to in- clude the issues and concerns surrounding the complex dynamics among the client, caregiver, and family. Sim- ilarly, services addressing independent living skills for adults coping with serious and persistent mental illness may also address the needs and expectations of state and local services agencies and of potential employers.

Clinical Reasoning

Throughout the process, occupational therapy prac- titioners are continually engaged in clinical reasoning about a client's occupational performance. Clinical rea- soning enables practitioners to

- Identify the multiple demands, required skills, and potential meanings of the activities and occu- pations and
- Gain a deeper understanding of the interrelation- ships between aspects of the domain that affect performance and that support client-centered in- terventions and outcomes.

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Occupational therapy practitioners use theoreti- cal principles and models, knowledge about the effects of conditions on participation, and available evidence of the effectiveness of intervention to guide their rea- soning. Clinical reasoning ensures the accurate selec- tion and application of evaluations, interventions, and client-centered outcome measures. Practitioners also apply their knowledge and skills to enhance clients' par- ticipation in occupations and promote their health and well-being regardless of the effects of disease, disability, and occupational disruption or deprivation.

Therapeutic Use of Self

An integral part of the occupational therapy process is *therapeutic use of self,* which allows occupational therapy practitioners to develop and manage their therapeutic relationship with clients by using narrative and clinical reasoning; empathy; and a client-centered, collaborative approach to service delivery (Taylor & Van Puymbroeck, 2013). *Empathy* is the emotional exchange between oc- cupational therapy practitioners and clients that allows more open communication, ensuring that practitioners connect with clients at an emotional level to assist them with their current life situation.

Occupational therapy practitioners use narrative and clinical reasoning to help clients make sense of the infor- mation they are receiving in the intervention process, to discover meaning, and to build hope (Peloquin, 2003; Taylor & Van Puymbroeck, 2013). Clients have identified the therapeutic relationship as critical to the outcome of oc- cupational therapy intervention (Cole & McLean, 2003). Occupational therapy practitioners develop a collab- orative relationship with clients to understand their ex- periences and desires for intervention. The collaborative approach used throughout the process honors the contri- butions of clients along with practitioners. Through the use of interpersonal communication skills, occupational therapy practitioners shift the power of the relationship to allow clients more control in decision making and prob-

lem solving, which is essential to effective intervention.

Clients bring to the occupational therapy process their knowledge about their life experiences and their hopes and dreams for the future. They identify and share their needs and priorities. Occupational therapy practitioners bring their knowledge about how engage- ment in occupation affects health, well-being, and par- ticipation; they use this information, coupled with the- oretical perspectives and clinical reasoning, to critically observe, analyze, describe, and interpret human perfor- mance. Practitioners and clients, together with caregiv- ers, family members, community members, and other

stakeholders (as appropriate), identify and prioritize the focus of the intervention plan.

Activity Analysis

Activity analysis is an important process occupational therapy practitioners use to understand the demands a specific activity places on a client:

> *Activity analysis* addresses the typical demands of an activity, the range of skills involved in its per- formance, and the various cultural meanings that might be ascribed to it. . . . Occupation-based activ-
> ity analysis places the person in the foreground. It takes into account the particular person's interests, goals, abilities, and contexts, as well as the demands of the activity itself. These considerations shape the practitioner's efforts to help

the . . . person reach his/her goals through carefully designed evaluation and intervention. (Crepeau, 2003, pp. 192-193)

Occupational therapy practitioners analyze the demands of an activity or occupation to understand the specific body structures, body functions, performance skills, and perfor- mance patterns that are required and to determine the ge- neric demands the activity or occupation makes on the client. *Activity and occupational demands* are the specific features of an activity and occupation that influence its meaning for the client and the type and amount of ef- fort required to engage in it. Activity and occupational demands include the following (see Table 7 for definitions and examples):

- *The tools and resources needed to engage in the activ- ity*—What specific objects are used in the activity? What are their properties, and what transporta- tion, money, or other resources are needed to par- ticipate in the activity?
- *Where and with whom the activity takes place*— What are the physical space requirements of the ac- tivity, and what are the social interaction demands?
- *How the activity is accomplished*—What process is used in carrying out the activity, including the sequence and timing of the steps and necessary procedures and rules?
- *How the activity challenges the client's capacities*— What actions, performance skills, body functions, and body structures are the individual, group, or population required to use during the perfor- mance of the activity?
- *The meaning the client derives from the activity*— What potential symbolic, unconscious, and meta- phorical meanings does the individual attach to the activity (e.g., driving a car equates with indepen- dence, preparing a holiday meal connects with fam- ily tradition, voting is a rite of passage to adulthood)?

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Activity and occupational demands are specific to each activity. A change in one feature of an activity may change the extent of the demand in another feature. For example, an increase in the number or sequence of steps in an activity increases the demand on attention skills.

Evaluation Process

The evaluation process is focused on finding out what a client wants and needs to do; determining what a client can do and has done; and identifying supports and bar- riers to health, well-being, and participation. Evaluation occurs during the initial and all subsequent interactions with a client. The type and focus of the evaluation differ depending on the practice setting.

The evaluation consists of the occupational profile and an analysis of occupational performance. The occupational profile includes information about the client's needs, problems, and concerns about performance in occupations. The analysis of occupational performance fo- cuses on collecting and interpreting information to more specifically identify supports and barriers related to oc- cupational performance and identify targeted outcomes.

Although the *Framework* describes the components of the evaluation process separately and sequentially, the exact manner in which occupational therapists collect client information is influenced by client needs, practice settings, and therapists' frames of reference or practice models. Information related to the occupational profile is gathered throughout the occupational therapy process.

Occupational Profile

The *occupational profile* is a summary of a client's occu- pational history and experiences, patterns of daily living, interests, values, and needs. Developing the occupational profile provides the occupational therapy practitioner with an understanding of a client's perspective and background. Using a client-centered approach, the practitioner gathers information to understand what is currently im- portant and meaningful to the client (i.e., what he or she wants and needs to do) and to identify past experiences and interests that may assist in the understanding of cur- rent issues and problems. During the process of collect- ing this information, the client, with the assistance of the occupational therapy practitioner, identifies priorities and desired targeted outcomes that will lead to the client's engagement in occupations that support participation in life. Only clients can identify the occupations that give meaning to their lives and select the goals and priorities that are important to them. By valuing and respecting clients' input, practitioners help foster their involvement and can more efficiently guide interventions.

Occupational therapy practitioners collect infor- mation for the occupational profile at the beginning of contact with clients to establish client-centered out- comes. Over time, practitioners collect additional infor- mation, refine the profile, and ensure that the additional information is reflected in changes subsequently made to targeted outcomes. The process of completing and refining the occupational profile varies by setting and client. The information gathered in the profile may be completed in one session or over a longer period while working with a client. For clients who are unable to par- ticipate in this process, their profiles may be compiled through interaction with family members or other sig- nificant people in their lives.

Obtaining information for the occupational profile through both formal interview techniques and casual conversation is a way to establish a therapeutic relation- ship with clients and their support network. The infor- mation obtained through the occupational profile leads to an individualized approach in the evaluation, inter- vention planning, and intervention implementation stages. Information is collected in the following areas:

- Why is the client seeking service, and what are the client's current concerns relative to engaging in occupations and in daily life activities?
- In what occupations does the client feel successful, and what barriers are affecting his or her success?
- What aspects of his or her environments or con- texts does the client see as supporting engagement in desired occupations, and what aspects are in- hibiting engagement?
- What is the client's occupational history (i.e., life experiences)?
- What are the client's values and interests?
- What are the client's daily life roles?
- What are the client's patterns of engagement in occupations, and how have they changed over time?
- What are the client's priorities and desired targeted outcomes related to occupational performance, prevention, participation, role competence, health and wellness, quality of life, well-being, and occu- pational justice?

After collecting profile data, occupational therapists view the information and develop a working hypoth- esis regarding possible reasons for the identified prob- lems and concerns. Reasons could include impairments in client factors, performance skills, and performance patterns or barriers within the context and environ- ment. Therapists then work with clients to establish preliminary goals and outcome measures. In addition,

therapists note strengths and supports within all areas because these can inform the intervention plan and af- fect future outcomes.

Analysis of Occupational Performance

Occupational performance is the accomplishment of the selected occupation resulting from the dynamic trans- action among the client, the context and environment, and the activity or occupation. In the *analysis of occu- pational performance,* the client's assets and problems or potential problems are more specifically identified through assessment tools designed to observe, mea- sure, and inquire about factors that support or hinder occupational performance. Targeted outcomes also are identified. The analysis of occupational performance in- volves one or more of the following activities:

- Synthesizing information from the occupational profile to focus on specific occupations and con- texts that need to be addressed
- Observing a client's performance during activi- ties relevant to desired occupations, noting effec- tiveness of performance skills and performance patterns
- Selecting and using specific assessments to mea- sure performance skills and performance patterns, as appropriate
- Selecting and administering assessments, as needed, to identify and measure more specifically the contexts or environments, activity demands, and client factors that influence performance skills and performance patterns
- Selecting outcome measures
- Interpreting the assessment data to identify sup- ports and hindrances toperformance
- Developing and refining hypotheses about the client's occupational performance strengths and limitations
- Creating goals in collaboration with the client that address the desired outcomes
- Determining procedures to measure the outcomes of intervention
- Delineating a potential intervention approach or approaches based on best practices and available evidence.

Multiple methods often are used during the evalu- ation process to assess client, environment or context, occupation or activity, and occupational performance. Methods may include an interview with the client and significant others, observation of performance and con- text, record review, and direct assessment of specific aspects of performance. Formal and informal, struc-

tured and unstructured, and standardized criterion- or norm-referenced assessment tools can be used. Standard- ized assessments are preferred, when available, to pro- vide objective data about various aspects of the domain influencing engagement and performance. The use of valid and reliable assessments for obtaining trustworthy information can also help support and justify the need for occupational therapy services (Doucet & Gutman, 2013; Gutman, Mortera, Hinojosa, & Kramer, 2007).

Implicit in any outcome assessment used by occu- pational therapy practitioners are clients' belief systems and underlying assumptions regarding their desired occupational performance. Occupational therapists select outcome assessments pertinent to clients' needs and goals, congruent with the practitioner's theoretical model of practice and based on knowledge of the psy- chometric properties of standardized measures or the rationale and protocols of nonstandardized yet struc- tured measures and the available evidence. In addition, clients' perception of success in engaging in desired oc- cupations is vital to any outcomes assessment (Bandura, 1986).

Intervention Process

The intervention process consists of the skilled services provided by occupational therapy practitioners in collaboration with clients to facilitate engagement in occu- pation related to health, well-being, and participation. Practitioners use the information about clients gathered during the evaluation and theoretical principles to direct occupation-centered interventions. Intervention is then provided to assist clients in reaching a state of physical, mental, and social well-being; identifying and realizing aspirations; satisfying needs; and changing or coping with the environment. Types of occupational therapy interventions are discussed in Table 6.

Intervention is intended to promote health, well- being, and participation. *Health promotion* is "the pro- cess of enabling people to increase control over, and to improve, their health" (WHO, 1986). Wilcock (2006) stated,

> Following an occupation-focused health promotion approach to well-being embraces a belief that the potential range of what people can do, be, and strive to become is the primary concern, and that health is a by-product. A varied and full occupational lifestyle will coincidentally maintain and improve health and well-being if it enables people to be creative and adventurous physically, mentally, and socially. (p. 315)

Interventions vary depending on the client—person, group, or population—and the context of service delivery (Moyers & Dale, 2007). The actual term used for clients or groups of clients receiving occupational ther- apy varies among practice settings and delivery models. For example, when working in a hospital, the person or group might be referred to as a *patient* or *patients,* and in a school, the clients might be *students.* When providing consultation to an organization, clients may be called *consumers* or *members.* The term *person* includes others who may help or be served indirectly, such as caregiver, teacher, parent, employer, or spouse.

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Interventions provided to groups and populations are directed to all the members collectively rather than individualized to specific people within the group. Practitioners direct their interventions toward current or potential disabling conditions with the goal of en- hancing the health, well-being, and participation of all group members collectively. The intervention focus of- ten is on health promotion activities, self-management, educational services, and environmental modification. For instance, occupational therapy practitioners may provide education on falls prevention and the impact of fear of falling to a group of residents in an assisted living center or provide support to people with psychiatric dis- ability as they learn to use the Internet to identify and coordinate community resources that meet their needs. Practitioners may work with a wide variety of popula- tions experiencing difficulty in accessing and engaging in healthy occupations because of conditions such as poverty, homelessness, and discrimination.

The intervention process is divided into three steps: (1) intervention plan, (2) intervention implementation, and (3) intervention review. During the intervention process, information from the evaluation is integrated with theory, practice models, frames of reference, and evidence. This information guides occupational therapy practitioners' clinical reasoning in the development, implementation, and review of the intervention plan.

Intervention Plan

The *intervention plan,* which directs the actions of occu- pational therapy practitioners, describes selected occupational therapy approaches and types of interventions to be used in reaching clients' identified outcomes. The intervention plan is developed collaboratively with cli- ents or their proxies and is directed by

- Client goals, values, beliefs, and occupational needs;
- Client health and well-being;
- Client performance skills and performance patterns;
- Collective influence of the context and environment, activity demands, and client factors on the client;
- Context of service delivery in which the interven- tion is provided; and
- Best available evidence.

The selection and design of the intervention plan and goals are directed toward addressing clients' current and potential situation related to engagement in occu- pations or activities. Intervention planning includes the following steps:

1. Developing the plan, which involves selecting
   - Objective and measurable occupation- focused goals and related time frames;
   - The occupational therapy intervention ap- proach or approaches, such as create or pro- mote, establish or restore, maintain, modify, and prevent (Table 8); and
   - Methods for service delivery, including who will provide the intervention, types of interven- tions, and service delivery models to be used.
2. Considering potential discharge needs and plans.
3. Making recommendations or referrals to other professionals as needed.

Intervention Implementation

Intervention implementation is the process of putting the intervention plan into action. Interventions may focus on a single aspect of the domain, such as a specific oc- cupation, or on several aspects of the domain, such as context and environment, performance patterns, and performance skills.

Given that aspects of the domain are interrelated and influence one another in a continuous, dynamic process, occupational therapy practitioners expect that a client's ability to adapt, change, and develop in one area will affect other areas. Because of this dynamic in- terrelationship, evaluation and intervention planning continue throughout the implementation process.

Intervention implementation includes the follow- ing steps:

1. Determining and carrying out the occupational therapy intervention or interventions to be used (see Table 6), which may include the following:
   - Therapeutic use of occupations and activities
   - Preparatory methods (e.g., splinting, assistive technology, wheeled mobility) and prepara- tory tasks
   - Education and training
   - Advocacy (e.g., advocacy, self-advocacy)
   - Group interventions.
2. Monitoring a client's response to specific inter- ventions on the basis of ongoing evaluation and reevaluation of his or her progress toward goals.

Intervention Review

Intervention review is the continuous process of reeval- uating and reviewing the intervention plan, the effectiveness of its delivery, and progress toward outcomes. As during intervention planning, this process includes collaboration with the client on the basis of identified goals and progress toward the associated outcomes. Re-evaluation and review may lead to change in the inter- vention plan.

The intervention review includes the following steps:

1. Reevaluating the plan and how it is implemented relative to achieving outcomes
2. Modifying the plan as needed
3. Determining the need for continuation or dis- continuation of occupational therapy services and for referral to other services.

Targeting of Outcomes

Outcomes are the end result of the occupational therapy process; they describe what clients can achieve through occupational therapy intervention. The benefits of oc- cupational therapy are multifaceted and may occur in all aspects of the domain of concern. Outcomes are directly related to the interventions provided and to the occu- pations, client factors, performance skills, performance patterns, and contexts and environments targeted. Out- comes may also be traced to the improved transactional relationship among the areas of the domain that result in clients' ability to engage in desired occupations sec- ondary to improved abilities at the client factor and per- formance skill level (Table 9).

In addition, outcomes may relate to clients' sub- jective impressions regarding goal attainment, such as improved outlook, confidence, hope, playfulness, self- efficacy, sustainability of valued occupations, resilience, and perceived well-being. An example of a subjective out- come of intervention is parents' greater perceived efficacy about their parenting through a new understanding of their child's behavior after receiving occupational therapy services (Cohn, 2001; Cohn, Miller, & Tickle-Degnen, 2000; Graham, Rodger, & Ziviani, 2013).

Interventions can also be designed for caregivers of people with dementia to improve quality of life for both care recipient and caregiver. Caregivers who received in- tervention reported fewer declines in occupational per- formance, enhanced mastery and skill, improved sense of self-efficacy and well-being, and less need for help with care recipients (Gitlin & Corcoran, 2005; Gitlin, Corcoran, Winter, Boyce, & Hauck, 2001; Gitlin et al., 2003, 2008; Graff et al., 2007).

Outcomes for groups may include improved social in- teraction, increased self-awareness through peer support, a larger social network, or increased workplace productivity with fewer injuries. Outcomes for populations may include health promotion, occupational justice and self-advocacy, and access to services. The impact of outcomes and the way they are defined are specific to clients and to other stake- holders such as payers and regulators. Specific outcomes and documentation of those outcomes vary by practice set- ting and are influenced by the stakeholders in each setting. The focus on outcomes is woven throughout the process of occupational therapy. Occupational therapists and clients collaborate during evaluation to identify ini- tial client outcomes related to engagement in valued occupations or daily life activities. During intervention implementation and reevaluation, clients, occupational therapists, and, when appropriate, occupational ther- apy assistants may modify outcomes to accommodate changing needs, contexts, and performance abilities. As further analysis of occupational performance and the development of the intervention plan occur, therapists

and clients may redefine the desired outcomes.

Implementation of the outcomes process includes the following steps:

1. Selecting types of outcomes and measures, in- cluding but not limited to occupational perfor- mance, prevention, health and wellness, quality of life, participation, role competence, well- being, and occupational justice (see Table 9). Outcome measures are
   - Selected early in the intervention process (see "Evaluation Process" section);
   - Valid, reliable, and appropriately sensitive to change in clients' occupational performance;
   - Consistent with targeted outcomes;
   - Congruent with clients' goals; and
   - Selected on the basis of their actual or pur- ported ability to predict future outcomes.
2. Using outcomes to measure progress and adjust goals and interventions by
   - Comparing progress toward goal achieve- ment to outcomes throughout the interven- tion process and
   - Assessing outcome use and results to make decisions about the future direction of inter- vention (e.g., continue intervention, modify intervention, discontinue intervention, pro- vide follow-up, refer for other services).

Outcomes and the other aspects of the occupational therapy process are summarized in Exhibit 3.

Evaluation		Intervention			Targeting of Outcomes
Occupational Profile	Analysis of Occupational Performance	Intervention Plan	Intervention Implementation	Intervention Review	Outcomes

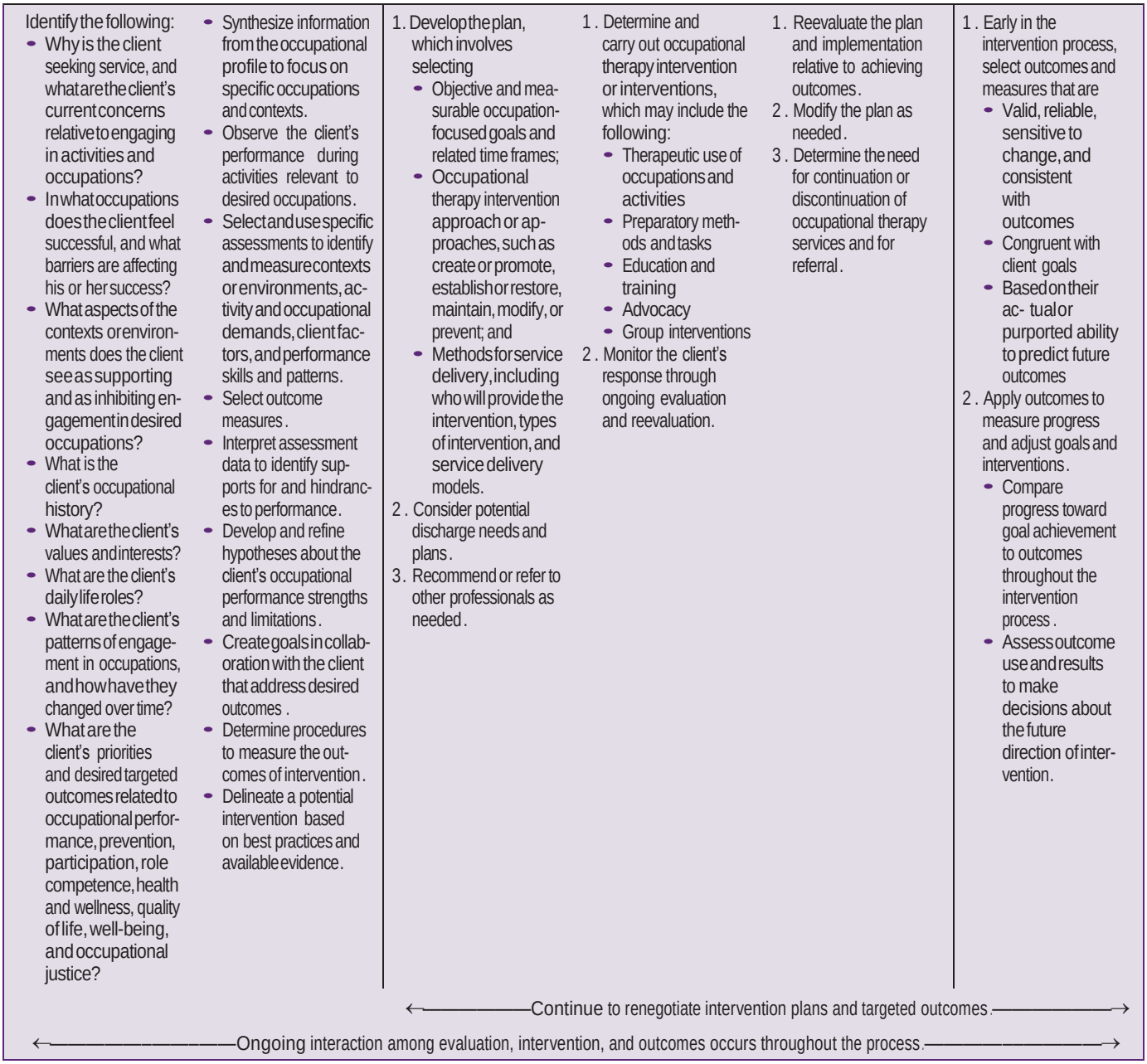

Exhibit 3. Operationalizing the occupational therapy process.

Conclusion

The *Framework* describes the central concepts that ground occupational therapy practice and builds a common understanding of the basic tenets and dis- tinct contribution of the profession. The occupational therapy domain and process are linked inextricably in a transactional relationship, as illustrated in Figure 3. An understanding of this relationship supports and

guides the complex decision making required in the daily practice of occupational therapy and enhances practitioners' ability to define the reasons for and di- rect interventions to clients (persons, groups, and populations), family members, team members, payers, and policymakers. The *Framework* highlights the distinct value of occupation and occupational therapy in con- tributing to client health, well-being, and participation in life.

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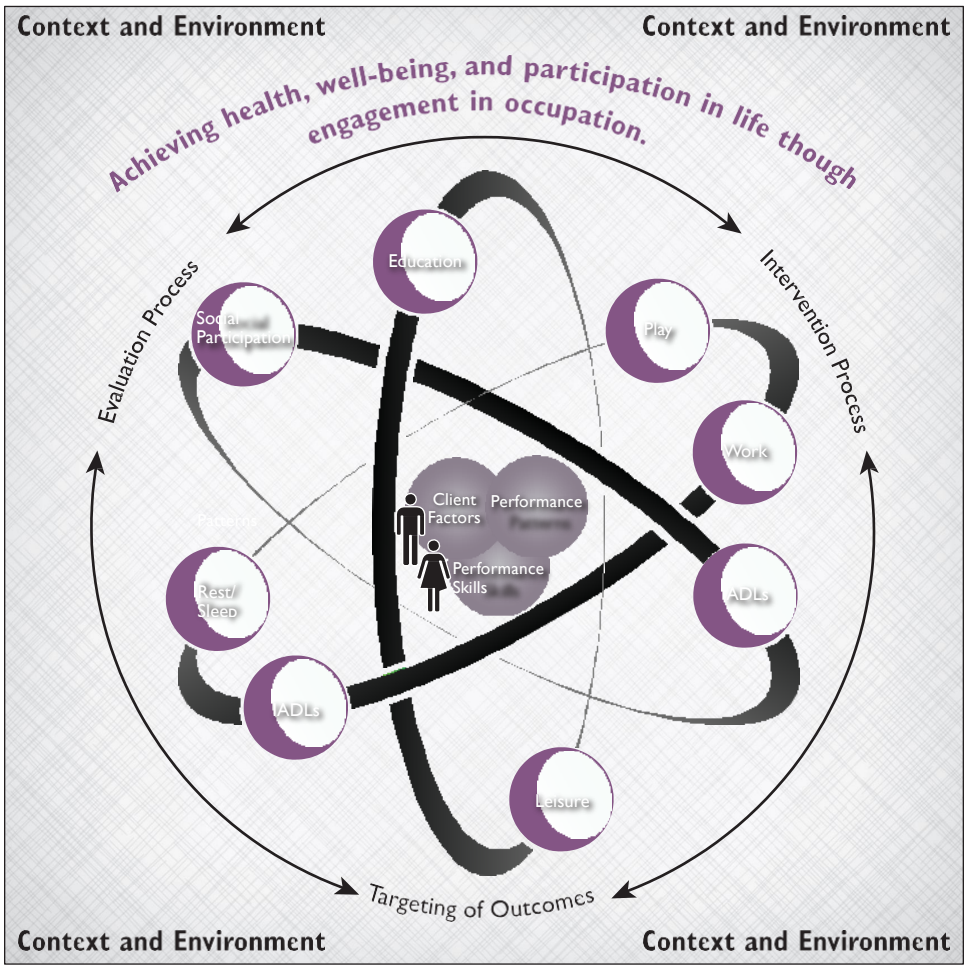

Figure 3. Occupational therapy domain and process.

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TABLE 1. OCCUPATIONS

Occupations *are various kinds of life activities in which individuals, groups, or populations engage, including activities of daily living, instrumental activities of daily living, rest and sleep, education, work, play, leisure, and social participation.*

Category	Description
■ **ACTIVITIES OF DAILY LIVING (ADLs)—**Activities oriented toward taking care of one's own body (adapted from Rogers & Holm, 1994). ADLs also are referred to as *basic activities of daily living (BADLs)* and *personal activities of daily living (PADLs).* These activities are "fundamental to living in a social world; they enable basic survival and well-being" (Christiansen & Hammecker, 2001, p. 156).	
Bathing, showering	Obtaining and using supplies; soaping, rinsing, and drying body parts; maintaining bathing position; and transferring to and from bathing positions
Toileting and toilet hygiene	Obtaining and using toileting supplies, managing clothing, maintaining toileting position, transferring to and from toileting position, cleaning body, and caring for menstrual and continence needs (including catheter, colostomy, and suppository management), as well as completing intentional control of bowel movements and urination and, if necessary, using equipment or agents for bladder control (Uniform Data System for Medical Rehabilitation, 1996, pp. III-20, III-24)
Dressing	Selecting clothing and accessories appropriate to time of day, weather, and occasion; obtaining clothing from storage area; dressing and undressing in a sequential fashion; fastening and adjusting clothing and shoes; and applying and removing personal devices, prosthetic devices, or splints
Swallowing/eating	Keeping and manipulating food or fluid in the mouth and swallowing it; *swallowing* is moving food from the mouth to the stomach
Feeding	Setting up, arranging, and bringing food [or fluid] from the plate or cup to the mouth; sometimes called *self-feeding*
Functional mobility	Moving from one position or place to another (during performance of everyday activities), such as in-bed mobility, wheelchair mobility, and transfers (e.g., wheelchair, bed, car, shower, tub, toilet, chair, floor). Includes functional ambulation and transportation of objects.
Personal device care	Using, cleaning, and maintaining personal care items, such as hearing aids, contact lenses, glasses, orthotics, prosthetics, adaptive equipment, glucometers, and contraceptive and sexual devices
Personal hygiene and grooming	Obtaining and using supplies; removing body hair (e.g., using razor, tweezers, lotion); applying and removing cosmetics; washing, drying, combing, styling, brushing, and trimming hair; caring for nails (hands and feet); caring for skin, ears, eyes, and nose; applying deodorant; cleaning mouth; brushing and flossing teeth; and removing, cleaning, and reinserting dental orthotics and prosthetics
Sexual activity	Engaging in activities that result in sexual satisfaction and/or meet relational or reproductive needs
■ **INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADLs)—**Activities to support daily life within the home and community that often require more complex interactions than those used in ADLs.	
Care of others (including selecting and supervising caregivers)	Arranging, supervising, or providing care for others
Care of pets	Arranging, supervising, or providing care for pets and service animals
Child rearing	Providing care and supervision to support the developmental needs of a child
Communication management	Sending, receiving, and interpreting information using a variety of systems and equipment, including writing tools, telephones (cell phones or smartphones), keyboards, audiovisual recorders, computers or tablets, communication boards, call lights, emergency systems, Braille writers, telecommunication devices for deaf people, augmentative communication systems, and personal digital assistants
Driving and community mobility	Planning and moving around in the community and using public or private transportation, such as driving, walking, bicycling, or accessing and riding in buses, taxi cabs, or other transportation systems

Financial management	Using fiscal resources, including alternate methods of financial transaction, and planning and using finances with long-term and short-term goals
Health management and maintenance	Developing, managing, and maintaining routines for health and wellness promotion, such as physical fitness, nutrition, decreased health risk behaviors, and medication routines
Home establishment and management	Obtaining and maintaining personal and household possessions and environment (e.g., home, yard, garden, appliances, vehicles), including maintaining and repairing personal possessions (e.g., clothing, household items) and knowing how to seek help or whom to contact

(Continued)

TABLE 1. OCCUPATIONS

(Continued)

Category	Description
Meal preparation and cleanup	Planning, preparing, and serving well-balanced, nutritious meals and cleaning up food and utensils after meals
Religious and spiritual activities and expression	Participating in *religion,* "an organized system of beliefs, practices, rituals, and symbols designed to facilitate closeness to the sacred or transcendent" (Moreira-Almeida & Koenig, 2006, p. 844), and engaging in activities that allow a sense of connectedness to something larger than oneself or that are especially meaningful, such as taking time out to play with a child, engaging in activities in nature, and helping others in need (Spencer, Davidson, & White, 1997)
Safety and emergency maintenance	Knowing and performing preventive procedures to maintain a safe environment; recognizing sudden, unexpected hazardous situations; and initiating emergency action to reduce the threat to health and safety; examples include ensuring safety when entering and exiting the home, identifying emergency contact numbers, and replacing items such as batteries in smoke alarms and light bulbs
Shopping	Preparing shopping lists (grocery and other); selecting, purchasing, and transporting items; selecting method of payment; and completing money transactions; included are Internet shopping and related use of electronic devices such as computers, cell phones, and tablets
■ **REST AND SLEEP—**Activities related to obtaining restorative rest and sleep to support healthy, active engagement in other occupations.	
Rest	Engaging in quiet and effortless actions that interrupt physical and mental activity, resulting in a relaxed state (Nurit & Michal, 2003, p. 227); included are identifying the need to relax; reducing involvement in taxing physical, mental, or social activities; and engaging in relaxation or other endeavors that restore energy and calm and renew interest in engagement
Sleep preparation	(1) Engaging in routines that prepare the self for a comfortable rest, such as grooming and undressing, reading or listening to music to fall asleep, saying goodnight to others, and engaging in meditation or prayers; determining the time of day and length of time desired for sleeping and the time needed to wake; and establishing sleep patterns that support growth and health (patterns are often personally and culturally determined). (2) Preparing the physical environment for periods of unconsciousness, such as making the bed or space on which to sleep; ensuring warmth or coolness and protection; setting an alarm clock; securing the home, such as locking doors or closing windows or curtains; and turning off electronics or lights.

Sleep participation	Taking care of personal needs for sleep, such as ceasing activities to ensure onset of sleep, napping, and dreaming; sustaining a sleep state without disruption; and performing nighttime care of toileting needs and hydration; also includes negotiating the needs and requirements of and interacting with others within the social environment such as children or partners, including providing nighttime caregiving such as breastfeeding and monitoring the comfort and safety of others who are sleeping
■ **EDUCATION—**Activities needed for learning and participating in the educational environment.	
Formal educational participation	Participating in academic (e.g., math, reading, degree coursework), nonacademic (e.g., recess, lunchroom, hallway), extracurricular (e.g., sports, band, cheerleading, dances), and vocational (prevocational and vocational) educational activities
Informal personal educational needs or interests exploration (beyond formal education)	Identifying topics and methods for obtaining topic-related information or skills
Informal personal education participation	Participating in informal classes, programs, and activities that provide instruction or training in identified areas of interest
■ **WORK—**"Labor or exertion; to make, construct, manufacture, form, fashion, or shape objects; to organize, plan, or evaluate services or processes of living or governing; committed occupations that are performed with or without financial reward" (Christiansen & Townsend, 2010, p. 423).	
Employment interests and pursuits	Identifying and selecting work opportunities based on assets, limitations, likes, and dislikes relative to work (adapted from Mosey, 1996, p. 342)
Employment seeking and acquisition	Advocating for oneself; completing, submitting, and reviewing appropriate application materials; preparing for interviews; participating in interviews and following up afterward; discussing job benefits; and finalizing negotiations
Job performance	Performing the requirements of a job, including work skills and patterns; time management; relationships with coworkers, managers, and customers; leadership and supervision; creation, production, and distribution of products and services; initiation, sustainment, and completion of work; and compliance with work norms and procedures
Retirement preparation and adjustment	Determining aptitudes, developing interests and skills, selecting appropriate avocational pursuits, and adjusting lifestyle in the absence of the worker role

(Continued)

TABLE 1. OCCUPATIONS

(Continued)

Category	Description
Volunteer exploration	Determining community causes, organizations, or opportunities for unpaid work in relationship to personal skills, interests, location, and time available
Volunteer participation	Performing unpaid work activities for the benefit of selected causes, organizations, or facilities
■ **PLAY—**"Any spontaneous or organized activity that provides enjoyment, entertainment, amusement, or diversion" (Parham & Fazio, 1997, p. 252).	
Play exploration	Identifying appropriate play activities, including exploration play, practice play, pretend play, games with rules, constructive play, and symbolic play (adapted from Bergen, 1988, pp. 64–65)
Play participation	Participating in play; maintaining a balance of play with other occupations; and obtaining, using, and maintaining toys, equipment, and supplies appropriately
■ **LEISURE—**"Nonobligatory activity that is intrinsically motivated and engaged in during discretionary time, that is, time not committed to obligatory occupations such as work, self-care, or sleep" (Parham & Fazio, 1997, p. 250).	
Leisure exploration	Identifying interests, skills, opportunities, and appropriate leisure activities

Leisure participation	Planning and participating in appropriate leisure activities; maintaining a balance of leisure activities with other occupations; and obtaining, using, and maintaining equipment and supplies as appropriate
■ **SOCIAL PARTICIPATION—**"The interweaving of occupations to support desired engagement in community and family activities as well as those involving peers and friends" (Gillen & Boyt Schell, 2014, p. 607); involvement in a subset of activities that involve social situations with others (Bedell, 2012) and that support social interdependence (Magasi & Hammel, 2004). Social participation can occur in person or through remote technologies such as telephone calls, computer interaction, and video conferencing.	
Community	Engaging in activities that result in successful interaction at the community level (e.g., neighborhood, organization, workplace, school, religious or spiritual group)
Family	Engaging in activities that result in "successful interaction in specific required and/or desired familial roles" (Mosey, 1996, p. 340)
Peer, friend	Engaging in activities at different levels of interaction and intimacy, including engaging in desired sexual activity

TABLE 2. CLIENT FACTORS

Client factors *include (1) values, beliefs, and spirituality; (2) body functions; and (3) body structures that reside within the client that influence the client's perfor- mance in occupations.*

■ **VALUES, BELIEFS, AND SPIRITUALITY—**Clients' perceptions, motivations, and related meaning that influence or are influenced by engagement in occupations.

Category and Definition	Examples
Values—Acquired beliefs and commitments, derived from culture, about what is good, right, and important to do (Kielhofner, 2008)	*Person:* • Honesty with self and others • Commitment to family *Group:* • Obligation to provide a service • Fairness *Population:* • Freedom of speech • Equal opportunities for all • Tolerance toward others
Beliefs—Cognitive content held as true by or about the client	*Person:* • One is powerless to influence others. • Hard work pays off. *Group and population:* • Some personal rights are worth fighting for. • A new health care policy, as yet untried, will positively affect society.
Spirituality—"The aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred" (Puchalski et al., 2009, p. 887)	*Person:* • Daily search for purpose and meaning in one's life • Guidance of actions by a sense of value beyond the personal acquisition of wealth or fame *Group and population:* • Common search for purpose and meaning in life • Guidance of actions by values agreed on by the collective
■ **BODY FUNCTIONS—**"The physiological functions of body systems (including psychological functions)" (WHO, 2001, p. 10). This section of the table is organized according to the classifications of the *International Classification of Functioning, Disability and Health (ICF);* for fuller descriptions and definitions, refer to WHO (2001).	

Category (not an all-inclusive list)	Description
Mental functions (affective, cognitive, perceptual)	
Specific mental functions	
Higher-level cognitive	Judgment, concept formation, metacognition, executive functions, praxis, cognitive flexibility, insight
Attention	Sustained shifting and divided attention, concentration, distractibility
Memory	Short-term, long-term, and working memory
Perception	Discrimination of sensations (e.g., auditory, tactile, visual, olfactory, gustatory, vestibular, proprioceptive)
Thought	Control and content of thought, awareness of reality vs. delusions, logical and coherent thought
Mental functions of sequencing complex movement	Mental functions that regulate the speed, response, quality, and time of motor production, such as restlessness, toe tapping, or hand wringing, in response to inner tension
Emotional	Regulation and range of emotions; appropriateness of emotions, including anger, love, tension, and anxiety; lability of emotions
Experience of self and time	Awareness of one's identity, body, and position in the reality of one's environment and of time
Global mental functions	
Consciousness	State of awareness and alertness, including the clarity and continuity of the wakeful state
Orientation	Orientation to person, place, time, self, and others
Temperament and personality	Extroversion, introversion, agreeableness, conscientiousness, emotional stability, openness to experience, self-control, self-expression, confidence, motivation, impulse control, appetite

(Continued)

TABLE 2. CLIENT FACTORS

(Continued)

Category (not an all-inclusive list)	Description
Energy and drive	Energy level, motivation, appetite, craving, impulse control
Sleep	Physiological process, quality of sleep
Sensory functions	
Visual functions	Quality of vision, visual acuity, visual stability, and visual field functions to promote visual awareness of environment at various distances for functioning
Hearing functions	Sound detection and discrimination; awareness of location and distance of sounds
Vestibular functions	Sensation related to position, balance, and secure movement against gravity
Taste functions	Association of taste qualities of bitterness, sweetness, sourness, and saltiness

Smell functions	Sensing odors and smells
Proprioceptive functions	Awareness of body position and space
Touch functions	Feeling of being touched by others or touching various textures, such as those of food; presence of numbness, paresthesia, hyperesthesia
Pain (e.g., diffuse, dull, sharp, phantom)	Unpleasant feeling indicating potential or actual damage to some body structure; sensations of generalized or localized pain (e.g., diffuse, dull, sharp, phantom)
Sensitivity to temperature and pressure	Thermal awareness (hot and cold), sense of force applied to skin
Neuromusculoskeletal and movement-related functions	
Functions of joints and bones	
Joint mobility	Joint range of motion
Joint stability	Maintenance of structural integrity of joints throughout the body; physiological stability of joints related to structural integrity
Muscle functions	
Muscle power	Strength
Muscle tone	Degree of muscle tension (e.g., flaccidity, spasticity, fluctuation)
Muscle endurance	Sustaining muscle contraction
Movement functions	
Motor reflexes	Involuntary contraction of muscles automatically induced by specific stimuli (e.g., stretch, asymmetrical tonic neck, symmetrical tonic neck)
Involuntary movement reactions	Postural reactions, body adjustment reactions, supporting reactions
Control of voluntary movement	Eye–hand and eye–foot coordination, bilateral integration, crossing of the midline, fine and gross motor control, and oculomotor function (e.g., saccades, pursuits, accommodation, binocularity)
Gait patterns	Gait and mobility considered in relation to how they affect ability to engage in occupations in daily life activities; for example, walking patterns and impairments, asymmetric gait, stiff gait
Cardiovascular, hematological, immunological, and respiratory system functions (*Note.* Occupational therapy practitioners have knowledge of these body functions and understand broadly the interaction that occurs among these functions to support health, well-being, and participation in life through engagement in occupation.)	
Cardiovascular system functions Hematological and immunological system functions	Maintenance of blood pressure functions (hypertension, hypotension, postural hypotension), heart rate and rhythm
Respiratory system functions	Rate, rhythm, and depth of respiration
Additional functions and sensations of the cardiovascular and respiratory systems	Physical endurance, aerobic capacity, stamina, fatigability
Voice and speech functions; digestive, metabolic, and endocrine system functions; genitourinary and reproductive functions (*Note.* Occupational therapy practitioners have knowledge of these body functions and understand broadly the interaction that occurs among these functions to support health, well-being, and participation in life through engagement in occupation.)	
Voice and speech functions	Fluency and rhythm, alternative vocalization functions

(Continued)

TABLE 2. CLIENT FACTORS

(Continued)

Category (not an all-inclusive list)	Description
Digestive, metabolic, and endocrine system functions	Digestive system functions, metabolic system and endocrine system functions
Genitourinary and reproductive functions	Urinary functions, genital and reproductive functions
Skin and related structure functions (*Note.* Occupational therapy practitioners have knowledge of these body functions and understand broadly the interaction that occurs among these functions to support health, well-being, and participation in life through engagement in occupation.)	
Skin functions Hair and nail functions	Protection (presence or absence of wounds, cuts, or abrasions), repair (wound healing)
■ **BODY STRUCTURES:** "Anatomical parts of the body, such as organs, limbs, and their components" that support body function (WHO, 2001, p. 10). The "Body Structures" section of the table is organized according to the *ICF* classifications; for fuller descriptions and definitions, refer to WHO (2001).	
Category section of this table	**Examples not delineated in the "Body Structure"**
Structure of the nervous system **Eyes, ear, and related structures** **Structures involved in voice and speech** **Structures of the cardiovascular, immunological, and respiratory systems** **Structures related to the digestive, metabolic, and endocrine systems** **Structures related to the genitourinary and reproductive systems** **Structures related to movement** **Skin and related structures**	(*Note.* Occupational therapy practitioners have knowledge of body structures and understand broadly the interaction that occurs between these structures to support health, well-being, and participation in life through engagement in occupation.)

Note. The categorization of body function and body structure client factors outlined in Table 2 is based on the *ICF* proposed by WHO (2001). The classification was selected because it has received wide exposure and presents a language that is understood by external audiences. WHO = World Health Organization.

TABLE 3. PERFORMANCE SKILLS

Performance skills *are observable elements of action that have an implicit functional purpose; skills are considered a classification of actions, encompassing mul- tiple capacities (body functions and body structures) and, when combined, underlie the ability to participate in desired occupations and activities. This list is not all inclusive and may not include all possible skills addressed during occupational therapy interventions.*

Skill	Definition
■ **MOTOR SKILLS—**"Occupational performance skills observed as the person interacts with and moves task objects and self around the task environment" (e.g., activity of daily living [ADL] motor skills, school motor skills; Boyt Schell, Gillen, & Scaffa, 2014a, p. 1237).	
Aligns	Interacts with task objects without evidence of persistent propping or persistent leaning
Stabilizes	Moves through task environment and interacts with task objects without momentary propping or loss of balance
Positions	Positions self an effective distance from task objects and without evidence of awkward body positioning
Reaches	Effectively extends the arm and, when appropriate, bends the trunk to effectively grasp or place task objects that are out of reach
Bends	Flexes or rotates the trunk as appropriate to the task to grasp or place task objects out of reach or when sitting down
Grips	Effectively pinches or grasps task objects such that the objects do not slip (e.g., from the person's fingers, between teeth)

Manipulates	Uses dexterous finger movements, without evidence of fumbling, when manipulating task objects (e.g., manipulating buttons when buttoning)
Coordinates	Uses two or more body parts together to manipulate, hold, and/or stabilize task objects without evidence of fumbling task objects or slipping from one's grasp
Moves	Effectively pushes or pulls task objects along a supporting surface, pulls to open or pushes to close doors and drawers, or pushes on wheels to propel a wheelchair
Lifts	Effectively raises or lifts task objects without evidence of increased effort
Walks	During task performance, ambulates on level surfaces without shuffling the feet, becoming unstable, propping, or using assistive devices
Transports	Carries task objects from one place to another while walking or moving in a wheelchair
Calibrates	Uses movements of appropriate force, speed, or extent when interacting with task objects (e.g., not crushing objects, pushing a door with enough force that it closes)
Flows	Uses smooth and fluid arm and wrist movements when interacting with task objects
Endures	Persists and completes the task without showing obvious evidence of physical fatigue, pausing to rest, or stopping to catch one's breath
Paces	Maintains a consistent and effective rate or tempo of performance throughout the entire task
■ **PROCESS SKILLS—**"Occupational performance skills [e.g., ADL process skills, school process skills] observed as a person (1) selects, interacts with, and uses task tools and materials; (2) carries out individual actions and steps; and (3) modifies performance when problems are encountered" (Boyt Schell et al., 2014a, p. 1239).	
Paces	Maintains a consistent and effective rate or tempo of performance throughout the entire task
Attends	Does not look away from what he or she is doing, interrupting the ongoing task progression
Heeds	Carries out and completes the task originally agreed on or specified by another
Chooses	Selects necessary and appropriate type and number of tools and materials for the task, including the tools and materials that the person was directed to use or specified he or she would use
Uses	Applies tools and materials as they are intended (e.g., uses a pencil sharpener to sharpen a pencil but not to sharpen a crayon) and in a hygienic fashion
Handles	Supports or stabilizes tools and materials in an appropriate manner, protecting them from being damaged, slipping, moving, and falling
Inquires	(1) Seeks needed verbal or written information by asking questions or reading directions or labels and (2) does not ask for information when he or she was fully oriented to the task and environment and had immediate prior awareness of the answer
Initiates	Starts or begins the next action or step without hesitation
Continues	Performs single actions or steps without interruptions such that once an action or task is initiated, the person continues without pauses or delays until the action or step is completed
Sequences	Performs steps in an effective or logical order and with an absence of (1) randomness or lack of logic in the ordering and (2) inappropriate repetition of steps
Terminates	Brings to completion single actions or single steps without inappropriate persistence or premature cessation
Searches/locates	Looks for and locates tools and materials in a logical manner, both within and beyond the immediate environment
Gathers	Collects related tools and materials into the same work space and regathers tools or materials that have spilled, fallen, or been misplaced

(Continued)

TABLE 3. PERFORMANCE SKILLS

(Continued)

Skill	Definition
Organizes	Logically positions or spatially arranges tools and materials in an orderly fashion within a single work space and between multiple appropriate work spaces such that the work space is not too spread out or too crowded
Restores	Puts away tools and materials in appropriate places and ensures that the immediate work space is restored to its original condition
Navigates	Moves the arm, body, or wheelchair without bumping into obstacles when moving in the task environment or interacting with task objects
Notices/responds	Responds appropriately to (1) nonverbal task-related cues (e.g., heat, movement), (2) the spatial arrangement and alignment of task objects to one another, and (3) cupboard doors and drawers that have been left open during task performance
Adjusts	Effectively (1) goes to new work spaces; (2) moves tools and materials out of the current work space; and (3) adjusts knobs, dials, or water taps to overcome problems with ongoing task performance
Accommodates	Prevents ineffective task performance
Benefits	Prevents problems with task performance from recurring or persisting
■ **SOCIAL INTERACTION SKILLS—**"Occupational performance skills observed during the ongoing stream of a social exchange" (Boyt Schell et al., 2014a, p. 1241).	
Approaches/starts	Approaches or initiates interaction with the social partner in a manner that is socially appropriate
Concludes/disengages	Effectively terminates the conversation or social interaction, brings to closure the topic under discussion, and disengages or says good-bye
Produces speech	Produces spoken, signed, or augmentative (i.e., computer-generated) messages that are audible and clearly articulated
Gesticulates	Uses socially appropriate gestures to communicate or support a message
Speaks fluently	Speaks in a fluent and continuous manner, with an even pace (not too fast, not too slow) and without pauses or delays during the message being sent
Turns toward	Actively positions or turns the body and face toward the social partner or person who is speaking
Looks	Makes eye contact with the social partner
Places self	Positions self at an appropriate distance from the social partner during the social interaction
Touches	Responds to and uses touch or bodily contact with the social partner in a manner that is socially appropriate
Regulates	Does not demonstrate irrelevant, repetitive, or impulsive behaviors that are not part of social interaction
Questions	Requests relevant facts and information and asks questions that support the intended purpose of the social interaction
Replies	Keeps conversation going by replying appropriately to question and comments
Discloses	Reveals opinions, feelings, and private information about self or others in a manner that is socially appropriate
Expresses emotion	Displays affect and emotions in a way that is socially appropriate
Disagrees	Expresses differences of opinion in a socially appropriate manner
Thanks	Uses appropriate words and gestures to acknowledge receipt of services, gifts, or compliments
Transitions	Handles transitions in the conversation smoothly or changes the topic without disrupting the ongoing conversation
Times response	Replies to social messages without delay or hesitation and without interrupting the social partner
Times duration	Speaks for reasonable periods given the complexity of the message sent
Takes turns	Takes his or her turn and gives the social partner the freedom to take his or her turn
Matches language	Uses a tone of voice, dialect, and level of language that are socially appropriate and matched to the social partner's abilities and level of understanding
Clarifies	Responds to gestures or verbal messages signaling that the social partner does not comprehend or understand a message and ensures that the social partner is following the conversation

Acknowledges and encourages	Acknowledges receipt of messages, encourages the social partner to continue interaction, and encourages all social partners to participate in social interaction
Empathizes	Expresses a supportive attitude toward the social partner by agreeing with, empathizing with, or expressing understanding of the social partner's feelings and experiences
Heeds	Uses goal-directed social interactions focused on carrying out and completing the intended purpose of the social interaction
Accommodates	Prevents ineffective or socially inappropriate social interaction
Benefits	Prevents problems with ineffective or socially inappropriate social interaction from recurring or persisting

Source. From "Performance Skills: Implementing Performance Analyses to Evaluate Quality of Occupational Performance," by A. G. Fisher and L. A. Griswold, in *Willard and Spackman's Occupational Therapy* (12th ed., pp. 252–254), by B. A. B. Schell, G. Gillen, M. E. Scaffa, and E. S. Cohn (Eds.), 2014, Philadelphia: Wolters Kluwer/Lippincott Williams & Wilkins; http://lww.com. Copyright © 2014 by Wolters Kluwer/Lippincott Williams & Wilkins. Adapted with permission.

TABLE 4. PERFORMANCE PATTERNS

Performance patterns *are the habits, routines, roles, and rituals used in the process of engaging in occupations or activities; these patterns can support or hinder occupational performance.*

Category	Description	Examples
PERSON		
Habits	"Acquired tendencies to respond and perform in certain consistent ways in familiar environments or situations; specific, automatic behaviors performed repeatedly, relatively automatically, and with little variation" (Boyt Schell, Gillen, & Scaffa, 2014a, p. 1234). Habits can be useful, dominating, or impoverished and can either support or interfere with performance in occupations (Dunn, 2000).	• Automatically puts car keys in the same place • Spontaneously looks both ways before crossing the street • Always turns off the stove burner before removing a cooking pot • Activates the alarm system before leaving the home
Routines	Patterns of behavior that are observable, regular, and repetitive and that provide structure for daily life. They can be satisfying, promoting, or damaging. Routines require momentary time commitment and are embedded in cultural and ecological contexts (Fiese, 2007; Segal, 2004).	• Follows a morning sequence to complete toileting, bathing, hygiene, and dressing • Follows the sequence of steps involved in meal preparation • Follows a daily routine of dropping children off at school, going to work, picking children up from school, doing homework, and making dinner
Rituals	Symbolic actions with spiritual, cultural, or social meaning contributing to the client's identity and reinforcing values and beliefs. Rituals have a strong affective component and consist of a collection of events (Fiese, 2007; Fiese et al., 2002; Segal, 2004).	• Uses an inherited antique hairbrush to brush hair 100 strokes nightly as her mother had done • Prepares holiday meals with favorite or traditional accoutrements using designated dishware • Kisses a sacred book before opening the pages to read • Attends a spiritual gathering on a particular day
Roles	Sets of behaviors expected by society and shaped by culture and context that may be further conceptualized and defined by the client.	• Mother of an adolescent with developmental disabilities • Student with a learning disability studying computer technology • Corporate executive returning to work after a stroke
GROUP OR POPULATION		

Routines	Patterns of behavior that are observable, regular, and repetitive and that provide structure for daily life. They can be satisfying, promoting, or damaging. Routines require momentary time commitment and are embedded in cultural and ecological contexts (Segal, 2004).	• Follows health practices, such as scheduled immunizations for children and yearly health screenings for adults • Follows business practices, such as provision of services for disadvantaged populations (e.g., loans to underrepresented groups) • Follows legislative procedures, such as those associated with the Individuals With Disabilities Education Improvement Act of 2004 (Pub. L. 108–446) or Medicare • Follows social customs for greeting
Rituals	Shared social actions with traditional, emotional, purposive, and technological meaning contributing to values and beliefs within the group or population.	• Holds cultural celebrations • Has parades or demonstrations • Shows national affiliations or allegiances • Follows religious, spiritual, and cultural practices, such as touching the mezuzah or using holy water when leaving and entering or praying while facing Mecca
Roles	Sets of behaviors by the group or population expected by society and shaped by culture and context that may be further conceptualized and defined by the group or population.	• Nonprofit civic group providing housing for people with mental illness • Humanitarian group distributing food and clothing donations to refugees • Student organization in a university educating elementary school children about preventing bullying

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TABLE 5. CONTEXT AND ENVIRONMENT

Context *refers to a variety of interrelated conditions that are within and surrounding the client. Contexts include cultural, personal, temporal, and virtual. The term*
environment *refers to the external physical and social conditions that surround the client and in which the client's daily life occupations occur.*

Category	Definition	Examples
■ **CONTEXTS**		
Cultural	Customs, beliefs, activity patterns, behavioral standards, and expectations accepted by the society of which a client is a member. The cultural context influences the client's identity and activity choices.	• *Person:* A person delivering Thanksgiving meals to homebound individuals • *Group:* Employees marking the end of the work week with casual dress on Friday • *Population:* People engaging in an afternoon siesta or high tea
Personal	"Features of the individual that are not part of a health condition or health status" (WHO, 2001, p. 17). The personal context includes age, gender, socioeconomic status, and educational status and can also include group membership (e.g., volunteers, employees) and population membership (e.g., members of society).	• *Person:* A 25-year-old unemployed man with a high school diploma • *Group:* Volunteers working in a homeless shelter • *Population:* Older drivers learning about community mobility options
Temporal	The experience of time as shaped by engagement in occupations; the temporal aspects of occupation that "contribute to the patterns of daily occupations" include "rhythm . . . tempo . . . synchronization . . . duration . . . and sequence" (Larson & Zemke, 2003, p. 82; Zemke, 2004, p. 610). The temporal context includes stage of life, time of day or year, duration and rhythm of activity, and history.	• *Person:* A person retired from work for 10 years • *Group:* A community organization's annual fundraising campaign • *Population:* People celebrating Independence Day on July 4

Virtual	Environment in which communication occurs by means of airwaves or computers and in the absence of physical contact. The virtual context includes simulated, real-time, or near-time environments such as chat rooms, email, video conferencing, or radio transmissions; remote monitoring via wireless sensors; or computer-based data collection.	• *Person:* Friends who text message each other • *Group:* Members who participate in a video conference, telephone conference call, instant message, or interactive white board use • *Population:* Virtual community of gamers
■ **ENVIRONMENTS**		
Physical	Natural and built nonhuman surroundings and the objects in them. The natural environment includes geographic terrain, plants, and animals, as well as the sensory qualities of the surroundings . The built environment includes buildings, furniture, tools, and devices.	• *Person:* Individual's house or apartment • *Group:* Office building or factory • *Population:* Transportation system
Social	Presence of, relationships with, and expectations of persons, groups, or populations with whom clients have contact. The social environment includes availability and expectations of significant individuals, such as spouse, friends, and caregivers; relationships with individuals, groups, or populations; and relationships with systems (e.g., political, legal, economic, institutional) that influence norms, role expectations, and social routines.	• *Person:* Friends, colleagues • *Group:* Occupational therapy students conducting a class get-together • *Population:* People influenced by a city government

Note. WHO = World Health Organization.

TABLE 6. TYPES OF OCCUPATIONAL THERAPY INTERVENTIONS

Occupational therapy interventions *include the use of occupations and activities, preparatory methods and tasks, education and training, advocacy, and group inter- ventions to facilitate engagement in occupations to promote health and participation. The examples provided illustrate the types of interventions occupational therapy practitioners provide and are not intended to be all inclusive.*

Category	Description	Examples
■ **OCCUPATIONS AND ACTIVITIES—**Occupations and activities selected as interventions for specific clients and designed to meet therapeutic goals and address the underlying needs of the mind, body, and spirit of the client. To use occupations and activities therapeutically, the practitioner considers activity demands and client factors in relation to the client's therapeutic goals, contexts, and environments.		
Occupations	Client-directed daily life activities that match and support or address identified participation goals.	The client • Completes morning dressing and hygiene using adaptive devices • Purchases groceries and prepares a meal • Visits a friend using public transportation independently • Applies for a job in the retail industry • Plays on a playground with children and adults • Participates in a community festival by setting up a booth to sell baked goods • Engages in a pattern of self-care and relaxation activities in preparation for sleep • Engages in a statewide advocacy program to improve services to people with mental illness

Activities	Actions designed and selected to support the development of performance skills and performance patterns to enhance occupational engagement. Activities often are components of occupations and always hold meaning, relevance, and perceived utility for clients at their level of interest and motivation.	The client • Selects clothing and manipulates clothing fasteners in advance of dressing • Practices safe ways to get into and out of the bathtub • Prepares a food list and practices using cooking appliances • Reviews how to use a map and transportation schedule • Writes answers on an application form • Climbs on and off playground and recreation equipment • Greets people and initiates conversation in a role-play situation • Develops a weekly schedule to manage time and organize daily and weekly responsibilities required to live independently • Uses adaptive switches to operate the home environmental control system • Completes a desired expressive activity (e.g., art, craft, dance) that is not otherwise classified • Plays a desired game either as a solo player or in competition with others
■ **PREPARATORY METHODS AND TASKS—**Methods and tasks that prepare the client for occupational performance, used as *part of a treatment session* in preparation for or concurrently with occupations and activities or provided to a client as a home-based engagement to support daily occupational performance.		
Preparatory methods	Modalities, devices, and techniques to prepare the client for occupational performance. Often preparatory methods are interventions that are "done to" the client without the client's active participation.	The practitioner • Administers physical agent modalities to decrease pain, assist with wound healing or edema control, or prepare muscles for movement • Provides massage • Performs manual lymphatic drainage techniques • Performs wound care techniques, including dressing changes
Splints	Construction and use of devices to mobilize, immobilize, and support body structures to enhance participation in occupations.	The practitioner • Fabricates and issues a splint or orthotic to support a weakened hand and decrease pain • Fabricates and issues a wrist splint to facilitate movement and enhance participation in household activities
Assistive technology and environmental modifications	Identification and use of assistive technologies (high and low tech), application of universal design principles, and recommends changes to the environment or activity to support the client's ability to engage in occupations. This preparatory method includes assessment, selection, provision, and education and training in use of devices.	The practitioner • Provides a pencil grip and slant board • Provides electronic books with text-to-speech software • Recommends visual supports (e.g., a social story) to guide behavior • Recommends replacing steps with an appropriately graded ramp • Recommends universally designed curriculum materials
Wheeled mobility	Use of products and technologies that facilitate a client's ability to maneuver through space, including seating and positioning, and that improve mobility, enhance participation in desired daily occupations, and reduce risk for complications such as skin breakdown or limb contractures.	The practitioner • Recommends, in conjunction with the wheelchair team, a sip-and-puff switch to allow the client to maneuver the power wheelchair independently and interface with an environmental control unit in the home

(Continued)

TABLE 6. TYPES OF OCCUPATIONAL THERAPY INTERVENTIONS

(Continued)

Category	Description	Examples

Preparatory tasks	Actions selected and provided to the client to target specific client factors or performance skills. Tasks involve active participation of the client and sometimes comprise engagements that use various materials to simulate activities or components of occupations. Preparatory tasks themselves may not hold inherent meaning, relevance, or perceived utility as stand-alone entities.	The client • Refolds towels taken from a clean linen cart to address shoulder range of motion • Participates in fabricated sensory environment (e.g., through movement, tactile sensations, scents) to promote alertness • Uses visual imagery and rhythmic breathing to promote rest and relaxation • Performs a home-based conditioning regimen using free weights • Does hand-strengthening exercises using therapy putty, exercise bands, grippers, and clothespins • Participates in an assertiveness training program to prepare for self-advocacy
■ **EDUCATION AND TRAINING**		
Education	Imparting of knowledge and information about occupation, health, well-being, and participation that enables the client to acquire helpful behaviors, habits, and routines that may or may not require application at the time of the intervention session	The practitioner • Provides education regarding home and activity modifications to the spouse or family member of a person with dementia to support maximum independence • Educates town officials about the value of and strategies for making walking and biking paths accessible for all community members • Educates providers of care for people who have experienced trauma on the use of sensory strategies • Provides education to people with mental health issues and their families on the psychological and social factors that influence engagement in occupation
Training	Facilitation of the acquisition of concrete skills for meeting specific goals in a real-life, applied situation. In this case, *skills* refers to measurable components of function that enable mastery. Training is differentiated from education by its goal of enhanced performance as opposed to enhanced understanding, although these goals often go hand in hand (Collins & O'Brien, 2003).	The practitioner • Instructs the client in how to operate a universal control device to manage household appliances • Instructs family members in the use and maintenance of the father's power wheelchair • Instructs the client in the use of self range of motion as a preparatory technique to avoid joint contracture of wrist • Instructs the client in the use of a handheld electronic device and applications to recall and manage weekly activities and medications • Instructs the client in how to direct a personal care attendant in assisting with self-care activities • Trains parents and teachers to focus on a child's strengths to foster positive behaviors
■ **ADVOCACY—**Efforts directed toward promoting occupational justice and empowering clients to seek and obtain resources to fully participate in daily life occupations. The outcomes of advocacy and self-advocacy support health, well-being, and occupational participation at the individual or systems level.		
Advocacy	Advocacy efforts undertaken by the practitioner.	The practitioner • Collaborates with a person to procure reasonable accommodations at a work site • Serves on the policy board of an organization to procure supportive housing accommodations for people with disabilities • Serves on the board of a local park district to encourage inclusion of children with disabilities in mainstream district sports programs when possible • Collaborates with adults who have serious mental illness to raise public awareness of the impact of stigma • Collaborates with and educates staff at federal funding sources for persons with disabling conditions

Self-advocacy	Advocacy efforts undertaken by the client, which the practitioner can promote and support.	• A student with a learning disability requests and receives reasonable accommodations such as textbooks on tape. • A grassroots employee committee requests and procures ergonomically designed keyboards for their work computers. • People with disabilities advocate for the use of universal design principles with all new public construction. • Young adults contact their Internet service provider to request support for cyberbullying prevention.

(Continued)

TABLE 6. TYPES OF OCCUPATIONAL THERAPY INTERVENTIONS

(Continued)

Category	Description	Examples
■ **GROUP INTERVENTIONS—**Use of distinct knowledge and leadership techniques to facilitate learning and skill acquisition across the lifespan through the dynamics of group and social interaction. Groups may also be used as a method of service delivery.		
Groups	Functional groups, activity groups, task groups, social groups, and other groups used on inpatient units, within the community, or in schools that allow clients to explore and develop skills for participation, including basic social interaction skills, tools for self-regulation, goal setting, and positive choice making.	• A group for older adults focuses on maintaining participation despite increasing disability, such as exploring alternative transportation if driving is no longer an option and participating in volunteer and social opportunities after retirement. • A community group addresses issues of self-efficacy and self-esteem as the basis for creating resiliency in preadolescent children at risk for being bullied. • A group in a mental health program addresses establishment of social connections in the community.

TABLE 7. ACTIVITY AND OCCUPATIONAL DEMANDS

Activity and occupational demands *are the components of activities and occupations that occupational therapy practitioners consider during the clinical reasoning process. Depending on the context and needs of the client, these demands can be deemed barriers to or supports for participation. Specific knowledge about the de- mands of activities and occupations assists practitioners in selecting activities for therapeutic purposes. Demands of the activity or occupation include the relevance and importance to the client, objects used and their properties, space demands, social demands, sequencing and timing, required actions and performance skills, and required underlying body functions and body structures.*

Type of Demand	Description	Examples
Relevance and importance to client	Alignment with the client's goals, values, beliefs, and needs and perceived utility	• Driving a car equates with independence. • Preparing a holiday meal connects with family tradition. • Voting is a rite of passage to adulthood.

Objects used and their properties	Tools, supplies, and equipment required in the process of carrying out the activity	• Tools (e.g., scissors, dishes, shoes, volleyball) • Supplies (e.g., paints, milk, lipstick) • Equipment (e.g., workbench, stove, basketball hoop) • Inherent properties (e.g., heavy, rough, sharp, colorful, loud, bitter tasting)
Space demands (related to the physical environment)	Physical environmental requirements of the activity (e.g., size, arrangement, surface, lighting, temperature, noise, humidity, ventilation)	• Large, open space outdoors for a baseball game • Bathroom door and stall width to accommodate wheelchair • Noise, lighting, and temperature controls for a library
Social demands (related to the social environment and virtual and cultural contexts)	Elements of the social environment and virtual and cultural contexts that may be required by the activity	• Rules of the game • Expectations of other participants in the activity (e.g., sharing supplies, using language appropriate for the meeting, appropriate virtual decorum)
Sequencing and timing	Process required to carry out the activity (e.g., specific steps, sequence of steps, timing requirements)	• *Steps to make tea:* Gather cup and tea bag, heat water, pour water into cup, let steep, add sugar. • *Sequence:* Heat water before placing tea bag in water. • *Timing:* Leave tea bag to steep for 2 minutes. • *Steps to conduct a meeting:* Establish goals for meeting, arrange time and location, prepare agenda, call meeting to order. • *Sequence:* Have people introduce themselves before beginning discussion of topic. • *Timing:* Allot sufficient time for discussion of topic and determination of action items.
Required actions and performance skills	Actions (performance skills—motor, process, and social interaction) required by the client that are an inherent part of the activity	• Feeling the heat of the stove • Gripping a handlebar • Choosing ceremonial clothes • Determining how to move limbs to control the car • Adjusting the tone of voice • Answering a question
Required body functions	"Physiological functions of body systems (including psychological functions)" (WHO, 2001, p. 10) required to support the actions used to perform the activity	• Mobility of joints • Level of consciousness • Cognitive level
Required body structures	"Anatomical parts of the body such as organs, limbs, and their components" that support body functions (WHO, 2001, p. 10) and are required to perform the activity	• Number of hands or feet • Olfactory or taste organs

TABLE 8. APPROACHES TO INTERVENTION

Approaches to intervention *are specific strategies selected to direct the process of evaluation and intervention planning, selection, and implementation on the basis of the client's desired outcomes, evaluation data, and evidence. Approaches inform the selection of practice models, frames of references, or treatment theories.*

Approach	Description	Examples

Create, promote (health promotion)	An intervention approach that does not assume a disability is present or that any aspect would interfere with performance. This approach is designed to provide enriched contextual and activity experiences that will enhance performance for all people in the natural contexts of life (adapted from Dunn, McClain, Brown, & Youngstrom, 1998, p. 534).	• Create a parenting class to help first-time parents engage their children in developmentally appropriate play • Provide a falls prevention class to a group of older adults at the local senior center to encourage safe mobility throughout the home
Establish, restore (remediation, restoration)	An intervention approach designed to change client variables to establish a skill or ability that has not yet developed or to restore a skill or ability that has been impaired (adapted from Dunn et al., 1998, p. 533).	• Restore a client's upper-extremity movement to enable transfer of dishes from the dishwasher into the upper kitchen cabinets • Develop a structured schedule, chunking tasks to decrease the risk of being overwhelmed when faced with the many responsibilities of daily life roles • Collaborate with a client to help establish morning routines needed to arrive at school or work on time
Maintain	An intervention approach designed to provide the supports that will allow clients to preserve the performance capabilities they have regained, that continue to meet their occupational needs, or both. The assumption is that without continued maintenance intervention, performance would decrease, occupational needs would not be met, or both, thereby affecting health, well-being, and quality of life.	• Provide ongoing intervention for a client with amyotrophic lateral sclerosis to address participation in desired occupations through provision of assistive technology • Maintain independent gardening for people with arthritis by recommending tools with modified grips, long-handled tools, seating alternatives, and raised gardens • Maintain safe and independent access for people with low vision by increasing hallway lighting in the home
Modify (compensation, adaptation)	An intervention approach directed at "finding ways to revise the current context or activity demands to support performance in the natural setting, [including] compensatory techniques . . . [such as] enhancing some features to provide cues or reducing other features to reduce distractibility" (Dunn et al., 1998, p. 533).	• Simplify task sequence to help a person with cognitive impairments complete a morning self-care routine • Consult with builders to design homes that will allow families to provide living space for aging parents (e.g., bedroom and full bath on the main floor of a multilevel dwelling) • Modify the clutter in a room to decrease a client's distractibility
Prevent (disability prevention)	An intervention approach designed to address the needs of clients with or without a disability who are at risk for occupational performance problems. This approach is designed to prevent the occurrence or evolution of barriers to performance in context. Interventions may be directed at client, context, or activity variables (adapted from Dunn et al., 1998, p. 534).	• Aid in the prevention of illicit chemical substance use by introducing self-initiated routine strategies that support drug-free behavior • Prevent social isolation of employees by promoting participation in after-work group activities • Consult with a hotel chain to provide an ergonomics educational program designed to prevent back injuries in housekeepers

TABLE 9. OUTCOMES

Outcomes *are the end result of the occupational therapy process; they describe what clients can achieve through occupational therapy intervention. The outcomes of occupational therapy can be described in two ways. Some outcomes are measurable and are used for intervention planning, monitoring, and discharge planning.*
These outcomes reflect the attainment of treatment goals that relate to engagement in occupation. Other outcomes are experienced by clients when they have realized the effects of engagement in occupation and are able to return to desired habits, routines, roles, and rituals. The examples listed specify how the broad outcome of health and participation in life may be operationalized and are not intended to be all inclusive.

Category	Description	Examples

Occupational performance	Act of doing and accomplishing a selected action (performance skill), activity, or occupation (Fisher, 2009; Fisher & Griswold, 2014; Kielhofner, 2008) and results from the dynamic transaction among the client, the context, and the activity. Improving or enabling skills and patterns in occupational performance leads to engagement in occupations or activities (adapted in part from Law et al., 1996, p. 16).	See "Improvement" and "Enhancement," below.
Improvement	Outcomes targeted when a performance limitation is present. These outcomes reflect increased occupational performance for the person, group, or population.	• A child with autism playing interactively with a peer (person) • An older adult returning to a desired living situation in the home from a skilled nursing facility (person) • Decreased incidence of back strain in nursing personnel as a result of an in-service education program in body mechanics for carrying out job duties that require bending, lifting, and so forth (group) • Construction of accessible playground facilities for all children in local city parks (population)
Enhancement	Outcomes targeted when a performance limitation is not currently present. These outcomes reflect the development of performance skills and performance patterns that augment existing performance in life occupations.	• Increased confidence and competence of teenage mothers in parenting their children as a result of structured social groups and child development classes (person) • Increased membership in the local senior citizen center as a result of expanding social wellness and exercise programs (group) • Increased ability of school staff to address and manage school-age youth violence as a result of conflict resolution training to address bullying (group) • Increased opportunities for older adults to participate in community activities through ride-share programs (population)
Prevention	Education or health promotion efforts designed to identify, reduce, or prevent the onset and reduce the incidence of unhealthy conditions, risk factors, diseases, or injuries (AOTA, 2013b). Occupational therapy promotes a healthy lifestyle at the individual, group, community (societal), and governmental or policy level (adapted from AOTA, 2001).	• Appropriate seating and play area for a child with orthopedic impairments (person) • Implementation of a program of leisure and educational activities for a drop-in center for adults with severe mental illness (group) • Access to occupational therapy services in underserved areas regardless of cultural or ethnic background (population)
Health and wellness	Resources for everyday life, not the objective of living. For individuals, *health* is a state of physical, mental, and social well-being, as well as a positive concept emphasizing social and personal resources and physical capacities (WHO, 1986). Health for groups and populations includes these individual aspects but also includes social responsibility of members to the group or population as a whole. *Wellness* is "an active process through which individuals [or groups or populations] become aware of and make choices toward a more successful existence" (Hettler, 1984, p. 1117). Wellness is more than a lack of disease symptoms; it is a state of mental and physical balance and fitness (adapted from *Taber's Cyclopedic Medical Dictionary,* 1997, p. 2110).	• Participation by a person with a psychiatric disability in an empowerment and advocacy group to improve services in the community (person) • Implementation of a company-wide program for employees to identify problems and solutions regarding the balance among work, leisure, and family life (group) • Decreased incidence of childhood obesity (population)

(Continued)

TABLE 9. OUTCOMES

(Continued)

Category	Description	Examples
Quality of life	Dynamic appraisal of the client's life satisfaction (perceptions of progress toward goals), hope (real or perceived belief that one can move toward a goal through selected pathways), self-concept (the composite of beliefs and feelings about oneself), health and functioning (e.g., health status, self-care capabilities), and socioeconomic factors (e.g., vocation, education, income; adapted from Radomski, 1995).	• Full and active participation of a deaf child from a hearing family during a recreational activity (person) • Residents being able to prepare for outings and travel independently as a result of independent living skills training for care providers (group) • Formation of a lobby to support opportunities for social networking, advocacy activities, and sharing of scientific information for stroke survivors and their families (population)
Participation	Engagement in desired occupations in ways that are personally satisfying and congruent with expectations within the culture.	• A person recovering the ability to perform the essential duties of his or her job after a flexor tendon laceration (person) • A family enjoying a vacation while traveling cross-country in their adapted van (group) • All children within a state having access to school sports programs (population)
Role competence	Ability to effectively meet the demands of roles in which the client engages.	• An individual with cerebral palsy being able to take notes or type papers to meet the demands of the student role (person) • Implementation of job rotation at a factory that allows sharing of higher demand tasks to meet the demands of the worker role (group) • Improved accessibility of polling places to all people with disabilities to meet the demands of the citizen role (population)
Well-being	Contentment with one's health, self-esteem, sense of belonging, security, and opportunities for self-determination, meaning, roles, and helping others (Hammell, 2009). *Well-being* is "a general term encompassing the total universe of human life domains, including physical, mental, and social aspects" (WHO, 2006, p. 211).	• A person with amyotrophic lateral sclerosis being content with his ability to find meaning in fulfilling the role of father through compensatory strategies and environmental modifications (person) • Members of an outpatient depression and anxiety support group feeling secure in their sense of group belonging and ability to help other members (group) • Residents of a town celebrating the groundbreaking of a school during reconstruction after a natural disaster (population)
Occupational justice	Access to and participation in the full range of meaningful and enriching occupations afforded to others, including opportunities for social inclusion and the resources to participate in occupations to satisfy personal, health, and societal needs (adapted from Townsend & Wilcock, 2004).	• An individual with an intellectual disability serving on an advisory board to establish programs offered by a community recreation center (person) • Workers having enough break time to have lunch with their young children in their day care center (group) • Increased sense of empowerment and self-advocacy skills for people with persistent mental illness, enabling them to develop an antistigma campaign promoting engagement in the civic arena (group) and alternative adapted housing options for older adults to age in place (population)

Electronic Signature

DISTRICT OF COLUMBIA PUBLIC SCHOOLS

QUICK REFERENCE GUIDE

Adding Signature & Uploading Assessments in SEDS

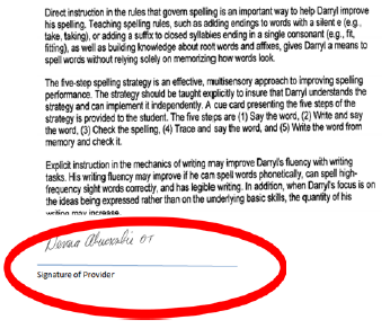
Scan Your Signature to Email

1. Using a Blank Sheet of Paper – Sign your Signature to the sheet of paper.
2. Go to a copy/fax machine with scanning capabilities. Scan the document.
3. Enter the destination email. ex. Janice.Joplin@dc.gov
4. Once the scanned signature has been received in email. Save it as a JPG or Picture file.

Note **The fax or copier must have scanning capabilities.**

Adding Your Signature to Documents

1. Open your document or assessment in Microsoft Word.
2. Go to the signature line of the document.



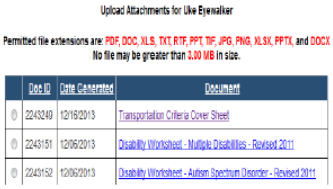
3. Click Insert Picture.
4. Select the file containing your signature and Click Insert.

Upload Document in SEDS

Note The Upload Document feature can be accessed from both the documents tab and the associated section of SEDS.

1. Click on the Documents tab and scroll to the bottom of the page.
2. Click on the Upload External Attachment(s).

3. Click the button next to the document you want to associate a file with



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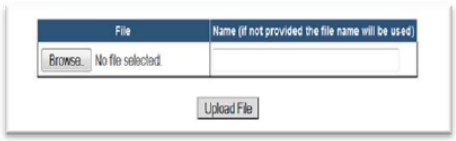

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APPENDIX P

Bilingual Assessment Referral Guidelines

Version 4.0

Introduction

The Individuals with Disabilities Education Act (IDEA) regulations require assessments and other evaluation materials to be provided and administered in the student's native language or other mode of communication.

This set of guidelines is intended to help the Local Education Agency (LEAs) and case managers meet these requirements and provide appropriate assessments to inform the evaluation of students who are not native speakers of English.

Table of Contents

Definitions

English as a Second Language (ESL) - A model of instruction for students whose native language is other than English

English Language Learner (ELL) - A linguistically and culturally diverse student who has an overall English Language Proficiency level of 1-4 on the ACCESS for ELLs test

ACCESS for ELLs- An assessment anchored in the WIDA English Language Proficiency Standards to help educators, parents and students better understand a student's development of English language proficiency on an annual basis (see page 4 of this guidebook)

Bilingual Assessment Team- The Office of Student Wellness maintains a team of fully itinerant bilingual related service providers in different disciplines to conduct assessments of ELLs in DCPS local schools, public charter schools for whom DCPS is LEA, and DCPS tuition-grant students in non-public schools. These providers present the results of their reports at MDT meetings and assist the IEP team in developing or modifying IEPs for the students they assess

Language Acquisition Division (LAD)- Division, formerly known as the Office of Bilingual Education, that provides translation and interpretation services to central offices and local schools to enable parents of other language backgrounds to fully participate in the education of their children

Local Education Agency (LEA) Representative- The point of contact for all special education matters at a DCPS school. LEAs and IEP case managers are responsible for identifying children who may have a disability and for organizing all meetings related to special education. At some DCPS schools, a child's teacher serves as his or her IEP case manager

Multidisciplinary Disciplinary Team (MDT) - A group of persons whose responsibility it is to evaluate the abilities and needs, based on presenting data, of a child referred for evaluation and to determine whether or not the child meets the eligibility criteria

The Office of The Office of Student Wellness - Works with schools to ensure that students with disabilities have the services and support needed to achieve success

OSI Bilingual Coordinator- Point of contact for intake and assignment of requests for bilingual assessments

What is the ACCESS for ELLs test?

The Assessing Comprehension and Communication in English State to State (ACCESS for ELLs) test places students in English language proficiency levels 1 to 5.

DCPS provides services to students scoring levels 1 to 4 and exits students from support programs when they reach level 5.

If a student's composite ACCESS score is less than 5 (i.e. 4.9 or below), they are eligible to be evaluated by a bilingual provider. The LEA may follow the process outlined in this document to proceed with a bilingual referral.

See the chart below for an explanation of the five scoring levels. It is expected that at level 5 students are ready to meet state academic standards with minimal language support services. ACCESS for ELLs measures language across the four domains: listening, speaking, reading and writing. It also measures across the following content areas: social studies; social and instructional English; math; science and language arts.

Level	Category	Description
1	Entering	Knows and uses minimal social English and minimal academic language with visual and graphic support
2	Beginning	Knows and uses some social English and generic academic language with visual and graphic support
3	Developing	Knows and uses social English and some specific academic language with visual and graphic support
4	Expanding	Knows and uses social English and some technical and academic language
5	Bridging	Knows and uses social English and academic language working with modified grade level material

For additional information, visit http://www.wida.us/assessment/access/

When to refer a student for bilingual assessment

As with any student, the IEP team must review all existing data before determining that additional assessments are necessary to make an eligibility determination

If the team has decided additional assessments are necessary, the student should always be referred for *bilingual assessment* if any of the following are true:

The student currently receives ESL services

or

The student's composite ACCESS score is less than 5

or

The student has lived in the United States for 7 years or less

or

The student is 7 years old or younger and a non-native speaker of English

In cases of extenuating circumstances, the IEP team (including the parent) can refer an ELL student for bilingual assessment even if none of the above criterion is met. **Each bilingual referral that does not meet one of the aforementioned criteria is subject to review by the Office of Student Wellness.**

For example:

A ten year old fifth grade student who was born and has lived in the United States does not receive ELL services because she scored above 4 on the ACCESS test. However, her Spanish speaking parents do not speak any English and the student was never exposed to English before entering school at age 5. Her teachers have noticed that she does not seem to understand very well when spoken to in English, and seems to mix English and Spanish when speaking. When she is referred to Special Education, the team decides a speech-language assessment is necessary. Her case manager decides to refer her for a bilingual assessment.

How to refer a student for bilingual assessment

The LEA Representative or case manager should request a bilingual assessment as follows:

1. ocate the students ACCESS scores **prior** to obtaining signed parental consent.	For assistance, contact Margaret Miller (Margaret.Miller@dc.gov) in the Language Acquisition Division (202) 671-0755 to request a copy for your school's files. **ACCESS scores must be obtained prior to the parent's signing consent**
2. rder a Bilingual Social History for initial assessments	It is preferred that social history is completed before any requests are made for a Functional Behavior Assessment (FBA). A bilingual social worker must complete Bilingual Social History in the case of an: • nitial evaluation • ajor changes in the family • ocial emotional or behavioral concerns
3. ollect and evaluate appropriate data points	Consult the **Bilingual Checklist** in the handbook
4. omplete the *Bilingual Assessment Justification Form* (page 16)	Fax to the Bilingual Coordinator at (202) 654-6078 *and upload to SEDS as Miscellaneous Doc*: • ilingual Assessment Justification form • ACCESS scores • ilingual Checklist
5. omplete the "Additional Assessment" component in SEDS (Easy IEP) under the Eligibility section	Complete this component just as you would for any initial or re-evaluation assessment.
6. ssign each assessment to the "**Program Coordinator**"	Be certain to check the box that indicates "Send email to provider."

Assigning bilingual assessments

Within 72 hours of receiving the complete bilingual assessment request, the Bilingual Coordinator will contact the LEA representative by mail with the course of action for each assessment.

Actions may include:

1. **The Bilingual Coordinator assigns the assessment to a bilingual provider in Easy IEP for the following languages available directly through providers:**

Physical Supports	Psychology	Social Work	Speech-Language Pathology
	Japanese		
	Mandarin		
Spanish	Spanish	Spanish	Spanish

2. **The Bilingual Coordinator assigns the assessment to a monolingual provider in Easy IEP, and the LEA representative schedules an interpreter for each testing session** (for instructions on how to schedule an interpreter for testing sessions, see the following section entitled "Requesting an Interpreter.")

Requesting an interpreter

An interpreter may be necessary to facilitate the bilingual assessment of ELL students. An interpreter may also be necessary to facilitate review meetings or other MDT meetings with non-English speaking parents. **Scheduling an interpreter for testing or meeting is the responsibility of the LEA Representative.**

There are two options to consider regarding interpreting for testing:

Option 1	***Option 2***
A bilingual teacher (i.e. an ESL teacher) at the school who is fluent in the student's native language may serve as an interpreter.	First, the LEA Representative may decide to use a professional interpreter from the Language Acquisition Division (LAD).
	Next, submit the Interpreter Request Form (available through the LAD) leaving the "purchase order number," "blanket purchase agreement number" and "requisition number" fields blank.
	The form must be received by the point of contact for interpreters, Ivy Chaine, ivy.chaine@dc.gov; phone (202) 671-0755; fax (202) 671-2667 **at least 5 business days in advance.**
	At the conclusion, the LAD relies on your feedback to determine that interpretation services were provided and ask that a feedback form is faxed to their office at (202) 671-2667.

Note: Meetings may be interpreted using the Language Line provided by the District of Columbia Office of Human Rights. However, this line ***may not*** be used for assessments.

- Call the Language Line at 1-800-367-9559
- Agency Client ID **511049**
- Access Code **701001**

Translation of documents

According to DCPS policy, the Language Acquisition Division will provide translation of vital documents into any non-English language spoken by a limited or non-English proficient population that constitutes 3% or 500 individuals, whichever is less, of the population served or encountered. Vital documents are defined as document(s) which are for district-wide distribution and do not include individual student records. For example, the Chancellor's Letter to Parents about the last day of school and DCPS Enrollment packets are considered vital documents. These are documents for all DCPS parents including ELL parents. Translation for the document will be provided for the language group that constitutes 500 or 3% of the total population of DCPS.

Frequently asked questions

What if there is a bilingual provider assigned to work with the school regularly who can complete a bilingual assessment?
If the school has a regularly scheduled provider who is bilingual, for data tracking purposes, the LEA representative or case manager should still follow the bilingual referral process above as the school based provider may not ultimately be assigned to complete the assessment. Providing referral data to the OSI Bilingual Coordinator is important because it allows OSI to assign bilingual providers to work with the schools that have the highest volume of bilingual referrals. At this time, OSI cannot capture this data unless the procedure is followed.

Where are student ACCESS scores located?
ACCESS scores are provided to the parent and school ACCESS or testing coordinator. If the scores are not available, contact Margaret Miller, Margaret.Miller@dc.gov, (202) 671-0755 at the Language Acquisition Division to request a copy for your school's files. **Note: ACCESS scores must be obtained prior to obtaining signed parental consent.**

What if the student has no English language proficiency scores?
The school should immediately ask the parent to take the student to the Language Acquisition Division's Intake Center for testing. Current English language proficiency scores are essential to ensure that ELL students get access to the full range of appropriate supports available. The LAD Intake Center contact information is as follows:

Ivy Chaine
Language Acquisition Division Program Coordinator
Garrison Administrative Unit
1200 S Street, NW
Washington, DC 20009
Ivy.Chaine@dc.gov
Phone: (202) 671-0755
Fax: (202) 671-2667

What if the student does not require a bilingual assessment but his/her parent does not speak English?
Conducting social histories and adaptive behavior assessments are interview based and require a bilingual assessor or interpreter if the parent is not proficient in English, *even if the student does not require a bilingual assessment*. For these assessments, the LEA representative should follow the bilingual referral process described above to order those portions of the assessment (i.e. Adaptive Behavior Assessment) that are to be completed by the bilingual team. If the

student does not require a bilingual assessment, the school based psychologist will be responsible for completing assessments that can be administered in English.

Who should perform bilingual educational assessments?
In the case of an initial assessment, a psychologist from the Bilingual Assessment Team will administer the educational assessment and the student should be referred for a bilingual evaluation.

However, during re-evaluations, if there is a special education teacher at the school who is also fluent in the student's native language, and the school has bilingual educational assessment materials, the special education teacher can complete assessments. This course of action should be noted on the Bilingual Assessment Justification Form.

Should the bilingual provider present his/her report at the review meeting?
Yes, this is best practice. Please include the bilingual assessor when scheduling the review MDT meeting.

Will the bilingual provider deliver general language interpretation at the review meeting?
No, the LEA representative should include a separate interpreter.

What school based staff may interpret during assessments or at IEP meetings?
The MDT meeting may utilize teachers fluent in the student's native language to interpret. Community members or family members may interpret if the parent agrees to consider them as a consultative member of the IEP team. Remember, information discussed at MDT meetings or in the process of special education assessments is private. Contracted interpreters procured through the LAD have a professional commitment to confidentiality. Any school-based staff the team decides to use to interpret for an assessment or at a meeting should be individuals who could otherwise have access to the student's file and be considered members of the MDT.

School support staff, such as secretaries, custodians, and cafeteria support should not be used as interpreters.

What if the student is enrolled in a private/religious school?
The student's case manager should follow the same process as any other case manager to refer the student for a bilingual assessment.

What if the student is between 3 years (3.0) and 5 years 10 months (5.10) of age?
If the evaluation is an initial evaluation, then the student should be evaluated at Early Stages. The LEA representative should send the Child Find Referral form with information about the student's primary language to Early Stages at email: referrals@earlystagesdc.org, fax: (202)

535-1112 or call (202) 698-8037. Re-evaluations are to be completed in the school where the student is enrolled.

Does this process apply for deaf or hearing impaired students fluent in American Sign Language?
American Sign Language is a "language" and requires the same process be followed for assessment. Contact, OSI Representative, Karen Morgan, Karen.Morgan@dc.gov, to inquire about assessments and services for students who are hearing impaired.

How can I request a sign-language interpreter for a parent?
If the team requires a sign-language interpreter for a parent of a hearing impaired student at a meeting, the LEA representative should fax the Request for Sign Language Interpreter Form to the DC Office of Disability Rights. Please note that requests should be received by ODR at least 5 business days for processing. Contact Haydn.Demas@dc.gov at (202) 442-4692 or (202)724-5055.

Points of contact

Office of Special Education: Program Managers

Name	Discipline	Email	Phone	Fax
Darla Kimbrough, Program Manager	Speech-Language Pathology	darla.kimbrough@dc.gov	(202) 505.0756	(202) 654-6099
Dr. Ramonia Rich, Program Manager	Psychology	Ramonia.rich@dc.gov	(202) 369-2886	(202) 654-6150
Tamara Dukes, Program Manager	Social Work	Tamara.dukes@dc.gov	(202) 907-8056	(202) 654-6153

Office of Specialized Instruction: Bilingual Consultation Contacts

Please contact the consultant assigned to your school below for specific questions about bilingual cases. ***DO NOT*** assign assessments directly to the psychologists; *please follow the Bilingual Referral process found in this guidebook.*

Name	Role	Email	Phone
Camille Robinson	Psychologist	Camille.robinson2@dc.gov	(202) 603-9171
Isora Cruz-Cardona	Psychologist	Isora.cruz-cardona@dc.gov	(202) 276-9802
Maura Garibay	Social Worker	Maura.garibay@dc.gov	(202) 534-2740
Robert Soriano	Psychologist	Robert.soriano@dc.gov	(202) 607-4694
Dr. Sonia Pilot	Psychologist	Sonia.pilot@dc.gov	(202) 281-0183

Language Acquisition Division (LAD)

Name	Questions about	Email	Phone/Fax
Main Office	General Inquiries		**(202) 671-0750**/2667
Ivy Chaine	Interpreter	Ivy.chaine@dc.gov	(202) 671-0755
Margaret Miller	Data/Records	Margaret.miller@dc.gov	(202) 671-0750
Elba Garcia	Director	Elba.garcia@dc.gov	(202) 671-0750
Leidy Navarro	Intake Manager	Leidy.Navarro@dc.gov	(202) 671-0750

Bilingual Assessment Justification Form

Providers from the Bilingual Assessment Team or interpreters will be assigned **only after both steps below are completed** by the LEA representative or case manager.

Step One: This completed form and a copy of the student's ACCESS scores and/or any other English language proficiency documentation are faxed to (202) 654-6078.

Step Two: Each required assessment is ordered in Easy IEP and assigned to the Program Coordinator

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Information requested below about the student to be assessed must be complete and accurate.

Student's Name	
Student DCPS ID#	
Date of Birth	
Attending School	
Native Language	
Dominant Language	
LEA Representative or case manager	

Justification for Bilingual Assessment (check all that apply)

- ○ Student currently receives ESL services

- Student's composite ACCESS score is lower than 5
- Student has lived in the United States for fewer than 7 years
- Student is younger than 7 and not a native speaker of English
- None of the above, an explanation must accompany this form for review by the OSI

Note: If school based staff will complete one or more bilingual assessments, must attach explanation

BILINGUAL CHECKLIST

DATE: _____

NAME OF REQUESTER: _____

TITLE: _____

SCHOOL/LOCATION: _____ CONTACT PHONE #: _____

NAME OF STUDENT: _____ STUDENT ID#_____

NAME OF PARENT/GUARDIAN: _____

LANGUAGE/DILECT SUPPORT REQUESTED:
☐ SPANISH ☐VIETNAMESE ☐CHINESE ☐AMHARIC ☐FRENCH ☐OTHER: _____

DOCUMENTATION PROVIDED:
☐ PARENT/TEACHER/RTI MEETING
☐ SPECIAL EDUCATION MEETING/MDT
☐ PREVIOUS EDUCATION **Y** **N**
☐ NEWCOMER (>2YEAR) **Y** **N**
☐ HEARING/VISION **Y** **N**
☐ SOCIAL HISTORY **Y** **N**

INCLUDED:
☐ ACCESS LEVEL _____
☐ RTI READING
☐ RTI MATH
☐ RTI WRITTEN LANGUAGE
☐ RTI SOCIAL EMOTIONAL/BEHAVIOR (*PLUS, SOCIAL HISTORY)*
☐ HOW MANY YEARS OF PREVIOUS SCHOOLING?_____

PREVIOUS BILINGUAL EVALUATION?
Y **N**
EVALUATOR _____

HOW MANY YEARS LIVED IN US?_____REJOINING FAMILY IN US?_____

SERVICE LOCATION: _____PHONE (DIRECT LINE/CELL): _____

DAY OF CONTACT NAME: _____PHONE (DIRECT LINE/CELL): _____

FOR MORE INFORMATION CONTACT BILINGUAL COORDINATOR, LISBETH ALMONTE AT (202) 442-5445

APPROVED: ☐ **YES** ☐ **NO** _____
SIGNATURE OF SCHOOL BASED PSYCHOLOGIST

DATE: _____

FAX THIS FORM TO *(202)* 654-6078 *AND upload to SEDS*

Bilingual Interpreter Request Form

DISTRICT OF COLUMBIA
PUBLIC SCHOOLS

Requisition Number: _____

Purchase Order Number: _____

Blanket Purchase Agreement Number: _____

INTERPRETER REQUEST FORM

DATE: _____

NAME OF REQUESTER: _____

TITLE: _____

SCHOOL/LOCATION: _____ PRINCIPAL'S NAME: _____ ☐ N/A

NAME OF STUDENT: _____ STUDENT ID#_____

NAME OF PARENT/GUARDIAN: _____

LANGUAGE/DILECT SUPPORT REQUESTED:
☐ SPANISH ☐VIETNAMESE ☐CHINESE ☐AMHARIC ☐FRENCH ☐OTHER: _____

AREA OF SERVICE REQUESTED:
☐ PARENT/TEACHER/ADMINISTRATOR MEETING
☐ SPECIAL EDUCATION MEETING/IEP
☐ EVALUATION _____
☐ OTHER _____
☐ EAR SETS/LANGUAGE _____
☐ TRANSMITTER/LANGUAGE _____

FUNDING SOURCES:
☐ FROM SCHOOL
☐ LAD (FORMERLY OBE)
☐ EARLY STAGES-HEAD START
☐ EARLY STAGES
☐ OFFICE OF SPECIALIZED INSTRUCTION
☐ OTHER _____

NAME OF PREFERRED INTERPRETER (IF ANY):
_____

DATE/TIME FOR SERVICES: _____

SERVICE LOCATION: _____PHONE (DIRECT LINE/CELL): _____

DAY OF CONTACT NAME: _____PHONE (DIRECT LINE/CELL): _____

FOR MORE INFORMATION CALL IVY CHAINE (202) 671-0755 (LANGUAGE ACQUISION DIVISION) OR JENNIFER FULLER (202) 480-0898 (EARLY STAGES) or ROBERT RICHARDSON (202)-384-7870

APPROVED: ☐ YES ☐ NO _____

☐ IVY CHAINE (LAD) or ☐ JENNIFER FULLER/MEGHAN BROWN (EARLY STAGES)

DATE: **FAX THIS FORM TO** *(202) 671-2667*

To request an interpreter for an evaluation please fill out this form online:
https://docs.google.com/a/dc.gov/forms/d/1zC__1BLdGezxcSgn8SUZ58X510VP5aFYSrsMVzuMpV0/viewform

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