MISSISSIPPI DEPARTMENT OF EDUCATION

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Handbook for Speech-Language Pathologists in Mississippi Schools

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Purpose

Speech-language pathology services have significant impacts on children and their educational success in a variety of practices, including screening, testing, providing direct services, assisting students in accessing or making progress in the general education curriculum, supervising, and providing professional development growth opportunities. These services ultimately contribute to student success in their transition from school to work.

All speech-language pathology services in schools are guided by the Mississippi Department of Education State Policies Regarding Children with Disabilities under the Individuals with Disabilities Education Act Amendments of 2004, or State Board Policy (SBP) 7219, available here: http://www.mde.k12.ms.us/docs/sped-july-2009-policies/state-board-polices-7219-effective-september-15-2013.pdf?sfvrsn=2.

This document was developed to assist administrators, educators, parents, students and others in the knowledge of the roles and responsibilities of Speech-Language Pathologists and therapists in Mississippi schools in the areas of evaluation, determination of eligibility and implementation of the Individualized Education Program (IEP) of students with disabilities.

In order to provide a Free Appropriate Public Education (FAPE) in the Least Restrictive Environment (LRE), knowledge of the curriculum and Mississippi College and Career Readiness Standards is critical. The student's IEP should represent a prioritized set of skills and objectives, services, supports, and extensions (accommodations and specially designed instruction) that learners with diverse needs require in order to successfully participate in the Mississippi College and Career Readiness Standards and in curricular activities. A critical component to the provision of these services is the Speech-Language Pathologist/Speech Therapist. They ensure the instructional alignment of goals and objectives with academic expectations, Mississippi College and Career Readiness Standards and school curricula.

CHAPTER I

Roles and Responsibilities and Scope of Practice of Speech-Language Pathologists/Therapists in Schools

In the school setting, a Speech-Language Pathologist is an individual qualified in the prevention, identification, diagnosis, and treatment of students with communication or educationally relevant swallowing deficits (for children with specific medical conditions). Speech-Language Pathologists (SLP) are individuals who hold a 215 AA license (issued by the Mississippi Department of Education (MDE), Office of Educator Licensure) and/or a Certificate of Clinical Competency (CCC) issued by the American Speech-Language-Hearing Association (ASHA). ASHA is the guiding organization for standards of best practice in speech-language pathology, audiology, and speech and hearing sciences.

ASHA (2010) outlines four areas of SLP responsibilities in schools: **(1) Range of Responsibilities; (2) Critical Roles; (3) Collaboration; and (4) Leadership.** SLPs have a **Range of Responsibilities** in schools that help students succeed by meeting performance standards in school (ASHA, 2010). SLPs are responsible for prevention of academic failure by students, are trained with using Evidence-Based Practice (EBP) in prevention, and can be involved in prevention in various forms, such as analyzing school-wide assessment data and in Response to Intervention efforts (RtI). SLPs conduct assessments for communication and swallowing related disorders (when educationally relevant) in collaboration with others that help identify student needs, and can inform instruction and intervention. SLPs use evidence-based decision making to design interventions that are appropriate for the student's age, ability, and learning needs, and are supported with evidence in research. SLPs contribute to a school's program design that utilizes "a continuum of service delivery models in the least restrictive environment for students with disabilities, and provide services to other students as appropriate," (ASHA, 2010). SLPs participate in gathering and interpreting data with individual students and the overall school program. Finally, SLPs are responsible for meeting the requirements of all Federal and State mandates, and following local policies implemented by their district.

Mississippi State Board Policy 7219 34 C.F.R. **§ 300.34 (15)** Related Services (SBP 7219) define the services which are to be provided by a qualified Speech-Language Pathologist:

- Identification of children with language-speech impairments;
- Diagnosis and appraisal of specific language-speech impairments;
- Referral for medical or other professional attention necessary for the habilitation or prevention of communicative impairments;
- Provision of speech and language services for the habilitation or prevention of communication impairments; and
- Counseling and guidance of parents, children and teachers regarding speech and language impairments.

The **Critical Roles** SLPs have in education include working across all levels of school services (ASHA, 2010), which in Mississippi includes ages 3 to 20, with some districts meeting the needs of students younger than 3. SLPs serve a range of disorders, including language, voice/resonance, fluency, articulation (speech sound disorders), and swallowing (when educationally relevant). SLPs ensure educational relevance by determining if the communication or swallowing problem has an impact on the student's educational, social/behavioral or vocational performance. SLPs provide unique contributions to curriculum to aid struggling learners and students with disabilities based on their expertise in language, linguistics, and metalinguistics. They highlight the language/literacy connection with their expertise on the interrelationships of listening, speaking, reading and writing, which aids in student literacy achievement. Finally, SLPs provide culturally competent services through their expertise of distinguishing a language disorder from other contributing factors, such as cultural/linguistic differences, socioeconomic factors, lack of adequate prior instruction, and the acquisition of the dialect of English used in the schools, as well as addressing the impact of language differences and English as a second language acquisition on student learning. These responsibilities in Mississippi include:

- Determine, along with the Multidisciplinary Evaluation Team (MET), initial eligibility of a student with a language-speech impairment in the area of speech sound production and use, language, fluency and/or voice;
- Provide suggested assessment guidelines, example forms and *Communication Rating Scales* for use throughout the evaluation process;
- Provide a systematic format for the organization and presentation of functional and formal assessment information for documenting adverse effects of a communication disability on educational, social/behavioral, and/or vocational performance; and
- Provide guidelines for the provision of language and speech services as a related service, for implementation of the IEP for a child with a disability in a category other than language-speech impairment.

SLPs work in **Collaboration** with other professionals to best meet the needs of students (ASHA, 2010). In schools, SLPs work in conjunction with other staff members to contribute to the school's overall instructional program. SLPs work collaboratively with a variety of professionals, including general education

teachers, special education teachers, reading/literacy specialists, occupational therapists, physical therapists, psychometrists and school psychologists, audiologists, counselors, social workers, behavior specialists, and others. Additionally, SLPs work with both school and district administrators in the successful selection and implementation of the school's instructional program. SLPs collaborate with universities when serving in the capacity of teaching university students and conducting research. SLPs work with many community agencies (such as physicians, private practitioners, private schools, etc.) that provide services to children. SLPs collaborate with the families of students in training, planning, and implementing language-speech services to children. Perhaps most importantly, SLPs actively involve the students in successful planning, implementation, self-monitoring/awareness, and advocacy of communication goals.

SLPs exhibit **Leadership** to provide direction for defining their roles and responsibilities in schools and providing language-speech services to students (ASHA, 2010). SLPs must advocate for evidence-based practices and programs when providing service to children, such as workloads versus caseloads, professional development, and support for programs. SLPs have a responsibility to advocate for their roles to other professionals, families, and members of the community, and they must work to influence laws, regulations, and policies that promote the best practices in the field. SLPs have a responsibility to supervise student SLPs, clinical fellows, and speech associates, as well as mentor new SLPs. SLPs can be utilized to design and conduct professional development that works to augment the performance of students in the general curriculum goals and objectives. SLPs can train parents in the processes of communication development, the characteristics of communication disorders, and the process of creating a language and literacy-rich environment. SLPs must also participate in research of communication and swallowing disorders (as appropriate for students who have complex medical conditions) that supports the use of evidence-based assessment and interventions.

In Mississippi, the MDE issues two licenses for individuals practicing in the public schools in speech and language services. Regarding these licenses, individuals with a 215 AA license are able to:

- Provide services for articulation, language, voice, and fluency disorders, and any language related services that are inherent to the primary disability;
- Provide direct and active mentoring, modeling and feedback on all clinical duties and responsibilities of the 216 Speech-language therapist; and
- Mentor those who hold a valid 216 license (mentoring as described is not an administrative role).

Individuals who hold a 216 license issued by the Mississippi Department of Education, Office of Educator Licensure, will be expected to:

- Provide ***only*** articulation therapy services to students identified with speech sound production impairments;
- Work under the direction/guidance of a 215 AA license holder;
- Participate in Child Find activities as assigned/directed by the district's director of special education and/or building principal;
- Conduct *articulation assessment and develop reports;*
- Participate in meetings, including, but not limited to Teacher Support Team (TST), Multidisciplinary Evaluation Team (MET), Individualized Education Program (IEP), etc. and ***may not*** serve as the chairperson of the eligibility determination committee; and
- Maintain confidentiality of personal student information and educational records as required by State and Federal regulations.

CHAPTER II

Language-Speech Assessment and Evaluation Procedures

Child Find/Teacher Support Team

For children **Birth-21**, the Local Education Agency (LEA) is responsible for identifying students who need Special Education Services through Child Find. Complete definitions for Child Find can be located in the Mississippi Department of Education (MDE) State Policies Regarding Children with Disabilities under the Individuals with Disabilities Education Act Amendments of 2004 (IDEA 04), section 34 C.F.R. **§ 300.15**.

For children enrolled in school, **ages 5-21**, within each individual school, students are referred for educational assessment through the Teacher Support Team (TST) and Multidisciplinary Evaluation Team (MET).

Screening

Screening should be conducted by a health care professional. Screenings which involve the Speech-Language Pathologist are: hearing screening, speech sound production, language, fluency and voice screenings. The SLP must follow State Board Policy (SBP 7219) 34 C.F.R. **§ 300.8** and **§ 300.39**, **§§ 300.302-300.311** and the ***Special Education Eligibility Determination Guidelines*** when conducting screenings. An additional resource is provided by the American Speech-Language-Hearing Association for best practices. (*See Appendices: Suggested Forms.*)

Hearing Screenings

Hearing screenings shall consist of pure tone audiometric screening at **1000, 2000**, and **4000 Hz** at **25 dB** and at **500 Hz**, **6000 Hz** and **8000 Hz** at **30 dB** at the discretion of the SLP. At-risk children should be rescheduled within seven **(7)** calendar days for a second screening. If a child fails the second screening (or cannot be conditioned to respond), the child shall be referred to a licensed or certified audiologist or otolaryngologist by the SLP for further evaluation (and a quantitative description must be completed by the SLP).

Language and Other Screenings

The SLP may conduct a Language-Speech screening for assessment based on the following;

- Observation(s);
- Review of records, data and all other information pertinent to the child to determine if further Language-Speech assessment is warranted; and
- Administer published and/or non-published screener(s) and other screening methods such as non-word repetition tasks, rapid word recall task, checklist, etc.

The SLP shall be included on the MET when further Language-Speech assessment is required.

Teacher Support Team

If a student is struggling in school, the Teacher Support Team (TST) meets to determine if interventions should be designed to meet the student's needs, or if/when referral to MET for special education assessment is warranted. The process of referring students to TST is known as Response to Intervention (RtI), and there are 3 tiers of RtI. Tier 1 is for all students, and is quality classroom instruction in the general education classroom. Tier 2 is strategic and targeted intervention and supplemental instruction designed to meet the student's individual needs. Tier 3 is intensive intervention in the student's area(s) of need. If a student's needs cannot be met through the RtI process, then referral to MET may be warranted. Complete regulations for TST can be found in the *MDE Response to Intervention (RtI) Best Practices Handbook*. RtI is not required for students experiencing communication (language) deficits, but may be beneficial for some students.

Evaluation

It is imperative that the SLP follow all of the MDE State Board Policies (SBP 7219) Regarding Children with Disabilities under IDEA 04, specifically Subpart D and Special Education Eligibility Determination Guidelines, when conducting an evaluation.

Multidisciplinary Evaluation Team

When a parent, public agency (the LEA or a representative of the LEA, such as a teacher, an SLP, etc.), or TST makes a written request for an evaluation, the Multidisciplinary Evaluation Team (MET) must meet within **fourteen (14) calendar days** to consider the request and determine if special education evaluation is warranted. If the MET determines that evaluation is necessary, Written Prior Notice (WPN) for evaluation must be given to the parent within

seven (7) calendar days of the MET meeting. The WPN for evaluation can be given to the parent at the MET meeting if the parent is in attendance.

Members of the MET should include:

1. Parent and/or student
2. General education representative (usually the child's teacher)
3. Special education teacher
4. Agency representative
5. Speech-Language Pathologist
6. Any other pertinent member to the child's educational needs

Parental permission for special education testing **MUST** be obtained if a child is to be tested for special education services. When a recommendation for testing is made, the **Procedural Safeguards: Your Family's Special Education Rights** from the MDE Office of Special Education must be given and explained to the parent before the parent gives permission for testing (available here: http://www.mde.k12.ms.us/special-education/special-education-for-parents).

Once parental permission is obtained, the LEA has a maximum of **sixty (60) calendar days** to complete the evaluation.

Other Considerations

The SLP must be a part of MET when a child exhibits language difficulties as a result of any of these suspected areas of disabilities:

- Autism
- Developmentally Delayed
- Hearing Impairment (if applicable)
- Language-Speech Impairment
- Specific Learning Disability
- Traumatic Brain Injury

The SLP must follow State Board Policy (SBP 7219) 34 C.F.R. **§ 300.8** and **§ 300.39**, **§§ 300.304-300.311** and the ***Special Education Eligibility Determination Guidelines*** when conducting evaluations. An additional resource is information provided by the American Speech-Language-Hearing Association for best practices.

Essential Components for Evaluation/Reevaluation

Student assessment reports should include: student demographic information; social history; reason for evaluation/reevaluation; results and recommendations; and formal and/or informal assessment of communication in conversational speech, including the adverse impact on educational, social/behavioral or vocational performance. Reevaluation should also consist of a review of the current IEP and progress made toward annual goals and objectives, hearing and vision screening information as/when appropriate. For preschool children, the assessment report should state the impact the articulation, language, fluency, and/or voice impairment has on the child's participation in appropriate activities.

Hearing Evaluation Guidelines

An evaluation of a child's hearing by a licensed/certified audiologist/otolaryngologist shall include *all* of the components of a complete hearing evaluation used to determine the eligibility of *Hearing Impairment* as defined in State Board Policy 7219. For a child who fails the hearing screening, a statement of adequate hearing by a licensed/certified audiologist/otolaryngologist is sufficient. If the child's hearing ability cannot be formally determined by the licensed/certified audiologist/otolaryngologist and there is evidence that a disability exists, the MET can continue with the comprehensive assessment *and* eligibility determination while taking the results of the audiological assessment into consideration.

Screening should be conducted by a health care professional as defined by State Board Policy (SBP 7219) ***Special Education Eligibility Determination Guidelines***.

The MDE hearing screening shall consist of pure tone screening at **1000, 2000,** and **4000 Hz** at **25 dB HL**. The ASHA guidelines recommend **20 dB HL** for hearing screening, and the SLP can elect to screen at this level.

At-risk children should be rescheduled seven **(7)** calendar days for a second screening.

What constitutes "at-risk"?

- Failure to pass one or more frequencies (**1000**, **2000 or 4000Hz** at **20dB**) in either ear OR
- Tympanometry results reveal:
    - middle ear pressure beyond -200 daPa
    - "stiff" middle ear system as evidenced by a tympanogram with the static admittance <0.3 mmho or gradient >200 daPa

- a Type B tympanogram with a large ear canal volume for a student who has no pressure equalization tubes (PE tubes). (It should be noted that if a student with PE tubes has a Type B tympanogram with a large ear canal volume, then the student should "pass".)

If the initial hearing screening was conducted using automated audiometry but not passed, the follow-up screening shall consist of traditional pure tone screening of **1000, 2000, 4000 Hz** at **25 dB.**

Referrals should be made to the appropriate agency and the student seen within **14-21 days**. Every effort should be made to expedite this process so the child can receive the necessary assistance. Preferably, the referral process should take **14-21 days** so that the child can receive timely services if needed.

A screening of a child's hearing by a licensed or certified audiologist or otolaryngologist shall consist of a protocol deemed appropriate for the individual child, and should determine if the child is at risk of having a hearing impairment.

When the child cannot be conditioned for screening, the child should be referred to an audiologist for a hearing evaluation. In the meantime, so as not to delay further testing, a quantitative description of hearing can be completed by:

- an individual who works with the child;
- has knowledge of the child's hearing; and
- is trained in recognizing developmentally appropriate hearing behavior.

Other Hearing Evaluation Considerations

For a child who fails hearing screening, a statement of adequate hearing by a licensed or certified audiologist or otolaryngologist is sufficient after the child has been seen.

If a child's hearing ability cannot be formally determined by a licensed or certified audiologist or otolaryngologist, and there is evidence that a disability other than hearing loss exists,

- Until the child's hearing can be satisfactorily determined, the Multidisciplinary Team (MET) can continue with the comprehensive assessment and eligibility determination while taking into account the results from the audiologic assessment.
    - Use appropriate assessment tools and methods.
    - Report any deviations from standard assessment procedures.

An evaluation of a child's hearing by a licensed or certified audiologist or otolaryngologist shall include all of the components of a complete hearing

evaluation to be used in determining the eligibility of Hearing Impairment as defined in MDE State Board Policies 7219.

Articulation/Phonological Processing Assessment

For articulation eligibility, normative data refers to articulation norms from standardized instruments, oral-peripheral examinations and current research. Recent research has moved away from using formal norms for articulation and normative data is just one small component of a comprehensive assessment that includes the following:

- Articulation stimulability;
- Conversational speech intelligibility;
- Academic, social, emotional and behavioral, and vocational impact of an articulation disorder on the child's educational, social/behavioral, and/or vocational performance.

Speech Sound Production and Use

A speech sound disorder is a disorder of the phonological system and/or its articulatory aspect.

The disorder is characterized by speech that is difficult to understand or that calls attention to the speaker's production of speech and adversely impacts the child's educational, social/behavioral, and/or vocational performance. "Adverse impact" means that the progress of the child is impeded by the disability to the extent that the educational, vocational, and/or social/behavioral performance is significantly and consistently below the level of similar age peers.

An evaluation of speech sound production and use includes, but is not limited to:

- Administration of a standardized norm-referenced measure, and
- Functional procedures which assess use of speech sounds in conversation.

Speech sound disorders may be assessed and treated as:

- Phonetic or articulation disorders; speech sound errors are motorically based (the ability to produce a target sound is not within the person's repertoire of motor skills).
- Phonemic or phonological disorders: speech sound errors are considered to be linguistically based and result from a rule system different from the adult model.
- Phonological processes include, but are not limited to:
    - Voicing Processes – processes in which the voicing of the phoneme(s) are changed.

- Deletion Processes – processes in which a phoneme(s) is deleted from a word.
- Fronting Processes – processes in which frontal consonants replace the correct phonemes.
- Syllable Processes – processes in which the syllable structure of a word is changed, such as deleting one syllable in a two syllable word.
- Phoneme Processes – processes in which the distinctive features of a phoneme are changed, such as gliding processes (/w/ for /r/) and stopping processes (/p/ for /f/).

The suggested *Communication Rating Scale: Speech Sound Production and Use* form encompasses observations of phonetic/articulatory production and/or the phonological system to rate proficiency in speech sound production and use. Students for whom this rating scale is appropriate are those who may have functional articulation disorders, or speech sound disorders with a neurological and/or structural origin, such as dysarthria, apraxia, etc.

The components that must be assessed to determine if a student has a speech sound disorder and is eligible for special education and related services, as listed in the suggested *Communication Rating Scale: Speech Sound Production and Use* are:

- Intelligibility of connected speech;
- Data from standardized test(s);
- Error types characterized on a range from common to atypical;
- Structure and function of the speech mechanism as it affects speech sound production (oral-peripheral examination); and
- Adverse impact of the speech sound disorder on educational, social/behavioral, and/or vocational performance.

Special Assessment Considerations: Judging Severity of Error Type in Speech Sound Production and Use

If speech sound productions are analyzed traditionally, (e.g. omissions, substitutions, distortions) most common errors generally involve substitutions of earlier developing sounds for similar, later developing sounds. These errors are usually considered less severe. Substitution errors most commonly involve a change in one distinctive feature, not two or more features. For example, when /t/ is substituted for /s/, only the manner feature is in error; when /θ/ is substituted for /s/, only the place feature is in error. These common errors would typically indicate a less severe disorder. If, however, /b/ is substituted for /s/, the error would involve changes in 3 features: manner, place, and voicing. This error would indicate a more severe disorder. Omissions are generally considered more unusual than substitutions and are typical of more severe disorders. Distortions

of an unusual nature (e.g. lateral air emission on /s/) often represent a more severe error type than more common, frontal distortions.

The table below lists the most frequent substitutions made by students with disorders of speech sound production and use.

Most Frequent Phonemic Substitutions Examples:

/w/ for /r/ or /l/ w□d/red; wæmp/lamp (phoneme process)
/θ/ or /t/ for /s/ bʌθ /bus; bʌt/bus (phoneme process)
/ʒ/ for /d/ for /z/ /d/ibr□/zebra; dibr□/zebra (fronting process)
/f/ for /θ/ fʌm/thumb
/d/ for / ʒ/ or /g/ d□s/this; do/go (fronting process)
/t/ for /k/ tæt/cat (fronting process)
/b/ for /v/ bæl□nta□n/valentine
/s/ for /ʧ, ʃ/ or /θ, t/ for /s/,/p/ chip; su/shoe
/l/ for /j/ lɛs/yes

The substitutions listed above would likely be rated 3 for error types in the suggested *Communication Rating Scale: Speech Sound Production and Use*. Substitutions involving two or more feature changes would probably be rated 4 for error type. Numerous omissions resulting in a limited inventory of sounds would typically be rated 5 for error type. Additionally moderate or more severe articulation impairments may require an assessment of the phonological processes. Phonological processing disorders can be assessed using standardized testing instruments. Those processes exhibited by the child should be identified, documented and described in the Language-Speech evaluation to the IEP Committee. ***Note: If a child presents with a phonological processing disorder, this may be an indicator of a language disorder and further assessment in language may be warranted.***

Exclusions

A student with a suspected disorder of speech sound production and use is not eligible for special education and related services when severity rating values fall within the normal range (non-disabling = 0), or speech sound differences are due to limited English proficiency or dialectal differences, *or* the speech sound errors do not interfere with educational, social, and/or vocational performance. *(Note: Such students may be eligible for Language-Speech services when a disorder exists in their native language or in their dialectal form of English. Tongue thrust is unaccompanied by significant speech sound errors.)*

Assessment Checklist for Speech Sound Production and Use Disorders

- Review documentation of hearing and vision status.
- Review information from the communication screening to consider the possibility of a disorder in other area(s), for example, language, fluency and voice.
- Engage the student in conversational speech to assess intelligibility and phoneme production patterns in connected speech.
- Examine oral/motor structures and function. This includes examination of the facial characteristics (appearance, frontal view, and profile); intraoral characteristics (dentition, hard palate, soft palate, uvula, fauces, pharynx, and tongue); and function (lips, tongue tip, tongue based, and diadochokinesis).
- Administer a standardized test of articulation or phonology.
- *Note*: When the SLP completes the "Sound System" section of the suggested *Communication Rating Scale: Speech Sound Production and Use*, it should be noted that not all standardized measures have a consistent correlation among standard deviations, standard scores, and percentiles. This section of the rating scale should only be marked after the standard score or percentile is compared to the standard deviation using the test manual for the specific test administered.
- Conduct behavior observations and/or other informal measures to validate test results, make intelligibility judgment, and assess adverse effect. Complete *Communication Behavior Observation*.
- For preschoolers, additional functional settings may be playtime, or activities in the community or at home. Parental input should be elicited to assess the adverse effect on educational, social/behavioral, and/or vocational (developmental) performance. Complete *Teacher/Parent Interview: Preschool*.
- Complete the suggested *Speech Sound Production and Use Assessment Summary*.
- Complete the suggested *Communication Rating Scale: Speech Sound Production and Use* and assign a severity rating. Gather all assessment data and relate it to each of the components on the suggested *Communication Rating Scale: Speech Sound Production and Use*. Circle the appropriate scores within each component area to correspond with the assessment data.
- See *Special Assessment Considerations: Speech Sound Production and Use.*
- Do not include regional or dialectal differences.
- Total the values assigned to each component area, adding comments when appropriate. Assign a corresponding Speech Sound Severity Rating of 0 - 3. (*Note*: All data from functional and standardized assessments are compiled and used to complete the suggested

Communication Rating Scale: Speech Sound Production and Use. This constitutes the Speech-Language Pathologist's recommendation to the IEP Committee regarding whether there is a speech sound disorder and whether there is indication of an adverse impact on educational, social/behavioral, or vocational performance. The IEP Committee makes the final determination of eligibility or the MET if initial determination of eligibility.)

- Complete the suggested *Communication Written Report* and attach the *Speech Sound Production and Use Assessment Summary* and completed suggested *Rating Scale*.

Language Assessment

A language disorder, defined broadly, includes an impaired ability to understand or use language as well as one's same-age peers of the same community. The disorder may involve:

- Form of language (phonology, morphology, syntax);
- Content of language (semantics); and/or
- Use of language in communication (pragmatics).

A comprehensive language evaluation examines a child's skills in the areas of listening and speaking as related to a suspected language disorder, across form, content and use. The evaluation determines the student's ability to:

- Understand and interpret language;
- Use appropriate language to successfully communicate in a variety of situations and for a variety of purposes, as well as documenting the type of language deficit, including, but not limited to:
    - Morphology
    - Syntax
    - Semantics
    - Pragmatics and/or
    - Phonology

The suggested *Communication Rating Scale: Language* is appropriate for students who have specific language impairment, or who have a language disorder secondary to Autism, cognitive impairment, Attention Deficit Disorder, auditory processing skill deficits, Central Auditory Processing Disorder, Traumatic Brain Injury, Hearing Impairment, or other related conditions. The components that must be assessed to determine if a student has a language disorder and is eligible for special education and related services, as listed in the suggested *Communication Rating Scale: Language* are:

- Functional assessment measures across form, content and use;

- Administration of standardized/norm-referenced test(s);
- Adverse effect of the language disorder on educational, social, and/or vocational performance.

If more data is needed to determine eligibility, a dynamic assessment approach should be undertaken during the **sixty *(60)-day*** timeline.

When a parent, district personnel, another agency or Teacher Support Team (TST) suspect that a student has a communication (language) disability, a request should be made for an evaluation. **Interventions are not required for determining eligibility.** The SLP shall be a part of the MET and shall complete the language evaluation. If a dynamic assessment is used, it shall be a part of the SLP's report and/or in the SLP's portion of the report which will assist in the eligibility determination. Students for whom English is a second language and who demonstrate dialectal variations may demonstrate impairment in their primary language. Collaboration with an interpreter or translator may be necessary when assessing students for whom English is a second language. **(§ 300.304 (c)(1)(ii))**

Functional Assessment

Observation and analysis of the student's language skills within his/her everyday contexts and environments provide essential information about language strengths and possible area(s) of weakness. Information gained within functional settings and contexts may be used not only as partial documentation of a language disorder, but also to learn more about the patterns/areas of the language disorder and to assist in intervention planning. Functional data should also be used to validate the results of standardized tests. While not inclusive of all possibilities within the school and home settings (especially for preschoolers), some examples of sources of functional assessment are listed below:

Language sampling/narratives

The informal language sample may be a key component of the functional assessment for preschool and/or students with severe language delays. Analysis of the language sample to validate standardized assessment data relies upon the use of developmental scales in the areas of phonology, morphology, syntax, semantics and pragmatics. For older students, an oral narrative may be an appropriate tool for functional analysis.

Classroom observation

The Speech-Language Pathologist should observe how the student's language disorder affects his/her involvement and progress in the general curriculum. This informal assessment of the student's language skills may be used to validate the results of standardized tests. It may also help to support a teacher's description of the student's communicative behaviors. The observation should assess how

well the student is able to follow classroom routine, interact with his/her teachers and peers, respond to and participate in classroom discussion or other activities needed to progress in the general curriculum.

Teacher/Parent interviews

- Information gathered from parents and/or teacher(s) about the student's language performance in familiar settings can be used by the Speech-Language Pathologist to verify the student's language performance.
- Evaluation and other information from the parent(s)
- Teacher narratives
- Developmental history
- Evidence of appropriate instruction in reading and math

Criterion-referenced activities (e.g., student telling a story)

Criterion-referenced measures indicate ability with respect to specific skills, such as curriculum-based language assessments and overall communication ability. Such measures aid in the understanding of a student's abilities and needs by complementing findings from norm-referenced measures, and by providing a means of describing the student's strengths and needs in terms of actual performance.

Review of written products (work samples, portfolio entries, etc.)

- Assessment of specific language skills within the context of academic tasks using the curriculum provides performance-based data to verify information gained from standardized instruments.
- Language tasks are used to probe for specific skills. Valuable assessment information may be gathered from clinician-generated activities using functional tasks with curricular materials. *Note*: *For preschoolers, or students in environments different from the traditional classroom, additional information related to social interaction, behavior, and emotional development may be obtained through observation(s) of the student within a small group or age-appropriate setting (e.g., preschool program, daycare, community, vocational/technical program, and home).*

Special Assessment Considerations: Language

Comparison of Language with Mental Ability *(ASHA, 2000, pp. 16 & 17)*, the practice of excluding students with language problems from eligibility for services when language and cognitive scores are commensurate (i.e., cognitive referencing) has been challenged and criticized for more than a decade for several reasons:

- Such comparisons are made based on norm-referenced tests which: **a.)** tend to focus on narrow aspects of language such as receptive

vocabulary, rather than broader aspects such as pragmatics or discourse; **b.)** do not include valid, technically adequate, age-appropriate tools to assess all aspects of language for all age levels; and **c.)** many times lack adequate reliability or validity. Norm-referenced intelligence tests may actually reflect factors such as cognition, achievement, ethnicity, and motivational factors. Therefore, conclusions based solely on these norm-referenced tests are likely to be inaccurate. (Differences in communication skills (e.g. dialectical differences or English as a Second Language) do not constitute language disabilities under IDEA.)

- Cognitive referencing is based on the assumption that cognitive skills are prerequisites for language development, and that intelligence measures are a meaningful predictor of whether a child will benefit from language services. Research results in recent years have challenged this assumption. In fact, language may surpass cognition, particularly for individuals with Intellectual Disability (ID). Language intervention has been shown to benefit children whose cognitive levels were commensurate with their language levels, as well as children whose cognitive levels exceeded their language levels.
- Scores across tests having different standardization populations and different theoretical bases cannot validly be compared. It is psychometrically incorrect to compare language test scores with test scores that measure other abilities.
- There are no "pure" measures of either verbal or nonverbal abilities. Children with language difficulties exhibit problems with nonverbal tasks that could affect their IQ scores, thereby leading to a convergence of test scores.
- Cognitive referencing for children with cultural differences will be adversely affected by the linguistic bias, format bias, and content bias prevalent in many formal tests.

Exclusions

A student with a suspected language disorder is not eligible for special education and related services when:

- Language differences are due to:
  - Limited English proficiency
  - Dialectal differences *(Note*: Such students may be eligible for Language-Speech services when a disorder exists in their native language or in their dialectal form of English.)
- Language performance does not interfere with educational, social/behavioral, and/or vocational performance.

Assessment Checklist for Language Disorders

- Review documentation of hearing and vision status.

- Review information from the communication screening to consider the possibility of a disorder in other area(s), for example, speech sound production and use, fluency and voice.
- Gather data regarding the child's communication functioning in the educational/developmental setting. It is suggested that this be initiated prior to the standardized assessment to assist in the selection of appropriate test(s).
- Complete the *Teacher/Parent Interview: Language.*
- Administer relevant standardized/norm-referenced tests, which are both comprehensive and specific to identified areas of weakness. *(Note: When the SLP completes the "Standardized/Norm-Referenced Assessment" section of the suggested Communication Rating Scale: Language, it should be noted that not all standardized measures have a consistent correlation among standard deviations, standard scores, and percentiles. This section should be marked only after the standard score or percentile is compared to the standard deviation using the test manual for the specific test administered.)*
- Collect any additional documentation needed to assess adverse effect of the language disorder on the student's educational, social/behavioral, and/or vocational performance.
- For preschoolers, additional functional settings may be playtime, or activities in the community or at home. Parental input should be elicited to assess the adverse effect on educational (developmental) performance.
- Complete the suggested *Language Assessment Summary*.
- Complete the suggested *Communication Rating Scale: Language* and assign a severity rating. Gather all assessment data and relate it to each of the components on the suggested *Communication Rating Scale; Language.* Circle the appropriate scores within each component area to correspond with the assessment data.
- See *Special Assessment Considerations: Language.*
- Do not include regional or dialectal differences.
- Total the values assigned to each component area, adding comments when appropriate. Assign a corresponding Language Severity Rating of 0 - 3. *(Note: All data from functional and standardized assessments are compiled and used to complete the suggested Communication Rating Scale: Language. This constitutes the Speech-Language Pathologist's recommendation to the IEP Committee regarding whether there is a language disorder and whether there is indication of an adverse effect on education. The IEP Committee makes final determination of eligibility or MET if an initial evaluation.)*
- Complete the suggested *Communication Written Report* and attach the suggested *Language Assessment Summary* and completed suggested *Rating Scale*.

Fluency Assessment

A fluency disorder is a disorder of the flow or smoothness of speech beyond what is considered typical. The disorder may be characterized by abnormalities in the behavioral dimensions of speech production (i.e., rate, rhythm, continuity, and effort used to produce speech). These abnormalities in speech production are often accompanied by affective (emotional) and cognitive symptoms that may have an adverse effect on successful student participation in educational, social/behavioral and/or vocational activities.

Fluency disorders are identified by a process of differential diagnosis. An evaluation of fluency includes, but is not limited to:

- Assessment of observable behavioral components, including, but not limited to, repetitions, prolongations, sustained articulatory posturing, schwa replacement, physical concomitants, rhythm, rate, and physical effort.
- Assessment of any affective (emotional) components that may accompany the disorder, including: fear, anxiety, frustration, embarrassment, guilt, shame and helplessness related to communication.
- Assessment of any cognitive components that may accompany the disorder, including: verbal avoidance, situational avoidance and negative impact on self-confidence and/or self-image. The suggested *Communication Rating Scale: Fluency* encompasses observations of conversational fluency. Students for whom this rating scale is appropriate are those who may have abnormal timing and flow of conversational speech.

The components that must be assessed to determine if a student has a fluency disorder and is eligible for special education and related services, as listed in the suggested *Communication Rating Scale: Fluency* are:

- Frequency of dysfluencies;
- Type(s) of dysfluencies;
- Phonatory arrest or sustained articulatory posture;
- Speech sound prolongations;
- Schwa replacement for intended vowel;
- Physical concomitants (secondary characteristics/struggle behaviors);
- Awareness and emotional reaction to dysfluencies;
- Avoidance behaviors and peer reactions to dysfluencies;
- Adverse effect of the fluency disorder on educational, social/behavioral, and/or vocational performance.

Special Assessment Considerations: Fluency

Because fluency disorders are multidimensional in nature, more than just speech sampling and analysis must be used to diagnose a fluency disorder. A variety of assessment tools and strategies must be used to determine the presence or absence of behavioral, affective and cognitive symptoms. A fluency evaluation must include observations of the student in communicative situations in which communicative stress is varied. Efforts must be made to determine whether behavioral, affective, or cognitive symptoms have an adverse effect on educational, social/behavioral, and/or vocational performance. Behavioral components of the disorder may include presence of the following observable behaviors:

- Repetition of linguistic elements (listed from least to most disabling).
    - Whole multisyllabic word repetitions (e.g., "I want, I want to play.").
    - Whole monosyllabic word repetitions (e.g., "I can, can sing.").
    - Part-word syllable repetitions (e.g., "I eat spa-spaghetti.").
    - Part-word speech sound repetitions (e.g., "I can k-k-k-kick the ball.").
- Prolongation of speech sounds.
- Sustained articulatory posturing (i.e., position of the articulators may be correct for production of the speech sound, but posture is held for an abnormal length of time).
- Blockages or abnormal restriction of air or voicing, including phonatory arrest.
- Silent pauses.
- Broken words (e.g., "It was won *(pause)* derful.").
- Substitution of the schwa vowel for the intended vowel.
- Interjections.
- Pitch rise (typically present toward the end of a prolongation or linguistic sequence).
- Physical concomitants/struggle behaviors accompanying moments of stuttering (e.g., facial grimaces or tremors; leg, arm, or body movements; poor eye contact or eye blinking; production of extraneous distracting sounds such as sniffing or clicking sounds).
- Abnormal rhythm, continuity, physical effort, or rate of speech.
- Difficulty initiating, maintaining or terminating vocalizations or verbalizations.

Affective components include communicative stress and negative emotional reactions that may accompany the disorder, for example:

- Fear
- Anxiety
- Frustration

- Embarrassment
- Guilt
- Shame
- Helplessness

Cognitive components that may accompany the disorder may include

- Verbal avoidance (e.g., word substitutions, revisions, starters, postponements, circumlocution);
- Situational avoidance (e.g., avoidance of feared situations such as answering aloud in class, making class presentations, participating in class or group discussions);
- Negative impact on self-confidence, and/or self-image that negatively affects academic performance or participation in vocational development or social activities.

Exclusions

Based on an IEP Committee (MET if it is an initial eligibility determination) decision, a student with a suspected disorder of fluency may not be eligible for special education and related services when:

- Severity rating values fall within the normal range (non-disabling = 0);
- Fluency difference is related to normal development;
- Dysfluencies do not interfere with educational, social/behavioral, and/or vocational performance.

Assessment Checklist for Fluency Disorders

- Review documentation of hearing and vision status.
- Review information from the communication screening to consider the possibility of a disorder in other area(s), for example, articulation, language and voice.
- Collect and assess samples of communicative behavior in structured and unstructured communicative situations.
- Conduct behavior observations and/or other informal measures to validate the presence or absence of behavioral, emotional and/or cognitive symptoms of a fluency disorder, and to assess adverse effect.
- For preschoolers, additional functional settings may be playtime, or activities in the community or at home. Parental input should be elicited to assess the adverse effect on educational (developmental) performance.
- Complete the *Teacher/Parent Interview: Fluency*.
- Complete the suggested *Fluency Assessment Summary*.
- Complete the suggested *Communication Rating Scale: Fluency* and assign a severity rating.

- Gather all assessment data and relate it to each of the components on the suggested *Communication Rating Scale: Fluency.* Circle the appropriate scores within each component area to correspond with the assessment data.
- See *Special Assessment Considerations: Fluency.*
- Total the values assigned to each component area, adding comments when appropriate.
- Assign a corresponding Fluency Rating of 0 - 3. (Note: All data from functional assessments is compiled and used to complete the suggested *Communication Rating Scale: Fluency.* This constitutes the Speech-Language Pathologist's recommendation to the IEP Committee regarding whether there is a fluency disorder and whether there is indication of an adverse effect on education. The IEP Committee makes final determination of eligibility or MET, if it is an initial eligibility determination.)
- Complete the suggested *Communication Written Report* and attach the suggested *Fluency Assessment Summary* and completed suggested *Rating Scale*.

Voice Assessment

A voice disorder is characterized by the abnormal production and/or absence of vocal quality, pitch, loudness, resonance, and/or duration, which is inappropriate for an individual's age, sex and/or culture. A comprehensive voice evaluation includes an analysis of the student's respiration, phonation and resonance as well as data collected from observation, interview and/or case history regarding the student's vocal quality and appropriate use of voice throughout the day. The evaluation must also include a physical examination of the oral structure and a medical exam conducted by an appropriate medical professional (e.g., otolaryngologist). The suggested *Communication Rating Scale: Voice* outlines the primary variables of voice production measured during an assessment for voice disorder. Students for whom this rating scale is appropriate are those who may have vocal nodules, vocal fold thickening or other conditions of the laryngeal mechanism which cause noticeable differences in pitch, quality, loudness and resonance. The components that must be assessed to determine if a student has a voice disorder and is eligible for special education and related services, as listed on the suggested *Communication Rating Scale: Voice* are:

- Pitch;
- Loudness;
- Quality;
- Resonance;
- Vocal abuse/misuse;
- Physical condition/medical findings (including documentation of an oral peripheral examination);

- Adverse effect of the voice disorder on educational, social/behavioral, and/or vocational performance.

The medical examination may include evaluation of the vocal folds through indirect laryngoscopy, videoendoscopy and/or videostroboscopy. The voice evaluation shall include an oral peripheral exam, documentation that a **ten (10)** calendar day interval between measures was observed (measure may be the same, but must be approximately **ten (10)** days apart), formal/informal measures including observation during or prior to the assessment process and documentation of a physical exam/voice evaluation conducted by the appropriate medical specialist.

Special Assessment Considerations: Voice

When Language-Speech screening reveals vocal characteristics that are atypical for a student's age, gender and/or cultural background, the MET should convene to discuss comprehensive evaluation and referral to an appropriate medical specialist (e.g., otolaryngologist). A voice evaluation should include observations of the student's voice in a variety of communicative situations. The evaluation should also consider environmental and health factors which may contribute to the voice problem. The purpose of the medical referral is to evaluate the general status of the laryngeal mechanism. The results of the medical report should be used by the MET to determine whether voice therapy is an appropriate treatment. Some phonatory disorders do not respond to voice therapy, while other laryngeal conditions such as papilloma or carcinoma have serious contraindications to voice therapy. For these reasons, the SLP must not enroll a student in voice therapy unless current medical information is available. Voice disorders among school-age children are usually related to physical changes of the vocal folds, (e.g., vocal nodules); however, problems with vocal cord approximation can also cause dysphonia (hoarseness, breathiness, harshness, huskiness, stridency, etc.). Listed below are common terms used in the diagnosis of laryngeal pathology:

- **Vocal cord thickening**: An actual tissue change that typically results from prolonged abuse/misuse of the voice or chronic infection of the vocal folds. This condition is common among school-aged children. Voice therapy specifically directed toward reducing abuse/misuse of voice production is often considered the best treatment for reducing vocal cord thickening.
- **Vocal Nodule**: A benign, callous-like nodule that typically occurs on the anterior glottal margin of the vocal fold. Vocal nodules are one of the most common disorders of the larynx and are primarily caused by prolonged hyperfunctional use of the vocal mechanism. Treatment often encompasses voice therapy, surgical removal of the nodule(s) or a combination of surgery followed by voice therapy.

- **Vocal Polyp**: A bulging enlargement that typically occurs in the same junction of the vocal fold as nodules. Vocal polyps are more likely to be unilateral than bilateral and typically develop as a result of prolonged vocal abuse. While polyps respond to voice therapy, surgical removal with follow-up vocal rest and voice therapy is often required.
- **Papilloma**: A wart-like benign tumor of the larynx that frequently occurs among young children. Small papillomas often vanish without therapeutic or surgical intervention; however, large papillomas may require surgical removal and/or close monitoring by a laryngologist. Students with papillomas are NOT candidates for voice therapy.
- **Contact Ulcer**: A benign ulceration of the vocal folds that is often caused by tissue irritation resulting from esophageal reflux and/or vocal abuse. Contact ulcers are rarely seen in children. Vocal rehabilitation is often the preferred treatment for contact ulcers, although large ulcerations may require surgery with follow-up voice therapy.
- **Leukoplakia**: A benign growth of whitish patches on the vocal folds, caused by chronic irritation (i.e., smoking) that causes vocal hoarseness and chronic cough. Typically, leukoplakia is treated by removing the cause of the irritation (e.g. quit smoking). This condition is not responsive to voice therapy.
- **Hyperkeratosis**: A benign mass of accumulated tissue, which may grow on the inner glottal margins of the vocal folds, causing hoarseness. This condition is not responsive to voice therapy, but should be closely monitored by a laryngologist because it occasionally develops into a malignancy.
- **Granulomas or Hemangiomas**: Tissue lesions that are related to glottal trauma (e.g. intralaryngeal intubation during surgery) and result in a hoarse vocal quality. Temporary vocal rest often reduces the lesion and formal voice therapy is typically not required.
- **Vocal cord paralysis**: Lesions of the neural or muscular mechanism resulting in the inability of one or both cords to move. In adductor paralysis, the vocal fold(s) cannot move to the central position, while abductor paralysis causes an inability of the vocal fold(s) to move laterally.
- **Unilateral adductor paralysis**: Results in a breathy, hoarse vocal quality with poor intensity and range of pitch. Voice therapy may be somewhat helpful in achieving a stronger voice. Medical management, such as Teflon injection, is often recommended as well.
- **Bilateral adductor paralysis**: Results in almost aphonic speech, and voice therapy is seldom effective. Medical management, such as surgical repositioning of the vocal folds is sometimes helpful.

- **Unilateral abductor paralysis**: Seldom causes a significant speaking problem, but often results in shortness of breath due to the decreased size of the glottal opening.
- **Bilateral abductor paralysis**: Requires immediate surgical intervention (e.g., tracheotomy) followed by surgical repositioning of the vocal folds. Voice therapy may be prescribed to help the student learn to use the reconstructed phonatory mechanism.
- **Laryngeal web (synechia)**: A membranous tissue (webbing) that grows between the proximal vocal folds. Webbing may be congenital, but is typically the result of severe laryngeal infections or laryngeal trauma. Laryngeal webbing may cause shortness of breath and dysphonia. Laryngeal webs are typically treated with surgical intervention followed by vocal rest.

Exclusions

Based on an MET decision/IEP Committee, a student with a suspected voice disorder may not be eligible for special education and related services when:

- Severity rating values fall within the normal range (non-disabling = 0).
- Vocal characteristics are the results of temporary physical factors, such as: allergies, colds, abnormal tonsils or adenoids, or transient vocal abuse/misuse.
- Prepubertal laryngeal changes in male students
- Regional or dialectical differences
- Disorder does not interfere with the educational, social/behavioral, and/or vocational performance of the student. (*Note: The SLP should discuss any potential vocal harm with the student's parents and teachers to prevent acute or transient vocal patterns (e.g., transient abuse or allergy effects) from developing into chronic vocal problems.)*

Assessment Checklist for Voice

- Review documentation of hearing and vision status.
- Review information from the communication screening to consider the possibility of a disorder in other area(s), for example, speech sound production and use, language and fluency.
- Examine oral/motor structures and function (inclusive of an oral-peripheral examination).
- Complete *Teacher/Parent Interview: Voice*.
- Collect and record appropriate samples of the student's voice, including samples of connected speech and sustained vowel phonations. Collect information regarding the student's vocal habits and the onset, duration and variability of the suspected voice disorder. Analyze the student's

vocal characteristics according to the components on the suggested *Voice Assessment Summary*.

- Secure medical findings from an appropriate physician for additional assessment of the structure and function of the laryngeal and/or velopharyngeal mechanism(s). Without this information, eligibility for voice therapy cannot be determined and therapy should not be initiated.
- Conduct behavior observations and/or other informal measures to validate assessment data related to the observed vocal characteristics and to assess adverse effect. For preschoolers, additional functional settings may be playtime, or activities in the community or at home. Parental input should be elicited to assess the adverse effect on educational (developmental) performance.
- Complete the suggested *Voice Assessment Summary*.
- Complete the suggested *Communication Rating Scale: Voice* and assign a severity rating. Gather all assessment data and relate it to each of the components on the suggested *Communication Rating Scale: Voice*. Circle the appropriate scores within each component area to correspond with the assessment data.
- See *Special Assessment Considerations: Voice.*
- Do not include regional or dialectal differences.
- Total the values assigned to each component area, adding comments when appropriate. Assign a corresponding Voice Severity Rating of 0 - 3. *(Note: All data from functional and medical evaluations are compiled and used to complete the suggested Communication Rating Scale: Voice. This constitutes the Speech-Language Pathologist's recommendation to the IEP Committee/MET regarding whether there is a voice disorder and whether there is indication of an adverse effect on education. The IEP Committee /MET makes final determination of eligibility.)*
- Complete the suggested *Communication Written Report* and attach the suggested *Voice Assessment Summary* and completed suggested *Rating Scale*.

Additional Evaluation Considerations

The *Communication Written Report* and the *Language-Speech Impairment Eligibility Determination Form* are additional forms available for use in supporting eligibility decisions.

Autism (AU)

As a part of a comprehensive assessment for a child suspected of having Autism, the Language-Speech evaluation shall be completed by a *licensed* SLP. Receptive and expressive language skills, including language semantics and pragmatics; prosody (linguistics including intonation, rhythm and focus in speech); and the need for assisted communication must be assessed. The SLP

shall be a part of the TST and MET teams when making the determination to assess and/or determine eligibility.

In addition to the components for a language evaluation, complete the *Prosody Checklist.*

Developmentally Delayed (DD)

As a part of a comprehensive assessment for a child suspected of having a developmental delay, the SLP should determine if further language assessment is warranted based on the Language-Speech screening, observation(s) and or a review of the data. If further evaluation is warranted, the assessment shall be comprehensive in nature to include all components of aforementioned guidelines as outlined under speech sound production and language. The SLP shall be a part of the TST and MET when making the determination to assess and/or determine eligibility.

Specific Learning Disabilities (SLD)

As a part of a comprehensive assessment for a child suspected of having a specific learning disability, the Language-Speech evaluation should determine if further language assessment is warranted based on the Language-Speech screening, observation(s) and/or a review of the data and conduct such comprehensive assessment as warranted. The SLP shall be a part of the TST and MET when making the eligibility determination.

Other Health Impaired (OHI)

Children with complex medical needs may need a consult with the SLP. The MET and/or IEP Committee shall determine whether a child needs an SLP consultation in the area of swallowing when a complex medical condition does exist. Dysphagia is not a language-speech issue that is addressed through the school setting.

Augmentative Communication

An augmentative communication evaluation shall always be considered and documented as a part of a comprehensive language-speech assessment for students with minimum to limited functional communication skills.

Eligibility Determination

One of the most critical elements to be obtained from a student's evaluation information is the documentation of whether the student's disability adversely affects him/her within the educational, social/behavioral, and/or vocational setting. Specifically, adverse impact is the extent to which a student's disability affects the student's progress and involvement in the general curriculum as provided or, in the case of preschool students, how the disability affects the child's participation in appropriate developmental activities. Adverse impact is evident when a student's disability negatively impacts the student's:

- Involvement and advancement in the general education program (educational impact);
- Education and participation with other students with or without disabilities (social impact);
- Participation in extracurricular and other non-academic activities (vocational impact).

Documentation of adverse impact is a critical element in the determination of eligibility for the provision of language-speech services when language-speech impairment is the primary disability.

Multidisciplinary Evaluation Team (MET) Eligibility Determination

Within **fourteen (14) calendar days**, upon completion of an evaluation, the MET team shall hold an eligibility determination meeting to determine whether or not the child is eligible for one of the eligibility categories as defined by MDE, including:

1. Autism (AU)
2. Deaf-Blind (DB)
3. Developmentally Delayed (DD)
4. Emotional Disability (EmD)

5. Hearing Impairment (HI)
6. Language or Speech Impairment (L/S)
7. Intellectually Disabilities (ID)
8. Multiple Disabilities (MD)
9. Orthopedic Impairment (OI)
10. Other Health Impairment (OHI)
11. Specific Learning Disability (SLD)
12. Traumatic Brain Injury (TBI)
13. Visually Impaired (VI)

Members of the MET should include:

1. Parent and/or student
2. General education representative (usually the child's teacher)
3. Special education teacher
4. Agency representative
5. Speech-Language Pathologist
6. Any other pertinent member to the child's educational needs

All members of the MET do not have to agree to the eligibility determination. If a member disagrees with eligibility, then that member should make a separate written statement presenting the member's conclusions.

The parent **MUST** agree to the eligibility determination and give consent for placement in Special Education for the student to be eligible to receive special education services.

Once the MET has made an eligibility determination, the Individualized Education Program (IEP) shall be developed by the IEP team within **thirty (30) calendar days** of the eligibility determination.

The information gained through the assessment process may be used by the MET to determine:

- Eligibility for Language-Speech Services as a Primary Disability
- The Need for Language-Speech Therapy as a Related Service
- Continued Eligibility for Language-Speech Services

It also provides significant information for the MET and IEP Committee in identifying a student's instructional needs to be addressed in the IEP.

Eligibility for Language-Speech Service as a Primary Disability

Assessment data must provide information for two purposes: to determine whether a communication disorder or condition is present and determine whether the disorder or condition has an adverse effect on educational, social/behavioral, and/or vocational performance. *"Speech or language impairment" means a communication disorder, including stuttering, impaired articulation, language impairment, voice impairment, delayed acquisition of language, or an absence of language, that adversely affects a child's educational, social/behavioral, and/or vocational performance.* Assessment data must be comprehensive in order to provide information regarding a student's functioning across several parameters. Therefore, a variety of formal and functional evaluation measures may be needed to provide the MET with sufficient information for an eligibility determination as well as program planning. Formal assessment (standardized testing) provides quantifiable data regarding the existence of Language-Speech impairment while functional assessments (e.g. observations, teacher and/or parent interviews) further verify the results of the formal assessment. Functional assessments also provide information regarding the student's ability to participate and progress in the general curriculum. *Assessment tools and strategies shall be used that provide relevant information that directly assist and are used in the determination of the educational needs of the child. As part of an initial evaluation, if appropriate, or as part of any reevaluation, the MET or IEP Committee and other qualified professionals, if necessary, shall review existing evaluation data on the child including **a**) evaluations and information provided by the parents; **b**) current classroom-based assessments and observations; and **c**) observations by teachers and related services providers.*

Using this evaluation information, the MET then must determine if the findings verify that there is an "adverse effect on educational, social/behavioral, and/or vocational performance" that requires specially designed instruction (SDI).This manual assists in documenting the degree and nature of the student's communication disorder and the extent to which it impedes the student's ability to participate and make progress in the general curriculum. After completing the assessment process in each area of suspected communication disability, the scoring process gives SLPs a systematic format for presenting assessment information to the MET. The MET will then make a determination of eligibility as a student with Language-Speech impairment. *Specially designed instruction means adapting as appropriate, content, methodology, or delivery of instruction to address the unique needs of the child with a disability and to ensure access of the child to the general curriculum. Adverse effect means that the progress of the child is impeded by the disability to the extent that the educational, social, and/or vocational performance is significantly and consistently below the level of similar-aged peers.*

The Need for Language-Speech Therapy as a Related Service

Related services are services required to "*assist a child with a disability*" to benefit from special education. This assumes the child has already been determined to be eligible for special education services in one of the other categorical or non-categorical areas. Therefore, the evaluation process for the provision of language-speech therapy as a related service does **not** require determination of eligibility using the suggested *Communication Rating Scales*. It is important to note that although completion of the suggested rating scale(s) is not required when considering the need for language-speech services as a related service, it will provide valuable information for IEP development and program planning. Related services means transportation and such developmental, corrective, or supportive services as are required to assist a child with a disability to benefit from special education. *It includes speech-language pathology and audiology services, psychological services, physical and occupational therapy, recreation including therapeutic recreation, early identification and assessment of disabilities in students, counseling services including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. Related services also means school health services, social work services in school, and parent counseling and training.*

For students who are already deemed eligible to receive special education services under another area of disability (e.g., specific learning disability), the IEP Committee must determine if other services (e.g., language-speech therapy as a related service) are necessary to assist the child with a disability to benefit from special education. The MET, as part of the original evaluation process, should have identified areas of concern related to communication skills requiring further assessment. These areas of concern should be described under the Present Level of Academic Achievement and Functional Performance (PLAAFP) in the student's IEP. To verify the nature and extent of problems related to speech or language, the IEP Committee must use data from formal and functional assessments of communication skills. The IEP Committee will use this evaluation information to determine the type and amount of language-speech service needed in order to appropriately implement the student's IEP. For instance, if a child has been determined to have a mild intellectual disability, and the evaluation information also identifies problems in the area of speech sound production or use, then the IEP Committee must have sufficient information to determine if the speech sound production or use problems are severe enough to prevent the child from benefiting from the other aspects of their special education program. If so, the IEP Committee must determine the nature and extent of the related language-speech services to be provided to support successful implementation of the IEP.

Reevaluation

Continued Eligibility for Language-Speech Service

Mississippi State Board Policy 7219 34 C.F.R. **§ 300.305,** if for purposes of reevaluation, the IEP Committee determines that no additional data are needed to determine whether or not the child continues to be a child with a disability, the LEA shall notify the child's parents a) of that determination and reasons for it; and b) the right of the parents to request an assessment to determine whether, for purposes of services, the child continues to be a child with a disability. The IEP Committee must reconvene annually to review student progress and Present Level of Academic Achievement and Functional Performance information. During the annual review, the IEP Committee will determine whether a student needs continued provision of language-speech services and, if appropriate, will revise the Individual Education Program. Every three years the IEP Committee must redetermine eligibility by assessing whether the student still has a disability that requires the continued provision of language-speech services either as a primary disability or as a related service. This means there still needs to be documentation of adverse effect on educational, social/behavioral, and/or vocational performance, if the student's language-speech impairment is the primary disability. If the student is receiving language-speech as a related service, the IEP Committee must document continued need for this service.

Procedures for reevaluation should include:

1. A review of the current IEP and progress made towards annual goals.
2. Review of current data to determine adverse educational impact.
3. Administration of formal assessments/evaluations when appropriate (Parental consent required). Administration of informal assessments, including curriculum-based assessments (parental consent not required). Interviews with teachers, parents, and therapists.
4. Observations across settings.
5. A review of the initial evaluation or last reevaluation report.
6. A review of the student's current academic status, including but not limited to absences, report cards, progress reports, discipline reports, etc.
7. A review of the eligibility criteria of disabilities.
8. Hearing and vision screening information when appropriate.

Reevaluation does not necessitate the administration of formal testing. A reevaluation can be completed based on current IEP data. The IEP team determines whether or not formal testing procedures are warranted.

If testing is warranted, the parent **MUST** receive Written Prior Notice (WPN) and **Procedural Safeguards** and parental consent **MUST** be obtained in writing for further evaluation. Once parental permission for testing is obtained, the

reevaluation must be completed in a timely manner. If the IEP Committee determines that a change in services is needed (dismissal or other change), the IEP must be revised to reflect the change.

- A Change of Placement form must be given if the student's placement in special education changes.

If the IEP Committee suspects the child no longer has a disability, refer to the dismissal procedures and complete the reevaluation dismissal.

Continued Eligibility When Language-Speech Impairment is the Primary Disability

At least every three (3) years, the IEP Committee must review current performance data and, if necessary, update the student's evaluation information to determine whether the student continues to meet eligibility guidelines for speech or language impairment. The IEP Committee may determine through a review of existing performance data (e.g., progress data on IEP goals and objectives) that the student continues to have a language-speech impairment that causes an adverse effect on educational, social/behavioral, and/or vocational performance and that no additional formal or informal assessment is required. If, however, the data is unclear or insufficient to make an eligibility determination, the MET will need to conduct a more comprehensive assessment to determine if the student still has language-speech impairment and is in need of continued services.

Continued Need for Language-Speech Therapy as a Related Service

The IEP Committee may review reevaluation data and determine that a student continues to have a disability in another categorical area (e.g., Intellectual Disability, Specific Learning Disability) or non-categorical area (e.g., Developmental Delay). The IEP Committee must review existing evaluation data to determine the need for the continued provision of any related services, such as Language-Speech therapy. If this decision cannot be made because existing data is insufficient or inconclusive, additional data from formal and/or functional assessments (e.g., specially designed tasks) must be collected. It is important to note that if the student's parent(s) request a formal assessment, the MET will comply. *The Local Education Agency (LEA) shall not be required to conduct a reevaluation, if after review of the existing data, the IEP Committee determines no reevaluation is necessary to determine whether the child continues to be a child with a disability, unless the parent requests the reevaluation. A LEA shall ensure a reevaluation, which may consist of the review described above and is conducted at least every three (3) years to determine: a) the present levels of performance and educational needs of the child; b) whether the child continues to need special education and related services; and c) whether any additions or modifications to the special education and related services are needed to enable*

the child to meet the measurable annual goals set out in the IEP and to participate, as appropriate, in the general education curriculum.

CHAPTER III

Individualized Education Program Development & Implementation

Mississippi State Board Policy 7219 **§§ 300.320-300.324** describes what the IEP is and who is responsible for the development and implementation of the "written statement for which each child with a disability is developed". It is at the IEP Committee/MET meeting where eligibility is determined and the IEP is developed. IEPs for all students must include a statement of measurable annual goals including academic and functional goals. Benchmarks or short-term instructional objectives must be included in the IEP for a student with significant cognitive disabilities. **(P.L. 108-446, Section 614 (d))**

Statements developed should address these areas/components:

- How the student's disability affects involvement and progress in the general curriculum.
- Detailed description of the student's current performance in reading and math.
- Results of the initial or most recent evaluation of the student.
- Strengths of the student.
- Concerns of the parent/guardian for enhancing the education of the student.
- Description of the student's social, behavioral, and/or emotional skills.

*For preschool children, how the child's disability affects participation in appropriate developmental activities.

The ***Present Level of Academic Achievement and Functional Performance (PLAAFP)*** provides the informational basis for generating goals, objectives, supports, accommodations and services that are specifically designed to meet the student's *individual* needs. This area must describe what the student does (strengths) and does not do (weaknesses) in objective measurable terms. When appropriate, the present levels must reference the student's performance on district-level benchmarks and progress from the previous IEP. The PLAAFP should establish the foundation on which the rest of the IEP is developed, identify the impact of the disability on participation in the general education curriculum, and align the student's information with the content standards and benchmarks, annual goals, supplementary aids/services/supports and secondary transition services.

Measurability

The IEP must list measurable annual goals consistent with the student's needs and abilities as identified in the Present Level of Academic Achievement and Functional Performance. They are the statements that identify what knowledge skills and/or behaviors a student is expected to be able to demonstrate during the school year the IEP will be in effect. They are directly related to the student's PLAAFP.

The goals on a student's IEP should relate to the student's need for specially designed instruction (SDI) to address the student's area of deficit(s) and how the deficit(s) interferes with the student's ability to participate and make progress in the general curriculum. In developing the IEP goals and objectives, the IEP Committee/MET needs to select goals and objectives to answer the question: *"What does the student require to master the content of the curriculum (skill set)?"* rather than *"What curriculum does the student need to master?"* This must be written in observable and measurable terms, identifying objective procedures to evaluate progress and track the achievement of post-secondary goals. The objective is to assist the student in accessing and making progress in the general curriculum while providing the skill set needed to be successful toward desired outcomes. This measurable goal will also yield the same result if measured or as measured by several individuals, allowing for a calculation of how much progress it represents and can be understood without additional information. The following elements should be included in measurable goals: behavior, conditions and criterion. It should also include the following: *1) the student (who), 2) will do what (behavior), 3) to what level or degree (criterion); and 4) under what conditions or timeframe (conditions).* The behavior reflects the actions the student must do or exhibit, criterion-referencing explicitly how well the student will be expected to perform and the conditions describing the circumstances or the assistance that will be given while the student performs the behavior. While benchmarks must clearly communicate the expected progress or level of skill or behavior the student will reach for specified segments of the year or portions of the year, goals can be organized by essential components of instruction. For reading, it may include phonemic awareness, phonics, vocabulary development, reading fluency and reading comprehension. The goals may also be organized by a more general intended outcome as well.

The general rule of thumb in reviewing the IEP goals are: **SMART- S**- are they specific; **M**- are they measurable (who, behavior, criterion, condition); **A**- are they achievable; **R**- are they results-oriented (standards related); **T**- are they time-bound and lastly are they connected to (derived from) the PLAAFP?

Language/Communication needs must be addressed in the Consideration of Special Factors section of the IEP. Also consideration of Supplementary Aids

and Services must be reviewed as well. What device or provision of help or activity does the student need to have to complete their education by making up a deficit to enhance the student's ability to access and make progress in the general education curriculum? Key questions to consider are: *1) What aids and services are needed to enable the student to succeed? 2) What specific aspects of the child's education cannot be implemented in the general education setting? Why not? and 3) What supports are needed to assist the teacher in implementing the child's IEP (accommodations/modifications)?*

Assistive Technology

All eligible students receiving SDI through an IEP must be considered for assistive technology. While parameters of "consideration" are not specifically defined in the law, it is considered best practice to address this issue through the incorporation of an IEP Committee/MET member with knowledge or experience in the field of assistive technology. Specific assistive technology used to enhance a student's natural communication falls within the category of augmentative communication. Consideration of the need for augmentative communication devices or services is the responsibility of an SLP trained or experienced in this specialized field. For students with significant communication disorders, augmentative communication may be the primary mode of communication. Assessment of the student's communication abilities requires the inclusion of this communication modality in the assessment process. In order to effectively assess a student's abilities, adaptation of testing materials may be needed to allow the student to respond through non-standardized methods such as eye gaze, gesture or manual sign, symbol or text-based communication, or a speech generating device, etc.

When making the decision regarding the student's services, the focus is to provide a FAPE for the student including the beginning of implementation of aids and services, duration and the frequency of services provided by school personnel. Least Restrictive Environment (LRE) is also the consideration in the provision of services. Learning takes place across all educational settings; therefore, in considering settings and the objective in mind, the goals are to assist the student in accessing and making progress in the general education curriculum, not in a solo, one-on-one setting, and to provide training to other personnel on strategies related to the deficit the student is experiencing in communication (language-speech) and to provide ways to aid the student in making the appropriate adjustments to assist them in accessing and making progress in the general education curriculum. The educator's acceptance and support of the student is important to facilitate communication and manage the language-speech disorder. For example, if an oral presentation is required, the educator should discuss alternatives in advance with the student when applicable.

Service Delivery Options

Keep in mind that all IEPs should be different and relevant to the student with whom you are working. All students may not require 30 minutes twice a week for a year. The place of service should be contingent on where the student is, what the goals and objectives are for the student, how the goals and objectives will assist the student in accessing and making progress in the general education curriculum and the *Least Restrictive Environment (LRE).* An alternative delivery model guided by the SLP in inclusive settings could be helpful for addressing deficits in students whose language-speech difficulties have no adverse impact on their educational, social/behavioral, and/or vocational performance. *Training is imperative not only for SLPs, but for general educators, special educators and administrators, not to exclude parents.* SLPs can design and train appropriate stakeholders in strategies for intervention and for improving language-speech skills. Most helpful to student engagement and progress is a paradigm shift from a "caseload" approach to a "workload" approach, focusing not just on the number of students served, but also what each student needs in order to be successful in accessing and making progress in the general education curriculum. As particular skills are acquired, changes may be necessary in location, type, frequency and/or duration of therapy. Additional information may be found in Special Topics: Service Delivery Options and Response to Intervention.

CHAPTER IV

Dismissal

Criteria for Dismissal

When determining whether or not a student is a candidate for release or dismissal from language-speech services, the IEP Committee must determine if the student is no longer in need of specially designed instruction and related services. While current and comprehensive evaluation and performance data need to be available for review by the IEP Committee to make this decision, this does not mean that a full and formal evaluation is always needed. Current data must be sufficient to determine whether the student no longer has a language-speech disability that causes an adverse effect on his/her educational, social/behavioral, and/or vocational performance or his/her ability to benefit from special education. The IEP Committee may decide that current performance or assessment data and IEP progress data provide enough information to make that decision. If this information does not clearly indicate that there is no longer an adverse effect on educational, social/behavioral, and/or vocational performance or the need for language-speech services as a related service, a more extensive and formal evaluation may be needed to make a conclusive decision. It is important to note that the IEP Committee must accommodate any parental requests for additional assessment prior to determining that a student no longer has a language-speech disability or no longer requires language-speech therapy as a related service. A reevaluation is not required if the student is graduating with a standard high school diploma or if the student has exceeded the age limit for FAPE (20) under State law.

Students should be dismissed from language-speech therapy when one of the following criteria is met:

- they no longer have a disability; and/or
- they no longer require language-speech services due to their disability.

Procedures should include:

1. A review of the IEP
2. Review of current data to determine adverse educational impact
3. Administration of assessments/evaluations when appropriate
4. Interviews with teachers, parents, and therapists
5. Observations across settings

If testing is warranted, the parent **MUST** receive WPN and Procedural Safeguards and parental consent **MUST** be obtained in writing for further evaluation. If the IEP Committee determines that a change in services is needed (dismissal or other change), the IEP must be revised to reflect the change. If the IEP Committee suspects the child no longer has a disability, reevaluation procedures should be followed.

The IEP Committee determines that language-speech services are no longer warranted due to:

A) The student no longer meets the eligibility criteria for language-speech services.
   - The student has mastered IEP goals/objectives.
   - The student's language-speech skills are within the normal range.

B) The student's progress has plateaued or has shown a lack of progress, and the student no longer benefits from language-speech services.
   - Documentation of lack of progress should be shown on the IEP's report of progress.
   - A summary of the data that supports the student's lack of progress should be included in the reevaluation for dismissal, and shall include all of the components of a comprehensive evaluation (parent input, general education teacher, academic performance levels, etc.).
   - Students demonstrate lack of progress due to:
     1) Limited physical, mental, or emotional ability to self-monitor communication
     2) Poor attendance
     3) Lack of motivation
     4) Limited potential for a significant change in communication skills.

C) The student's communication no longer has an adverse educational impact on educational, social/behavioral or vocational performance.

D) The student no longer requires language-speech services due to their disability.
   - Skills are being monitored and maintained in the student's environment.
   - Skills are being addressed by others in the student's environment (i.e., special education teacher, general education teacher, etc.).

➢ Refer to **Appendix V** for a **Dismissal Form Checklist.**

CHAPTER V

Special Topics in Speech-Language Pathology

English Language Learners Assessment

By: Evelyn Kyler

As the population of Mississippi school students becomes more diverse, Speech-Language Pathologists (SLP) will increasingly face the challenge of accurately identifying bilingual children with communication disorders. According to Pena & Bedore (2011), in a study conducted by American Speech-Language-Hearing Association (ASHA), approximately 8% of school clinicians reported having received training in bilingual assessments and only 5% of SLPs report they use a language other than English (ASHA, n.d.a.).

It is the position of ASHA that Speech-Language Pathologists who possess the required knowledge and skills to provide English as a Second Language (ESL) instruction in school settings may provide direct ESL instruction. ESL instruction may require specialized academic preparation, and competencies in areas such as second language acquisition theory, comparative linguistics, and ESL methodologies, assessment, and practicum. Such specialized education may not be included in the education required for an SLP. There are SLPs, however, who as a result of their coursework and experience in those designated areas will meet the requirements for ESL instruction in a given jurisdiction. Because of variability in the requirements for ESL instruction, SLPs will have to examine their education and experience relative to each individual jurisdiction's requirements to determine their eligibility as an ESL instructor.

SLPs that do not possess the requisite skills should not provide direct instruction in ESL, but should collaborate with ESL instructors in providing pre-assessment, assessment, and/or intervention with English as second language speakers in school settings.

A. Code of Ethics

The Code of Ethics from ASHA and MDE require the provision of competent services to all populations and recognition of the cultural/linguistic or life experiences of both professionals and those they serve. Everyone has a culture. Therefore, cultural competence is as important to successful provision of services as are scientific, technical, and clinical knowledge and skills. Caution

must be taken not to attribute stereotypical characteristics to individuals. Rather, an attempt should be made to gain a better understanding of one's own culture, as well as the culture of those one serves. All professionals must continually improve their level of competence for providing services to all populations. Members and certificate holders should explore resources available from ASHA and other sources.

B. Definitions

1. **Speech-Language Pathologists or Audiologists** who present themselves as bilingual for the purposes of providing clinical services must be able to speak their primary language and to speak (or sign) at least one other language with native or near-native proficiency in lexicon (vocabulary), semantics (meaning), phonology (pronunciation), morphology/syntax (grammar), and pragmatics (uses) during clinical management.

   To provide bilingual assessment and remediation services in the client's language, the bilingual Speech-Language Pathologist or Audiologist should possess:

   a) ability to describe the process of normal speech and language acquisition for both bilingual and monolingual individuals and how those processes are manifested in oral (or manually coded) and written language;
   b) ability to administer and interpret formal and informal assessment procedures to distinguish between communication differences and communication disorders in oral (or manually coded) and written language;
   c) ability to apply intervention strategies for treatment of communication disorders in the client's language; and
   d) ability to recognize cultural factors which affect the delivery of speech-language pathology and audiology services to the client's language community.

2. **Communication disorder** is impairment in the ability to receive, send, process, and comprehend concepts or verbal, nonverbal and graphic symbol systems. A communication disorder may be evident in the processes of hearing, language, and/or speech. A communication disorder may range in severity from mild to profound. It may be developmental or acquired. Individuals may demonstrate one or any combination of communication disorders. A communication disorder may result in a primary disability or it may be secondary to other disabilities.

3. **Communication Difference/Dialect** is a variation of a symbol system used by a group of individuals that reflects and is determined by shared regional, social, or cultural/ethnic factors. A regional, social, or cultural/ethnic variation of a symbol system should not be considered a disorder of speech or language.

C. *Knowledge and Skills*

1. Introduction

The ethnic, cultural, and linguistic makeup of this country has been changing steadily over the past few decades. Cultural diversity can result from many factors and influences including ethnicity, religious beliefs, sexual orientation, socioeconomic levels, regionalisms, age-based peer groups, educational background, and mental/physical disability. With cultural diversity comes linguistic diversity, including an increase in the number of people who are English Language Learners, as well as those who speak non-mainstream dialects of English. In the United States, racial and ethnic projections for the years 2000–2015 indicate that the percentage of racial/ethnic minorities will increase to over 30% of the total population.

As professionals, we must be prepared to provide services that are responsive to this diversity to ensure our effectiveness. Every clinician has a culture, just as every client/patient has a culture. Similarly, every clinician speaks at least one dialect of English and perhaps dialects from other languages, as does every client/patient. Given the myriad factors that shape one's culture and linguistic background, it is not possible to match a clinician to clients/patients based upon their cultural and linguistic influences. Indeed, recent ASHA demographics indicate that only about 7% of the total memberships are from a racial/ethnic minority background and less than 6% of ASHA members identify themselves as bilingual or multilingual (ASHA, n.d.b).

Only by providing culturally and linguistically appropriate services can we provide the quality of services our clients/patients deserve. Regardless of our personal culture, practice setting, or caseload demographics, we must strive for culturally and linguistically appropriate service delivery. For example, we must consider how communication disorders or differences might be manifested, identified, or described in our client's/student's cultural and linguistic community. This will inform all aspects of our practice including our assessment procedures, diagnostic criteria, education plan, and dismissal decisions.

This document sets forth the knowledge and skills that we as professionals must strive to develop so that we can provide culturally and linguistically appropriate services to our clients/patients. The task may seem daunting at first. Given the knowledge and skills needed, we may shy away from working with clients/patients from certain cultural or linguistic groups. We may question whether it is ethical for us to work with these clients/patients. These guidelines provide a way to answer that question for each clinician.

It is true that "Individuals shall engage in only those aspects of the profession that are within the scope of their competence, considering their level of education, training, and experience" (ASHA Principles of Ethics II, Rule B). So, without the appropriate knowledge and skills, we ethically cannot provide services. Yet, this does not discharge our responsibilities in this area. The ASHA Principles of Ethics further state, "Individuals shall not discriminate in the delivery of professional services" (ASHA Principles of Ethics I, Rule C). Thus, this ethical principle essentially mandates that clinicians continue in lifelong learning to develop those knowledge and skills required to provide culturally and linguistically appropriate services, rather than interpret Principles of Ethics II, Rule B as a reason not to provide the services. This document sets forth those knowledge and skills needed to provide culturally and linguistically appropriate services. It can be used to identify one's strengths and weaknesses, and to develop a plan to fill in any gaps in one's knowledge and skills in this area.

2. Cultural Competence

   ASHA clearly defines the skills SLPs need to perform culturally competent assessments and services. Refer to ASHA policies and procedures, Practice Management, Multicultural Affairs and Resources (ASHA policies) for further information on this topic.

D. <u>The Assessment Process of English Language Learners</u>

When conducting assessments, professionals must be careful to consider the client's/patient's level of acculturation to the mainstream culture. It is important to determine how familiar and comfortable individuals are with social, interpersonal, academic, and testing practices in the United States. An appropriate evaluation may have to be completed over time.

Under the Individuals with Disabilities Education Act 2004, schools can employ "early intervening" services to determine which children have intrinsic learning problems that cannot be explained on the basis of lack of experience with the tasks. Responsiveness to intervention (RtI) and dynamic assessment (DA) are both early intervening approaches that can be used to decrease unnecessary

referral to special education for struggling children who can benefit from modified instructional techniques.

1. Gathering a Case History

   Cultural generalizations are never true of all individuals. One must refrain from creating assumptions about individuals or families based on general cultural, ethnic, or racial information. It is helpful to learn about the cultural values of the individual and his or her family through techniques such as ethnographic interviewing. Understanding the views of clients and their families often determines the success of clinical interactions.

2. Ethnographic Interviewing
   A) Through ethnographic interviews, SLPs and audiologists can develop an understanding of the client's and the family's perceptions, views, desires, and expectations.
      - In a traditional interview, the interviewer operates from the perspective that "I know what I want to find out, so I am setting the agenda for this interview."
      - In an ethnographic interview, in contrast, the client, spouse, or parents help determine the important information to share.

   B) Principles of ethnographic interviewing include:
      - Use open-ended questions rather than dichotomous questions that trigger a yes or no response.
      - Restate what the client says by repeating the client's exact words; do not paraphrase or interpret.
      - Summarize the client or parent's statements and give them the opportunity to correct you if you have misinterpreted something they have said.
      - Avoid asking multiple questions back-to-back and/or multipart questions.
      - Avoid leading questions that tend to orient the person to a particular response.
      - Avoid using "why" questions because such questions tend to sound judgmental and may increase the client's defensiveness.

C) Tips for Gathering Case History of Bilingual Clients

- Find out about the language history by eliciting information, such as:
  - The age of acquisition of the language(s).
  - The language(s) used at home and at school/work.
  - The length of exposure to each language.
  - The language of choice with peers.
  - Progress in receiving English as a second language (ESL) services or adult English language learning classes.
  - Academic performance.
  - The language(s) used within the family.

Practice Guidelines for the Assessment of Culturally and Linguistically Diverse School-Aged Children

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Background

As the population of Mississippi continues to become more diverse, school-based Speech-Language Pathologists are more likely to encounter students who speak English dialects other than Mainstream American English (MAE; also commonly known as Standard American English; the dialect used in government communications, printing, national television newscasts, and many businesses; Roseberry-McKibbin & Hedge, 2011). These dialects are often referred to as non-mainstream dialects of English and include African American English (AAE) and Southern White English (SWE). Non-mainstream dialects of English are typically characterized by linguistic features that differ from MAE. Syntactic features include, but are not limited to, variable use of morphemes such as past tense *–ed*, auxiliary *be* and *do* forms, third person singular *–s*, and possessive *–s*. Selected phonological features include /t/ for voiceless *th*, /d/ for voiced *th*, final consonant deletion, devoicing of final consonant sounds and consonant cluster reduction. Linguistically-based research has shown that each of these features and others that characterize nonmainstream dialects of English are pattern-based and are used systematically in speakers' spontaneous speech. Further, these dialects have been shown to be rule-governed, legitimate linguistic systems of communication and not slang or substandard forms of MAE. (For review of common features of AAE and SWE, see Oetting & McDonald, 2002; Roseberry-McKibbin & Hedge, 2011; Stockman, 1996. For review of the rule-governed nature of AAE and SWE, see Green, 2002, 2011; Garrity & Oetting, 2010; Oetting & Newkirk, 2011; Wyatt, 1996.)

School-aged children who are speakers of non-mainstream dialects of English present a unique assessment challenge to Speech-Language Pathologists who do not have a solid understanding of non-mainstream dialects. This is because many of the features of non-mainstream dialects of English, appear to be identical to symptoms of childhood language impairment (Seymour, Bland-Stewart, & Green, 1998). What may appear to be a symptom of impairment may actually be a legitimate linguistic feature of AAE or SWE. The inverse is true as well; what may appear to be a linguistic feature of AAE or SWE may in fact be a symptom of impairment. This presents a diagnostic conundrum for many Speech-Language Pathologists and those who are unfamiliar with linguistic systems of non-mainstream dialects such as AAE or SWE will likely have a challenge during the assessment process and with ultimately answering the question of problem/no problem.

What further adds to the challenge of assessing culturally and linguistically diverse school-aged children is limited access to or availability of appropriate assessment tools to adequately assess the communication skills of school-aged children who speak non-mainstream dialects of English. To date, very few culturally and linguistically appropriate commercial assessment tools are available for use with speakers of non-mainstream dialects of English. This requires Speech-Language Pathologists to rely even more on their linguistic knowledge and their understanding of the universal principles of typical language development than they would when assessing speakers of MAE.

Disorder vs. Difference (or Dialect)

When Speech-Language Pathologists are confronted with a culturally and linguistically diverse student whose speech and language skills may be contributing to his or her struggle in school, the first question that they usually ask is, "Is the student's speech and language reflective of a language difference or a language disorder?" Disorder has a clinical connotation and in general, refers to speech and language skills that deviate from what one would expect for peers of the same age and grade. In contrast, a difference refers to a rule-governed linguistic variety or dialect that is shared by a group of speakers and differs in some ways from other dialects, like MAE, due to factors such as geographic region, socioeconomic status, and subgroup membership (Battle, 2002; Wolfram & Schilling-Estes, 2006).

Although the term dialect often carries a negative connotation and thought of by many as corrupt English, a dialect or linguistic difference is not disordered speech or language. As a matter of fact, from a linguistic perspective, a non-mainstream dialect is just as rule-governed, systematic and regular across all linguistic parameters (i.e., phonology, morphology, syntax, semantics, and pragmatics) as any other dialect of English, including MAE. Since 1983, it has been the position of the American Speech-Language-Hearing Association that "no dialectal variety of English is a disorder or pathological form of speech or language". Further, the Association asserts that "each dialect is adequate as a functional and effective variety of American English" (p. 2).

Required Competencies for Speech-Language Pathologists

The American Speech-Language-Hearing Association (2003) has identified required competencies for Speech-Language Pathologists who serve culturally and linguistically diverse students. These competencies are required to distinguish between dialectal differences and communicative disorders. They include:

1. Recognizing all American English dialects as rule-governed linguistic systems,
2. Understanding the rules and linguistic features of American English dialect(s) represented by their clientele,
3. Being familiar with nondiscriminatory testing and dynamic assessment procedures, such as the following:
    a) Identifying potential sources of test bias,
    b) Administering and scoring standardized test in alternative manners,
    c) Using observation, nontraditional interviews, and language sampling techniques, and
    d) Analyzing test results in light of existing information regarding dialect use.

In addition to these, we would add completion of an attitudinal self-examination to reflect upon and address one's own attitudes toward culturally and linguistically diverse speakers. Cultural competence checklists can be found on the webpage of the American Speech-Language Hearing Association.

Important Federal Regulations to Consider

The speech and language assessment of any student should be guided by current Federal regulations. However, some regulations of the Individuals with Disabilities Education Act (2004) Section 300.304 are particularly relevant for students who are culturally and linguistically diverse. These regulations pertain to evaluation procedures and they mandate the following:

1. A variety of assessment tools and strategies must be used to gather relevant functional, developmental, and academic information about the children, including information by the parent, that may assist in determining whether the child has a disability and the content of the child's IEP [Sec. 300.304(b)(1)(i, ii)].
2. No single measure or assessment can be used as the sole criterion for determining whether a child is a child with a disability, and for determining an appropriate educational program for the child [Sec. 300.304(b)(2)].
3. In an evaluation, technically sound instruments that may assess the relative contribution of cognitive and behavioral factors, in addition to physical or developmental factors, must be used [Sec. 300.304(b)(3)].
4. In an evaluation, assessments and other evaluation materials must be selected and administered so as not to be discriminatory on a racial or cultural basis [Sec. 300.304(3)(c)(1)(i)].
5. In an evaluation, assessments and other evaluation materials must be provided and administered in the child's native language or other mode of communication and in the form most likely to yield accurate information on what the child knows and can do academically, developmentally, and functionally, unless it is clearly not feasible to so provide or administer [Sec. 300.304(3)(c)(1)(ii)].

6. In an evaluation, assessments and other evaluation materials must be used for the purposes for which the assessments or measures are valid and reliable [Sec.300.304(3)(c)(1)(iii)].
7. Assessments and other evaluation materials must be administered by trained and knowledgeable personnel [Sec. 300.304(3)(c)(1)(iv)].
8. Assessments and other evaluation materials must include those tailored to assess specific areas of educational need and not merely to provide a single general intelligence quotient [Sec. 300.304(3)(c)(2)].
9. No child is eligible for special education services if the determinate factor for eligibility is lack of appropriate instruction in reading, math or limited English proficiency [Sec.300.306(1)(i, ii, iii)].

Practice Guidelines When Assessing Culturally and Linguistically Diverse Students

With consideration of the position of the American Speech-Language-Hearing Association regarding dialects and the aforementioned regulations of the Individuals with Disabilities Education Act (2004), the following practice guidelines are suggested when assessing culturally and linguistically diverse school-aged children:

1. **Plan a well-balanced, culturally-sensitive assessment which includes ethnographic methods (i.e., methods that obtain information from the point of view of the student's culture).** Speech-language assessments of culturally and linguistically diverse students should always include nonstandardized, informal procedures and instruments such as Language-Speech sampling, portfolio assessments, parent and teacher reports, criterion-referenced testing procedures, curriculum-based language assessments, and dynamic assessment. Processing-based assessment methods such as nonword repetition should also be used. These methods are thought to minimize biases related to prior world knowledge and experience.
2. **Identify standardized tests with appropriate psychometric properties.** Speech-Language Pathologists should aim to use tests that have acceptable psychometric properties (e.g., sensitivity, specificity, validity, and reliability) and that have culturally and linguistically diverse students well represented in the standardization sample.
3. **Review standardized tests for possible bias.** Before using a particular standardized test in an evaluation, the Speech-Language Pathologist should examine the test items, picture stimuli, administration procedures, and oral instructions for evidence of bias. Three types of biases that are probable in standardized speech and language tests have been identified: content bias, linguistic bias, and disproportionate representation in normative samples (Laing & Kamhi, 2003). Content bias occurs when test stimuli, methods, or procedures reflect the assumption that all students

have been exposed to the same concepts and vocabulary or have had similar life experiences. SLPs who are assessing students who are from culturally and linguistically diverse backgrounds should closely evaluate standardized tests for items that assume that all students have been exposed to the same concepts and vocabulary or have had similar life experiences.

Linguistic bias occurs when there is a disparity between the language/dialect of the examiner, the language/dialect of the student, or the language/dialect that is expected in the student's response (Laing & Kamhi, 2003). Roseberry-McKibben (2011) highlight five types of test items on standardized speech and language tests that are most susceptible to linguistic bias. These include grammatical judgment items, sentence repetition items, grammatical closure tasks, receptive grammatical closure tasks, and articulation and phonological tasks. Speech-Language Pathologists who use standardized tests that contain these types of items should be careful not to identify a student as needing special education solely on the basis of test scores. Also, items that are linguistically biased should not be used solely as the basis for goals and objectives.

The final common type of bias associated with standardized tests is the disproportionate representation of culturally and linguistically diverse students in the normative samples of tests (Laing & Kamhi, 2003). This occurs when culturally and linguistically diverse students are not included, or underrepresented in the normative sample. Speech-Language Pathologists should examine the manuals of standardized test to ensure that the normative sample adequately includes children from diverse backgrounds.

4. **Consider Altering Standardized Tests.** If least-biased standardized tests are not available, the Speech-Language Pathologist may consider altering the administration of the test so that culturally and linguistically diverse students will perform optimally in ways that reflect their true speech and language abilities (Roseberry-McKibben & Hedge, 2011). Ways to alter tests include:
    - Omit items that reflect content and/or linguistic bias.
    - Re-word directions.
    - Give extra examples and practice items.
    - Give the student extra time to respond.
    - Repeat items if necessary.
    - Give instructions in MAE and in the child's dialect.
    - If a student gives a "wrong" answer, ask them to explain their answer. For answers that are correct according to the student's culture, give credit.

Be sure to report any alterations in standardized testing procedures in the language-speech report.

5. **Consider all assessment data in decision-making.** When analyzing the assessment data of culturally and linguistically diverse students, Speech-Language Pathologists should consider all assessment data – not just the standardized test data. Data analysis should focus on the universal aspects of speech and language development for identifying signs of a disorder and not dialect-specific aspects of speech and language. That is, Speech-Language Pathologists should look for speech and language patterns that are not typical in various dialects of English. Importantly, decisions of eligibility should never be made solely on standardized tests or on test items that reflect dialect-specific aspects of speech and language.
6. **Report assessment findings in a least biased fashion.** A report of assessment findings should always include a comprehensive review of the student's strengths and weaknesses. Cultural dialects should always be referred to in non-derogatory ways (i.e., as legitimate linguistic systems of communication) and with appropriate terminology and labels (e.g., *dialect* not *slang*). When writing the assessment report, be sure to report any departure from standardized testing procedures. Also, the Speech-Language Pathologist should express caution or disclaimers when reporting standard scores generated from tests that are biased.

An Additional Consideration: Socioeconomics Status

An additional factor to consider while assessing students who are culturally and linguistically diverse is socioeconomic status. A large proportion of school children in America's schools have been reared in poverty. In Mississippi for the 2010-2011 academic year, 70% of public school students qualified for and received free or reduced lunch (Mississippi Department of Education, 2011). Children reared in poverty frequently enter school at a disadvantage due to decreased language exposure, decreased opportunities to interact with books, and they may present differences in perception and expectations related to the classroom context (Croll, 2002; Hart & Risley, 1995; Haverman & Wolfe, 1995; Washington & Craig, 1999). The literature suggests that children from low socioeconomic backgrounds:

- hear less words spoken in the home than children reared in higher socioeconomic homes (Hart & Risley, 1995).
- are exposed to more directive language and verbal discouragement than children reared in higher socioeconomic homes (Hart & Risley, 1995).
- have a slower vocabulary growth rate (Hart & Risley, 1995).
- perform lower on standardized language tests (Qi, Kaiser, Milan & Hancock, 2006).

- have less literacy socialization experiences than children reared in higher socioeconomic homes (Smith, Brooks-Gunn & Klebanov, 1997).

These findings have important implications for Speech-Language Pathologists. When assessing students who are reared in poverty (who may also be culturally and linguistically diverse), it is important for Speech-Language Pathologists to recognize that the depressed language skills (often vocabulary skills) may be due to limited experiences, limited exposure or different cultural practices. A Speech-Language Pathologist's assessment should take these factors into consideration to determine if lower test scores are indicative of a true disorder or a result of experiences that are different from middle-class mainstream American culture. To that end, one assessment procedure that is particularly recommended for students who are from low income backgrounds is dynamic assessment. Dynamic assessment is a procedure that involves three phases: a test phase, a teach phase, and another test phase. This three phase procedure allows the Speech-Language Pathologist to assess the students' learning *process* and his/her language-learning *potential*.

The important point to make is that being reared in poverty does not guarantee a disorder; however poverty places children at a higher risk for developing deficits in language, literacy, and academic achievement. Due to the negative effects that poverty may have on children's language, literacy, and academic achievement there has been a push for Speech-Language Pathologists to work with families and early childhood educators from impoverished backgrounds using a prevention model (ASHA, 1998; 1991; Morris, 2010) to:

- Provide opportunities for children to read quietly or read to younger pupils in non-threatening environments.
- Provide instruction in classrooms so that all children may benefit from SLP instruction.
- Include literacy activities in after-school programs.
- Motivate children to read.
- Train parents to support their children's literacy development. This could be done during parent-teacher conferences or through "building literacy weekly tips" sent home in folders.

Consideration for Intervention

If after completing a culturally and linguistically appropriate assessment, the Speech-Language Pathologist determines that a disorder exists and that the disorder is adversely affecting academic performance, the following considerations are suggested. Prior to implementing the intervention process, therapists should consider their own values and belief systems and adapt approaches to service delivery to accommodate the needs of all students. We would suggest utilizing the following guidelines in order to provide culturally sensitive intervention.

- Know the culture of your students. Every culture has a set of pragmatic rules that guide communicative behaviors. Becoming familiar with these rules will allow you to engage in interactions with clients and caregivers in a culturally sensitive manner.
- Ensure that your treatment methods and procedures do not violate the beliefs and values of your clients.
- Understand differences in nonverbal communication rules across cultures.
- Learn to pronounce the names of your students, and do not attempt to shorten the names or use nicknames unless it is requested by your student. Avoid commenting on unusual names or spelling of names.
- Ensure that the goals of intervention are consistent with expected outcomes of parents and involve parents in the intervention process.

Service Delivery Options and Response to Intervention

By: Rachel Powell, Ph.D., CCC-SLP

There are a variety of service delivery options the SLP can choose to implement with a student in order to meet that student's individualized instructional needs. The SLP's knowledge and skills are difficult to implement under the traditional caseload model. While SLPs are funded by caseloads, a workload approach can be implemented to ensure academic success for all students.

By beginning to utilize workload instead of caseload, you can ascertain the amount of work required per student. For example, while a student's IEP may be 30 minutes, 2 times per week, the amount of time to consult with the teacher, plan therapy, communicate with the parents, etc. is actually an additional 30 minutes per week, so the workload for that student is 90 minutes per week. Students' IEPs should be individualized to meet their needs. This can be done by using non-traditional therapy methods, including push-in classroom therapy, consultation with teachers, collaboration with teachers, and co-teaching.

For the Workload Approach, a variety of Service Delivery Models should be considered:

- Traditional Pull-out (30 minutes 2 times per week) – may be appropriate for some, but does not meet the needs of all students.
- Push-in Therapy – Services are provided in the classroom setting individually or in a small group and provide more optimal conditions for classroom collaboration between SLPs and teachers.
- Consultation - For students whose language-speech difficulties have no adverse educational, social/behavioral, or vocational impact, and therefore should remain in general education, an alternative delivery model guided and/or delivered by the SLP in inclusive settings could be utilized.
- Collaborative/team teaching – SLPs work with the general education and/or special education teachers to plan lessons and instruction.
- Environmental contexts – services are delivered in a natural environment, such as the home, social context (i.e., on the playground), or employment contexts.

In addition, SLPs can use the workload approach to design interventions for children with mild language-speech deficits, and train others in strategies for improving language-speech skills.

- Flex/Block Scheduling – instead of scheduling in 30 minute therapy slots, scheduling is based on individual needs and directly collaborated with the general education instructional time.

- Schedule a "Kindergarten" block, where services are provided to L/S students in Kindergarten during the small group instructional time in the classroom. This allows for direct collaboration between the classroom teacher and the SLP on targeted weekly skills.
- Articulation Drill Block – schedule a block of time every day where students with minor articulation deficits can receive a 5-10 minute "drill" of the targeted speech sounds that does not interfere with the academic instruction.

This paradigm shift from caseload to workload means the amount of service delivery time should be made on an individual basis. As particular skills are acquired, changes may be needed in the location, type, frequency, or duration of the therapy services. More information on scheduling options in schools can be found on ASHA's website.

Response to Intervention (RtI) is the process by which tiered instructional strategies are used for all students to meet diverse learning needs. Mississippi State Board Policy 4300 adopts the RtI model, and the Mississippi Department of Education RtI Best Practices Handbook defines a tiered approach to student instruction:
Tier 1: Quality classroom instruction based on the MS curriculum (MS Curriculum Framework or Mississippi College and Career Readiness Standards).
Tier 2: Focused supplemental instruction.
Tier 3: Intensive interventions specifically designed to meet the individual needs of students.

RtI is a general education initiative in Mississippi. The SLP's role in RtI may come from consultation, collaboration, and as support as a member of the Teacher Support Team (TST). The SLP may not provide direct services for RtI to students as special education personnel, and may not serve as chair of the TST team. As an expert in language development, and the language influences on literacy acquisition and instruction, the SLP serves as a valuable resource to school and district instructional leaders. Research has shown that students demonstrate gains when SLPs collaborate with teachers on early literacy instruction, such as phonemic awareness (Koutsoftas et al., 2009; McCallister & Trumbo, 2009).

As a member of the TST, an SLP can lend diagnostic knowledge to the assessment of a student's academic weaknesses. Using the knowledge of language development, an SLP can identify the area of language that is causing a student's deficits, such as:

- Spelling errors
    - "cub" for "club" - phonological error, cluster reduction.

- "nis" for "nice" – phonics error, student does not know rules for long vowels.
- "anwise" for "unwise" – morphological awareness error, student does not understand prefix: example – (un-).

Universal Screening Data – SLPs can aid in analyzing data to identify student deficits. This may be identifying the area of reading that is the student's deficit, such as phonics vs. phonological awareness vs. fluency.

Once a student's academic deficit is identified, the SLP's expertise in language and literacy provides a valuable resource for the classroom teacher and all providers of services for students experiencing academic difficulties. The SLP can help the TST in prescribing targeted and focused instructional intervention that meet the student's' needs, including:

- Phonological Awareness – This pre-literacy skill is a required component of reading success. If students do not receive adequate instruction in Phonological Awareness, then there will be a missing foundational ability to break words into syllables and subsequently sounds, which impacts spelling and decoding abilities in otherwise fluent readers. The SLP's expertise in the fundamentals of speech phonemes, phoneme acquisition, and phoneme instruction allows him/her to serve as an expert consultant in effective phonological awareness instruction.
- Linguistic Principles of Language, Reading, and Writing – Reading is founded in language, and without the understanding of language structure and function, students will not achieve reading success. The SLP can share the knowledge of language structure, function, development, and acquisition to help teachers effectively understand and subsequently teach the linguistic principles of reading. This knowledge can be found in grammar instruction (morphology/morphological awareness) and sentence structure (syntax).
- Story Elements and Structure – The fundamentals in this skill are found in a student's ability to participate in oral narratives and discourse. The SLP can consult and collaborate with teachers in how to effectively teach discourse strategies, which carries over to the written component.
- Vocabulary – A student's ability to understand vocabulary related to the curriculum is a critical skill in academic success. By utilizing the strategies that SLPs use to teach and build oral vocabulary, the SLP can work with the teacher on effective strategies for teaching more complex academic vocabulary, such as synonyms, antonyms, prefixes, affixes, etc.

Students may benefit from using RtI models to treat mild articulation deficits. The SLP can train the classroom teacher, teacher assistant, childcare provider, or parent in how to target the error sound through interventions in the classroom.

The SLP can monitor the student's progress through a review of the data documentation, and consult with the teacher and/or parents. For example:

- A student is producing /t/ for /k/ in the initial position only, and is stimulable for production.
- Target exercises for correct /k/ production in the classroom.
- Monitor progress by tracking the student's accuracy of production.
- Give the parent, teacher, teacher assistant, and any other pertinent individual strategies for practicing and developing correct /k/ production in the student's environment, such as multisensory cueing, direct instruction in production, and auditory bombardment.

If the student shows improvement, then no further action is needed. If the student is unsuccessful, then further services from an SLP may be warranted, requiring a comprehensive special education evaluation.

Students with cultural differences may benefit from language enhancement in the classroom by the teacher, teacher assistant, or other provider under the direction of and with consultation from the SLP. This is known as a dynamic assessment approach, and is applicable to students from culturally deprived backgrounds because the academic deficit may be due to lack of adequate exposure to a language enriched environment, and not a true language disorder. The SLP may use a screening method, such as a curriculum-based assessment, to determine a student's area of strengths and weaknesses. The TST team may:

- Use the curriculum benchmark goals to identify the student's area(s) of weakness.
- Screening may be given by a teacher or SLP (with parental consent).
- Screening may be given prior to intervention, and throughout the intervention as needed, to determine growth and progress.

Based on the Screener, the TST selects a specific skill to target for a short time period (2-4 weeks). For example:

- The student will apply knowledge of phonological and phonemic awareness.
- Use multi-sensory and visual strategies to teach phonological awareness and increase spelling ability.
- The teacher or assistant works with the student individually or in a small group in an educational environment and documents the student's progress.
- If little or no progress is made, adjustments in implementation should be made.

- If progress is made then, based on the data, the intervention may be continued and gradually reduced in frequency and intensity.
- If little or no progress is made, referral is warranted.

The student may make progress, but still warrant referral if progress is slow enough to impact educational, social/behavioral, or vocational performance. At various times throughout the 'at risk' child's education, continued support in general education, additional district resources and/or alternative service delivery methods may be required. A student may successfully complete interventions for a targeted skill, but later on need interventions once again if he/she shows deficits. The "at risk" student's progress will need to be monitored regularly to ensure quality instruction and success in the general curriculum.

This student may always need a level of support, whether through RtI, 504, or other district services, but may not meet the qualifications for special education.

A dynamic assessment approach to language enhancements is sometimes needed to adequately discern a student's overall language ability, and not penalize students for a lack of exposure to language.

SLPs can serve as valuable team members beyond the TST at the school building or district level on curriculum and instruction teams. For example, not all reading programs teach spelling explicitly or systematically, and the assumption cannot be made that if a reading program includes phonics, then the phonological awareness instruction is adequate and appropriate. The SLP's knowledge of phoneme development is a valuable resource to curriculum teams determining the adequacy and effectiveness of a school's reading instruction. Ways the SLP can serve in a leadership role to analyze the overall effectiveness of reading instruction include:

- Work with the grade-level curriculum committee on developing systematic spelling instruction (i.e., silent e pattern). *[Consultation]*
- Work with classroom teachers with students receiving L/S services to teach whole class or small group spelling instruction using multi-sensory and visual strategies. *[Collaboration]*
- Train teachers in how to teach phonological awareness principles (i.e., the phonological awareness hierarchy). *[Consultation]*
- Based on school-wide assessment data (i.e., DIBELS Initial Sound Fluency and Phoneme Segmentation Fluency), select classrooms with deficient phonological awareness scores (majority of the class is *Some Risk* or *At Risk*) to train teachers on effective phonological awareness instruction. *[Collaboration]*

- Provide small group classroom instruction in phonological awareness skills with L/S students. *[Direct Services]*
- Work with the classroom teacher on the weekly story lesson. *[Consultation]*
- Co-teach comprehension strategies in classrooms with L/S students. *[Collaboration]*
- Use multisensory strategies, such as graphic organizers, to teach story structure. *[Collaboration or Consultation]*
- Write personal stories with questions and answers for student to practice. *[Collaboration]*
- Train teachers on the principles of morphological awareness and the benefits of teaching students this concept. *[Consultation]*
- Team-teach instruction on morphological awareness. *[Collaboration]*
- During the weekly spelling lesson, identify the morphemes in words and teach their relevance to the spelling (i.e., -y, -ion, -ed, -s, etc.). *[Collaboration]*

Because RtI is not traditionally viewed as an area in which SLPs can work, barriers may be encountered when trying to implement RtI. The process is most effective when all team members recognize the knowledge and role that the SLP can play. ASHA has information and research on the value of SLPs in RtI, and gives support to SLPs in sharing their role with teachers, principals, and administrators. SLPs can select teachers who are receptive and innovative to work with who have students with L/S rulings, and target classroom consultation and collaboration with teachers who are willing and desire strong collaboration. With the implementation of the Mississippi College and Career Readiness Standards, all personnel will be held accountable for student growth, and it is the SLP's job to provide teachers with the support they need for students to be successful in the general curriculum.

Practice Guidelines for Hearing Screening and Evaluation

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James E. Peck, Ph.D.

Both Federal and State legislation mandate hearing screening in schools. Through IDEA, hearing screening for children is authorized in their Child Find clause, while both the Mississippi Department of Education (MDE) and the nursing guidelines of Mississippi call for school hearing screening programs to be established. The purpose of hearing screening is to identify children who may have a hearing impairment, whether permanent or fluctuating, that adversely affects a child's educational, social/behavioral, and/or vocational performance (MDE, 2009). Hearing loss can have a tremendous negative impact on a student's Language-Speech development as well as on his/her academic career, if it is not identified and treated in a timely manner. This chapter addresses establishing and implementing hearing screening programs in schools.

Recommendations for Comprehensive Hearing Screening Programs in the Mississippi Schools

The American Academy of Audiology (AAA) Childhood Hearing Screening Guidelines (2011) outlines several components of a hearing screening program that schools should consider in establishing their own program. Johnson, Benson, and Seaton (1997), in their widely cited book, *Educational Audiology Handbook* (1997), also recommend that school hearing screening programs include specific obligatory components. Combining Johnson, Benson, and Seaton's with AAA's components, the following elements are considered "best practices" for school hearing screening programs.

- The identification and training of screening personnel
- Equipment selection and maintenance
- Infection control
- Room set-up
- Protocol recommendations for screening for hearing loss
- Protocol recommendations for screening for middle ear problems
- Referral and follow-up procedures
- Recordkeeping and reporting
- Hearing screening program evaluation

The intent of this chapter is to address each of these components in order to equip the SLP in schools with the knowledge to establish an effective hearing screening program. The ultimate goal is to identify and treat children with hearing loss in a timely manner, thereby lessening the impact that the hearing loss may have on their educational development.

The Identification and Training of Screening Personnel

The Mississippi Department of Education (MDE), (2009) specifies that any of the personnel who do the screenings should be "a health care professional." Typically, those health care professionals are nurses and SLPs. If school systems do not employ or contract with an audiologist, AAA recommends that they should have their "non-audiologist managers of the screening programs utilize one or a small group of representative audiologists from their community as an advisory board for hearing screening programs" (AAA, 2011, p. 52). This audiologist/advisory board would assist the schools in the appropriateness and maintenance of the equipment, the training of the personnel, and the technical details of protocols to be followed. Johnson, Benson, and Seaton (1997) recommend that training of new personnel be comprised of much more than how to perform the actual screening. Rather, it should include (1) the purpose of screening, (2) the screening equipment including maintenance and troubleshooting, (3) the room set-up where the equipment is to be used, (4) typical behaviors of children during screenings and how to manage these behaviors, (5) the basic operation of the program and the process for reporting results to parents and teachers, (6) the screener's role, (7) the need for supervised practice before the actual screening begins, and (8) the protocol to be used. They also recommend annual review training sessions for all personnel conducting screening.

Equipment Selection and Maintenance

There are pre-set screening audiometers which screen only a limited number of frequencies at fixed decibel levels. The MDE guidelines require screening for frequencies **1000 Hz, 2000 Hz,** and **4000 Hz** at **25 dB HL,** but the tester can also choose to screen **500 Hz** at **30 dB HL** as well as **6000 Hz** and **8000 Hz** at **25 dB** HL. Thus, there is merit in having a basic portable audiometer that produces a range of frequencies from **250 Hz** to **8000 Hz** at levels from **0 dB** to **90 dB HL**. The greater capability and flexibility of a portable audiometer hold distinct advantages over a dedicated screening device, making it a good choice for purchase.

For a screening program to be trustworthy, screening equipment must be checked and calibrated electronically every year. The school's equipment provider can arrange for such service. In addition to annual electronic calibrations, biologic listening checks should be made of screening equipment at the start of each screening day (Johnson, Benson, & Seaton, 1997). These listening checks help assure that the audiometer is producing an accurate decibel level at each frequency in each earphone without crackling or intermittent signal from damaged cords. See Appendix W, entitled "Calibration and Mechanical Check of Audiometer," for tips on how to perform a listening calibration check.

Data for both the annual calibrations and the listening checks should be kept for each audiometer. Appendix W, "Daily Biologic and Mechanical Check Data Sheet," is a sample form for the listening checks.

Infection Control

Both AAA (2011) and Johnson, Benson, and Seaton (1997) emphasize the importance of asepsis during screening. Otoscopy and tympanometry run the risk of transferring cerumen (ear wax), and therefore any infectious matter in the cerumen, from one individual to another (AAA, 2011). If an otoscope is used, one should either use disposable specula or clean and sanitize the non-disposable speculum after each use. The same holds true for the tips used for tympanometry. Surfaces of supra-aural headphones (headphones that are seated over the ear) should be cleaned after each use before the next student is tested. Screening stations should be equipped with disinfectant wipes and hand sanitizer for use throughout the day. Testers should wash their hands frequently or use disinfectant lotion. Tables and toys used in play audiometry should be wiped down with disinfectant wipes periodically throughout the day. Lastly, the tester should check with the school authorities prior to screening to find out if there has been an outbreak of head lice in the school. If so, screening should be rescheduled for another day.

Room Set-Up

The quietest room possible should be used for hearing screening for the obvious reason that tones can be masked by ambient noise. Rooms that are close to hallways, bathrooms, cafeterias, band rooms, and playgrounds should be avoided or the screening should be scheduled around their use. Rooms with carpeting and/or acoustic tiling have better sound absorption making them quieter.

To verify that a room is quiet enough for hearing screening, AAA (2011) suggests checking if a person with normal hearing can hear the test tones at **10 dB** below the screening level. For a **25 dB HL** hearing screening, the tester should set the dial at **15 dB HL**. If the person can hear all the tones at 15 dB HL, then the room should be sufficiently quiet to perform the screenings.

After selecting the most appropriate room, placement of the screening station within the room is an important consideration. The equipment should be set up in a corner or near a wall away from florescent lights and air condition/heating units. The child should be seated as close to the wall as possible while still not being able to see the screener during the actual screening. For further tips on ascertaining the appropriate room for screening and the room set-up, see Appendix X "Suggested Facility Criteria."

Protocol Recommendations for Hearing Screening According to MDE

Referral And Follow-Up Procedures

A. Referrals and follow-up for children who failed the pure tone screening twice:

MDE requires that a child needing audiologic evaluation be referred either to an audiologist who holds a Mississippi license, or ASHA or AAA certification, or to a physician with expertise in conducting audiologic evaluations using appropriate equipment. Prior to conducting the screenings, the person in charge of the program should obtain a list of qualified people in the surrounding area to give to parents of the students who need audiologic evaluation. MDE lists the following elements that the audiometric evaluation report must include and that must be part of the multidisciplinary team report: As these items are required to be in the multidisciplinary report, it would be helpful if the clinician would provide this list to the audiologist or physician to address in their report to the school.

Every effort should be made to expedite this process so that the child can receive the necessary assistance. Preferably, the referral process should take **14** to **21 days** so that the child can receive timely services if needed.

B. Referrals and follow-up for children who failed tympanometry twice:

A referral to the child's healthcare provider should be made if the child fails the tympanometric screening twice. Parents should be alerted that their child may have a medical problem involving the ears. If the child is under the care of an otolaryngologist, the family probably should take the child to that individual. Again, MDE does not specify a time period within which the child should be seen by the professional, but the sooner that the referral is made and the child seen, the quicker the assessment process can be completed.

Record Keeping and Reporting

Johnson, Benson, and Seaton (1997) emphasize the importance of keeping accurate records of each child screened and the results obtained. The screening forms should be concise and easy to use. MDE has a vision and screening form for recording the pass/fail results of the first and second screening. However, this reporting form does not have a place for tympanometry results, so if the school screens for middle ear problems using tympanometry, a different form may be devised to keep the data on those results. Appendix B is an example of a form which can be used to record both pure tone screening and tympanometry screening.

In addition to keeping data on each student's results, schools should have a reporting mechanism in place for the following individuals who are involved with the student:

A) **Parents:** Parents should be notified about (a) passing the screening, (b) the need to rescreen their child, and (c) the need to take the child for further evaluation. Appendix Y is a sample letter for reporting the "pass" results. Appendix Y is a sample letter for reporting the need for a rescreening, and Appendix Y is a sample letter recommending further evaluation. The local school district may include in this last letter a list of local audiologists to whom the parent can take their child.

B) **School personnel who are involved with the student:** During the time that the child is at-risk and going through the referral process, it would benefit the child greatly to receive simple assistance in the classroom. Appendix Z, "Teacher/Staff Notification Form with Suggested Instructional Adjustments for At-Risk Children" is a model form to make teachers aware that the child may have some hearing impairment, which may hinder educational progress. This form also lists a few simple instructional adjustments which can be helpful to the child in the classroom. Among the strategies are: seating the child near the teacher, enunciating carefully, and checking frequently for comprehension.

C) **Agencies from which follow-up results need to be obtained:** In order for assessment to proceed and appropriate services to be implemented, it is vital to obtain the results from the outside agency to which the child is referred. The agency should convey this information back to the school in an expeditious manner with full explanations of all the test results. In addition to obtaining the results of the audiologic evaluation, if the child was found to have a hearing loss, the following questions should also be addressed by the audiologist performing the evaluation, then sent to the schools:

1. how the conditions noted during the examination might interfere with educational testing and performance;
2. how the hearing loss might impact educational, social/behavioral, and/or vocational performance;
3. what the recommendations for accommodations, modifications, and educational programming are; and
4. what the communication needs and abilities of the child are. (Mississippi Department of Education, 2009).

With these questions answered, the school will know how best to assist the child with the necessary services to maximize educational, social/behavioral, and/or vocational performance. In Appendix AA there is a sample form which the school

can send to the outside agency in order to facilitate receiving the follow-up recommendations necessary to best assist the child.

Program Evaluation

Both AAA (2011) and Johnson, Benson, and Seaton (1997) recommend that the hearing screening program in each school be evaluated annually to determine its effectiveness. AAA recommends that data be kept on the following items:

A) Total number of children screened
B) Total number of children who passed the initial screening
C) Total number of children absent during the initial screening
D) Total number of children who failed the rescreening
E) Total number of children referred for audiologic follow-up
F) Total number of children referred for medical follow-up
G) Total number of children identified with hearing loss
H) Total number of children treated for medical problems

The person in charge of the hearing screening program can use data from the above list to monitor and evaluate the program's success. For example, if the number of children referred for an audiologic evaluation were far greater than the number of children actually identified with hearing loss, then the entire screening process could be examined to see what modifications are necessary to resolve the problem (i.e. – quieter rooms, different time of the day to screen, etc.). Likewise, if the total number of follow-up forms received were considerably smaller than the number of children referred for follow-up, then perhaps the follow-up reporting system needs to be changed. Evaluating the effectiveness of any screening program is essential in making sure excessive under-referrals or over-referrals are not occurring. The data can also demonstrate the benefit of having a hearing screening program. Appendix KK, entitled "Program Effectiveness Form," is an example of an easy-to-use form for keeping the data recommended by AAA on a hearing screening program.

Because hearing loss can impact the student in such a negative manner, the proper identification of children with hearing loss is critical. Therefore, hearing screening programs need to be well-planned and effective in meeting their goal of timely identification and intervention. This chapter addressed how to implement an effective program and how to document its successfulness.

Audiologic Forms

Forms for equipment and facility

A) Calibration and Mechanical Check of Audiometer
B) Daily Biologic and Mechanical Check Data Sheet
C) Suggested Facility Criteria

Forms for Pure Tone Screening

A) Pure Tone Screening for Hearing Loss Procedures (MDE)
B) Pure Tone Screening for Hearing Loss Procedures (ASHA)
C) Pure Tone Screening for Hearing Loss Procedures (AAA)

Tympanometry Forms

- Sample Hearing Screening/Tympanometry Screening Form – MDE Guidelines

Reporting Forms

A) Sample Parent Letter for Students who Pass
B) Sample Parent Letter for At-Risk Students who did Not Pass the 1st Screening Sample Parent Letter to Refer Students for Further Evaluation
C) Teacher/Staff Notification Form with Suggested Instructional Adjustments for At-Risk Children
D) Sample Referring Agency Reporting Form

Appendix Forward

This appendix provides sample forms for use in language-speech practice. These forms are samples only, are not mandated, and may be adapted to suit individual district needs. These forms should serve as an aid to support documentation for elements of language-speech evaluations, services, and dismissals.

Appendix A
Language-Speech Screening Form

Student Name: _____School:_____

Date of Birth: _____SLP: _____Teacher:_____

This form may be used as a quick checklist for language, speech, voice, and fluency deficits. Check the appropriate answer for each area below:

		YES	NO
1.	The student demonstrates more speech errors than his/her peers.	_____	_____
2.	The student is not stimulable for his/her errors.	_____	_____
3.	The student has interruptions in the flow of his/her speech.	_____	_____
4.	The student's speech is difficult to understand.	_____	_____
5.	The student's voice is too loud, too soft, or has an unusual quality (hoarseness, nasal, etc.).	_____	_____
6.	The student has difficulty with phonological awareness (rhyming, sound segmenting, etc.).	_____	_____
7.	The student has difficulty following directions.	_____	_____
8.	The student has difficulty comprehending new ideas.	_____	_____
9.	The student has poor/limited vocabulary.	_____	_____
10.	The student has difficulty telling/retelling a story and/or relating information.	_____	_____
11.	The student has difficulty answering questions.	_____	_____
12.	The student uses incorrect words and/or grammar that are atypical and not dialectal.	_____	_____
13.	The student does not use appropriate conversation skills (i.e., turn taking, topic maintenance, eye contact, etc.).	_____	_____
14.	The student appears frustrated when speaking.	_____	_____

_____ PASS The student has "NO" checked for ALL questions.

_____ FAIL The student has "YES" checked for ANY question.

Appendix B
Hearing Screening/Tympanometry Screening/Vision Screening Form

Enter District Name

Teacher's Classroom: _____ **Grade:** _____
Name of Child: _____ **Date:** _____
Examiner: _____ **Screening Level: 25 dB**

Tympanometry

Ear	Pass	Rescreen	Refer
Right			
Left			

Hearing Screening

Frequency	(500 Hz)*	1000 Hz	2000 Hz	4000 Hz	(6000 Hz)*	(8000 Hz)*
Right Ear						
Left Ear						

***500, 6000, 8000 Hz = 30 dB (at discretion of SLP)**

1st Screen _____
2nd Screen _____

Recommendations:

_____ Pass
_____ Rescreen outer/middle ear in 7 days
_____ Rescreen Pure Tones in 7 days
_____ Refer for full hearing evaluation
_____ Medical referral

Comments:

VISION SCREENING

	1st Screening		2nd Screening	
Screened Wearing Glasses?	YES		YES	
	NO		NO	
Both Eyes				
Right Eye				
Left Eye				
Near Vision	PASS		PASS	
	FAIL		FAIL	
Date				

Appendix C
TEACHER/PARENT INTERVIEW: PRESCHOOL

Enter District Name Here

Date:

Student's Name:	First:	Middle:	Last:
Date of Birth:		Grade:	
School:		Respondent:	
Primary Language:		SLP:	

Place a check in the appropriate column to rate student performance and return this form to the Speech-Language Pathologist.

As compared to peers in the same setting		**Always**	**Often**	**Sometimes**	**Rarely**	**Never**
		1	2	3	4	5
1.	Does this student eat, chew, swallow, and suck without drooling or choking?					
2.	Is this student in good health (e.g., does not have frequent colds, ear infections, or congestion)?					
3.	Does this student follow verbal directions?					
4.	Does this student listen to stories?					
5.	Does this student seem to understand what is [illegible]?					
6.	Does this student seem to remember what is [illegible]?					
7.	Does this student know his/her first and last [illegible]?					
8.	Can this student identify common body parts and some objects (e.g., touch your nose)?					
9.	Does this student look at books?					
10.	Does this student appear to learn new words every week?					

11.	Does this student participate in pretend play or imitate adult activities (i.e., cooking, mowing					
12.	Does this student appear to enjoy talking?					
13.	Does this student's speech include the use of many different speech sounds?					
14.	Does this student use words to communicate?					
15.	Does this student use words with more than one syllable (i.e., jacket, apple, banana)?					
16.	Does this student communicate with other					
17.	Can this student name common body parts and some objects?					
18.	Can this student answer questions?					
19.	Does this student seem to use longer sentences every month?					
20.	Does this student use sentences appropriate for his/her age?					
21.	Does this student ask for things without pointing or using gestures?					
22.	Does this student ask simple questions?					
23.	Does this student answer simple questions?					
24.	Does this student take turns when talking?					
As compared to peers in the same setting:		**Always**	**Often**	**Sometimes**	**Rarely**	**Never**
		1	2	3	4	5
25.	Does this student play beside another child (parallel play)?					
26.	Does this student play by him/herself (independent play)?					
27.	Does this student speak clearly?					
28.	Is this student understood by his/her family?					
29.	Is this student understood by people outside of the family?					

As compared to peers in the same setting:		Always	Often	Sometimes	Rarely	Never
		1	2	3	4	5
30.	Can this student imitate new sounds and words?					
31.	Is this student typically understood if asked to repeat a word a second time?					
32.	Will this student repeat a word or phrase when not understood, without getting upset?					
33.	Does this student have a clear voice?					
34.	Does this student use a voice that is the same volume as peers?					
35.	Does this student talk smoothly without repeating sounds/words?					
36.	Does this student's Language-Speech skills seem to be steadily improving?					

In your opinion, does this student participate appropriately and show progress in developmentally appropriate activities as compared to peers in the same setting?
☐ **yes** ☐ **no**
Please describe any other observations/concerns related to the communication skills of this student:

Please describe any other observations/concerns related to the communication skills of this student:

Respondent's Signature:			
Title:		**Date:**	

Appendix D
Communication Behavior Observation

Enter District Name Here

Date:

Student's Name:	First:	Middle:	Last:
Date of Birth:		Grade:	
School:		Age:	
Observer Name:		Observer Title:	

Target Behavior Being Observed:

☐ classroom	☐ playground	☐ cafeteria	☐ gym	☐ home
☐ other, specify				
Physical Environment:				
☐ at table	☐ at desk	☐ at listening center		☐ on the floor
☐ at chalkboard	☐ at learning center	☐ seated on a chair group		
☐ other, specify:				
Social Environment:				
☐ solitary play		☐ with group, number of students in the group:		
☐ with parent(s)/sibling(s)		☐ other, specify		

Task/Activity, which the teacher has defined for the student:

Task/Activity of other students *(if different from student being observed)*:

SUMMARY OF OBSERVED COMMUNICATION BEHAVIORS:			
Observer's Signature:			
Title:		**Date:**	

Appendix E
Teacher/Parent Interview: Speech Sound Production and Use

Enter District Name Here

Date:

Student's Name:	First:	Middle:	Last:
Date of Birth:		Grade:	
School:		Respondent:	
Primary Language:		SLP:	

Place a check in the appropriate column to rate student performance and return this form to the Speech-Language Pathologist/Speech-Language Therapist.

As compared to peers in the same setting:		**Always**	**Often**	**Sometimes**	**Rarely**	**Never**
		1	2	3	4	5
1.	Do you understand the student's speech in normal conversation?					
2.	Do the student's peers understand him/her in normal conversation?					
3.	Does the student appear to be free of frustration (crying, anger, refusal to repeat, etc.) if misunderstood?					
4.	Does the student answer questions and participate in discussions?					
5.	Do you feel the student is outgoing?					
6.	Do peers accept the student's speech and not comment to the student, each other, or you about his/her speech?					
7.	Does the student actively engage in social interactions with peers?					
8.	Can you listen to what the student is saying without being distracted by his/her speech?					
9.	Does the student's speech allow for participation and progress in activities? Please explain any difficulties below.					
10.	Does the student's speech allow for participation/progress in the general curriculum? Please explain any difficulties.					

Do you have any other observations related to the communication skills of this student? (Questions 9 &10)

Respondent's Signature:			
Title:		**Date:**	

Appendix F
Speech Sound Production and Use Assessment Summary

Enter District Name Here

Date:

Student's Name:	First:	Middle:	Last:
Date of Birth:		Grade:	
School:		Age:	
SLP:		Communication Assessment:	

1. INTELLIGIBILITY

a. Clinician's judgment of connected speech intelligibility:	
☐ intelligible	☐ occasionally unintelligible and/or noticeably in error
☐ frequently unintelligible	☐ unintelligible or only intelligible when the listener has knowledge of the context
b. Clinician's judgment of connected speech intelligibility:	
☐ conversation with clinician	☐ classroom observation
☐ other, specify:	

2. SOUND SYSTEM

Standardized test(s) administered:	**Date:**	**SD:**	**Percentile:**	**SS:**
Comments:				

3. ERROR TYPE

a. Sound errors or phonological processes typical of a child of younger age (list):													
b. Unusual or atypical sound errors or phonological processes (list):													
Student's Name:		First:				Middle:				Last:			
c. Phonetic Inventory (an X indicates the sound is not present in any context):													
☐	pencil	☐	toe	☐	fan	☐	send	☐	thin	☐	key	☐	path
☐	be	☐	duck	☐	TV	☐	zoo	☐	then	☐	bib	☐	hop
☐	man	☐	go	☐	run	☐	ship	☐	jump	☐	chair	☐	dog
☐	nose	☐	kite	☐	her	☐	chip	☐	pleasure	☐	bed	☐	toe
☐	house	☐	leaf	☐	wet	☐	ring	☐	hat	☐	foot	☐	bye
☐	who	☐	boy	☐	nut	☐	cow	☐	head	☐	way	☐	again
☐	no	☐	yes										
Comments:													

4. SPEECH MECHANISM STRUCTURE AND/OR FUNCTION

☐ adequate for speech	☐ significantly affects speech
☐ mildly affects speech	☐ inadequate for speech
Comments:	

5. INFORMAL ASSESSMENT INFORMATION (information from observation, interview, etc.):

Appendix G
Orofacial Examination Form

Enter District Name Here

Student's Name:	First:	Middle:	Last:
Date of Birth:		Grade:	
School:		Age:	
Date of Assessment:		SLP:	

The orofacial examination of the above child revealed the following:

Facial Characteristics- Intraoral Characteristics- Function	Adequate	Inadequate
Face (Appearance, Frontal View, Profile)		
Lips		
Tongue Characteristics (size, frenum, protrusion)		
Tongue Movement (Protrusion, Lateralization, Elevation)		
Uvula/Pharynx		
Dentition		
Hard Palate		
Soft Palate		
Velopharyngeal Closure		
Diadochokinetic Rate		
Comments on deviations or inadequacies:		
	Yes	No
Oral Facial Functioning is adequate for speech production.		

SLP Signature _____ Date _____

Appendix H
Communication Rating Scale: Speech Sound Production and Use

Enter District Name Here

Date:

Student's Name:	First:	Middle:	Last:	
Date of Birth:		Grade:		
School:		SLP:		
	Non-Disabling	**Mild**	**Moderate**	**Severe**
Intelligibility	☐ **0**	☐ **4**	☐ **6**	☐ **8**
	Connected speech is intelligible.	Connected speech is occasionally unintelligible and/or noticeably in error.	Connected speech is frequently unintelligible.	Connected speech is unintelligible or only intelligible when listener has knowledge of the context.
Sound System *See *Note Below*	☐ **0**	☐ **3**	☐ **4**	☐ **6**
	Scores on standardized instruments are within 1 1/3 standard deviations below the mean or above the 9th percentile.	Scores on standardized instruments are within 1 1/3 to 1 2/3 standard deviations below the mean or from the 9th to 5th percentile.	Scores on standardized instruments are within 1 2/3 to 2 standard deviations below the mean or from the 4th to 2nd percentile.	Scores on standardized instruments are 2 or more standard deviations below the 2nd percentile.
Error Types	☐ **0**	☐ **3**	☐ **4**	☐ **5**
	No significant errors are present. Differences may be typical or recognized dialectal patterns.	Productions reflect common phonological processes or sound errors.	Productions reflect atypical phonological processes or sound errors.	Productions reflect a limited phonetic inventory and/or numerous atypical phonological processes.
	☐ **0**	☐ **2**	☐ **4**	

Speech Mechanism Structure and Function				☐ **5**
	Structure and/or function are adequate for speech.	Structure and/or function difficulty mildly affects speech.	Structure and/or function difficulty affects speech.	Structure and/or function are inadequate for speech.
Adverse Impact on Educational, Social, and/or Vocational Performance	☐ **0**	☐ **4**	☐ **6**	☐ **8**
	No interference with performance in the educational setting.	Minimally impacts performance in the educational setting.	Moderately interferes with performance in the educational setting.	Seriously limits performance in the educational setting.
Total Score	**0-10**	**11-17**	**18-25**	**26-32**
Rating Scale	☐ Non-disabling	☐ Mild	☐ Moderate	☐ Severe
Severity Rating	☐ 0	☐ 1	☐ 2	☐ 3

Comments:

NOTE: Not all standardized measures have a consistent correlation among standard deviations, standard scores, and percentiles. This section should only be marked after the standard score or percentile has been compared to the standard deviation according to the test manual for that specific test.

Appendix I
Teacher/Parent Interview: Language

Enter District Name Here

Date:

Student's Name:	First:	Middle:	Last:
Date of Birth:		Grade:	
School:		Respondent:	
Primary Language:		SLP:	

Place a check in the appropriate column to rate student performance and return this form to the Speech-Language Pathologist.

As compared to peers in the same setting:		**Always**	**Often**	**Sometimes**	**Rarely**	**Never**
		1	2	3	4	5
1.	Does this student listen to a story or presentation as appropriately as his/her peers do?					
2.	Does the student follow directions for participation and transitioning between activities?					
3.	Does the student exhibit appropriate knowledge of basic concepts as compared to his/her peers?					
4.	Does the student appear to comprehend questions asked in discussions?					
5.	Does the student ask questions for clarification or further information when he/she does not understand?					
6.	Does the student follow the class/home routine?					
7.	Does the student demonstrate understanding of the intent of the message?					
8.	Does the student use sentences as long and complex as his/her peers?					
9.	Does the student tell stories and explain events or actions as appropriately as his/her peers?					
10.	Does the student answer questions as appropriately as his/her peers?					
11.	Does the student answer questions as quickly as his/her peers?					

12.	Does the student explain and elaborate during curriculum-related discussions?					
13.	Does the student recall names of known items and people quickly and efficiently (word finding)?					
14.	Does the student recall information from a book read?					
15.	Does the student use language relevant to the situation?					
16.	Does the student use appropriate language to successfully communicate in a variety of situations for a variety of purposes?					
17.	Does the student interact appropriately with the teacher and/or family members?					
18.	Does the student informally communicate with the teacher and/or family members as compared to peers?					
19.	Does the student interact appropriately with peers?					
20.	Does the student initiate, maintain, and terminate conversations appropriately?					
21.	Does the student establish and maintain appropriate social relationships?					
22.	Do the student's communication skills allow for participation and progress in activities? Please explain below.					
23.	Do the student's communication skills allow for participation and progress in the general curriculum? Please explain below.					

Do you have any other observations related to the communication skills of this student?

Respondent's Signature:			
Title:		**Date:**	

Appendix J
Language Assessment Summary

Enter District Name Here

Date:

Student's Name:	First:	Middle:	Last:
Date of Birth:		Grade:	
School:		Age:	
SLP:		Communication Assessment:	

1. FUNCTIONAL/NONSTANDARDIZED ASSESSMENT RESULTS:

Measure Used:	Findings:

2. STANDARDIZED/NORM-REFERENCED TEST RESULTS

	Non-Disabling	**Mild**	**Moderate**	**Severe**
Standard Deviation	X	-1 1/3 to -1 2/3	-1 2/3 to -2	-2 or more
Percentile	above the 9th	9th to 5th	4th to 2nd	below the 2nd
Name of Test(s)/Subtests(s) *Record Standard Score(s) in appropriate severity level*				

	Non-Disabling	Mild	Moderate	Severe

6. **INFORMAL ASSESSMENT INFORMATION (information from observation, interview, etc.):**

Appendix K
Communication Rating Scale: Language

Enter District Name Here

Date:

Student's Name:	First:	Middle:	Last:
Date of Birth:		Grade:	
School:		SLP:	

	Non-Disabling	**Mild**	**Moderate**	**Severe**
Functional Assessment	☐ **0**	☐ **4**	☐ **6**	☐ **8**
	Language skills are within the expected range.	Language skills are mildly impaired.	Language skills are moderately impaired.	Language skills are severely impaired.
	☐ Form/ Structure	☐ Form/ Structure	☐ Form/ Structure	☐ Form/Structure
	☐ Content/ Semantics	☐ Content/ Semantics	☐ Content/ Semantics	☐ Content/Semantics
	☐ Use/ Pragmatics	☐ Use/ Pragmatics	☐ Use/ Pragmatics	☐ Use/Pragmatics
Standardized/ Norm-Referenced Assessment See Note	☐ **0**	☐ **3**	☐ **4**	☐ **6**
	Scores on Standardized instruments are within 1 1/3 standard deviations below the mean or above the 9th percentile.	Scores on Standardized instruments are within 1 1/3 to 1 2/3 standard deviations below the mean or from the 9th to 5th percentile.	Scores on Standardized instruments are within 1 2/3 to 2 standard deviations below the mean or from the 4th to 2nd percentile.	Scores on Standardized instruments are 2 or more standard deviations below the 2nd percentile.

Adverse Impact on Educational, Social/Behavior-al, and/or Vocational Performance	☐ **0**	☐ **4**	☐ **6**	☐ **8**
	No interference with performance in the educational setting.	Minimally impacts performance in the educational setting.	Moderately interferes with performance in the educational setting.	Seriously limits performance in the educational setting.
Total Score	**0-7**	**8-12**	**13-17**	**18-22**
Rating Scale	☐ Non-disabling	☐ Mild	☐ Moderate	☐Severe
Severity Rating	☐ 0	☐ 1	☐ 2	☐ 3

Comments:

NOTE: Not all standardized measures have a consistent correlation among standard deviations, standard scores, and percentiles. This section should only be marked after the standard score or percentile has been compared to the standard deviation according to the test manual for that specific test.

Appendix L
Teacher/Parent Interview: Fluency

Enter District Name Here

Date:

Student's Name:	First:	Middle:	Last:
Date of Birth:		Grade:	
School:		Respondent:	
Primary Language:		SLP:	

Place a check in the appropriate column to rate student performance and return this form to the Speech-Language Pathologist.

As Compared to peers in the same setting:		**Always**	**Often**	**Sometimes**	**Rarely**	**Never**
		1	2	3	4	5
1.	Does the student verbalize appropriately?					
2.	Does the student verbalize effortlessly?					
3.	When verbalizing, are the student's facial and body movements appropriate?					
4.	Does this student readily participate in class discussions or activities that require speaking in front of groups?					
5.	Do you accept the student's pattern as adequate?					
6.	Do peers accept the student's pattern as adequate?					
7.	Do you understand the student's verbal intent without difficulty?					
8.	Does this student readily participate in conversation with peers? Please explain below.					
9.	Does the student's speech allow for participation/progress in the general curriculum? Please explain below.					

Do you have any other observations related to the communication skills of this student? (Question 8 & 9)

Respondent's Signature:			
Title:		**Date:**	

Appendix M
Fluency Assessment Summary

Enter District Name Here

Date:

Student's Name:	First:	Middle:	Last:
Date of Birth:		Grade:	
School:		Age:	
SLP:		Communication Assessment:	

2. BEHAVIORAL COMPONENTS:

a. Frequency of dysfluencies: _____/per 100 words produced in conversational context	
b. Types of dysfluencies observed:	
☐ whole multisyllabic word repetitions	☐ abnormal rhythm, continuity, rate or effort
☐ whole monosyllabic word repetitions	☐ interjections
☐ part-word syllable repetitions	☐ broken words
☐ part-word speech sound repetitions	☐ blocks/phonatory arrest
☐ rephrasing or revision of sentences	☐ silent or audible prolongations
☐ pitch rise	☐ pauses
c. Blocks/phonatory arrest/sustained articulatory posture observed:	
☐ no	☐ yes: average duration of ___ seconds
d. Speech sound prolongations observed:	
☐ no	☐ yes: average duration of ___ seconds
e. Schwa replacement for intended vowel observed:	
☐ no	☐ yes
f. Physical concomitants (secondary characteristics/struggle behaviors) observed:	
☐ none perceived	☐ noticeable to casual observer

☐ only noticeable to trained observer	☐ distracting or obvious to the listener
Description of behavior(s):	

3. AFFECTIVE COMPONENTS

a. Student awareness and emotional reaction to dysfluencies:	
☐ not aware	☐ often aware
☐ occasionally aware	☐ always aware
b. Student emotional reaction to dysfluencies:	
☐ not concerned	☐ negative emotions are often observed/reported
☐ mildly frustrated	☐ negative emotions are frequently observed/reported

4. COGNITIVE COMPONENTS

a. Verbal or situational avoidance behaviors:	
☐ non observed or reported	☐ frequently observed or reported
☐ occasionally observed or reported	☐ consistently observed or reported in numerous situations
b. Peer reactions to dysfluencies:	
☐ appear unaware	☐ frequent teasing noted/reported
☐ aware: some teasing noted/reported	☐ considerable teasing requires strong adult intervention

5. INFORMAL ASSESSMENT INFORMATION (information from observation, interview, etc.)

Appendix N
Communication Rating Scale: Fluency

Enter District Name Here

Date:

Student's Name:	First:	Middle:	Last:
Date of Birth:		Grade:	
School:		SLP:	

	Non-Disabling	Mild	Moderate	Severe
Frequency of Dysfluencies	☐ 0	☐ 2	☐ 3	☐ 4
	10 or fewer per 100 words in conversation.	11 to 12 per 100 words in conversation.	13 to 14 per 100 words in conversation.	15 or more per 100 words in conversation.
Types(s) of Dysfluencies	☐ 0	☐ 2	☐ 4	☐ 6
	Mostly whole multisyllabic word repetitions. Occasional whole-word interjections and phrase/sentence revisions.	Mostly whole monosyllabic word repetitions. Repetitions are rapid, tense and irregularly paced. Pitch rise may be present.	Mostly part-word syllable repetitions. Occasional speech sound repetitions. Prolongations and broken words noted. Repetitions are rapid, tense and irregularly paced. Pitch rise may be present. Blocks in which sound and airflow are shut off.	Frequent part-word speech sound repetitions. Frequent prolongations and broken words. Repetitions are rapid, tense and irregularly paced. Pitch rise may be present. Long, tense blocks, some with noticeable tremors.
Phonatory Arrest/ Sustained Articulatory Posture	☐ 0	☐ 4	☐ 6	☐ 8
	None observed or less than .5 seconds duration	0.5 to 2.0 seconds in duration	2.1 to 3.0 seconds in duration	3.1 or more seconds in duration
Speech Sound Prolongations	☐ 0	☐ 4	☐ 6	☐ 8
	None observed or less than 1.5 seconds duration	1.6 to 3.0 seconds in duration	3.1 to 4.0 seconds in duration	4.1 or more seconds in duration
	☐ 0	☐ 0	☐ 0	☐ 6

Schwa Replacement	Not Perceived	Not Perceived	Not Perceived	Perceived
Physical Concomitants	☐ **0**	☐ **2**	☐ **4**	☐ **6**
	None Perceived	Only noticeable to trained observer.	Noticeable to casual observer.	Distracting or obvious to the listener.
Awareness and Emotional Reactions	☐ **0**	☐ **2**	☐ **4**	☐ **6**
	Student is neither aware of, nor concerned about, dysfluencies.	Student is occasionally aware and mildly frustrated by dysfluencies.	Student is often aware of dysfluencies. Negative emotions are often observed/ reported.	Student is always aware of dysfluencies Negative emotions are frequently observed/reported.
Avoidance Behaviors and Peer Reactions	☐ **0**	☐ **2**	☐ **4**	☐ **6**
	No verbal or situational avoidance observed or reported. Peers appear unaware of dysfluencies.	Verbal or situational avoidance occasionally observed or reported. Peers are aware of dysfluencies; some teasing noted or reported.	Verbal or situational avoidance frequently observed or reported. Frequent teasing noted or reported.	Verbal or situational avoidance consistently observed or reported. Considerable teasing requiring strong adult intervention.
Adverse Impact on Educational, Social/Behavioral, and/or Vocational Performance	☐ **0**	☐ **4**	☐ **6**	☐ **8**
	No interference with performance in the educational setting.	Minimally impacts performance in the educational setting.	Moderately interferes with performance in the educational setting.	Seriously limits performance in the educational setting.
Total Score	**0-16**	**17-27**	**28-40**	**41-58**
Rating Scale	☐ Non-disabling	☐ Mild	☐ Moderate	☐ Severe
Severity Rating	☐ 0	☐ 1	☐ 2	☐ 3

Comments:

NOTE: Not all standardized measures have a consistent correlation among standard deviations, standard scores, and percentiles. This section should only be marked after the standard score or percentile has been compared to the standard deviation according to the test manual for that specific test.

Appendix O
Teacher/Parent Interview: Voice

Enter District Name Here

Date:

Student's Name:	First:	Middle:	Last:
Date of Birth:		Grade:	
School:		Respondent:	
Primary Language:		SLP:	

Place a check in the appropriate column to rate student performance and return this form to the Speech-Language Pathologist.

As compared to peers in the same setting:		Always	Often	Sometimes	Rarely	Never
		1	2	3	4	5
1.	Does the student maintain his/her voice throughout the day?					
2.	Can the student's voice be heard when answering questions or participating in class activities/discussions?					
3.	Does the student use a loudness level that is appropriate to the classroom environment?					
4.	Does the student have appropriate pitch as compared with peers (e.g., pitch is not too high/too low)?					
5.	Do peers accept the student's voice as normal?					
6.	Does the student use appropriate voice quality compared with peers (e.g., quality is not frequently hoarse)?					
7.	Does the student speak easily without excessive coughing or throat clearing?					
8.	Do you freely call on this student to answer questions?					
9.	Does the student readily participate in class discussions or activities that require speaking in front of peers? Please explain any difficulties below.					
10.	Does the student's voice allow for participation/progress in the general curriculum? Please explain any difficulties below.					

Do you have any other observations related to the communication skills of this student?(Questions 9 & 10)

Respondent's Signature:			
Title:		**Date:**	

Appendix P
Communication Rating Scale: Voice

Enter District Name Here

Student's Name:	First:	Last:		Grade:	
School:		Date of Birth:		Age:	
SLP:		Date:			

	Non-Disabling	Mild	Moderate	Severe
Pitch	**0**	**1**	**2**	**3**
	Normal for age, gender and culture.	Noticeable abnormality perceived by trained listener.	Intermittent abnormality perceived by untrained listener.	Persistent abnormality for age, sex and/or culture.
Loudness	**0**	**1**	**2**	**3**
	Within normal limits.	Noticeable abnormality perceived by trained listener.	Intermittent abnormality perceived by untrained listener.	Persistent abnormality for age, sex and/or culture.
Quality	**0**	**1**	**2**	**3**
	Within normal limits.	Noticeable abnormality perceived by trained listener.	Intermittent abnormality perceived by untrained listener.	Persistent breathiness, glottal fry, harshness, hoarseness, tenseness, stridency, aphonia or other abnormal vocal qualities.
Resonance	**0**	**1**	**2**	**3**
	Within normal limits.	Noticeable abnormality perceived by trained listener.	Intermittent abnormality perceived by untrained listener.	Persistent abnormality.

Vocal Abuse/Misuse	**0**	**2**	**3**	**4**
	Not observed.	Limited to specific situations.	Observed intermittently throughout the day.	Persistent throughout the day.
Medical Findings	**0**	**2**	**4**	**6**
	No laryngeal pathology reported by physician. Physical conditions influencing pitch, loudness, quality or resonance may include allergies, colds, abnormal tonsils and/or adenoids.	Minor laryngeal pathology reported by physician. Pathology may include vocal fold thickening, edema or nodules.	Laryngeal pathology reported by physician. Pathology may include nodules, polyps, ulcers, edema, partial paralysis of vocal folds, enlarged or insufficient tonsils and/or adenoids.	Persistent physical conditions reported by physician. Pathology may include unilateral or bilateral paralysis of vocal folds, neuromotor involvement of laryngeal/ velopharyngeal muscles, etc.
Adverse Impact on Educational, Social/Behavioral, and/or Vocational Performance	**0**	**4**	**6**	**8**
	No interference with performance in the educational setting.	Minimally impacts performance in the educational setting.	Moderately interferes with performance in the educational setting.	Seriously limits performance in the educational setting.
Total Score	**0-8**	**9-15**	**16-23**	**24-30**
Rating Scale	Non-disabling	Mild	Moderate	Severe
Severity Rating	0	1	2	3

Comments:

NOTE: Not all standardized measures have a consistent correlation among standard deviations, standard scores, and percentiles. This section should only be marked after the standard score or percentile has been compared to the standard deviation according to the test manual for that specific test.

Appendix Q
Communication Written Report

Enter District Name Here

Date(s) of Evaluation:

Student's Name:	First:	Middle:	Last:
Date of Birth:		Grade:	
School:		Communication Assessment:	
This information is being provided to the MET for the purposes of:			
☐ initial evaluation of Language-Speech skills *(Comprehensive assessment):*			
☐ reevaluation of Language-Speech skills *(comprehensive or skill-specific assessment):*			
☐ Other, specify:			

Contributors (Name/Title):

Speech-Language Pathologist:		Parent/Guardian:	
General Education Teacher:		Special Education Teacher *(if applicable)*:	
Other Contributors:			
Hearing Screening:			
☐ passed screening at 25 dB on_____ *(date of screening)*		☐ failed screening at 25 dB on _____ *(report results of medical/audiological follow-up)*	
Comments:			
Oral Examination:			
☐ structure and function within normal limits on _____*(date of evaluation)*			
Other, specify:			
Communication Screening *(check all areas found to be within normal limits):*			
☐ Speech Sound Production and Use		☐ Fluency	
☐ Language		☐ Voice	

Appendix R
Communication Written Report Summary

Enter District Name Here

Student's Name:	First:	Middle:	Last:

Speech-Language Assessment Summary
(Summarize formal and informal assessment information, Present Level of Academic Achievement and Functional Performance, and any adverse impact on educational, social/behavioral, and/or vocational performance.)

Other:

☐ **Yes** ☐ **No**	The student's communication difference is due to use of regional dialect or nonstandard English. (If yes, the assessment must reflect consideration of these issues.)
☐ **Yes** ☐ **No**	The student speaks two or more languages and/or is unfamiliar with the English language. (If yes, the assessment must reflect consideration of these issues.)
☐ **Yes** ☐ **No**	There is evidence that the student's communication disorder adversely affects his/her educational, social/behavioral, and/or vocational performance. (Supportive documentation must be summarized in this report on the appropriate Rating Scale.)
Speech-Language Pathologist(s) Signature:	
	Date:

Appendix S
Language-Speech Impairment (L/S) Eligibility Determination Form

Enter District Name Here

Attachment *to Multidisciplinary Team (MET) Conference Summary/Action Form*
NOTE: *This form documents the student's eligibility for Language-Speech as a category of disability only.*

☐ Initial Determination of Eligibility for this Category of Disability		☐ Re-Determination of Eligibility for this Category of Disability	
Student's Name:	First:	Middle:	Last:
Date of Birth:		Date of Eligibility Determination:	
School:			

The **MET** determines a student to have a **Language or Speech Impairment** and is eligible for specially designed instruction and related services when:

Complete During MET		***The MET compared and analyzed evaluation data and documents the following interpretation.***
☐ **Y** ☐ **N** ☐ **Insufficient**	1.	Communication disorder in one or more of the following: ☐ Stuttering ☐ Voice ☐ Articulation ☐ Delayed Acquisition of Language ☐ Language ☐ An Absence of Language
☐ **Y** ☐ **N** ☐ **Insufficient**	2.	Evaluation information confirms there is an adverse effect on educational, social/behavioral/, and/or vocational performance (must be present for eligibility).
☐ **Y** ☐ **N** ☐ **Insufficient**	3.	Evaluation information confirms that lack of instruction in reading and/or math was not a determinant factor in the eligibility decision.
☐ **Y** ☐ **N** ☐ **Insufficient**	4.	Evaluation information confirms that limited English proficiency was not a determinant factor in the eligibility decision.

On the following page provide Supporting Documentation that demonstrates the **MET**:

- Used multiple data sources that substantiate the existence of the disability (triangulation of data);
- Confirmed the progress of the child is impeded by the disability to the extent that the child's educational, social/behavioral, and/or vocational performance is significantly and consistently below the level of similar-aged peers.

Language or Speech Impairment

Student's Name	First:	Middle:	Last:
Supporting Evidence:			

The **MET** used the above interpretation of the evaluation data to determine:

- ☐ The student has a speech or language impairment that adversely impacts his/her education and is eligible for specially designed instruction.
- ☐ The student does not have a speech or language impairment and is not eligible for specially designed instruction.
- ☐ The student has a speech or language impairment, but it does not adversely impact his/her education; therefore, the student is not eligible for specially designed instruction.
- ☐ Evaluation data was insufficient to determine eligibility. Additional assessments and/or data will be obtained/collected the area(s) of:

The **MET** will reconvene by _____ to review and determine eligibility.

Appendix T
Prosody Checklist

Enter District Name Here

Student's Name:	First:	Middle:	Last:
Date of Birth:		Grade:	
School:		Communication Assessment:	

	Yes	No	Comments
Prosody in Speech			
Does the student's stress production change in conversation?			
Does the student's voice reflect changes in affect (i.e., monotone voice)?			
Does the student's intonation change when speaking (appropriately reflects mood, emotions, etc.)?			
Does the student perceive changes in prosody in other speakers (mood of speaker, emotions, sarcasm, etc.)?			

Appendix U
Reevaluation Checklist

Enter District Name Here

Student Name: _____Date of Birth: _____

District: _____SLP:_____

Procedures for Reevaluation (Date completed/NA for not applicable):

_____ WPN sent 7 days prior to meeting
_____ Reviewed current IEP and progress towards annual goals
_____ Conducted observation across settings
_____ Gathered information from teacher
_____ Gathered information from parent(s)/guardian(s)
_____ Reviewed initial evaluation or most recent reevaluation
_____ Used current date to determine adverse educational impact
_____ Reviewed current academic status (absences, report cards, progress reports, discipline reports, etc.)
_____ Reviewed eligibility criteria of disabilities
_____ Conducted hearing/vision screening if appropriate

Results:
Hearing _____/_____
pass/fail date
Vision _____/_____
pass/fail date

_____ Completed informal assessments (including curriculum based assessments)
_____ Completed formal assessments/evaluations
_____ Presented WPN for testing to parent
_____ Explained Procedural Safeguards with parent
_____ Obtained parental consent for testing
_____ Reevaluation completed
_____ If IEP Committee determines that a change in service is warranted, a change of placement form is given.
_____ The IEP Committee completes the reevaluation.
_____ The IEP is revised to reflect the most current reevaluation data and results.
Results of Reevaluation (Check one):
_____ Continued eligibility and placement of special education
_____ Change of eligibility/placement
New eligibility/placement: _____
_____ Dismissal from Special Education (change of placement form included)

Appendix V
Language-Speech Dismissal Form

Enter District Name Here

Student's Name: _____Date of Birth: _____

District: _____SLP:_____

The IEP Committee convened _____, and based on reevaluation data has determined that _____ is no longer eligible for Special Education services for the category of Language-Speech.

Procedures used to reach this determination include (check all that apply):

- ☐ A review of the IEP
- ☐ Review of current data to determine adverse educational impact
- ☐ Administration of assessments/evaluations when appropriate
- ☐ Interviews with teachers, parents, and therapists
- ☐ Observations across settings
- ☐ If testing was warranted, the parent received WPN and gave parental consent for testing (report of testing attached)

The IEP Committee determines that Language-Speech services are no longer warranted due to (check one):

- ☐ The student no longer meets the eligibility criteria for language-speech services because (check all that apply):
  - ☐ The student has mastered IEP goals/objectives.
  - ☐ The student's language-speech skills are within the normal range.

- ☐ The student's progress has plateaued or has shown a lack of progress, and the student no longer benefits from language-speech services due to (check all that apply):
  - ☐ Limited physical, mental, or emotional ability to self-monitor communication
  - ☐ Poor attendance
  - ☐ Lack of motivation
  - ☐ Limited potential for a significant change in communication skills

- ☐ The student's communication no longer has an adverse educational impact on educational, social/behavioral or vocational performance.

- ☐ The student no longer requires language-speech services due to their disability.
  - ☐ Skills are being monitored and maintained in the student's environment.
  - ☐ Skills are being addressed by others in the student's environment (i.e., special education teacher, general education teacher, etc.).

Appendix W
Calibration and Mechanical Check of the Audiometer

Enter District Name Here

1) Manually-operated pure tone audiometers (those which require the clinician to manually set the frequency and decibel level) must be calibrated annually and meet ANSI S3.6-2004 standards.

2) The manual for each audiometer will indicate which standards are met.

3) A "biologic check" of the audiometer should be performed before each day's use to ensure the results obtained for that day are valid. The following guidelines are recommended for the biologic check.
   a. Whenever possible, the same individual should perform the biological check each day for the specific audiometer being used.
   b. Obtain a true threshold (the softest level that can be heard 2 out of 3 times) on the better ear with the right earphone (red earphone) and record the results at each frequency.
   c. Using the SAME ear, obtain a threshold with the left earphone (blue earphone) and record the results.
   d. Compare the thresholds at each frequency to ensure that they do not differ by more than +/- 5 dB. If they do vary, the audiometer should not be used. This discrepancy between earphones indicates that one earphone is testing at a better level than the other earphone. The audiometer needs to be checked.

4) A maintenance check of the audiometer should be performed at the same time of the biologic check before each day's use to ensure the audiometer is in good working order. The following guidelines are recommended for the maintenance check. It is recommended that a clinician with normal hearing do the quick maintenance check immediately before use.

5) Preferably after use with each child, it is recommended that the earphones be cleaned with a **NON-ALCOHOLIC,** 100% tuberculocidal, bactericidal, fungicidal, and virucidal agent. When cleaning, keep all moisture away from the diaphragm.

Check	Problem	Send for Repair
Press the interrupter switch and present tone	Do you hear a "click"?	If so, send for repair
With earphone on the clinician's ears, present a 1000 Hz tone at 50 dB HL in each ear and shake or run fingers along the cords to the earphones	Is the tone intermittent or is static heard?	If so, send for repair
Check Earphone cushions	Are the earphone cushions clean and free from cracks and tears?	If not, obtain new ones
Check Dials	Are the frequency and attenuator dials tight and free from slippage?	If not, send for repair

Place headband on head	Is the headband snug with sufficient tension on the head?	If not, obtain a new one
Check for cross talk at 1000 Hz at 70 dB HL for each earphone	As you listen to the right earphone, no sound should be present in the left earphone.	If crosstalk occurs, send for repair

Daily Biologic Calibration and Mechanical Check Data Sheet

NAME OF INDIVIDUAL PERFORMING CHECK: _____

AUDIOMETER ID: _____ DATE: _____

Same Ear Hearing Threshold Level

PHONE	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz	8000 Hz
Right (red)							
Left (blue)							

Mechanical Checklist

Specific Check	Does Problem Exist (circle appropriate response)	Specific Repair Need
Is click heard with interrupter switch?	**Y/ N**	Send for repair
Are earphone cords intermittent?	**Y/ N**	Send for repair
Is static heard in earphone cords?	**Y/ N**	Send for repair
Are dials slipping?	**Y/ N**	Send for repair
Is crosstalk present?	**Y/ N**	Send for repair
Is headphone band loose?	**Y/ N**	Obtain new headband
Are earphone cushions cracked or torn?	**Y/ N**	Obtain new cushions

Appendix X
Suggested Hearing Screening Facility Criteria

Enter District Name Here

Most local agencies do not own sound level meters which are used to measure the ambient noise levels of the room being used in testing. A biologic check may be substituted if one does not have a sound level meter at his/her disposal.

Procedure for the Biologic Check for Ambient Noise:

1. Screen a person with normal hearing at 10 dB below the target screening level across all frequencies to be used in the screening.
    a. In using a screening level of 25 dB HL, set the attenuator dial at 15 dB HL and screen the person's hearing across all frequencies to be tested. If the person can hear the tones at all frequencies at 15 dB HL, then the room should be sufficiently quiet to perform the screenings.
    b. In using a screening level of 20 dB HL, set the attenuator dial at 10 dB HL and screen the person's hearing across all frequencies to be tested. If the person can hear the tones at all frequencies at 10 dB HL, then the room should be sufficiently quiet to perform the screenings.

Suggested criteria for the room and set-up of equipment:

1. Maintain as silent a screening site as possible
2. Preferably use room with floor covered with carpeting and ceiling with acoustic tile
3. Avoid areas near:
    a. Fans/ Air conditioners/ Heating units
    b. Hallway traffic
    c. Playground or street
    d. Music room
    e. Bathrooms
    f. Cafeterias
    g. Office equipment
4. Set up equipment in a corner or against a wall that does not separate the room from other noisy environments (see above)
5. Avoid excessive noise within screening area, such as:
    a. Talking
    b. Paper shuffling
    c. Open windows
    d. Movement of desks
    e. Pencil sharpeners

Appendix Y
Sample Parent Letter for Students who Pass Hearing Screening

Enter District Name

DATE:

PARENT NAME:

PARENT ADDRESS:

Dear Parent,

Good hearing is critical in the learning process and in your child's ability to progress successfully in school. For this reason, your child's class at _____ (name of school) was seen for a routine hearing screening. We are pleased to inform you that your child passed his/her pure tone screening.

Please be aware that hearing may change at any time for a variety of reasons. If you notice that your child may be experiencing difficulty with hearing, please let us know. If you have any questions about these results or about the hearing screening program at _____ (name of school), do not hesitate to call me at _____ (phone number).

Sincerely,

_____

Enter District Name Here

Sample Parent Letter for Students Who Failed 1st Hearing Screening

NAME OF SCHOOL

ADDRESS OF SCHOOL

DATE

PARENT NAME

PARENT ADDRESS

Dear Parent,

Good hearing is critical in the learning process and in your child's ability to progress successfully in school. For this reason, the child's class at _____ (name of school) was seen for a routine hearing screening on _____ (date). On this date, your child had difficulty with his/her pure tone screening (which screens how well he/she hears) and/or immittance screening (which measures middle-ear function). These results do NOT mean that your child has a hearing loss. His/her difficulties may be due to any numerous causes such as: noise in the testing area, distractions, a lack of understanding instructions, middle ear fluid, or any number of other reasons.

Since your child experienced difficulty with this screening, his/her hearing will be rescreened again within seven days. You will be notified of the results of the results at that time. If you have any questions about these results or about the hearing screening program at _____ (name of school), do not hesitate to call me at _____ (phone number).

Sincerely,

_____

Enter District Name Here

Sample Parent Letter to Refer Students for Further Evaluation

(Place check by appropriate referral)

NAME OF SCHOOL

ADDRESS OF SCHOOL

DATE

PARENT NAME

PARENT ADDRESS

Dear Parent,

Good hearing is critical in the learning process and in your child's ability to progress successfully in school. Because your child's initial screening at school indicated a possible concern, your child was rescreened on _____ (date).

During this second screening, your child continued to have difficulty with his/her pure tone screening and/or immittance screening. This screening is NOT conclusive, but it is recommended that your child be seen:

a. ____ for a full hearing evaluation to identify whether your child may be experiencing a hearing loss which might impact his learning.
b. ____ a family physician for possible middle ear problems.

Please note that several causes of hearing loss are not severe, nor permanent, but it is important to identify even a mild loss so that recommendations may be made to help minimize the effects of the loss.

We recommend that your child be evaluated within 14 to 21 days. See enclosed a list of licensed, certified audiologists (health professionals who specialize in hearing) or otolaryngologists in the surrounding area who would be pleased to assess your child's hearing.

I appreciate your willingness to have _____ (child's name) evaluated. If you have any questions or need further information, please do not hesitate to call me at _____.

Sincerely,

_____

Enter District Name Here

Teacher/Staff Notification Form with Suggested Instructional Adjustments for Children Who Failed Hearing Screening

Dear Staff:

Please be aware that _____ (name of child) failed his/her hearing screening on _____ (date), and therefore, may be experiencing difficulty in the classroom hearing and responding to verbal instruction. Until _____'s hearing status can be accurately identified, instructional adjustments are recommended for him/her. These adjustments may include, but are not limited to the following recommendations.

1. Preferential seating in the classroom: The child should be placed where he/she is in the line of sight with the teacher. Optimal distance of the student from teacher (when feasible) should be four to six feet. If this is not feasible, then the child should be placed as close to the teacher as possible to ensure the child has the best access to the teacher's verbal instruction. The student's better ear, if known, should be towards the teacher.

2. Gain the child's attention prior to speaking.

3. Clearly enunciate your speech.

4. Check for understanding periodically and be willing to repeat or modify instruction when necessary.

5. Whenever possible, avoid:
    a. Standing in front of a bright window while teaching.
    b. Speaking with his/her back to the child (i.e. – facing the chalk board and not the class).
    c. Positioning yourself so your face is not visible to the students.
    d. Speaking with objects in your mouth (gum, etc.).

Enter District Name Here

Sample Referring Agency Reporting Form

NAME OF SCHOOL

ADDRESS OF SCHOOL

Dear _____ (name of agency child to whom child was referred):

Recently, _____ (name of child) participated in a school screening program and the results of the screen and rescreen indicated that he/she needed further evaluation for a possible hearing loss and/or outer/middle ear disorder. It was therefore recommended that the student be seen by you for further evaluation.
We would appreciate your cooperation in completing the form below so that, if necessary, the appropriate accommodations and modifications may be made in order for _____ (name of student) to succeed in school. Please complete the form and return to the address at the top of this letter. If you have further questions or comments, please contact me at _____ (phone number).
Sincerely,

_____

(cut along dotted line and mail to the school address above)

STUDENT: _____ SCHOOL: _____
TYPE OF EVALUATION PERFORMED: _____
PERSON WHO COMPLETED EVALUATION and DATE:
_____

RESULTS OF FULL HEARING EVALUATION:

How could the child's condition noted during the examination interfere with educational testing and performance?

How might the hearing loss impact educational, social/behavioral, and/or vocational performance?

What are the recommendations for accommodations, modifications, and educational programming?

What are the communication needs and abilities of the child?

SIGNATURE: _____ DATE: _____

Appendix Z
Language Enrichment Teacher Checklist

Enter District Name Here

Student's Name:	First:	Middle:	Last:
Date of Birth:		Grade:	
School:		Communication Assessment:	

_____ **1. Student is referred to SLP for language deficit(s).**
_____ **2. SLP conducts screening of student using (check all that apply):**
_____a. observation(s)
Notes on observation: _____
_____
_____b. a review of records, data and other information specific to the student
Notes on review: _____
_____
_____c. administration of a published and/or non-published screener(s)
Specify screener: _____
Results of screening: _____
_____d. other screening methods such as non-word repetition tasks, rapid word recall tasks, checklist(s), etc.
Specify screening method: _____
Results of screening: _____
_____ **3. SLP determines area of weakness to target for dynamic assessment (D.A.)**
_____a. Method of determination (CBA, screener, etc.)
_____
_____b. Skill(s) targeted with 80% mastery:
_____
_____
_____
_____c. Duration of D.A. (not to exceed 4 weeks):
Begin Date: _____End Date: _____
_____d. Frequency/intensity of D.A.:
_____minutes/_____
_____ **4. Results of language intervention (check one):**
_____a. Target met (≥80%), intervention no longer required.
_____b. Progress made (60-79%), continued support needed.
_____1.) Continue support at current intensity/frequency.
_____2.) Continue support with (frequency/intensity):
_____minutes/_____
_____c. Minimal or no progress made (less than 60%), refer to MET.
_____ **5. Results of D.A. included in Language-Speech Report for MET.**

Appendix AA
Language-Speech Therapy Data Sheets

Name:
_____DOB:_____IEP:_____Evaluation:_____
Long Term
Goal(s):_____
List short term objectives below. On date of therapy, note % accuracy of targeted skills. Absentees, check-outs, student behavior, and other notes may be included.

Date	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5	Goal 6	Goal 7	Goal 8

Appendix BB
Language-Speech Screening Permission Form

Enter District Name Here

Student's Name:	First:	Middle:	Last:
Date of Birth:		Grade:	
School:		Communication Assessment:	

Dear Parent,

Your child has been recommended to the Teacher Support Team (TST) for additional support. After review of all information, TST is recommending that your child's language-speech skills be screened. Your permission for a language-speech screening is required to proceed. The results of the language-speech screener will be provided to you once completed. My rights, and those of my child, have been explained to me by the Procedural Safeguards. I understand my rights, and give my consent for screening.

I, _____ (Parent/Guardian) give consent for my child,
_____ to be screened for language and/or speech deficits.

_____
Signature

_____
Date

Appendix CC
Information for Parents/Teachers/Caregivers

Typical Language Development Lower Elementary (Ages 5-7)

What to Expect from a Kindergartener – Language at 5 years

1. Vocabulary approximately 5000 words
2. Refer to abstract ideas and personal evaluations (It's good because…)
3. Use subject related relative clauses, and comparatives and superlatives (er,- est)
4. Begins using school dialogue (classroom rules, turn-taking groups, etc.)
5. Most sounds have developed (r/s/l are exceptions)
6. Begin to identify initial sounds in words

What to Expect from a First Grader – Language at 6 years

1. Adds up to 5000 new words; greater depth of understanding of words develops; semantic hierarchies (dog-animal)
2. Understands concepts of words; learns abstractions by analogy (it's like a…); analyzes to figure out, differentiates
3. Begins to communicate in writing with invented spelling, simple sentences; begins to develop concepts of text structure for reading
4. Phonemic awareness concepts of onsets and rhymes develop (Consonant + at = cat, fat, hat); Blends sounds into a word
5. Most sounds, including /r, s, l/, should have developed

What to Expect from a Second Grader – Language at 7 years

1. 5000 words added yearly; metaphors are used appropriately; produces puns, riddles, word jokes; defines words
2. Derivational suffixes begin to emerge, including –ful, -less, -ly, -ness, -al, -ance; develop modal + have (could have eaten)
3. Spelling begins to use more conventional phonics patterns
4. Begins to internalize different genre structures (letters, stories, poems); Interactive stories (flashback, suspension)
5. Phonemic awareness manipulation to make new words (stand with /t/); can apply phonic rules

Appendix DD
Sample Letters

Sample Letter to Parents
Beginning of School

Dear Parents,

I would like to take this opportunity to introduce myself as your child's speech therapist for this school year. I hope you've had a wonderful summer and are ready to start working on speech-language again. I think we're going to have a wonderful year, and I look forward to working with you and your child.

Your child has a "speech folder" which contains the sounds and/or concepts we are working on in speech-language therapy. Please help your child to keep up with this folder by encouraging them to keep it in their backpack. This way, the folder is easily transported between school and home and doesn't get lost along the way. Also, home practice is very important for carryover of speech sounds. Whenever possible, please spend a few minutes practicing these sounds with your child. This is one reason why it is so important that the speech folder goes home every day.

If you should have any questions, please feel free to call me at _____, or email _____. Thank you and I look forward to working with your child this year!

Sincerely,

_____, (CCC-SLP or 216 Speech Therapist)
(Insert School)

Sample Home Practice Letter
Prevention

Dear Parent,

Your child, _____, was referred to the Speech/Language Pathologist for problems he had producing the ____ sound. _____ can produce it when cued, so instead of speech therapy, I am recommending that he/she practice the sound at home and over the summer.

I am attaching some speech sheets with /__/ in the beginning, middle, and end of words. Cue _____ to _____. For voiced /__ / (as in "____"), the only difference is the "voice motor is on" (you can put your fingers on your voice box to feel the difference).

If he/she still needs additional help after you have practiced at home, then a speech therapist can recheck him/her. If you have any additional questions or concerns, please feel free to contact me at _____, or by email at _____. Thanks for all you do as a parent!

Sincerely,

_____, (CCC-SLP or 216 Speech Therapist)
(Insert School Name)

Sample Summer Practice Letter

Dear Parent of _____,

What a wonderful year we had in speech! Here are some resources for you to use at home over the summer break in order to enhance your child's speech skills. Working at home with your child will pay off when they return to school in the fall, so please use any opportunity you may have to practice your child's sounds. Also, please set aside some time each day to read with your child – this helps them grow in discriminating sounds, building vocabulary, and many more reading and language skills. I have truly enjoyed having your child in speech this year, and I hope you have a safe and relaxing summer! Thank you,

_____, (CCC-SLP or 216 Speech Therapist)

Sample Letter to Teachers:
Therapy Schedule

Dear Classroom Teacher,

I will have the following student(s) in your class for speech-language therapy this year. The days/times for therapy listed below are tentative. Once I start running my schedule, some changes may need to be made. If you have any questions or concerns, please feel free to contact me. I am located in the speech therapy room, and I am always available to answer your questions and concerns regarding any of your students. I look forward to working with you this school year. Thank you!
_____, (CCC-SLP or 216 Speech Therapist)

Days: _____

Time: _____
Student(s):
_____

_____
_____
_____

Appendix EE
Sample Language-Speech Referral Form

Dear Teachers,

Some of you have inquired about speech referrals for students in your class. If you have concerns regarding the speech and/or language of one of your students, please complete the attached form and return it to one of the speech therapists (you can give it to us personally or place it in our boxes).

If you have any other questions or concerns, please let us know. We look forward to working with you this school year.

Thank you,

_____

Speech-Language Pathologist or 216 Speech Therapist

Student Name:		
Date of Birth:		
General Education Teacher:		
Area of Concern (circle all that apply):	Articulation Stuttering	Language Voice
Date of Request:		
Date Seen:		

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INTERNET RESOURCES

ASHA Office of Multicultural Affairs and Resources (search for: multicultural affairs): http://www.asha.org

Early Childhood Research Institute on Culturally and Linguistically Appropriate Services: http://www.clas.uiuc.edu

Mississippi Department of Education: http://www.mde.k12.ms.us

Acronyms

AAC	Augmentative and Alternative Communication
ASHA	American Speech-Language-Hearing Association
AU	Autism
BIP	Behavior Intervention Plan
CCC	Clinical Certificate of Competence
DB	Deaf-Blind
DD	Developmentally Delayed
EBP	Evidenced-Based Practice
ESY	Extended School Year
FAPE	Free and Appropriate Public Education
FBA	Functional Behavior Assessment
HI	Hearing Impaired
ID	Intellectual Disability
IEP	Individualized Education Program
IDEA 04	Individuals with Disabilities Education Act Amendments of 2004
LEA	Local Education Agency
LRE	Least Restrictive Environment
L/S	Language-Speech
MCCRS	Mississippi College and Career Readiness Standards
MD	Multiple Disabilities
MDE	Mississippi Department of Education
MET	Multidisciplinary Evaluation Team
MSIS	Mississippi Student Identification System
NOM	Notice of Meeting (formerly WPN)
OI	Orthopedic Impairment
OHI	Other Health Impairment
OT	Occupational Therapy
PLAAFP	Present Levels of Academic Achievement and Functional Performance
PT	Physical Therapy
RtI	Response to Intervention
SCD	Significant Cognitive Disability
SDI	Specially Designed Instruction
SLD	Specific Learning Disability
SLP	Speech-Language Pathologist
TBI	Traumatic Brain Injury
TST	Teacher Support Team
VI	Visually Impaired
WPN	Written Prior Notice