



DISABILITIES LAW PROGRAM

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MEMORANDUM

To: SCPD Policy & Law Committee

From: Brian J. Hartman

Re: Regulatory Initiatives

Date: December 9, 2012

I am providing my analysis of seventeen (17) regulatory initiatives in anticipation of the December 13 meeting. Given time constraints, my commentary should be considered preliminary and non-exhaustive.

1. DSS Final TANF/Transitional Work Program Sanction Reg. [16 DE Reg. 643 (12/1/12)]

The SCPD and GACEC commented on the proposed version of this regulation in October, 2012. A copy of the GACEC's October 31 letter is attached for facilitated reference. The Councils endorsed the regulation for the reasons compiled in the letter.

The Division of Social Services (DSS) has now acknowledged the endorsements and adopted a final regulation which conforms to the proposed version. I recommend no further action.

2. DSS Final General Assistance Time Limit Regulation [16 DE Reg. 642 (12/1/12)]

The SCPD and GACEC commented on the proposed version of this regulation in October, 2012. A copy of the GACEC's October 31 letter is attached for facilitated reference. The Councils endorsed the regulation for the reasons compiled in the letter. In a nutshell, it eliminated a 24-month time limit cap on enrollment in the GA program which pays qualified individuals \$95 monthly and provides automatic Medicaid coverage.

The Division of Social Services (DSS) has now acknowledged the endorsements and adopted a final regulation which conforms to the proposed version. I recommend no further action.

3. DMMA Final Medicaid LTC Home Equity Cap Reg. [16 DE Reg. 639 (12/1/12)]

The SCPD and GACEC commented on the proposed version of this regulation in October, 2012. A copy of the GACEC's October 31 letter is attached for facilitated reference.

The regulation was issued to comply to federal law which establishes a presumptive cap on Medicaid LTC eligibility of \$500,000 subject to annual increases based on the Consumer Price Index (CPI). The regulation updated the standards to reflect increases in the CPI.

The Councils endorsed the regulation since it enhanced eligibility for LTC services and conformed to federal law. However, the Councils recommended adoption of a revised standard for determining equity value. The Division agreed with the recommendation and adopted a final regulation which incorporated the revision suggested by the Councils verbatim.

I recommend no further action.

4. DLTCRP Final Nurse Assistant/CNA Training Regulation [16 DE Reg. 632 (12/1/12)]

The SCPD and GACEC commented on the proposed version of this regulation in October. A copy of the SCPD's October 31 memo is attached for facilitated reference. The Division has now adopted a final regulation with some changes prompted by the commentary. However, the Division omits any reference to GACEC comments and does not summarize the SCPD's comments as contemplated by the Administrative Procedures Act, Title 29 Del.C. §10118(b).

First, the Councils recommended editing the definitions section for consistency and to conform to the Register's Delaware Administrative Code Drafting and Style Manual. The Division effected twenty-six (26) discrete amendments to the definitions section in response to the recommendation.

Second, the Councils recommended a grammatical correction in §2.4. The correction was made.

Third, the Councils recommended a grammatical correction in §2.4.1. No correction was made.

Fourth, the Councils recommended a grammatical correction in §3.2.11. No correction was made.

Since the regulation is final, and the "overlooked" grammatical corrections are relatively minor, I recommend no further action.

5. DLTCRP Final Rest (Residential) Regulation [16 DE Reg. 637 (12/1/12)]

Both the SCPD and GACEC submitted eighteen (18) comments on the proposed version of this regulation in October, 2012. A copy of the SCPD's October 31, 2012 memo is attached for facilitated reference. The Division of Long Term Care Residents Protection (DLTCRP) has now adopted a final regulation with many edits prompted by the commentary. However, the Division omits any reference to GACEC comments.

1-5. The Councils recommended punctuation and grammatical corrections in five (5) sections. The references were corrected in all of the sections.

6. The Councils noted that the licensing statute permits residency of individuals under age 18 in rest (residential) facilities. The proposed regulation barred residency by anyone under 18. No amendment was made. The Division responded as follows:

Response: Rest Residential homes are intended for mature persons generally capable of making their own decisions and handling their own ADLs. This would not be the case with minor residents.

At 638. The validity of this rationale could be questioned.

7-8. The Councils recommended punctuation and grammatical corrections in two (2) sections. The references were corrected in both sections.

9. The Councils recommended embellishing the accessibility references. The Division added the following reference: "Existing facilities accommodating residents who regularly require wheelchairs shall comply with the Americans with Disabilities Act standards." At 638. This reference is helpful but could have been improved since it literally only refers to individuals using wheelchairs as juxtaposed to scooters, walkers, and other mobility-related AT.

10. The Councils recommended correction of punctuation. The error was corrected.

11. The Councils recommended incorporation of accessible door handle references. The Division added the following sentence: "All doors for areas used by residents shall be capable of being opened from either side and shall comply with the Americans with Disabilities Act standards."

12. The Councils objected to the term "institution" in §5.12.1. The Division responded that the reference has been edited.

13. The Councils recommended insertion of a water temperature standard at spigots used for hand-washing akin to standards in other regulations. The Division inserted a temperature standard.

14. The Councils recommended insertion of a standard to require dishwasher to have a sanitizing cycle. The Division responded that the regulation requires compliance with the Delaware Food Code which contains requirements for sanitation.

15. The Councils identified a punctuation error. The Division omitted a response to the comment.

16. The Councils identified a concern with lockable medicine containers. The Division responded that the section was edited.

17. The Councils identified a grammatical error. The Division noted that the error was corrected.

18. The Councils recommended adding a requirement of posting the LTC Bill of Rights in a prominent location. The Division inserted the following new section: "3.11. The Patient's Bill of Rights (Title 16) is posted in a conspicuous location within each residence to ensure easy access by individuals served."

Since the regulation is final, and the Division ostensibly effected approximately fifteen (15) amendments, I recommend either no action or sharing a "thank-you" communication.

6. DOE Prop. Teacher of Students Who Are Deaf or HOH Cert. Reg. [16 DE Reg. 582 (12/1/12)]

The Professional Standards Board previously shared the attached 10/31/12 pre-publication draft of this regulation with the GACEC. The GACEC then sent the attached November 14, 2012 comments on the draft regulation. The GACEC identified two (2) concerns: 1) the regulation had no "grandfather" provision and required educators to complete the required credits within only 18 months; and 2) a requirement of only three (3) credit hours in ASL seemed too low to achieve proficiency.

I have the following observations.

I. The published version of the regulation contains the following limited "grandfather" provision which is similar to the analogous provision in the "autism teacher" regulation cited in the GACEC's letter.

5.0 Past Certification Recognized

The Department shall recognize a Standard Certificate Teacher of Students Who are Deaf or Hard of Hearing issued by the Department between January 11, 2007 and the effective date of this regulation. A teacher holding a Standard Certificate Teacher of Students Who are Deaf or Hard of Hearing issued between January 11, 2007 and the effective date of this regulation shall be considered certified to teach children who are deaf or hard of hearing.

A. At a minimum, this section should be revised as follows: 1) capitalize “deaf” in last sentence for consistency; 2) capitalize two references to “are” in both sentences; and 3) substitute “students” for “children” in last sentence to match Part 1574 title.

B. The rationale for adopting the “2007 forward” date is unclear. The “autism teacher” standard has a “look back” period dating to 2005. See 16 DE Reg. 489, 493 (November 1, 2012) (proposed). If the qualifications did not change between 2005-2007, the DOE may wish to use a 2005 date.

C. The “grandfather” provision does not “cure” the GACEC’s concern that an educator would have only 18 months to complete the required 21 credits. A longer time frame should be considered.

II. The GACEC expressed concern that a requirement of 3 credits in ASL was ostensibly too low to develop proficiency. Upon closer reading, Sections 4.1.2.6 -4.1.2.8 actually makes the 3 credits in ASL optional. An educator can take either “Visual Language Development” or “American Sign Language.” I continue to question the lack of a more robust standard for ASL competency.

I recommend sharing the above observations with the Professional Standards Board, DOE, SBE, and CODHHE.

7. DOE Prop. Teacher of Students with Visual Impairments Cert. Reg. [16 DE Reg. 587 (12/1/12)]

The Professional Standard Board proposes to revise its certification standards for teachers of students with visual impairments. In general, the template for the regulation matches that of recent regulations proposed by the Professional Standards Board and DOE. Compare Teacher of Students with Autism or Severe Disabilities Certification, 16 DE Reg. 489 (November 1, 2012) (proposed); and Teacher of Students Who Are Deaf or Hard of Hearing Certification, 16 DE Reg. 582 (12/1/12) (proposed).

I have three (3) observations.

First, §5.0 contains a “grandfather” provision applicable to educators who obtained their certificate between January 11, 2007 and the effective date of the regulation. This is the same time frame as proposed under the above “Deaf” teacher certification regulation but shorter than the September, 2005 time frame in the “Autism” teacher certification regulation. The rationale for the different dates is not clear. The DOE may wish to consider whether an earlier date should be adopted.

Second, educators who do not meet all of the requirements in the regulation only have 18 months to achieve compliance. This is a relatively short time frame and could be lengthened.

Third, when the Professional Standards Board last revised this regulation, the Councils reminded it of the application of Title 14 Del.C. §206. That statute establishes a presumption that proficiency in Braille reading and writing is essential for each student. It also contains the following teacher certification mandate:

(d) As part of the certification process, all newly certified teachers of the visually impaired, after enactment of this section shall be required to demonstrate competence in reading and writing Braille. The Department of Education which certifies teachers shall require proof of a passing score on the Library of Congress Braille Competency Test (when it is completed and validated), or any comparable, nationally recognized validated test. Until that time, the Department of Education will continue to certify teachers of the visually impaired through its existing standards. All newly hired teacher aides will be required to achieve certification as Braille transcribers through the Library of Congress within 2 years of employment.

In its response to the Councils' comment, the DOE noted that "a reference to an existing statute was added to make the regulation compliant." See 10 DE Reg. 1147 (January 1, 2007). It then amended §3.0 to require applicants to meet the requirements in Title 14 Del.C. §206(d). At 1149. See also 16 DE Reg. 587, 589 (December 1, 2012), §3.0. Thus, at a minimum, the proposed regulation must continue to comply with §206(d) which requires a passing score on a validated test. The proposed regulation has no test requirement. Parenthetically, §206(d) was added to the Code in 1995. The DOE may wish to assess whether it still reflects current "best practice" or merits repeal or amendment.

I recommend sharing the above observations with the Professional Standard Board, DOE, SBE, and DVI.

8. DLTCRP Prop. Assisted Living Facility Emergency Prep. Reg. [16 DE Reg. 595 (12/1/12)]

The Division of Long Term Care Residents Protection proposes revisions to its assisted living regulation to address emergency preparedness.

As background, the Division notes that the changes are motivated by circumstances encountered during and after Hurricane Irene in 2011 as well as input from the University of Delaware and a consulting firm. The standards require facilities to have two active, full-time employees who have completed specific FEMA training within a 24-month period. The standards also require annual submission of a facility plan to the Division which conforms to a Division template.

I recommend endorsement subject to three (3) amendments.

First, "Assisted living" should be substituted for "Nursing" in §18.1.

Second, §18.6.3 could be “renumbered” as §18.7. Section 18.6 is a sentence which requires facilities to submit a plan and certificates. Section 18.6.3 is another independent sentence which does not comport with the format and grammar in §18.6.

Second, §18.6 recites that “(e)ach facility shall submit with its annual license” the “all hazards emergency plan” and documentation of FEMA training. Literally, the section is problematic since: 1) facilities do not “submit a license”; and 2) the requirement does not require submission of plans in connection with initial licenses. The assisted living facility “licensing requirements and procedures” regulation (16 DE Admin Code 3225, §4.0) requires facilities to comply with initial and renewal licensing standards codified at Title 16 Del.C. Ch. 11. Title 16 Del.C. §1104(a) refers to an application for a license or renewal of a license and §1104(e) refers to an “annual renewal application”. Therefore, I recommend amending §18.6 to read as follows:

Each facility shall submit with an application for a license and annual renewal of a license:

Parenthetically, the SCPD or DDC may wish to solicit a copy of the “template” mentioned in §18.3. The Councils may have additional recommendations to submit based on the content of the template.

9. DLTCRP Prop. Nursing Facility Emergency Preparedness Regulation [16 DE Reg. 592 (12/1/12)]

The Division of Long Term Care Residents Protection proposes revisions to its skilled and intermediate nursing facility regulation to address emergency preparedness.

As background, the Division notes that the changes are motivated by circumstances encountered during and after Hurricane Irene in 2011 as well as input from the University of Delaware and a consulting firm. The standards require facilities to have two active, full-time employees who have completed specific FEMA training within a 24-month period. The standards also require annual submission of a facility plan to the Division which conforms to a Division template.

I recommend endorsement subject to two (2) amendments.

First, §8.6.3 could be “renumbered” as §8.7. Section 8.6 is a sentence which requires facilities to submit a plan and certificates. Section 8.6.3 is another independent sentence which does not comport with the format and grammar in §8.6.

Second, §8.6 does not literally require submission of plans in connection with initial license applications. The skilled and intermediate nursing facility “licensing requirements and procedures” regulation (16 DE Admin Code 3201, §4.0) requires facilities to comply with initial and renewal licensing standards codified at Title 16 Del.C. Ch. 11. Title 16 Del.C. §1104(a) refers to an application for a license or renewal of a license and §1104(e) refers to an “annual renewal application”. Therefore, I recommend amending §8.6 to read as follows:

Each facility shall submit with an application for a license and annual renewal of a license:

Parenthetically, the SCPD or DDC may wish to solicit a copy of the “template” mentioned in §8.3. The Councils may have additional recommendations to submit based on the content of the template.

10. DLTCRP Prop. Pediatric Nursing Home Emergency Prep. Reg. [16 DE Reg. 593 (12/1/12)]

The Division of Long Term Care Residents Protection proposes revisions to its “Nursing Homes Admitting Pediatric Residents” regulation to address emergency preparedness.

As background, the Division notes that the changes are motivated by circumstances encountered during and after Hurricane Irene in 2011 as well as input from the University of Delaware and a consulting firm. The standards require facilities to have two active, full-time employees who have completed specific FEMA training within a 24-month period. The standards also require annual submission of a facility plan to the Division which conforms to a Division template.

I recommend endorsement subject to two (2) amendments.

First, §12.6.3 could be “renumbered” as §12.7. Section 12.6 is a sentence which requires facilities to submit a plan and certificates. Section 12.6.3 is another independent sentence which does not comport with the format and grammar in §12.6.

Second, §12.6 recites that “(e)ach facility shall submit with its annual license” the “all hazards emergency plan” and documentation of FEMA training. Literally, the section is problematic since: 1) facilities do not “submit a license”; and 2) the requirement does not require submission of plans in connection with initial licenses. The relevant licensing statutes are codified at Title 16 Del.C. Ch. 11. Title 16 Del.C. §1104(a) refers to an application for a license or renewal of a license and §1104(e) refers to an “annual renewal application”. Therefore, I recommend amending §18.6 to read as follows:

Each facility shall submit with an application for a license and annual renewal of a license:

Parenthetically, the SCPD or DDC may wish to solicit a copy of the “template” mentioned in §8.3. The Councils may have additional recommendations to submit based on the content of the template.

11. DMMA Prop. Psychiatric Hospital Reimbursement Regulation [16 DE Reg. 597 (12/1/12)]

The Division of Medicaid & Medical Assistance proposes to revise the Medicaid State Plan to describe reimbursement methodologies for inpatient psychiatric hospital services and outpatient hospital services.

As background, DMMA notes that it has been paying providers of inpatient psychiatric services and partial hospital psychiatric services an “individually negotiated rate with each provider”. CMS has disallowed this methodology and the Division is now adopting a more uniform rate for private providers of these services using Medicare rates as a point of reference. The Division recites that the new methodology will have “a fairly small fiscal impact”. At 598. The actual rate calculation standards are detailed and “technical”. At 599.

Since the initiative is prompted by CMS, and there is little fiscal impact, I recommend endorsement subject to a minor grammatical edit. In the first sentence on p. 599, insert “at” prior to “42 CFR 413”.

12. DPH Proposed School-Based Health Centers Regulation [16 DE Reg. 600 (12/1/12)]

The Division of Public Health proposes to adopt a regulation establishing standards for school-based health centers.

I have the following observations.

First, the Administration promoted legislation (H.B. No. 303) which was enacted in 2012 despite considerable debate and introduction of multiple amendments. The SCPD and GACEC identified a significant concern with the application of the legislation to parents of students with disabilities. The May 7, 2012 GACEC memo is attached for facilitated reference. In a nutshell, federal law bars claims against insurance policies of IDEA and §504-identified students if there would be any adverse financial impact without parental consent. At the behest of the Councils, Rep. Q. Johnson introduced the attached H.A. No. 3 to H.B. No. 303. In exchange for not pursuing the amendment, DHSS agreed to adopt a conforming regulation with specific language. This agreement was confirmed in writing through a May 10, 2012 email which can be provided on request. Unfortunately, the DPH proposed regulation does not conform to the Department’s commitment. The truncated reference in the regulation is as follows:

6.3. Any services provided by SBHCs pursuant to a student’s Individualized Education Program (IEP) are not subject to third-party billing.

This omits all federally required protections for students with §504 plans. It also omits federally required protections for students being evaluated for eligibility under the IDEA and §504 who do not yet have an IEP or §504 plan.

At a minimum, this section should be revised as follows:

6.3. *The following services shall be exempt from third-party billing:*

6.3.1. *Any services provided to a student related to an evaluation or assessment of eligibility under the Individuals with Disabilities Education Act, 20 U.S.C. §1400 et seq, or Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. §701 et seq.; and*

6.3.2. *Any services provided to a student implementing an Individualized Education Program (IEP) or Section 504 Plan developed in conformity with either of the above federal laws.*

Second, in §1.0, substitute “§§3365 and 3571G” for “§3365 and 3517G”.

Third, in §2.0 , the first sentence does not conform to the Administrative Code Drafting and Style Manual available at <http://regulations.delaware.gov/documents/drafting&stylemanual.pdf>. Section 3.1.2 of the Manual recites as follows:

The first paragraph should read, “The following words and terms, when used in this regulation, shall have the following meaning unless the context clearly indicates otherwise.”

Fourth, in §3.1, third sentence, the grammar is problematic. Consider substituting “SBHCs do not supplant...”.

Fifth, §4.1 limits the authority to enroll a minor to a parent or guardian. The Division should consider whether a “relative caretaker” or “custodian” could authorize enrollment or if a definition of “parent” should be added which includes a “relative caregiver” or “custodian”. See Title 14 Del.C. §§202 and 3101(7) and Title 13 Del.C. §707.

Sixth, there is no provision authorizing a student who has reached the age of majority to “self-enroll”. See Title 14 Del.C. §3101(7) and Title 13 Del.C. §707.

I recommend sharing the above observations with DPH, Rep. Q. Johnson, the DHSS Secretary, and the DHSS Chief Policy Advisor.

13. DSAMH Prop. MH Screener & Voluntary Admission Payment Reg. [16 DE Reg. 611 (12/1/12)]

The Division of Substance Abuse and Mental Health proposes to adopt standards in two contexts: 1) credentialing of mental health screeners; and 2) provider payment for voluntarily admitted patients.

As background, H.S. No. 1 for H.B. No. 311 was enacted and signed by the Governor on July 24, 2012. The bill revised the mental health commitment process. DHSS is authorized to issue regulations implementing the revised law. See Title 16 Del.C. §5122(m).

I have the following observations.

1. The regulation is inaccurate in some contexts. For example, the “background” section (p. 612) recites as follows:

Title 16 Ch. 51, Subchapter II now requires an assessment by a credentialed mental health screener before an individual is detained on a 24-hour psychiatric hold...

To the contrary, Title 16 Del.C. §5121A, which remains in effect until July 1, 2013, confers mental health detention authority on peace officers and physicians, not mental health screeners.

2. Section 1.0 recites as follows:

Title 16, Chapter 51 of the Delaware Code states that only psychiatrists and people credentialed by the Department of Health & Social Services (DHSS) as a Mental Health Screener (MH Screener) have the authority to detain or abrogate a detainment of a person involuntarily for a psychiatric evaluation.

A. This is inaccurate since it ignores Title 16 Del.C.§5121A which remains in effect until July 1, 2013.

B. The reference to “a detainment of a person involuntarily for a psychiatric evaluation” is oddly worded. It suggests that there could be a “voluntary” detainment. Moreover, the statutory term is “detention” and there is a statutory definition of “involuntary detention”. See Title 16 Del.C. §§5122 and 5122(a)(9). Finally, since the DHSS regulation only covers adults, the reference could be more specific. Consider substituting “detention of an adult for a psychiatric evaluation”.

3. The title to §1.0 (“Mental Health Screener Credentialing”) is inapposite. The title to the overall regulation identifies two (2) topics: 1) credentialing of MH screeners; and 2) payment for voluntary admission. It makes no sense to have §1.0 titled “Mental Health Credentialing” since this is the topic of §§1.0-8.0. It would be much clearer if the regulation were divided into two prominent subparts with headings, i.e. Mental Health Screener Credentialing and Payment for Voluntary Admission. The current format is to have §§1.0- 8.0 and 10.0 address credentialing and then to “bury” payment for voluntary admission out of order as §9.0. The current text in §1.0 could be placed under a heading of “Purpose; Use of “Mental Health Screener” Designation” or “Background; Use of “Mental Health Screener” Designation”.

4. In §1.0, substitute “professionals” for “people” to conform to Title 16 Del.C. §5122(a)(9).

5. In §1.0, second sentence, substitute “regulation” for “chapter”.

6. In §1.0, second sentence, the reference to “himself or herself” is disfavored. The Delaware Administrative Code Style Manual provides the following guidance:

3.3.2 Gender

3.3.2.1. Avoid using pronouns that indicate gender. Use the noun which the pronoun would replace. However, if pronoun gender must be indicated, use “his” instead of “his/her” and “he” instead of “he/she” or “(s)he.” The use of the masculine gender is addressed in 1 Del.C. §304 of the Delaware Code.

7 In §2.0, the definition of “Credentialed Mental Health Screener” uses a plural pronoun (“their”) with a singular antecedent (“DSAMH”). However, the entire reference to “or their designee” should be stricken. The statute contemplates credentialing by the Department, not some non-Departmental entity.

8. In §2.0, substitute “Correction” for “Corrections” to conform to Title 29 Del.C. Ch. 89.

9. Section 2.0, definition of “Crisis Experience in a mental health setting” is grammatically infirm. In pertinent part, it recites as follows:

“Crisis experience in a mental health setting” means a crisis experience in a mental health setting is defined as direct experience...

Substitute: ““Crisis experience in a mental health setting” means direct experience...”

10. Section 2.0, definition of “Licensed Mental Health Professionals”, the grammar merits correction. Consider inserting a period after the term “Chapter 51”. Then, begin the next sentence with “The term includes licensed physicians...”.

11. In Section 2.0, definition of “Licensed Mental Health Professionals”, I question the requirement that a licensed registered nurse have “a bachelor’s degree in nursing (BSN)” since this is not required by the licensing statute. See Title 29 Del.C. §1910. There may be many qualified registered nurses with considerable experience who would be disqualified by this extraneous limitation.

12. In Section 2.0, the definition of “Supervision of unlicensed mental health professionals by a psychiatrist” is problematic.

A. It would be preferable to convert this section to a substantive standard rather than a definition. For example, the second sentence is an operational protocol, not a definition.

B. There are multiple grammatical errors in this definition. For example, there is a singular indefinite adjective (“an”) with a plural noun (“professionals”).

C. The references to “need to work” and “will need to be placed” are not typical regulatory terms. Consider substituting “must work” and “shall be placed”.

D. The reference to “agency’s by-laws” makes no sense. Most agencies do not have “by-laws” apart from corporate by-laws defining the work of the board of directors. Moreover, some individuals may not work for an “agency”. Cf. §3.4.1.1 reference to “professional not affiliated with any Delaware health care facility”.

13. In Section 3.2.2. strike “that such person is licensed” and substitute “that he is licensed” or “of a current license”.

14. In §3.4.1, it is anomalous to require 5 years of experience for DSAMH employees but only 2 years of experience for employees of any other public or private health care facility.

15. In §3.4.2, there is no provision for a public agency apart from DSAMH (e.g. Veterans Hospital) “vouching” for the years of experience.

16. In §3.4.1.2, there is a plural pronoun (“their”) with a singular antecedent (“facility”).

17. In §3.4.2.1., there is a plural pronoun (“they”) with a singular antecedent (“applicant”). Moreover, consistent with Par. 11 above, I question the categorical requirement that a licenced RN have a BSN degree.

18. In §3.4.2, the multiple references to “relating to Professions and Occupations” are superfluous and should be deleted.

19. In §§3.4.2, strike the multiple references to “that such person is licensed” and substitute “that he is licensed” or “of a current license”.

20. I recommend deletion of §3.4.2.4.2 as superfluous. See Title 24 Del.C. §3908.

21. I recommend deletion of §3.4.2.5.2 as superfluous. See Title 24 Del.C. §3032. If not deleted, the reference to “Board” makes no sense in the context of the regulation.

22. I recommend deletion of §3.4.2.6.2 as superfluous. See Title 24 Del.C. §3052. If not deleted, the reference to “Board” makes no sense in the context of the regulation.

23. Section 3.5.1 requires unlicensed mental health professionals applying for screener status to pay both an application fee and credentialing fee. There is no analog for licensed professionals. It is unclear of the latter professionals are expected to pay such fees.

24. Since the standards are identical, §§3.5.1.1 and 3.5.1.2 could be merged.

25. In §§3.5.1.3 and 3.5.1.4, it is anomalous to allow an unlicensed State employee to qualify with a Bachelor’s degree while requiring a Master’s degree for a private sector employee. This is reminiscent of the former practice of allowing unlicensed physicians to practice at DPC. There is little logic to adopting a lesser credentialing qualification for State employees.

26. While the credentials sections address clinical experience, they are completely silent on expertise in utilizing police power and involuntary detention procedures. The statute contemplates the screeners promptly “taking into custody” individuals whose behavior constitutes a danger to self or others. See Title 16 Del.C. §5122(b). The statute also contemplates the screener transporting the individual involuntarily to another screener or facility. See Title 16 Del.C. §5122(c). The former Attorney General opposed granting police power to mental health personnel in the commitment context based on concerns about lack of training and capacity to detain violent individuals. Query whether physical fitness standards should be included in the credentialing criteria? Obviously, the ability to physically detain an unruly individual is contemplated by the statute and some individuals may initially appear cooperative but change their “affect” quickly. Training would be also be essential.

27. Definitions should be compiled in the front of the regulation. See Delaware Administrative Code Style Manual, §3.1.2. It makes no sense to have both a §2.0 definitions section and a §4.0 definitions section. Alternatively, Section 4.0 contains substantive standards rather than “definitions” and could be converted to a “contents of initial application” section and a “reapplication standards” section. The format of §4.0 could then be converted to the following: “An initial application for approval as an MH Screener shall include the following:...”. The 2-year term of approval should then be inserted. Finally, a section could then require a reapplication to be filed at least X days prior to the expiration of the 2-year term. Otherwise, the regulation would literally permit a reapplication to be filed on the 2-year expiration date.

28. In §4.0, delete “or their designee”. See Par. 7 above.

29. In §4.0, the reference to “group” is inapposite since there are two sets of exempt professionals.

30. In §5.1, first definition, substitute “credentialed” for “credential”.

31. Consistent with Par. 27 above, it makes no sense to have a §2.0 definitions section, §4.0 definitions section, and §5.0 definitions section.

32. In Section 5.0, there is no operative sentence. The section consists of definitions and an outline. There is no sentence akin to “(T)he following standards will apply to the credentialing and recredentialing of MH screeners...”

33. The grammar in §5.1, first definition, is incorrect. At a minimum, consider inserting “which” prior to “will”. However, substantively, the “definition” makes no sense and is not used anywhere in the text of the regulation.

34. The grammar in §5.1, second definition, is incorrect. At a minimum, consider inserting “which” prior to “will”. However, substantively, the “definition” makes no sense and is not used anywhere in the text of the regulation.

35. In §5.0, the third definition is a putative substantive standard, not a definition.
36. In §5.2.1.1, I suspect the word “specific” was intended to be “specified”.
37. In §5.2, the multiple references to “specified above” should be converted to “specified in §5.1” for clarity.
38. Punctuation is missing from the end of §5.3.2.2.
39. There is a lack of parallel form in §§5.2.4.4, 5.3.1.3, , 5.3.2.3, and 5.3.3.3. See Delaware Administrative Code Style Manual, §6.2.3
40. Section 6.0 (“Data”) is not within the scope of the title to the regulation which is limited to credentialing and payment for voluntary patients. Moreover, the lengthy narrative is not written in regulatory form and is extremely difficult to follow.
41. In §6.0, substitute “detentions” for “detainments” to conform to the statute and §7.0. See discussion in Par. 2. B above. The Delaware Administrative Code Style Manual provides the following guidance:
- 6.2.2. Strive for consistency in terminology, expression and arrangement. Avoid using the same work or term in more than one sense. Conversely, avoid using different words to denote the same idea.
42. Section 7.0 has a plural pronoun (“their”) with a singular antecedent (“client”).
43. In §7.0, substitute “self” for “that person”.
44. Section 9.0 consists of a single 78-word sentence. Consider “breaking out” the last three concepts as subparts. For example, it could be revised as follows: Payment....confirmation of the following: 9.1. The admission represents...; 9.2. The duration of stay...; and 9.3. The State is the payer...
45. In §10.0, there are three instances of use of plural pronouns (“their”) with a singular antecedent (“individual”).

I recommend sharing the above observations with the Division. A courtesy copy could also be shared with the DHSS Secretary.

14. DSS Proposed Food Supp. Program Identification Card Reg. [16 DE Reg. 607 (12/1/12)]

The Division of Social Services proposes to amend its Food Supplement Program regulation.

As background, the current regulation requires DSS to “issue a serially numbered photo-ID card to each certified Food Stamp household”. With implementation of the Electronic Benefit Transfer (EBT) Card, DSS notes that it is no longer necessary for program participants to be issued a DSS identification card. Moreover, DSS observes that CMS has deleted the requirement from the federal regulations. Therefore, DSS proposes deletion of the requirement of issuance of the identification card.

Since the card is no longer necessary, and CMS has deleted the card requirement from the federal regulations, I recommend endorsement.

15. DSS Prop. Child Care Subsidy Income Elig. & Provider Reim. Reg. [16 DE Reg. 609 (12/1/12)]

The Division of Social Services proposes to revise its regulation covering financial eligibility of families participating in the program and provider reimbursement rates.

As background, based on findings of the 2011 Delaware Child Care Market Rate Study, the Legislature increased provider rates in this program to 65% of Market Rate plus 50 cents effective October 1, 2011. At 610. However, the actual regulation contains outdated family income eligibility and provider reimbursement charts. DSS proposes to eliminate the charts from the regulation and publish them on its Website. This should result in quicker updates.

I recommend endorsement subject to one observation. DSS indicates that the income limits chart is already on the Website. This is accurate. DSS also indicates that the provider rate chart “will be posted” on the Website. When I checked on December 6, I could not locate it. The Councils may wish to share a reminder to post the latter chart to facilitate easy access to the information.

16. DSS Prop. Child Care Subsidy Purchase of Care+ Phase Out Reg. [16 DE Reg. 603 (12/1/12)]

The Division of Social Services proposed to initiate a phase out of its Purchase of Care Plus program commencing January 1, 2013.

As background, this program is an option which allows providers to charge DSS clients the difference between the DSS reimbursement rate up to the provider’s private fee for service rate. Historically, I believe some providers have limited DSS purchase of care slots since the compensation was so low the providers arguably could not sustain their businesses if they had too many POC slots. By inference, the POC+ program gave families an option, i.e., if a preferred provider had no POC slots, the family could offer the DSS subsidized compensation supplemented by a family payment. The family would still enjoy a State subsidy but have to pay a supplement resulting in the provider receiving an aggregate of its “private-pay” rate.

DSS describes its rationale for discontinuing this option as follows:

The purpose and rationale for the proposed phase-out is: In 2011, the provider rates were raised to sixty five percent of the market rate plus fifty cents. In addition, providers who join the Quality Rating and Improvement System known as Stars can potentially receive up to one hundred percent of the market rate. Some providers may choose the option of not participating in Stars, but will make up the difference by collecting the additional POC Plus fees through low income families. Phasing out of POC+ will encourage providers to participate in Stars and give some financial relief to our low income families.

At 604.

There are pros and cons to this initiative.

The “pros” are as follows: 1) giving providers an incentive to participate in Stars quality rating program; 2) giving providers an incentive to offer more “regular” POC slots; and 3) reducing prospects for providers to negotiate payment of supplemental fees from families.

The “cons” are as follows: 1) reducing the network of providers who are willing to participate in the overall State subsidy program; and 2) eliminating an option for families seeking a preferred provider with no “open” POC slots.

Conceptually, the “pros and cons” are reminiscent of the public school system. Parents either enroll children in totally free public school or pay the full tuition at a private school. There are no partial “vouchers” to subsidize tuition in a private school. It’s an “all or none” public payment system. By analogy, the POC+ program is a partial voucher system for child care.

I do not know how many families participate in the POC+ program, how attractive the 65% + 50 cent payments are, and how difficult it is to identify child care providers with openings. These factors would influence the assessment of whether this initiative is a “good idea” or a “bad idea”. I recommend that the SCPD share the potential pros and cons of this initiative and note that the Council lacks sufficient background to adopt a position on the proposed phase out of the POC+ program.

17. DSS Proposed Interpreter & Translation Services Regulation [16 DE Reg. 605 (12/1/12)]

The Division of Social Services proposes to revise its regulations covering interpreter services for non-English speaking clients and clients with hearing impairments. DSS offers the following rationale for the changes:

The language in DSSM §§1009 and 1010 is changed to People First and the titles are changed to more accurately reflect the activity performed. In addition, the outdated listing of contracted vendors is removed. Finally, procedure is removed from the manual.

At 606.

I have the following observations:

§1009

First, the title to §1009 refers to “non-English speaking clients”. Likewise, the second paragraph of text refers to “non-English speaking clients. This is unduly narrow. The first sentence of text more accurately refers to individuals who have “limited English proficiency”. Moreover, the latter reference conforms to the attached HHS guidance excerpted from 68 Fed Reg. 47311 (August 8, 2003):

IV. Who Is a Limited English Proficient Individual?

Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak or understand English may be limited English proficient, or “LEP,” and may be eligible to receive language assistance with respect to a particular type of service, benefit, or encounter.

See also attached excerpt from HHS OCR Website describing “LEP” as covering individuals who have “not developed fluency in the English language”. Individuals who speak “some English” but lack “fluency” still qualify for “LEP” services.

DSS may wish to use the term “limited English proficiency” and include a definition.

Second, the regulation authorizes interpreter services only to “applicants” and “recipients”. This is unduly narrow. There may be individuals who request information on their behalf or on behalf of others. The above HHS standard refers to a “service, benefit, or encounter”.

Third, the second paragraph of text suggests that staff or vendor translation is the exclusive approach to address the needs of persons who would benefit from interpreter services. Consistent with the attached HHS OCR guidance, individuals should be offered the option of relying on their own interpreter. OCR notes that some individuals may be more comfortable with a family member interpreting. See also attached resolution agreement. Moreover, an individual may prefer to use a “personal” interpreter in lieu of waiting for a State interpreter or rescheduling a visit.

Fourth, it would be preferable to include a standard of “timely” provision of interpreter services. HHS characterizes undue delay in providing interpreter services as a “frequently encountered” Title VI violation. See attached 67 Fed Reg. 4975-76 (February 1, 2002).

Fifth, the exclusive context for determining need for interpreter services is a receptionist assessment upon the physical appearance of the individual:

The receptionist will identify the need for services when the applicant or recipient arrives at the office.

HSS guidance contemplates advertising the availability of interpreter services. It would be preferable to allow individuals to request an interpreter in advance (e.g. via phone).

§1010

First, the title to the section suggests that only existing “clients” are covered by the policy. This is too narrow to meet ADA standards. See attached DOJ ADA guidance:

The effective communication requirement applies to ALL members of the public with disabilities, including job applicants, program participants, and even people who simply contact state or local government agencies seeking information about programs, services, or activities.

Second, the regulation authorizes interpreter services only to “applicants” and “recipients”. This is unduly narrow. There may be individuals who request information on their behalf or on behalf of others. Id.

Third, the policy recites that it covers “auxiliary aids” for persons with hearing impairments. It then omits any accommodations apart from interpreter services. Consistent with the attached DSAMH policy, “30% to 50% of persons > 65 years of age have significant hearing loss leading to impairment in functioning.” If a person presents a “hard of hearing” profile, providing an ASL interpreter will not be useful. Moreover, the attached DOJ ADA guidance provides a long list of “auxiliary aids” apart from interpreters for individuals with hearing impairments.

Fourth, it would be preferable to incorporate a reference to “effective communication” in the regulation since this is the operative ADA benchmark. Id.

Fifth, covering the arrangement of services for individuals with hearing impairments with the 3-sentence policy is ostensibly inadequate guidance to staff.

I recommend sharing the above observations with DSS and CODHHE. If desired, the SCPD or CODHHE could offer technical assistance in preparing a more robust version of §1010.

Attachments

8g:legreg/1212bils

F:pub/bjh/legis/2012p&L/1212bils

STATE OF



DELAWARE

GOVERNOR'S ADVISORY COUNCIL FOR EXCEPTIONAL CITIZENS

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October 31, 2012

Sharon L. Summers
Policy, Program and Development Unit
Division of Social Services
1901 North DuPont Highway
P. O. Box 906
New Castle, DE 19720-0906

**RE: DSS Proposed TANF/Transitional Work Program Regulation [16 DE Reg. 379
(October 1, 2012)]**

Dear Ms. Summers:

The Governor's Advisory Council for Exceptional Citizens (GACEC) has reviewed the Division of Social Services (DSS) proposal to revise its standards covering sanctions for non-compliance with the Temporary Assistance for Needy Families (TANF) or Transitional Work Program (TWP). The current regulation imposes restrictions on access to child care services for individuals working to cure a second or subsequent sanction. The Division proposes to repeal the specific restrictions which DSS acknowledges "have not been implemented operationally".

Since the amendment offers flexibility in access to child care for individuals working to cure second or subsequent sanctions, the Council endorses the proposed revision. Access to child care is an important support enabling individuals to pursue employment or training.

Thank you for your time and consideration of our comments. Please feel free to contact me or Wendy Strauss should you have any questions.

Sincerely,

A handwritten signature in cursive script that reads "Terri Hancharick".

Terri A. Hancharick
Chairperson

TAH:kpc

STATE OF



DELAWARE

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October 31, 2012

Sharon L. Summers
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Division of Social Services
1901 North DuPont Highway
P. O. Box 906
New Castle, DE 19720-0906

RE: DSS Proposed General Assistance Time Limit Regulation [16 DE Reg. 378 (October 1, 2012)]

Dear Ms. Summers:

The Governor's Advisory Council for Exceptional Citizens (GACEC) has reviewed the Division of Social Services (DSS) proposal to repeal the regulation authorizing a 24-month time limit cap on the General Assistance program. This program pays qualified individuals \$95 per month and provides automatic Medicaid coverage. The DSS proposal to repeal the cap is based on the following rationale:

Many recipients if not most of the GA caseload are destitute and have no access to other cash resources to meet basic needs. Given the unavailability of other resources, the vulnerability of the population in the program, and the relative stabilization of the General Assistance caseload, DSS is repealing the 24-month time limit.

At 379.

This program covers many unemployable adults with disabilities who do not qualify for other programs (e.g. SSI); therefore, the Council **strongly endorses** the DSS proposal to repeal the time limit.

Thank you for your time and consideration of our comments. Please feel free to contact me or Wendy Strauss should you have any questions.

Sincerely,

A handwritten signature in cursive script that reads "Terri Hancharick".

Terri A. Hancharick
Chairperson

TAH:kpc

STATE OF



DELAWARE

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October 31, 2012

Sharon L. Summers
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1901 North DuPont Highway
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New Castle, DE 19720-0906

RE: DMMA Proposed Medicaid Long Term Care Home Equity Cap Regulation [16 DE Reg. 377 (October 1, 2012)]

Dear Ms. Summers:

The Governor's Advisory Council for Exceptional Citizens (GACEC) has reviewed the Division of Medicaid & Medical Assistance (DMMA) proposal to amend its financial eligibility standards for qualification for long-term care (LTC) Medicaid. Federal law establishes a presumptive cap on Medicaid LTC eligibility of \$500,000 subject to annual increases based on the Consumer Price Index (CPI). The DMMA is now updating its standards to reflect the increases in the cap, i.e. to \$525,000 effective January 1, 2012. Council would like to share one concern.

The regulation recites as follows: "Equity value is determined by using the current market value of the home minus any mortgages or loans on the home." This is "underinclusive" and misleading. The attached CMS guidance recites as follows:

The equity value of a resource is the current market value minus any encumbrance on it. ...An encumbrance is a legally binding debt against the resource. This can be a mortgage, reverse mortgage, home equity loan, or other debt that is secured by the home.

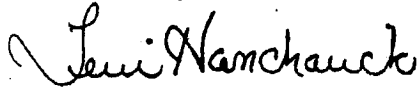
Other states adopt the term "encumbrance" in their regulations. This would cover judgment liens, IRS liens, lis pendens claims, and other legally binding "encumbrances" on the home. Council recommends substitution of the following sentence: "Equity value is determined by using the current market value of the home minus any encumbrance (e.g. mortgage; loan; lien) on it." The APA allows such revision without pre-publication "to correct technical errors" or "to make (regulations) consistent with changes in basic law but which do not otherwise alter the

substance of the regulations". Title 29 Del.C. §10112(b).

Council endorses the proposed regulation subject to correction of the sentence noted above which omits many forms of encumbrances which can reduce equity based on the CMS guidance.

Thank you for your time and consideration of our comments and concerns. Please feel free to contact me or Wendy Strauss should you have any questions.

Sincerely,

A handwritten signature in cursive script that reads "Terri Hancharick".

Terri A. Hancharick
Chairperson

TAH:kpc

Enclosure

Enclosure

Section 6014

**Disqualification for Long-Term Care Coverage for
Individuals with Substantial Home Equity Under the
Deficit Reduction Act of 2005**

**Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations**

July 27, 2006

I. New Provision

Section 6014 of the DRA amends section 1917 of the Social Security Act (the Act) to provide that in determining the eligibility of an individual to receive medical assistance payment for nursing facility services or other long-term care services, States must deny payment if the individual's equity interest in his or her home exceeds \$500,000. States have the option to substitute an amount exceeding \$500,000, but not in excess of \$750,000. States that choose to use a higher amount than the \$500,000 need not use the higher amount on a statewide basis. Also, States need not apply their higher amount to all eligibility groups.

For purposes of this provision, "other long-term care services" include:

- A level of care in any institution equivalent to nursing facility services;
- Home or community-based services furnished under a waiver under sections 1915(c) or (d) of the Act; and
- Services provided to a noninstitutionalized individual that are described in paragraph (7), (22), or (24) of section 1905(a) of the Act, and, if a State has elected to apply section 1917(c) to other long-term care services for which medical assistance is otherwise available under the State plan to individuals requiring long-term care, those services.

NOTE: This is not a change in the general rule that excludes a home of any value for purposes of determining eligibility for Medicaid. It applies only to medical assistance payment for nursing facility services, or other long-term care services as defined above.

II. Methodology

* In determining the value of home equity, States should follow the basic policies of the Supplemental Security Income (SSI) program. The equity value of a resource is the current market value minus any encumbrance on it. Current market value is the going price of the home, or the amount for which it can reasonably be expected to sell on the open market in the particular geographic area involved. An encumbrance is a legally binding debt against the resource. This can be a mortgage, reverse mortgage, home equity loan, or other debt that is secured by the home. States should follow their existing policies to determine current market value. States should also apply their usual verification procedures if an encumbrance is alleged.

If the home is held in any form of shared ownership, e.g., joint tenancy, tenancy in common, or other arrangement, only the fractional interest of the applicant for medical assistance for nursing facility or other long-term care services should be considered. For example, if the home is owned in joint tenancy by an applicant and a sibling, one-half of the home's current market value should be used in calculating the equity value of the individual, unless the individual can rebut the presumption that he or she has equal ownership interest in the property.

III. Limitations

The limitations on home equity do not apply if the spouse of the individual, the individual's child under 21, or the individual's blind or disabled child is residing in the home. A child is considered disabled if he or she meets the definition of disability in section 1614(a)(3) of the Act. In Guam, Puerto Rico, and the Virgin Islands, instead of using the section 1614(a)(3) definition of disability, the child must be permanently and totally disabled (as defined for purposes of the State plan



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
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VOICE: (302) 739-3620
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MEMORANDUM

DATE: October 31, 2012

TO: Ms. Deborah Gottschalk, Chief Policy Advisor
Department of Health & Social Services

FROM: Daniese McMullin-Powell, Chairperson
DMP/KW
State Council for Persons with Disabilities

RE: 16 DE Reg. 371 [DLTCRP Proposed Nurse Assistant/CNA Training Reg.]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Long Term Care Residents Protection's (DLTCRP) proposal to adopt some discrete amendments to its regulation covering training and qualifications of nursing assistants and certified nursing assistants ("CNAs"). The proposed regulation was published as 16 DE Reg. 371 in the October 1, 2012 issue of the Register of Regulations. SCPD has the following non-substantive observations related to style and grammar.

First, in §1.0, definition of "CE Hour", consider the following revision: "CE Hour" means continuing education...instruction.". This would be consistent with the form used in the preceding definition of "CE Track". It would also conform to the Register of Regulations Delaware Administrative Code Drafting & Style Manual published at <http://regulations.delaware.gov/documents/drafting&stylemanual.pdf>. Section 3.1.2 of the Manual offers the following guidance on definitions: "Immediately after the defined word or term, insert the word "means". Parenthetically, the Division may wish to consider editing all the definitions in §1.0 for consistency. Some refer to "shall mean". Some refer to "means". Some refer to "are defined". Some lack a verb altogether.

Second, in §2.4, there is a plural pronoun ("their") with a singular antecedent (CNA). The Division could either substitute "CNAs" for "A CNA" or delete the word "their".

Third, in §2.4.1, the introduction should be amended as follows: "The CNA dementia specific training shall include:...". Compare references to "the CNA Training Curriculum Committee" (§2.1); and "CNA training program" (§3.1.6).

Fourth, in §3.2.11, substitute “pillows” for “pillow”.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations on the proposed regulation.

cc: The Honorable Susan Del Pesco
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council
16reg371 dlcrp-can training 10-31-12



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MEMORANDUM

DATE: October 31, 2012

TO: Ms. Deborah Gottschalk, Chief Policy Advisor
Department of Health & Social Services

FROM: Daniese McMullin-Powell, Chairperson
State Council for Persons with Disabilities

RE: 16 DE Reg. 376 [DLTCRP Proposed Rest (Residential) Home Regulation]

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Health and Social Services/Division of Long Term Care Residents Protection's (DLTCRP) proposal to adopt wholesale revision of its *Rest (Residential) Home Regulations*. The proposed regulation was published as 16 DE Reg. 376 in the October 1, 2012 issue of the Register of Regulations. SCPD has the following observations and recommendations.

1. In §2.0, definition of "Continuous", insert a comma after "cessation".
2. In §2.0, definition of "Department", capitalize "Department of Health and Social Services".
3. In §2.0, definition of "Homelike", do not capitalize "having".
4. In §2.0, definition of "Personal Care Services", SCPD assumes the Division does not intend to authorize "hosing down" the residents. Substitute "those services" for "a hose services".
5. In §2.0, definition of "Rehabilitation", the reference to "at his the highest" is grammatically incorrect.
6. In §2.0, definition of "Resident", the regulation indicates that only individuals 18 years or older can live in a covered home. The licensing statute would permit residency in a rest (residential) facility by someone less than 18 years of age. See Title 16 Del.C. §1102(4). See also Title 16 Del.C. §§1119B and 1119C. This may implicate a systemic problem with the Division's regulatory system. The above statutes (§§1119B and 1119C) require the Department to ensure the inclusion of special training and standards in all long-term care facilities serving

- juveniles. However, the Department has only issued such standards for nursing homes. See 16 DE Admin Code 3210, §2.1. At a minimum, the reference to "18 years or older" should be deleted from the definition of "Resident" in §2.0. The Division should also consider adding some provisions applicable to pediatric residents.
7. In §§4.2 and 4.3, there is a lack of punctuation (semi-colons). Compare §§3.5 and 8.1.8.
 8. There is an extraneous period after the word "ventilation" in §5.3.2.1.
 9. Section 5.3.2.4 could be improved. The local building code and the guidelines referenced in §5.3.1 may or may not adequately address ramp specifications. By analogy, the ADA generally contemplates installation of handrails for any ramp with a rise in excess of 6 inches or horizontal projection greater than 72 inches. The Division may wish to consider adding some ramp standards apart from grade. Compare 16 DE Admin Code 3310, §5.10. The Division should also consider adding an accessibility reference akin to that in 16 DE Admin Code 3201, §7.2.
 10. The period is missing at the end of §5.7.3.
 11. It would be preferable to address the door handles in §5.7.6. By analogy, see attached description of ADA door hardware requirements. This could be a major safety issue in the event of a fire or other emergency. SCPD notes that the Division includes handgrips in showers (§5.9.4) to promote safety. The accessibility of doors is no less important.
 12. There is some "tension" between the exhortation that covered entities be "homelike" (§1.1) and the reference to "institution" in §5.12.1. SCPD recommends striking "of the institution" in the latter section.
 13. Section 5.12.9 requires hand washing facilities. The Division may wish to insert a temperature standard. Compare 16 DE Admin Code 3225, §17.8 and 16 DE Admin Code 3305, §13.3.
 14. The Division may wish to require that dishwashers be capable of sanitizing dishes to deter spread of infections. Compare 16 DE Admin Code 3305, §13.21 and 16 DE Admin Code 3310, §6.4.
 15. There is an extraneous period after the word "personal" in §7.1.2.
 16. There is some "tension" between §8.1.3.4 and §8.1.4. Query whether a facility could provide a locking medicine cabinet or a resident could keep a lockable container in a bathroom?
 17. In §10.1.6, SCPD believes the Division intended to insert the word "or" after "facility". The published regulation contains only an "r".
 18. It would be preferable to include a specific requirement that the LTC Bill of Rights be posted

and copy provided to each resident. See Title 16 Del.C. §1123. Compare 16 DE Admin Code 3310, §4.2.3.4.

Thank you for your consideration and please contact SCPD if you have any questions or comments regarding our observations or recommendations on the proposed regulation.

cc: The Honorable Susan Del Pesco
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

16reg376 dlcrp-rest residential 10-31-12



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eHow » Legal » Government Law » ADA Regulations » ADA Door Hardware Requirements

ADA Door Hardware Requirements

By David Clair, eHow Contributor

The Americans with Disabilities Act, or ADA, was established to prevent discrimination against persons with disabilities. It also has provisions to make sure persons with disabilities can function normally from day to day by regulating construction and building accessibility. To comply with ADA guidelines, the hardware used in the construction of doors must meet certain specifications.



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Hardware Must Be Accessible

The hardware used in a door must be sufficient to allow easy access to persons with disabilities. To meet ADA requirements, doors must have pull handles or push bars. Knobs that the disabled must grasp with both hands and twist are not authorized under the guidelines. Sliding doors must have operating hardware that is accessible and usable from both sides when the door is in an open position. The hardware for opening the door must be within 48 inches of the floor.

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Door Closers Must Meet Certain Criteria

Doors that are equipped with a door closer must meet certain requirements. The time it takes for the door to sweep closed must be prolonged enough to allow passage through the door at a comfortable pace. Under ADA guidelines, the sweep time from an open position of 70 degrees must be at least three seconds until the door reaches within 3 inches of the latch. The ADA recommends using door closers on frequently used interior doors.

Doors Must Open With Low Force

When doors are installed, adjustments are required so they open with a low amount of force to accommodate persons with disabilities. Doors that are mounted on hinges should move with under 3 lbs. of force when the force is applied perpendicular to the door.

Sliding and folding doors should open with less than 3 lbs. of force that is applied parallel to the door at the handle or pull latch.

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1574 Teacher of Students Who Are Deaf or Hard of Hearing

1.0 Content

1.1 This regulation shall apply to the requirements for issuance of a Standard Certificate, pursuant to 14 Del.C. §1220(a), for a Teacher of Students Who Are Deaf or Hard of Hearing pursuant to 14 Del.C. §1220. Eighteen (18) months from the effective date of this regulation, this certification shall be required for all educators within the Delaware public school system whose primary assignment is teaching children who are deaf or hard of hearing.

1.2 Except as otherwise provided, the requirements set forth in 14 DE Admin. Code 1505 Standard Certificate, including any subsequent amendment or revision thereto, are incorporated herein by reference.

2.0 Definitions

2.1 The definitions set forth in 14 DE Admin. Code 1505 Standard Certificate, including any subsequent amendment or revision thereto, are incorporated herein by reference.

The following words and terms, when used in this regulation, shall have the following meaning unless the context clearly indicates otherwise:

“Certification” means the issuance of a certificate, which may occur regardless of a recipient’s assignment or employment status.

“Department” means the Delaware Department of Education.

“Educator” means a person licensed and certified by the State under 14 Del.C. §1202 to engage in the practice of instruction, administration or other related professional support services in Delaware public schools, including charter schools, pursuant to rules and regulations promulgated by the Standards Board and approved by the State Board. The term ‘educator’ does not include substitute teachers.

“Examination of Content Knowledge” means a standardized test which measures knowledge in a specific content area, such as PRAXIS™ II.

“Fifteen (15) Credits or Their Equivalent in Professional Development” means college credits or an equivalent number of hours, with one (1) credit equating to fifteen (15) hours taken either as part of a degree program or in addition to it, from a regionally accredited college or university or a professional development provider approved by the employing school district or charter school.

“Immorality” means conduct which is inconsistent with the rules and principles of morality expected of an educator and may reasonably be found to impair an educator’s effectiveness by reason of his or her unfitness.

“License” means a credential which authorizes the holder to engage in the practice for which the license is issued.

“Major or its Equivalent” means a minimum of thirty (30) semester hours of course work in a particular content area.

“NASDTEC” means The National Association of State Directors of Teacher Education and Certification. The organization represents professional standards boards, commissions and departments of education in all 50 states, the District of Columbia, the Department of Defense Dependent Schools, the U.S.

~~Territories, New Zealand, and British Columbia, which are responsible for the preparation, licensure, and discipline of educational personnel.~~

~~“NCATE” means The National Council for Accreditation of Teacher Education, a national accrediting body for schools, colleges, and departments of education authorized by the U.S. Department of Education.~~

~~“Standard Certificate” means a credential issued to certify that an educator has the prescribed knowledge, skill or education to practice in a particular area, teach a particular subject, or teach a category of students.~~

~~“Standards Board” means the Professional Standards Board established pursuant to 14 Del.C. §1201.~~

~~“State Board” means the State Board of Education of the State pursuant to 14 Del.C. § 104.~~

~~“Valid and Current License or Certificate from Another State” means a current full or permanent certificate or license issued by another state. It does not include temporary, emergency or expired certificates or licenses issued from another state.~~

3.0 Standard Certificate

~~3.1 In accordance with 14 Del.C. §1220(a), the Department shall issue a Standard Certificate as a Teacher of Students Who Are Deaf or Hard of Hearing to an educator who holds a valid Delaware Initial, Continuing, or Advanced License; or a Limited Standard, Standard or Professional Status Certificate issued by the Department prior to August 31, 2003 who has met the following requirements:~~

~~3.1 Acquired the prescribed knowledge, skill or education to practice in a particular area, to teach a particular subject or to instruct a particular category of students by:~~

~~3.1.1 Obtaining National Board for Professional Teaching Standards certification in the area, subject, or category for which a Standard Certificate is requested; or~~

~~3.1.2 Graduating from an NCATE specialty organization recognized educator preparation program or from a state approved educator preparation program, where the state approval body employed the appropriate NASDTEC or NCATE specialty organization standards, offered by a regionally accredited college or university, with a major or its equivalent in Deaf Education; or~~

~~3.1.3 Satisfactorily completing the Alternative Routes for Licensure and Certification Program, the Special Institute for Licensure and Certification, or such other alternative educator preparation programs as the Secretary may approve; or~~

~~3.1.4 Holding a master’s degree in Deaf Education from a program approved by the Council for Education of the Deaf offered through a regionally accredited college or university; or~~

~~3.1.5 Holding a bachelor’s degree from a regionally accredited college or university in any content area and for applicants applying after June 30, 2006 for their first standard certificate, satisfactory completion of fifteen (15) credits or their equivalent in professional development related to their area of certification, of which at least six (6) credits or their equivalent must focus on pedagogy, selected by the~~

~~applicant with the approval of the employing school district or charter school which is submitted to the Department; and~~

~~3.2 For applicants applying after December 31, 2005, where a Praxis™ II examination in the area of the Standard Certificate requested is applicable and available, achieved a passing score as established by the Standards Board, in consultation with the Department and with the concurrence of the State Board, on the examination; or~~

~~3.3 Met the requirements for licensure and holding a valid and current license or certificate from another state as a Teacher of Students Who Are Deaf or Hard of Hearing;~~

~~3.3.1 The Department shall not act on an application for certification if the applicant is under official investigation by any state or local authority with the power to issue educator licenses or certifications, where the alleged conduct involves allegations of immorality, misconduct in office, incompetence, willful neglect of duty, disloyalty or falsification of credentials, until the applicant provides evidence of the investigation's resolution; or~~

~~3.4 Met the requirements for a Meritorious New Teacher Candidate Designation adopted pursuant to 14 DeL.C. §1203.~~

~~3.5 If additional criteria are imposed by a specific regulation in the area for which a Standard Certificate is sought, the additional requirements must also be met.~~

3.1.1 Holds a valid Delaware Initial, Continuing, or Advanced License; or a Standard or Professional Status Certificate issued by the Department prior to August 31, 2003; and.

3.1.2 Has met the requirements as set forth in 14 DE Admin Code 1505 Standard Certificate, including any subsequent amendment or revision thereto; and.

3.1.3 Has satisfied the additional requirements in this regulation.

4.0 Multiple Certificates Additional Requirements

~~Educators may hold certificates in more than one area.~~

An educator must also have met one the following additional education requirements:

4.1 Holding a master's degree from a regionally accredited college or university in Deaf Education from a program approved by the Council for Education of the Deaf; or

4.2 The successful completion of twenty-one (21) credits from a regionally accredited college or university or their equivalent in professional development as approved by the Department in the following areas:

4.2.1 Human Growth and Development Characteristics of the Deaf and Hard of Hearing (3 credits);

4.2.2 Assessment, Diagnosis and Prescriptive Techniques for the Deaf or Hard of Hearing (3 credits);

4.2.3 Curriculum and Instructional Methods for the Deaf or Hard of Hearing (3 credits);

4.2.4 Auditory Language Development (3 credits);

4.2.5 Audiology (3 credits);

- 4.2.6 Deaf and Hard of Hearing Practicum (3 credits); and either
- 4.2.7 Visual Language Development (3 credits); or
- 4.2.8 American Sign Language (3 credits).

5.0 Application Requirements

An applicant for a Standard Certificate shall submit:

- 5.1 Official transcripts; and
- 5.2 Official scores on the Praxis II examination if applicable and available;

or

- 5.3 Evidence of passage of the National Board for Professional Teaching Standards Certificate, if applicable; or
- 5.4 An official copy of the out of state license or certification, if applicable.
- 5.5 If applied for simultaneously with application for an Initial License, the applicant shall provide all required documentation for that application in addition to the documentation cited above.

6.0 Application Procedures for License Holders

If an applicant holds a valid Initial, Continuing, or Advanced Delaware License; or a Limited Standard, Standard or Professional Status Certificate issued prior to August 31, 2003 and is requesting additional Standard Certificates, only that documentation necessary to demonstrate acquisition of the prescribed knowledge, skill or education required for the additional Standard Certificate requested is required.

7.0 Effect of Regulation

This regulation shall apply to all requests for issuance of a Standard Certificate, except as specifically addressed herein. Educators holding a Professional Status Certificate or a Standard Certificate issued on or before August 31, 2003 shall be issued a Continuing License upon the expiration of their current Professional Status Certificate or Standard Certificate. The Standard Certificate for each area in which they held a Professional Status Certificate or a Standard Certificate shall be listed on the Continuing License or the Advanced License. The Department shall also recognize a Limited Standard Certificate issued prior to August 31, 2003, provided that the educator successfully completes the requirements set forth in the prescription letter received with the Limited Standard Certificate. Requirements must be completed by the expiration date of the Limited Standard Certificate, but in no case later than December 31, 2008.

8.0 Validity of a Standard Certificate

A Standard Certificate is valid regardless of the assignment or employment status of the holder of a certificate or certificates, and is not subject to renewal. It shall be revoked in the event the educator's Initial, Continuing, or Advanced License or Limited Standard, Standard, or Professional Status Certificate is revoked in accordance with 14 DE Admin. Code 1514. An educator whose license or certificate is revoked is entitled to a full and fair hearing before the Professional Standards Board. Hearings shall be conducted in accordance with the Standards Board's Hearing Procedures and Rules.

9.0 Secretary of Education Review

~~The Secretary of Education may, upon the written request of the superintendent of a local school district or charter school administrator or other employing authority, review credentials submitted in application for a Standard Certificate on an individual basis and grant a Standard Certificate to an applicant who otherwise does not meet the requirements for a Standard Certificate, but whose effectiveness is documented by the local school district or charter school administrator or other employing authority.~~

**GOVERNOR'S ADVISORY COUNCIL FOR EXCEPTIONAL CITIZENS**

GEORGE V. MASSEY STATION
516 WEST LOOCKERMAN STREET
DOVER, DELAWARE 19904
TELEPHONE: (302) 739-4553
FAX: (302) 739-6126

November 14, 2012

Charles Michels, Executive Director
Delaware Professional Standards Board
John G. Townsend Building
401 Federal Street
Dover, DE 19901

RE: DOE Proposed Teacher of Students Who Are Deaf or Hard of Hearing Certification Regulation [Pre-publication Draft]

Dear Mr. Michels:

The Governor's Advisory Council for Exceptional Citizens (GACEC) has reviewed the pre-publication draft of the DOE Proposed Teacher of Students Who Are Deaf or Hard of Hearing Certification, which was forwarded to us by the Director of Statewide Programs for the Deaf, Hard of Hearing and Deaf-Blind on October 31, 2012. Similar to raising standards for interpreters, this regulation raises standards for people who are employed to teach students who are deaf or hard of hearing.

Council would like to share the following observations.

First, the template for the regulation matches that of the recent regulations proposed by the Professional Standards Board and DOE. Compare proposed Teacher of Students with Autism or Severe Disabilities, 16 DE Reg. 489 (November 1, 2012). However, there is one major difference. Other regulations contain a "grandfather" provision. See, e.g., 16 DE Reg. 489, 493, §5.0 (Past Certification Recognized). The draft regulation does not contain a "grandfather" provision. Rather, §1.0 requires compliance with the new standards within eighteen months:

Eighteen (18) months from the effective date of this regulation, this certification shall be required for all educators within the Delaware public school system whose primary assignment is teaching children who are deaf or hard of hearing.

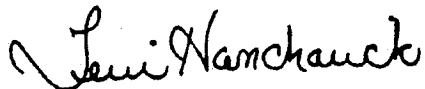
Providing only 18 months to complete the required twenty-one (21) credits (§4.2) is clearly too

short a period. Council recommends a longer time period to complete the necessary coursework.

Second, Council questions whether three (3) credits in American Sign Language (ASL) (§4.2.8) is sufficient to provide proficiency for middle and high school level instruction in which complicated subjects such as Algebra or Calculus are addressed.

Thank you in advance for your consideration of our comments and observations. Please feel free to contact me or Wendy Strauss should you have any questions.

Sincerely,

A handwritten signature in cursive script that reads "Terri Hancharick".

Terri A Hancharick
Chairperson

TAH:kpc

CC: The Honorable Mark Murphy, Secretary of Education
Dr. Teri Quinn Gray, State Board of Education
Mary Ann Mieczkowski, DOE
Susan Haberstroh, DOE
John Hindman, Esq., DOE
Terry Hickey, Esq., DOE
Paula Fontello, Esq., DOE



Governor's Advisory Council for Exceptional Citizens (GACEC) 516 West Loockerman St., Dover, DE 19904
302-739-4553 (voice) 302-739-6126 (fax) <http://www.gacec.delaware.gov>

MEMORANDUM

DATE: May 7, 2012

TO: The Honorable Members of the Delaware General Assembly

FROM: Terri A. Hancharick, Chairperson
GACEC

RE: House Bill No. 303 (School Based Health Centers: Insurer Reimbursement)

The Governor's Advisory Council for Exceptional Citizens (GACEC) has reviewed House Bill No. 303 on School Based Health Center Insurance Reimbursements. This bill was introduced on April 24, 2012 and released from the House Economic Development/Banking/Insurance/Commerce Committee on May 2nd. Two amendments have been placed with the bill. Council would like to share the following observations.

First, consistent with the synopsis, School Based Health Centers (SBHCs) exist in twenty-eight (28) Delaware high schools. The Centers offer a wide array of diagnostic and treatment services to students (lines 23-30 and 53-60). The bill is designed to implement a general Medicaid requirement that private insurance be billed for a covered service prior to billing to Medicaid (lines 9-10). The bill disallows an SBHC from charging a student a co-pay or out-of-pocket fee (lines 41-42 and 72-73). State-regulated health insurers would be required to reimburse SBHCs for the cost of services "as if those services were provided by a network provider" (lines 33-35 and 63-65). The amendments appear to address the sensitive issue of parental consent to reproductive services.

Second, Council notes that there is a significant oversight in the legislation. Public schools may incorporate SBHC services into an IEP or Section 504 Plan (e.g. counseling; medical evaluation; school health services). Federal law bars billing a parent's health insurance for services required for a free, appropriate public education ("FAPE") without parental consent. A parent cannot be forced to allow access to his/her insurance if such access could potentially result in a "financial loss". The attached HHS Policy Clarification [18 IDELR 558 (November, 1991)] summarizes the law:

Medicaid providers, including schools and their health care practitioners, must bill private plans first if a Medicaid recipient has private coverage for the relevant service. ...

Whether a school would actually choose to bill private insurers for services covered by more than one source of insurance would depend on the school's policies regarding health insurance billing

and the potential for an associated cost to the family. Under Federal policy on the use of parents' insurance proceeds, the requirements that a free, appropriate public education be provided "without charge" or "without cost" mean that an agency may not compel parents to file an insurance claim when filing the claim would pose a realistic threat that the parents of children with disabilities would suffer a financial loss not incurred by similarly situated parents of other children. Financial losses include, but are not limited to, the following:

- A decrease in available lifetime coverage or any other benefit under an insurance policy;
- An increase in premium under an insurance policy; or
- An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim.

At 561. See also attached OSERS Policy Letter to D.Rose, 18 IDELR 531 (September 19, 1991) [public agencies may not require parents to consent to filing of claim with private insurance or Medicaid]; and attached OSERS Policy Letter to G. Spinner, 18 IDELR 310 (November 13, 1991) [parents must give explicit consent to the filing of a claim by a public agency against their insurance policies to pay for required special education and related services where doing so poses a realistic threat of financial loss and be fully informed that refusal will not result in denial of services]. This policy applies to students covered by both the IDEA and Section 504 of the Rehabilitation Act. OSERS Policy Letter to G. Spinner, 18 IDELR 310, 311 (November 13, 1991). These policy interpretations are essentially reiterated in the relevant IDEA regulation, 34 C.F.R. 300.154.

Given these considerations, Council would suggest that the sponsors of House Bill No. 303 consider adding the following subsection to the bill:

Insurer reimbursement to an SBHC for provision of services in fulfillment of an obligation under either the Individuals with Disabilities Education Act or Rehabilitation Act of 1973, codified at 20 U.S.C. 1400 and 29 U.S.C. 794 respectively, shall conform to any limitations established by such federal laws, including any requirement of parental consent and assurance of no adverse financial effect under a health insurance policy. The Division of Public Health, in consultation with the Department of Education, may issue regulations implementing this subsection.

Thank you for your time and consideration of our observations and recommendations. Please feel free to contact me or Wendy Strauss at the GACEC office should you have any questions.

TAH:kpc

CC: The Honorable Rita Landgraf, Delaware Health and Social Services (DHSS)
The Honorable Lillian Lowery, Department of Education (DOE)
Debbie Gottschalk, DHSS
Mary Ann Mieczkowski, DOE

Enclosures

Mr. Gerald A. Spinner
Assistant Legal Adviser
Illinois State Board of Education
100 North First Street
Springfield, IL 62777-0001

Digest of Inquiry
[Date Not Provided]

- Does the purchase of an insurance policy by the parents of a child with disabilities constitute consent to a public agency's filing of a claim against that policy for the costs of special education or related services?

Digest of Response
(November 13, 1991)

*Purchase of Insurance Does Not Constitute
Consent to Claim Filing*

The parents of a child with disabilities must provide explicit consent to a public agency's filing of a claim against their insurance policy for the purposes of recovering the costs of special education or related services, when such a claim would pose a realistic threat of financial loss to the parents. The mere act of purchasing an insurance policy is not sufficient to this consent requirement. In addition, the state educational agency is responsible to inform the parents that their refusal to consent to the filing of a claim cannot result in the denial of services to their child.

Text of Response

On April 26, 1991, Ms. Joy Rogers submitted a request to this Office for Secretarial review of the April 19, 1991 decision

of the Illinois State Board of Education (ISBE) to deny her complaint, which was filed with your agency pursuant to 34 CFR §§ 76.780-76.782. As the enclosed letter indicates, a decision has been reached to deny Ms. Rogers' request for Secretarial review. We are concerned, however, that ISBE's April 19, 1991 letter to Ms. Rogers may wrongly assume that a parent's purchase of an insurance policy constitutes consent to a public agency filing a claim against that policy to pay for required special education and related services. Specifically, the April 19, 1991 letter states that:

As to the text of any notice given to parents requesting information and assuring them that services to their child will not be adversely [a]ffected should they refuse to consent to claims being filed against a private contract of insurance, two points must be noted. First, as the purchase of the contract of insurance is voluntary and is a contract under Illinois law which may be enforceable by a third party, consent to a third party's filing of a claim may have been waived by the purchaser at the time of purchase; this being very likely in a State not favoring exclusionary clauses against public sector service providers. Therefore, the seemingly widespread relief (sic) that a parent can preclude claims against a private contract of insurance simply by withholding consent to the filing of such claims is erroneous.

April 19, 1991 letter from ISBE to Joy Rogers, at pages 2-3 (emphasis added).

The Notice of Interpretation published by the U.S. Department of Education on the use of insurance proceeds, however, very clearly states that:

Both Part B and Section 504 prohibit a public agency from requiring parents, where they would incur a financial loss, to use insurance proceeds to pay for services that must be provided to a handicapped child under the 'free appropriate public education' requirements of those statutes. The use of parents' insurance proceeds to pay for services in these circumstances must be voluntary on the part of the parents.

45 Fed. Reg. 86390 (December 30, 1980).

Consequently, parents must give explicit consent to the filing of a claim by a public agency against their insurance policies, to pay for required special education and related services, where doing so poses a realistic threat of financial loss. The mere act of a parent purchasing an insurance policy does not satisfy this requirement. Moreover, ISBE is required to ensure that parents are fully informed that a decision to refuse to submit a claim will not result in a denial of services that the child would otherwise be entitled to receive under Part B. In addition, TAMES of Flossmoor, Inc., is bound by the May 30, 1990 Letter of Findings issued by the U.S. Department of Education's Office for Civil Rights.

If you have any further questions on this issue, please do not hesitate to contact my Office.

Robert R. Davila
Assistant Secretary

realistic threat of financial loss. Moreover, the school district may not condition the provision of special education services on parental consent to the filing of an insurance claim, including a claim to be filed with the State Medicaid agency.

Use of Medicaid Funds Does Not Alleviate Part B Obligations

Despite the use of Medicaid funds to pay for the costs of special education services, a school district remains obligated under Part B to provide special education and related services in conformity with a child's IEP, to place a child according to the placement and least restrictive environment requirements, and to provide the requisite due process rights and procedural safeguards.

Text of Inquiry

I am writing to inquire about two issues concerning the utilization of Medicaid funds to satisfy a public school's obligation to provide a free and appropriate education ("F.A.P.E.") under the Individual with Disabilities Education Act ("I.D.E.A."), 20 U.S.C. § 1400 *et seq.* First, may a public school require a parent or child to permit the school to access Medicaid to provide services required under F.A.P.E.? Second, does the accessing of Medicaid in any way alter the public school's obligations or rights under I.D.E.A.?

Thank you for your time and consideration.

Text of Response

This is in response to your letter in which you request clarification of the circumstances under which public agencies may access Medicaid payments to pay for the cost of required special education and related services.

In 1980, the Department published a Notice of Interpretation on Use of Insurance Proceeds (NOI), published at 45 *Fed. Reg.* 86390 (Dec. 30, 1980). A copy of the NOI, which also is applicable to use of Medicaid payments to pay for the cost of required special education and related services, is enclosed for your information. Your specific questions and the Department's responses follow.

1. May a public school require a parent or child to permit the school to access Medicaid to provide services required under [free appropriate public education (FAPE)]?

Part B of the Individuals with Disabilities Education Act (Part B) requires State educational agencies (SEAs) to assure that FAPE is available to all children with disabilities within specified age ranges. 20 U.S.C. § 1412. The term "free appropriate public education" means special education and related services which (A) have been provided at public expense, under public supervision and direction, and without charge, (B) meet the standards of the State educational agency, (C) include an appropriate preschool, elementary, or secondary school education in the State involved, and (D) are provided in conformity with the individualized education program required under sec-

Daniel J. Rose, Esq.
Drummond, Woodsum, Plimpton & MacMahon
Attorneys at Law
245 Commercial Street
Portland, ME 04101-1117

Digest of Inquiry
(April 19, 1991)

- May a school district require a parent of a child with disabilities to file a Medicaid claim to recover the cost of special education services?
- Does the accessing of Medicaid to pay for special education services alter, in any way, a school district's obligations under Part B?

Digest of Response
(September 19, 1991)

School Districts May Use Medicaid as Funding Source

A school district may access private insurance and Medicaid sources to pay for the cost of special education services; however, the use of a parent's insurance proceeds must be voluntary in circumstances where the parent would be likely to incur a

tion 614(a)(5), 20 U.S.C. § 1401(a)(18). Public agencies, however, in meeting their obligation to provide special education and related services without charge, "may use whatever State, local, Federal and private sources are available in the State to meet the requirements of this part." 34 CFR § 300.301(a). This regulation also provides that "[n]othing in this part relieves an insurer or similar third party from an otherwise valid obligation to provide or pay for services provided to a [child with a disability]." 34 CFR § 300.301(b).¹

Based on the above regulations, it is permissible for school districts to access sources other than Part B funds to pay for the cost of required special education and related services for children with disabilities. However, in the NOI, the Department emphasizes that use of parents' insurance proceeds must be voluntary in circumstances where parents would incur a realistic threat of a financial loss. The NOI explains:

the requirements that a free appropriate public education be provided 'without charge' or 'without cost' ... mean that an agency may not compel parents to file an insurance claim when filing the claim would pose a realistic threat that the parents of [children with disabilities] would suffer a financial loss not incurred by similarly situated parents of [nondisabled] children. Financial losses include, but are not limited to, the following:

- (1) A decrease in available lifetime coverage or any other benefit under an insurance policy;
- (2) An increase in premiums under an insurance policy; or
- (3) An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim.

45 Fed. Reg. 86390 (December 30, 1980).

In addition, public agencies may not condition the provision of special education and related services on parental consent to the filing of an insurance claim. The Part B regulations provide that "[e]xcept for preplacement evaluation and initial placement consent may not be used as a condition of a benefit to a parent or child." 34 CFR § 300.504(b)(2). Thus, public agencies are not authorized to condition the provision of special education and related services to a child with a disability on a parent's willingness to consent to the filing of an insurance claim, including the filing of a claim with a State Medicaid agency. Therefore, parents may refuse to sign a consent form without jeopardizing receipt of services to their child.

2. Does the accessing of Medicaid in any way alter the public school's obligations or rights under [Part B]?

Under Part B, States and local school districts have an ongoing responsibility to provide FAPE to eligible children determined to have 1 or more of 13 specified disabilities. 20 U.S.C. 1412(2); 34 CFR §§ 300.121 and 300.2. Thus, regardless of whether Medicaid funds are accessed to pay the cost of required special education and related services for children with disabilities, the public agency responsible for educating each child must ensure that the services and program provided to the

child are at no cost to the child and the child's parents in accordance with the child's individualized education program (IEP), and that the other rights and procedural protections in Part B are extended to the child and the child's parents. These include the provision of special education and related services in conformity with an IEP developed and implemented in accordance with §§ 300.340-300.349; placement of the child in accordance with the placement and least restrictive environment requirements of §§ 300.550-300.554 and 300.533; and the provision of the due process rights and other procedural safeguards guaranteed by §§ 300.500, 300.502-300.514, 20 U.S.C. 1415(d)(4) and 20 U.S.C. 1415(e)(4).

I hope the above information has been helpful. If we can be of further assistance, please let me know.

Robert R. Davila
Assistant Secretary

¹ A statutory amendment to Part B made by the Education of the Handicapped Act Amendments of 1986 recognizes the importance of Medicaid funds in paying the cost of required special education and related services for children eligible under both programs. See 20 U.S.C. § 1413(e). The Department's regulation implementing this statutory requirement provides:

This part may not be construed to permit a State to reduce medical and other assistance available to [children with disabilities], or to alter a [child with a disability's] eligibility, under Title V (Maternal and Child Health) or Title XIX (Medicaid) of the Social Security Act, to receive services that are also part of a free appropriate public education.

34 CFR § 300.601.

HHS Policy Clarification

Prepared for: Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services

In cooperation with: Health Care Financing Administration, U.S. Department of Health and Human Services, and the Office of Special Education and Rehabilitative Services, U.S. Department of Education

Prepared by: Lewin/ICF, a division of Health & Sciences International, and Fox Health Policy Consultants
November 1991

The U.S. Department of Health and Human Services (HHS), in cooperation with HCFA and OSERS, issued a policy clarification on the use of Medicaid funds in the provision of health-related services under the IDEA. The purpose of the joint policy statement was to explain, in plain language, the extent to which services contained in an IEP under Part B can be reimbursed by Medicaid. The HHS guidance was intended to encourage state and local educational agencies to cooperate more closely with state Medicaid agencies in the provision and funding of special education and related services.

Medicaid Coverage of Health-Related Services for Children Receiving Special Education: An Examination of Federal Policies

Overview

Part B of the Individuals with Disabilities Education Act (IDEA) authorizes Federal funding to states in order to ensure that children with one or more of thirteen specified disabilities receive a free appropriate public education. The law was established by Public Law 94-142 and was formerly called the Education of the Handicapped Act. Under the law, school districts must prepare an Individualized Education Program (IEP) for each child eligible for services under Part B, specifying all special education and "related services" needed by the child. A state Medicaid program can pay for those "related services" that are specified in the Federal Medicaid statute and determined to be medically necessary by the state Medicaid agency.

Within Federal and state Medicaid program requirements regarding allowable services and providers, school districts can bill the Medicaid program for these health-related services when

provided to children enrolled in Medicaid. This is important because of the additional financing it offers to educational agencies. The Part B program requires states to provide all special education and related services to eligible students at no cost to parents, but many states find this difficult because they are constrained by limited education budgets.

This booklet is designed to help state and local education officials, Medicaid officials, and other interested parties understand the conditions under which the Medicaid program can pay for the related services required by an IEP. It also describes the extent to which state Medicaid eligibility, coverage, and reimbursement policies are governed by Federal law.¹

The booklet is organized in a "Question and Answer" format. We strongly recommend that the reader review the complete range of questions and answers given the complexity of the issues presented. The remainder of this overview provides background information on the two relevant programs: the Assistance to States Program established under Part B of IDEA, and the Federal/state Medicaid program established under Title XIX of the Social Security Act. A list of the questions addressed by the booklet is provided in Exhibit 1.

A. The Part B Program

The Federal entitlement program that governs services to children with one or more of thirteen specified physical or mental disabilities who by reason thereof require special education and related services is authorized under Part B of the Individuals with Disabilities Education Act.² The Part B program is administered by the Office of Special Education and Rehabilitative Services within the U.S. Department of Education. Grants are distributed to states, which then disburse most of the funds to local education agencies (e.g., school districts) to support their special education activities.

The grants under Part B are intended to assist states in assuring that children with specified disabilities receive a free appropriate public education as specified in the Act. A "free appropriate public education" is defined to include special education and related services at no cost to the parents.

- "Special education" is defined as "specially designed instruction, at no cost to the parent, to meet the unique needs of a child with a disability." It can include classroom instruction, instruction in physical education, home instruction, and instruction in hospitals and institutions to ensure that children with disabilities receive a free appropriate public education.

- "Related services" are defined as "transportation, and such developmental, corrective and other supportive services as are required to assist a child with a disability to benefit from special education." These include several health-related services that must be available, including speech pathology, audiology, psychological services, physical and occupational therapy, early identification and assessment of disabilities, counseling services, school health services, social work services in school, and medical services for evaluation and diagnostic purposes only.³

Although states and localities fund the bulk of special education services, Federal Part B funds are an important supplement. To receive Part B funds, a state must submit a plan through its state education agency (SEA) detailing state policy for ensuring that children with specified disabilities have access to a free appropriate public education. The state application also must include an estimate of the total number of children with disabilities currently receiving and/or in need of special education and related services. The state must also provide estimates of the personnel and other resources necessary to meet the special education needs of children as specified by the Act. The distribution of funds among states is determined by a formula based on the number of children with disabilities age 3 through 21 receiving special education and related services within each state.

Once Part B monies have been approved, they are forwarded to the SEA for distribution to local education agencies (LEAs). LEAs generally are comprised of one or more local school districts. The LEAs receive funds only after they have submitted a program plan and been granted approval by the SEA. The LEAs are then expected to provide services to students with specified disabilities. State and local education agencies are prohibited from reducing their existing financial commitments to special education in response to the receipt of Part B funds.

For students with specified disabilities eligible for special education services under Part B, an Individualized Education Program (IEP) must be developed cooperatively by the school, the child's teacher, the child's parent or guardian, and others if deemed appropriate. Developed by the beginning of the school year, and reviewed (and if appropriate revised) at least annually, the IEP must detail specific special education and related services that are to be provided to the child. The LEA is responsible for assuring that all services included in the IEP are provided to the child and that education occurs in the "least restrictive environment," meaning that the child is educated with non-disabled peers to the maximum extent appropriate.

B. The Medicaid Program

Medicaid is a nationwide Federal/state medical assistance program for selected low-income populations. The Medicaid program was established in 1965 as Title XIX of the Social Security Act. It is federally administered by the Health Care Financing Administration (HCFA) within the U.S. Department of Health and Human Services (DHHS). While Congress and HCFA set broad Federal guidelines for the program, states have considerable flexibility in formulating eligibility, benefits, and reimbursement policies. Every state documents these policies in a state Medicaid plan which must be approved by HCFA.

The Medicaid program is funded by a combination of Federal and state dollars. The Federal Government "matches" state dollars as long as both the services and the eligible populations are within the parameters approved in the state plan. The level of the Federal match, known as Federal Financial Participation (FFP), is determined by a formula based on state per capita income. The minimum FFP in state expenditures for medical services is 50 percent of total program costs; the maximum FFP is 83 percent.

Medicaid is a "categorical," means-tested program. Individuals must fit into specific categories (e.g., dependent children) and must have income and resources below specified thresholds. Until recently, Medicaid eligibility was linked almost exclusively to eligibility for Federally funded cash assistance under two programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). AFDC and SSI are "categorical" programs. AFDC recipients live in families with a single or unemployed parent and SSI recipients are aged, blind, or disabled. States are also able to establish "Medically Needy" programs to cover individuals who meet the categorical eligibility criteria for cash assistance but not the income and resource eligibility criteria. Under a Medically Needy program, states may extend eligibility to individuals with family incomes up to 133 percent of the state's AFDC payment standard and also to individuals who incur health expenses which, when deducted from income, bring their net income below the medically needy level.

Recent Federal legislation has diminished the link between eligibility for cash assistance and Medicaid. Medicaid has been expanded to include many young children with family incomes and resources well above state eligibility standards for cash assistance. Moreover, many of these children qualify for Medicaid regardless of whether they have disabilities or are in single-parent families.

Medicaid covers a broad range of medical and remedial services. Federally allowable services include not only traditional medical services and remedial care, such as physicians' services and prescription drugs, but also several health and therapeutic interventions, such as occupational therapy. Some services are mandated by Federal law and must be provided by every state, while other services are provided at a state's discretion. One special program established for children is the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Under the EPSDT program, children must receive not only screening and diagnostic services, but also any medically necessary treatments that may not otherwise be available under a state's Medicaid plan but are allowable under Federal Medicaid law.

Medicaid services may be provided by a range of health professionals in a variety of settings, including a child's home or school. However, in defining service benefits, states have some latitude in specifying the types of providers and settings in which services must be provided in order to be reimbursable.

In general, state Medicaid programs pay participating providers for covered services on a per unit of service basis (such as a physician office visit). Within Federal guidelines, states have flexibility in determining reimbursement rates for particular services and providers. Providers generally bill Medicaid directly for payment for covered services provided to Medicaid recipients. States have the option of requiring nominal cost-sharing by Medicaid recipients for some services, meaning that the recipient pays a small "copayment" (e.g., \$2.00) to the provider for a given service.

In sum, states have considerable flexibility in defining Medicaid eligibility groups, benefits, provider participation requirements, and reimbursement levels within Federal guidelines. It is because of this flexibility that states can shape their programs to include reimbursement for health-related services

required under the Part B program, a process that can be facilitated through interagency agreements between the state's Medicaid agency and education agencies.

C. Questions Addressed By The Handbook

Federal policy has established that education agencies can bill Medicaid for health-related services covered under the state's Medicaid program. However, there has been considerable confusion about Federal policy, and the various laws and regulations governing the billing and reimbursement process can be complicated and ambiguous. This booklet seeks to clarify the relevant Federal policies in response to the questions shown in Exhibit 1. (Exhibit 1 Omitted)

Questions and Answers

A. Idea Policy Regarding Medicaid Billing

1. Does Federal Part B policy allow Medicaid billing for health-related services covered under a state's Medicaid program. . .

Yes. Although Part B does not expressly require Medicaid billing for covered health-related services, Congress anticipated the use of Medicaid and other resources to finance health-related Part B services. The Senate Report accompanying the original act, P.L. 94-142, states that "the state education agency is responsible for assuring that funds for the education of handicapped children under other Federal laws will be utilized" and that "there are local and state funds and other Federal funds available to assist in this process."

Moreover, three statutory amendments to Part B, made in 1986 by P.L. 99-457, further support the use of Medicaid and other sources to finance IEP-related services. Under these amendments:

- States are prohibited from using Part B funds to satisfy a financial commitment for services that would have been paid for by other Federal, state, and local agencies but for the enactment of Part B and the listing of the services in an IEP;
 - States are required to establish interagency agreements with appropriate state agencies to define the responsibility of each for providing or paying for a free appropriate public education and resolving disputes; and
 - It is clarified that P.L. 94-142 cannot be construed as permitting a state to reduce medical or other available assistance, or to alter Title V Maternal and Child Health Block Grant or Medicaid eligibility with respect to the provision of a free appropriate public education.
2. Are there any Federal special education policies that limit the circumstances under which the Medicaid program can be billed for health-related services?

The only Federal education policy that could restrict Medicaid payment for covered health services is the basic IDEA requirement that special education services be provided "at no cost to parents." The effect of this provision is that state or local education agencies must assume any costs the Medicaid agency

does not pay for so that no costs are imposed on the parents. For example, if the state Medicaid agency has elected to exercise its Federal option to impose nominal cost-sharing requirements on Medicaid recipients for services that include health-related services furnished by schools, the state or local education agency would be required to meet these copayment obligations for an eligible family.⁴

B. Medicaid Policy Regarding Payment For Health-Related Services

1. What are the Federal Medicaid program requirements regarding reimbursement for health-related services?

The Federal Medicaid statute does not require that Medicaid programs reimburse schools for health-related services delivered to Medicaid-eligible children. However, the Medicare Catastrophic Coverage Act of 1988 (MCCA) amended the law to make clear that Medicaid funds are available to pay for health-related services.⁵ The amendment states that nothing under the Medicaid statute is to be construed as prohibiting or restricting, or authorizing HCFA to prohibit or restrict, payment for services covered under a Medicaid state plan simply because they are furnished to a handicapped child pursuant to an individualized education program (IEP). The implication, as explained in the Conference Report, is that state education agencies are responsible for furnishing special instruction and educational services to children with disabilities, but that state Medicaid agencies are responsible for reimbursing health-related services provided to Medicaid-eligible children to the extent the state covers them under its Medicaid plan.

2. Are there any Federal Medicaid policies that limit the circumstances under which the Medicaid program can be billed for health-related services?

Under Federal law, the Medicaid program can only be billed for medically necessary services that are included in the state's Medicaid plan and provided by participating Medicaid providers. An exception to this is services provided under the EPSDT program (see Section C). In addition, except under circumstances described in Section F, Medicaid does not pay medical expenses that a third party, such as a private insurance company, is legally obligated to pay.

3. What state Medicaid policies must be in place in order for schools to bill Medicaid for medically necessary health-related services?

In order for schools to be able to bill Medicaid, the state Medicaid program must cover the various health-related services a child may need (e.g., physical therapy) under one of the service categories in its Medicaid state plan. In addition, the state Medicaid agency needs to have qualifications for providers of health-related services that schools or their practitioners would be able to meet (see Section E for a discussion of provider qualifications). These policies need to be reflected in the state Medicaid plan (see section G). However, while the state Medicaid agency can establish qualifications which would allow schools or their practitioners to be providers, it may not specify schools or their practitioners as the sole providers of health-related services.

4. If a Medicaid recipient also has private insurance, must the private plan be billed for health-related services?

Yes. Medicaid does not pay medical expenses that a third party, such as a private insurance company, is legally obligated to pay. When individuals apply for Medicaid, they are required to inform the state Medicaid agency or any other health care coverage they have and permit the state Medicaid agency to pursue payment from these third-parties for covered services.

Medicaid providers, including schools and their health care practitioners, must bill private plans first if a Medicaid recipient has private coverage for the relevant service.⁶ As a result, Medicaid reimbursement would not be available, or would be available only in a substantially reduced amount, for services to Medicaid-enrolled children who also have private health insurance coverage for health-related services.

Whether a school actually would choose to bill private insurers for services covered by more than one source of insurance would depend on the school's policies regarding health insurance billing and the potential for an associated cost to the family. Under Federal policy on use of parents' insurance proceeds, the requirements that a free appropriate public education be provided "without charge" or "without cost" mean that an agency may not compel parents to file an insurance claim when filing the claim would pose a realistic threat that the parents of children with disabilities would suffer a financial loss not incurred by similarly situated parents of other children. Financial losses include, but are not limited to, the following:

- A decrease in available lifetime coverage or any other benefit under an insurance policy;
- An increase in premiums under an insurance policy; or
- An out-of-pocket expense such as the payment of a deductible amount incurred in filing a claim.⁷

If such a cost would be incurred, a parent's use of insurance proceeds would have to be voluntary. If a school determined that private insurers could not be billed for dually insured services, then Medicaid could not be billed for these services either, and the state or local education agency would have to bear the costs which Medicaid and the third parties would have been obligated to pay.

5. If providers bill a state Medicaid program for services to Medicaid recipients, must they also bill non-Medicaid children's parents or third-party payers for health-related services?

No. This question often arises because of the Federal requirement that Medicaid payments are not available for services that are otherwise provided free of charge. Federal Medicaid policy is that all health-related services provided under Part B that are covered by a state's Medicaid program may be billed to Medicaid *regardless* of whether parents and third-party payers for non-Medicaid eligible children also are billed. (See Questions A.1 and B.1 above)

C. Medicaid Coverage of Health-Related Services

1. Which health-related services are Federally allowable Medicaid services?

The Medicaid statute establishes a broad scope of services including health-related services that may be furnished as part of a special education program and reimbursed. Part B services are potentially reimbursable if the State chooses to include them in its Medicaid plan.⁸ These include: speech pathology services; occupational therapy; physical therapy; psychological services; school health social worker services; early identification, screening, and assessment services; and medical services for diagnostic or evaluative purposes.

The Federal Government requires that states cover certain Medicaid service categories and allows states the option of covering others.⁹ The mandatory categories (i.e., those that are Federally required) include physician services, outpatient hospital services, and EPSDT. The optional categories include: physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders; medical and other remedial care provided by licensed practitioners (such as psychologists, social workers, and nurses); clinic services; diagnostic, screening, and rehabilitative services; nursing facility services (including services in institutions for the mentally retarded); and inpatient psychiatric services for individuals under age 21. Among these various Medicaid benefits, the rehabilitative services category—which carries no Federal requirements for physician prescription, provider qualifications, or setting limitations—is the most flexible.

Many Part B health-related services can be reimbursed under more than one Medicaid service category. The ancillary therapies, for example, can be reimbursed as therapies furnished by independent practitioners or as components of clinic or rehabilitative services.

While all medically necessary health-related services are potentially reimbursable, payment can only occur if the state Medicaid plan clearly covers the service. Thus, it is important that education agencies work closely with the state Medicaid agency to ensure that the scope of the appropriate benefit category is defined by the Medicaid plan so as to include health-related services that might be furnished in a school and to ensure that the provider qualifications in the plan are defined in a way which would permit schools to participate.

2. What is meant by the Federal Medicaid requirement that a service be medically necessary?

Medical necessity is a prerequisite for service payment under the Medicaid program. This stems from various provisions in the Medicaid statute that require states to safeguard against unnecessary utilization of care and services.

Federal law leaves the specification of medical necessity criteria for particular Medicaid services to the discretion of the state. There are a few services, though, including the ancillary therapies, for which physician referrals or prescriptions are Federally required as evidence of medical necessity. For instance, prescriptions are required for both physical and occupational therapy services and referral is necessary for speech pathology and audiology services. States then are free to establish more specific medical necessity criteria as they wish, and

to limit the coverage for services based on these criteria as well as on utilization control procedures. (State Medicaid coverage limits, of course, do not relieve a state of its responsibility for providing services to children under an IEP.)

3. What is the Medicaid EPSDT program for children?

Early and periodic screening, diagnosis, and treatment services—EPSDT—is a Federally required benefit for Medicaid-eligible children from birth to age 21. The EPSDT benefit is substantially different from other Medicaid benefits in that it obligates states to provide for all necessary Federally allowable Medicaid services regardless of the limitations in a particular state's Medicaid plan. To be in compliance with the Federal mandate for furnishing EPSDT, states are required to inform families of Medicaid-enrolled children about the benefits of preventive health care and the availability of EPSDT services, to assist with referrals and transportation to providers, and to arrange for provision of necessary diagnostic and treatment services, either directly or through referral.

EPSDT screening services include a comprehensive health and developmental screen (which includes a mental health assessment), a dental examination, a hearing examination, and a vision examination. These services are to be available in accordance with a state's periodicity schedule (or timetable), which must be established for each of the four components of the screening package and must meet reasonable standards of practice. These services are covered at other times as well, provided that the particular screening service is determined to be medically necessary.

Services for diagnosis and treatment include all Federally allowable Medicaid services. Diagnostic services are covered whenever a screening examination indicates the need to conduct a more in-depth evaluation of the child's health status and to provide diagnostic studies. Treatment services are covered whenever they are medically necessary to correct or ameliorate defects, physical or mental illnesses, or other conditions discovered (or found to have worsened) through an EPSDT screening. Both types of services are to be covered whether or not they are included in the state Medicaid plan and available to other Medicaid recipients.

4. What is the significance of the new Federal EPSDT mandate to furnish all medically necessary diagnostic and treatment services?

Federal law now requires states to provide reimbursement for any Federally allowable service found to be necessary to treat a condition discovered during an EPSDT screen, regardless of whether the service is included in the state Medicaid plan. Prior to this change, state Medicaid programs had the option to provide EPSDT-screened children an expanded package of Medicaid benefits but were not required to do so.

The new EPSDT mandate means that a broader scope of services and more generous coverage may be available to many Medicaid children. State Medicaid programs must now reimburse for diagnostic and medically necessary treatment services that otherwise are considered optional under Medicaid law. They also are prohibited from imposing limits on services that are not based on medical necessity requirements.

Recent HCFA preliminary instructions on EPSDT make clear, however, that states retain at least some of their usual limit-setting authority. Importantly, they remain responsible for setting medical necessity criteria for all EPSDT services. Using these criteria they also can limit both the scope of services—the nature of the intervention and the types of delivery settings for which reimbursement will be available—and the amount of service covered. Yet, any limitation imposed must be reasonable and related to medical necessity, and the benefit provided must be sufficient to achieve its purpose for EPSDT children.

5. Are health-related services included under the new EPSDT mandate?

Yes. Federally allowable Medicaid services mandated under EPSDT when medically necessary include, for example: clinic services; rehabilitative services; physical therapist services; occupational therapist services; speech pathology and audiology services; licensed psychologist and social worker services; and inpatient psychiatric facility services for individuals under age 21. Again, if a child is determined to need these services through an EPSDT screen, the services must be provided whether or not they are otherwise included in the state plan.

6. What is necessary for schools to bill for expanded EPSDT services?

To bill for a medically necessary EPSDT diagnostic and treatment services not otherwise covered under a state's Medicaid plan, a school must take steps to assure that:

- It or its health care practitioners, depending on the Medicaid service, is certified by the state as a Medicaid EPSDT provider;
- It can document the ongoing medical necessity of the health-related services it furnishes for conditions discovered or found to have worsened on the basis of a screening examination; and
- If required to do so by the state, it has obtained prior authorization for payment on a case-by-case basis.

D. Medicaid Eligibility and Enrollment

1. Which children are eligible for Medicaid?

Medicaid coverage is currently required for all children under the age of six with family incomes below 133 percent of the Federal poverty level. States also must cover most children eligible for the two major Federally subsidized cash assistance programs: Supplemental Security Income (SSI), a program for the aged, blind, and disabled; and Aid to Families with Dependent Children (AFDC). Both programs are means-tested. The income eligibility standards for AFDC, which are established by the states, are generally much lower than the Federal poverty level. By the year 2002, states will be required to cover all school-age children (up to age 19) in families with incomes below 100 percent of poverty. Coverage of this group of children is being phased in one year at a time beginning with ages six and seven in July 1991.

State Medicaid programs have the option of covering some additional school-aged children who cannot qualify for either

SSI or AFDC. Financially eligible children in two-parent families, for example, may be unable to obtain AFDC but may nonetheless qualify for Medicaid in many states. Likewise, children with family incomes somewhat higher than the AFDC or SSI eligibility standards may qualify for Medicaid under the optional "Medically Needy" program. Adopting this program option allows states to set an income standard up to one-third higher than for the AFDC program and allows families to qualify for Medicaid when their income is below this medically needy standard or when they meet the medically needy standard by deducting incurred medical expenses from income.¹⁰

2. How do eligible children become enrolled in Medicaid?

Medicaid-eligible children cannot receive Medicaid benefits until they are formally enrolled in the program.¹¹ While most children receiving AFDC and SSI are automatically enrolled in Medicaid when their application for those programs is completed, children not receiving cash assistance must apply specifically for Medicaid coverage. Families, though, cannot be forced either to apply for or accept Medicaid benefits.

Families who want to have Medicaid coverage are Federally required to meet several specific eligibility criteria which must be documented and verified by the state through the enrollment process. States establish their own eligibility determination and enrollment procedures. In general, the process includes completing an application with information on family income and assets, other health insurance coverage, family size and composition, and other factors. The application process is usually conducted at local welfare or social service offices, although states are required (beginning July 1, 1991) to deploy outreach eligibility workers at other sites, such as hospitals or clinics. Once an application is submitted, the state has 45 days from the date of application to complete the eligibility determination (90 days for persons claiming disability as a reason for eligibility). When eligibility has been established, individuals must identify any other health care coverage they have and permit the state Medicaid agency to pursue payment from this third party coverage if it is legally obligated to pay for covered services. The family then is issued documentation (often a card) identifying their enrollment in Medicaid.

Importantly, establishment of eligibility is not permanent. Federal regulations require that states must conduct Medicaid eligibility redeterminations at least every 12 months. Redeterminations for AFDC recipients are conducted every six months. Redetermination generally entails verification of eligibility criteria—such as income, family composition, and age of children—and does not require reapplication.

Is it a violation of Medicaid confidentiality requirements for local education agencies to require parents to provide information on the Medicaid enrollment status of children receiving health-related services?

No. Federal Medicaid regulations do not preclude providers or others from requiring parents to provide information on whether their children are enrolled in Medicaid. Under Part B, however, state and local education agencies are prohibited from requiring parents to identify whether their children are enrolled in Medicaid as a condition for receiving health-related services.

Education agencies may request this information from parents, but parents are under no obligation to provide it.

4. Can Medicaid enrollment information be furnished to education agencies by the state Medicaid program?

If the local education agency is a certified provider under the state's Medicaid plan, it may obtain information from the state Medicaid agency to verify the enrollment status of a particular child. It may not, however, request a comprehensive list of Medicaid-enrolled children. While Federal regulations require that the state Medicaid agency obtain permission from a family or individual for the release of any personal Medicaid-related information to an outside source, the Medicaid agency is permitted to release information without that consent if the information is necessary to verify enrollment.

E. Provider Participation In The Medicaid Program

1. What Federal requirements must be met to become a provider of Medicaid services?

Federal law is specific about standards and certification procedures for hospitals and other inpatient care providers, but it leaves states considerable discretion in establishing Medicaid qualifications for individual practitioners and most other types of community-based providers. HCFA requires only that state provider standards be reasonable and objective with respect to the services covered. Because Federal law requires that Medicaid recipients have "freedom-of-choice" among providers—that is, the opportunity to choose among all health care providers who are qualified to participate—state Medicaid programs are expected to permit all qualified providers of Medicaid services to participate in the program.¹² The state Medicaid agency cannot specify a particular provider, such as schools, as the sole provider of Medicaid services.

All Medicaid providers, including schools or their practitioners, must abide by the Federal payment-of-claims provisions where third parties are involved. This means that, as a Medicaid provider, a school or its medical practitioner may be required to bill a private health insurance company first before billing Medicaid, unless the specific service meets one of the regulatory exceptions or the state has obtained a waiver of the cost avoidance requirements. If by billing the private insurer the school or its medical practitioner would be in violation of the IDEA requirement that services be provided at no cost to the parents, then the state or local education agencies must assume full financial responsibility for those services for which Medicaid would otherwise pay.

2. Is state licensure ever Federally required for providers of particular Medicaid Services?

Yes. Licensure is a Federal condition of participation for the services of physicians, dentists, and certain other practitioners such as psychologists, social workers, and nurses. Where they exist, state licensure requirements also apply to physical therapists. Otherwise, ancillary therapists are only Federally required to meet standards concerning education and professional certification.

3. May schools qualify as Medicaid providers and bill for health-related services?

Yes. Schools may be certified as Medicaid providers if they meet the state's provider qualifications (see Questions E.1 and E.2 above) for the appropriate covered service. Depending on the state, schools may qualify as rehabilitative service providers. They may also qualify, on the basis of their salaried and consultant practitioner staff, as providers of ancillary therapist, psychologist, social worker, and certain other practitioner services. Billing by schools or other facilities for the services of individual practitioners is permitted as long as it is a condition of employment or a service contract.

Federal Medicaid law otherwise requires that only providers who directly furnish Medicaid services may bill the Medicaid program. On a voluntary basis, direct providers may allow schools to bill for them. Medicaid providers, including schools, may elect to use a third party as a billing agent to prepare and submit Medicaid claims. Billing agents may charge providers a reasonable fee for their services if the amount is unrelated to the amount of Medicaid revenues collected, but they may not advance providers funds prior to the payment of Medicaid claims.

4. What are examples of provider qualifications that have been Federally approved for health-related services?

It is common and acceptable practice for states to establish Medicaid provider qualifications that reference the standards of applicable licensing agencies or boards. For certain types of services, though, particularly those not traditionally recognized by state licensure laws, Medicaid agencies generally develop their own provider standards and certification procedures. In many states, Medicaid plan amendments specifying provider qualifications for health-related services already have been approved by HCFA. These qualifications have addressed criteria such as education, training, experience and, depending on the service, supervisory capacity and participation in referral agreements.

5. What is the financial liability of Medicaid providers in cases where reimbursement is subsequently disallowed by HCFA?

HCFA's relationship is with the state Medicaid agency. In cases where HCFA disallows Federal funds for an already reimbursed service, it is the state Medicaid agency's decision whether to require that some or all of the Medicaid payment be returned by the provider.

F. Medicaid Reimbursement Rates and Claims Submission

1. What are the Federal requirements governing Medicaid payments to providers?

Under Medicaid law, states have considerable freedom in developing their own methods and standards for Medicaid reimbursement rates. Only three general Federal requirements apply to all types of services. First, "methods and procedures" for making payments must be such as to assure that payments will be "consistent with efficiency, economy, and quality of

care." Second, payment rates must be sufficient to attract enough providers so that covered services will be as available to Medicaid recipients to the same extent as to the general population in the geographic area. Third, Medicaid providers must accept the amount reimbursed by Medicaid as payment in full.

A few other Federal rules apply to specific types of providers, but they are less likely to be relevant to health-related services. For example, payment for services furnished by organized health providers (such as clinics) must not exceed the amount that would have been paid for comparable services in comparable settings if provided to a Medicare beneficiary. Most Part B health-related services, however, are rarely comparable to services provided to a Medicare beneficiary.¹³ Also, payment for ambulatory services provided by Federally qualified health centers (including community health centers and migrant health centers) must equal 100 percent of reasonable costs. This provision would be relevant in situations where a Federally qualified health center is rendering Part B services for the local education agency.

Importantly, states are permitted to establish separate classes of providers and pay them differentially. Publicly operated health care facilities and state-employed individual practitioners, for example, could be a class of providers paid by Medicaid at or near their full costs (provided that costs do not violate the guidelines and rules described above).¹⁴ Facilities and practitioners that receive state funds (other than Medicaid) could be another class of providers. At the same time, other private agencies and practitioners could be a class of providers reimbursed through existing methodologies in the state, such as a percentage of their usual and customary charges.

2. What methods can states use to determine Medicaid payment rates for covered services?

With the exception of the requirements described above, there are no specific rules governing how states should develop Medicaid payment rates. State Medicaid agencies thus have established a variety of methodologies for determining reimbursement rates. The methodologies are detailed in their state Medicaid plans and generally vary by type of provider. For individual practitioners, Medicaid payment is usually the provider's actual charge for the service or a maximum payment amount established by the state, whichever is lower. Fixed fee schedules are the most common method for determining maximum payment amounts, although states may use other methods. For organized health providers, such as clinics, state Medicaid agencies generally determine payment rates using either cost-based reimbursement principles or fee schedules. Thus, it is possible in many states for particular classes of organized providers to have their full costs covered by the Medicaid payment, provided that the Federal guidelines described above are met.

3. How are Medicaid-covered services billed?

There are no specific Federal requirements establishing standard billing procedures for Medicaid services. Providers may send claims directly to the state Medicaid agency or its designated fiscal agency (i.e., an organization under contract with the Medicaid agency to complete claims processing) for

reimbursement. Claims generally must be submitted on a state standard form and must include pertinent information, such as a valid recipient number and a complete description of the services provided, in order to be processed in a timely manner.

4. Who can bill for reimbursable services?

Any provider who is qualified under a state's Medicaid rules (see Section E) may bill Medicaid for medically necessary covered services provided to Medicaid recipients. Qualified Medicaid providers are usually issued a provider number that identifies them as such and must be included when filing claims.

As discussed earlier, Medicaid providers (including schools) may elect to use a third party as a billing agent to prepare and submit Medicaid claims. Billing agents may charge providers a reasonable fee for their services if the amount is unrelated to the amount of Medicaid revenues collected, but they may not advance providers funds prior to the payment of Medicaid claims.

5. What kinds of records must be maintained by Medicaid providers?

Federal regulations require providers to keep any records necessary to establish the extent of services they provide to individual Medicaid recipients and information regarding payment for services requested by the state Medicaid agency. State Medicaid agencies generally specify a record and billing format that is compatible with their information and payments data systems. In addition, they often require providers to submit uniform cost reports as well as financial and statistical data.

6. Must providers show evidence of billing other liable third parties prior to billing Medicaid?

If a provider is aware of another liable third party, then the provider must bill that third party and show evidence of billing (such as the denial of the claim) to the state Medicaid agency before Medicaid will remit payment. This practice, known as cost-avoidance, is required except if the specific service for which reimbursement is sought meets one of the regulatory exceptions or if the State has obtained a waiver of the cost avoidance requirements. Under these circumstances, the state Medicaid agency is permitted to pay for the service and subsequently seek to recover costs from liable third parties.

Federal regulations allow providers to obtain information on a Medicaid recipient's other insurance through access to the recipient's case file. However, if a provider is unaware of other third-party liability, or has no reason to believe that the services provided will be covered under the recipient's other insurance (as is likely to be the case with several health-related services for children), the provider may proceed to bill Medicaid.

G. Medicaid State Plans

1. What are the Federal requirements for state Medicaid plans?

To receive Federal matching funds, each state must have an approved state Medicaid plan that includes, among other items, descriptions of eligibility, benefits, reimbursement, and administrative policies. States provide the required information by filling out the HCFA-prepared "state plan pre-print" and furnishing necessary attachments.

Annual state Medicaid plan submissions are not required by HCFA, although state laws frequently dictate that Medicaid plans be prepared and reviewed each year. Similarly, public notice is not Federally required for state plan amendments (except for significant payment methodology changes), but is often mandated by states.

2. How are state Medicaid plans revised?

State Medicaid plans may be revised at any time. Amendment requests are sent to the appropriate HCFA regional office, which has 90 days within which to approve the amendment, reject it, or request additional information. Regional offices have authority to approve or request additional information on plan amendments but do not have the authority to reject a state plan amendment. Only the HCFA Administrator can disapprove an amendment following consultation with the Secretary of DHHS. Moreover, if at the end of the 90-day period HCFA has not responded to the request, the amendment is deemed to be approved. If additional information is requested on a plan amendment, HCFA has a new 90-day period to approve or disapprove the amendments once the additional information is received.

3. Who can submit Medicaid plan amendments?

Only the single state agency responsible for administration of the Medicaid plan can submit Medicaid plan amendments.

H. Certification Of The State's Share Of Medicaid Program Costs

1. What kinds of funds may be used to provide a state's share of Medicaid program costs?

Federal law provides that both public and private donated funds may be considered as the state's share of Medicaid program costs. There are certain conditions, though, that apply to each source of funds.

Public funds used to claim Federal Financial Participation (FFP) must be funds that are appropriated directly to the state or local Medicaid agency, are transferred to the Medicaid agency from another public agency, or are certified by a contributing public agency as eligible state-match expenditures under the Medicaid program. Public funds may not be Federal funds, such as IDEA funds, that are otherwise provided for the state's use. Nor may they be state funds already obligated as state matching funds for another Federal program.¹⁵

Privately donated funds used to claim FFP must be funds that are transferred to the state or local Medicaid agency and are under its administrative control. Such funds may revert to a donor's facility only at the discretion of the Medicaid agency and only if the donor is a non-profit organization.¹⁶

2. What is required for state and local education agencies to certify their contribution?

There are no Federal requirements regarding certification of the state Medicaid match by schools and other contributing public agencies. Federal policies concerning the receipt of FFP pertain only to state Medicaid agencies, which are required to document allowable Medicaid expenditures for broad service categories in the HCFA-prepared "state Medicaid expenditure report" form. States are expected to generate the requisite data

for this report on the basis of their own expenditure reporting systems.

¹ Several states have been subject to court decisions in this area. However, since courts have limited jurisdiction and since Medicaid and education policies differ across states, these decisions may not apply generally to all states. Consequently, we do not discuss these legal cases in the booklet.

² This booklet does not address Part H of IDEA, which provides for services to infants and toddlers with disabilities. As with Part B services, Medicaid can be billed for health-related services under Part H. We did not cover Part H Medicaid funding in this booklet, however, because it is subject to fewer complex requirements than Part B and has already been covered in such documents as "The Role of Medicaid and EPSDT in Financing Early Intervention and Preschool Special Education Services" prepared by Fox Health Policy Consultants with funding from the Bureau of Maternal and Child Health, Department of Health and Human Services (DHHS).

³ In certain instances, some of the services in this list could be furnished for educational or vocational purposes rather than for health purposes. Such services would not be reimbursable by Medicaid. The remainder of this booklet addresses health-related services provided for medical or remedial purposes.

⁴ In addition, Medicaid does not pay medical expenses that a third party, such as a private health insurance company, is legally obligated to pay. While Medicaid can be billed for covered health-related services provided to an eligible Medicaid recipient, to the extent that Medicaid copayment or third-party liability rules apply, the state or local education agency (or the third party) would have to bear those costs. Third party liability is discussed in greater detail in Section F.

⁵ Shortly before the Medicaid statute was amended, the First Circuit Court of Appeals in the case of *Massachusetts vs. Secretary of HHS*, 816 F.2d 796 (1st Cir. 1987) upheld a Federal District Court decision prohibiting the denial of Federal Medicaid funds for an otherwise covered service solely on the basis that the service was provided pursuant to the state special education law and included in a child's IEP. The Court had held that the Massachusetts Department of Education was not liable as a first-party payer under Medicaid law. It also had held that the inclusion of a service in an IEP did not automatically establish the service as educational, rather than medical, in nature. The Supreme Court affirmed the jurisdiction of the Federal District Court to make such a determination in *Bowen vs. Massachusetts*, 487 U.S. 879 (1988).

⁶ There are some exceptions to the usual requirement that state Medicaid agencies refuse to make payment until other liable third parties are billed. Final regulations published January 16, 1990 require states to pay claims first and then seek reimbursement from other liable third parties for several specific services, including preventive pediatric services such as EPSDT and services provided to a child where an absent parent is under court order to provide medical support.

⁷ 45 *Federal Register* 86390 (December 30, 1980).

⁸ The reader should note that these reimbursable services do not include educational and vocational services.

⁹ The Federal requirement applies only to services provided to categorically eligible recipients (i.e., those receiving cash assistance and pregnant women and young children). States are permitted to provide more limited coverage of ambulatory services to medically needy recipients.

¹⁰ There are several other categories of eligible children, some of which include a large proportion of children in need of special education. These are primarily adopted children, and children in foster care covered under provisions of Title IV-E of the Social Security Act, and (at the state's option), children with disabilities living at home who otherwise would be eligible for Medicaid only if they were institutionalized.

¹¹ HCFA uses the term "eligible" to denote individuals who are enrolled in Medicaid. For purposes of clarity, we define eligible individuals as persons who meet Medicaid eligibility criteria regardless of whether they have applied for the program, and we use the term "enrolled" to denote those persons who have completed the application process and have been issued a Medicaid card.

¹² If a family chooses to receive health-related services from providers that are not affiliated with a school, they would be expected to pay any applicable copayments specified by the state Medicaid agency.

¹³ For example, occupational therapy may be provided to overcome sensory integration or motor planning deficits among children, but may be used to address problems associated with physical inactivity and inability to perform self-care among the elderly.

¹⁴ Cost principles for state and local government entities are set forth in the U.S. Office of Management and Budget (OMB) Circular A-87.

¹⁵ Public funds may be derived from both general tax revenue and provider-specific tax revenues. However, as specified in an interim final rule (implementing statutory provisions) issued on September 12, 1991 and clarified on October 31, 1991, FFP is not available for that portion of states' payment to facilities for costs attributable to a provider-specific tax. The issue of using provider-specific taxes as the state share of Medicaid program costs has been the subject of controversy.

¹⁶ The issue of using voluntary private contributions to finance a state's share of Medicaid program costs has also been controversial. HCFA's September 12, 1991 interim final rule and the October 31, 1991 clarification require that donations from providers be offset from Medicaid expenditures before calculating the Federal share. Currently, however, there is a Congressionally mandated moratorium on issuing final regulations until January 1, 1992.

been decided in a due process hearing involving the same parties—

- (3) The due process hearing decision is binding on that issue; and
- (1) The SEA must inform the complainant to that effect.
- (3) A complaint alleging a public agency's failure to implement a due process hearing decision must be resolved by the SEA.

Approved by the Office of Management and Budget under control numbers 1820-0030 and 1820-0600)

(Authority: 20 U.S.C. 1221e-3)

300.153 Filing a complaint.

(a) An organization or individual may file a signed written complaint under the procedures described in §§ 300.151 through 300.152.

(b) The complaint must include—

(1) A statement that a public agency has violated a requirement of Part B of the Act or of this part;

(2) The facts on which the statement is based;

(3) The signature and contact information for the complainant; and

(4) If alleging violations with respect to a specific child—

(i) The name and address of the residence of the child;

(ii) The name of the school the child is attending;

(iii) In the case of a homeless child or youth (within the meaning of section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2))), available contact information for the child, and the name of the school the child is attending;

(iv) A description of the nature of the problem of the child, including facts relating to the problem; and

(v) A proposed resolution of the problem to the extent known and available to the party at the time the complaint is filed.

(c) The complaint must allege a violation that occurred not more than one year prior to the date that the complaint is received in accordance with § 300.151.

(d) The party filing the complaint must forward a copy of the complaint to the LEA or public agency serving the child at the same time the party files the complaint with the SEA.

(Approved by the Office of Management and Budget under control numbers 1820-0030 and 1820-0600)

(Authority: 20 U.S.C. 1221e-3)

Methods of Ensuring Services

§ 300.154 Methods of ensuring services.

(a) *Establishing responsibility for services.* The Chief Executive Officer of a State or designee of that officer must

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

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

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

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

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

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

agreement pursuant to paragraph (c) of this section.

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

(2) If a public agency other than an educational agency fails to provide or pay for the special education and related services described in paragraph (b)(1) of this section, the LEA (or State agency responsible for developing the child's IEP) must provide or pay for these services to the child in a timely manner. The LEA or State agency is authorized to claim reimbursement for the services from the noneducational public agency that failed to provide or pay for these services and that agency must reimburse the LEA or State agency in accordance with the terms of the interagency agreement or other mechanism described in paragraph (a) of this section.

(c) *Special rule.* The requirements of paragraph (a) of this section may be met through—

(1) State statute or regulation;

(2) Signed agreements between respective agency officials that clearly identify the responsibilities of each agency relating to the provision of services; or

(3) Other appropriate written methods as determined by the Chief Executive Officer of the State or designee of that officer and approved by the Secretary.

(d) *Children with disabilities who are covered by public benefits or insurance.*

(1) A public agency may use the Medicaid or other public benefits or insurance programs in which a child participates to provide or pay for services required under this part, as permitted under the public benefits or insurance program, except as provided in paragraph (d)(2) of this section.

(2) With regard to services required to provide FAPE to an eligible child under this part, the public agency—

(i) May not require parents to sign up for or enroll in public benefits or insurance programs in order for their child to receive FAPE under Part B of the Act;

(ii) May not require parents to incur an out-of-pocket expense such as the payment of a deductible or co-pay amount incurred in filing a claim for services provided pursuant to this part, but pursuant to paragraph (g)(2) of this section, may pay the cost that the parents otherwise would be required to pay;

(iii) May not use a child's benefits under a public benefits or insurance program if that use would—

(A) Decrease available lifetime coverage or any other insured benefit;

(B) Result in the family paying for services that would otherwise be covered by the public benefits or insurance program and that are required for the child outside of the time the child is in school;

(C) Increase premiums or lead to the discontinuation of benefits or insurance; or

(D) Risk loss of eligibility for home and community-based waivers, based on aggregate health-related expenditures; and

(iv)(A) Must obtain parental consent, consistent with § 300.9, each time that access to public benefits or insurance is sought; and

(B) Notify parents that the parents' refusal to allow access to their public benefits or insurance does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parents.

(e) *Children with disabilities who are covered by private insurance.* (1) With regard to services required to provide FAPE to an eligible child under this part, a public agency may access the parents' private insurance proceeds only if the parents provide consent consistent with § 300.9.

(2) Each time the public agency proposes to access the parents' private insurance proceeds, the agency must—

(i) Obtain parental consent in accordance with paragraph (e)(1) of this section; and

(ii) Inform the parents that their refusal to permit the public agency to access their private insurance does not relieve the public agency of its responsibility to ensure that all required services are provided at no cost to the parents.

(f) *Use of Part B funds.* (1) If a public agency is unable to obtain parental consent to use the parents' private insurance, or public benefits or insurance when the parents would incur a cost for a specified service required under this part, to ensure FAPE the public agency may use its Part B funds to pay for the service.

(2) To avoid financial cost to parents who otherwise would consent to use private insurance, or public benefits or insurance if the parents would incur a cost, the public agency may use its Part B funds to pay the cost that the parents otherwise would have to pay to use the parents' benefits or insurance (e.g., the deductible or co-pay amounts).

(g) *Proceeds from public benefits or insurance or private insurance.* (1) Proceeds from public benefits or insurance or private insurance will not

be treated as program income for purposes of 34 CFR 80.25.

(2) If a public agency spends reimbursements from Federal funds (e.g., Medicaid) for services under this part, those funds will not be considered "State or local" funds for purposes of the maintenance of effort provisions in §§ 300.163 and 300.203.

(h) *Construction.* Nothing in this part should be construed to alter the requirements imposed on a State Medicaid agency, or any other agency administering a public benefits or insurance program by Federal statute, regulations or policy under title XIX, or title XXI of the Social Security Act, 42 U.S.C. 1396 through 1396v and 42 U.S.C. 1397aa through 1397jj, or any other public benefits or insurance program.

(Approved by the Office of Management and Budget under control number 1820-0030)

(Authority: 20 U.S.C. 1412(a)(12) and (e))

Additional Eligibility Requirements

§ 300.155 Hearings relating to LEA eligibility.

The SEA must not make any final determination that an LEA is not eligible for assistance under Part B of the Act without first giving the LEA reasonable notice and an opportunity for a hearing under 34 CFR 76.401(d).

(Approved by the Office of Management and Budget under control number 1820-0030)

(Authority: 20 U.S.C. 1412(a)(13))

§ 300.156 Personnel qualifications.

(a) *General.* The SEA must establish and maintain qualifications to ensure that personnel necessary to carry out the purposes of this part are appropriately and adequately prepared and trained, including that those personnel have the content knowledge and skills to serve children with disabilities.

(b) *Related services personnel and paraprofessionals.* The qualifications under paragraph (a) of this section must include qualifications for related services personnel and paraprofessionals that—

(1) Are consistent with any State-approved or State-recognized certification, licensing, registration, or other comparable requirements that apply to the professional discipline in which those personnel are providing special education or related services; and

(2) Ensure that related services personnel who deliver services in their discipline or profession—

(i) Meet the requirements of paragraph (b)(1) of this section; and

(ii) Have not had certification or licensure requirements waived on an

emergency, temporary, or provisional basis; and

(iii) Allow paraprofessionals and assistants who are appropriately trained and supervised, in accordance with State law, regulation, or written policy, in meeting the requirements of this part to be used to assist in the provision of special education and related services under this part to children with disabilities.

(c) *Qualifications for special education teachers.* The qualifications described in paragraph (a) of this section must ensure that each person employed as a public school special education teacher in the State who teaches in an elementary school, middle school, or secondary school is highly qualified as a special education teacher by the deadline established in section 1119(a)(2) of the ESEA.

(d) *Policy.* In implementing this section, a State must adopt a policy that includes a requirement that LEAs in the State take measurable steps to recruit, hire, train, and retain highly qualified personnel to provide special education and related services under this part to children with disabilities.

(e) *Rule of construction.* Notwithstanding any other individual right of action that a parent or student may maintain under this part, nothing in this part shall be construed to create a right of action on behalf of an individual student or a class of students for the failure of a particular SEA or LEA employee to be highly qualified, or to prevent a parent from filing a complaint about staff qualifications with the SEA as provided for under this part.

(Approved by the Office of Management and Budget under control number 1820-0030)

(Authority: 20 U.S.C. 1412(a)(14))

§ 300.157 Performance goals and indicators.

The State must—

(a) Have in effect established goals for the performance of children with disabilities in the State that—

(1) Promote the purposes of this part, as stated in § 300.1;

(2) Are the same as the State's objectives for progress by children in its definition of adequate yearly progress, including the State's objectives for progress by children with disabilities, under section 1111(b)(2)(C) of the ESEA, 20 U.S.C. 6311;

(3) Address graduation rates and dropout rates, as well as such other factors as the State may determine; and

(4) Are consistent, to the extent appropriate, with any other goals and academic standards for children established by the State;



PWB
5-8-12

SPONSOR: Rep. Q. Johnson

HOUSE OF REPRESENTATIVES
146th GENERAL ASSEMBLY

HOUSE AMENDMENT NO. 3

TO

HOUSE BILL NO. 303

1 AMEND House Bill No. 303 after line 50 and after line 81 by making insertions as shown by underlining:
2 (h) A carrier's reimbursement to an SBHC for provision of services fulfilling an obligation under either the
3 Individuals with Disabilities Education Act, 20 U.S.C. § 1400 et seq., or the Rehabilitation Act of 1973, 29 U.S.C. § 701 et
4 seq., shall conform to any requirements and limitations established by such federal laws, including parental consent and
5 assurance of no adverse financial effect under a health insurance policy. The Delaware Division of Public Health, in
6 coordination with the Delaware Department of Education, shall issue regulations implementing this subsection.

SYNOPSIS

This amendment expressly provides that any reimbursement from an insurance carrier to an SBHC must comply with federal laws that may apply and limit billing a parent's health insurance for services required for a free, appropriate public education.

to the particular program or activity that is out of compliance could be terminated. 42 U.S.C. 2000d-1.

Example: HHS provides assistance to a state department of health to provide immunizations for children. All of the operations of the entire state department of health--not just the particular immunization programs--are covered.

Finally, some recipients operate in jurisdictions in which English has been declared the official language. Nonetheless, these recipients continue to be subject to federal non-discrimination requirements, including those applicable to the provision of federally assisted services to persons with limited English proficiency.

IV. Who Is a Limited English Proficient Individual?

Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be limited English proficient, or "LEP," and may be eligible to receive language assistance with respect to a particular type of service, benefit, or encounter.

Examples of populations likely to include LEP persons who are encountered and/or served by HHS recipients and should be considered when planning language services may include such as those:

- Persons seeking Temporary Assistance for Needy Families (TANF), and other social services.
- Persons seeking health and health-related services.
- Community members seeking to participate in health promotion or awareness activities.
- Persons who encounter the public health system. *47314
- Parents and legal guardians of minors eligible for coverage concerning such programs.

V. How Does a Recipient Determine the Extent of Its Obligation To Provide LEP Services?

Recipients are required to take reasonable steps to ensure meaningful access to their programs and activities by LEP persons. While designed to be a flexible and fact-dependent standard, the starting point is an individualized assessment that balances the following four factors: (1) The number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come in contact with the program; (3) the nature and importance of the program, activity, or service provided by the program to people's lives; and (4) the resources available to the grantee/recipient and costs. As indicated above, the intent of this guidance is to suggest a balance that ensures meaningful access by LEP persons to critical services while not imposing undue burdens on small business, small local governments, or small nonprofits.

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U.S. Department of Health & Human Services

Improving the health, safety, and well-being of America

Civil Rights

Limited English Proficiency (LEP)



This section includes documents pertaining to persons with Limited English Proficiency (LEP). This means persons who are unable to communicate effectively in English because their primary language is not English and they have not developed fluency in the English language. A person with Limited English Proficiency may have difficulty speaking or reading English. An LEP person will benefit from an interpreter who will translate to and from the person's primary language. An LEP person may also need documents written in English translated into his or her primary language so that person can understand important documents related to health and human services. Information on OCR's work in the area of

nondiscrimination on the basis of national origin can be found at www.hhs.gov/ocr/nationalorigin.

LEP Resources and Tools

- [Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons](#)
- [Questions and Answers Regarding the Department of Health and Human Services Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons](#)
- [Summary of the Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons](#)
- [Fact Sheet on Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient \(LEP\) Persons](#)
- [Limited English Proficiency Video \(captioned\)](#)
- [Summary of Selected OCR LEP Complaint Investigations and Compliance Reviews](#)
- [OCR Guidance](#)
- [HHS Strategic Plan To Improve Access To HHS Programs and Activities By Limited English Proficient \(LEP\) Persons](#)
- [Other Federal resources](#) (includes documents, references from other HHS components, promising practices and other Federal agencies)
- [State and Local Government resources](#) (includes documents, references from State and Local Governments and promising practices)
- [Non-Government resources](#) (includes documents, references from Non-Government agencies and promising practices)

Teaming up for Language Access Education



- Improving Patient-Provider Communication Video [Part1](#) [Part2](#) [Part3](#) [Part4](#)
- [\(CC\) video available on request](#)
- [HHS Press Release - 11/7/09](#)

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U.S. Department of Health & Human Services

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Civil Rights

Office for Civil Rights

Guidance to Federal Financial Assistance Recipients Regarding Title VI and the Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons - Summary

The U.S. Department of Health and Human Services has published revised Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient (LEP) Persons. The Revised LEP Guidance is issued pursuant to Executive Order 13166. It is effective immediately and replaces the Guidance issued August 30, 2000. You can print out a copy of the Guidance from OCR's website at <http://www.hhs.gov/ocr/civilrights/resources/specialtopics/lep/index.html> or contact one of the OCR Regional Offices listed below.

LEGAL AUTHORITY

Title VI and Department of Health and Human Services regulations, 45 C.F.R. Section 80.3(b)(2), require recipients of Federal financial assistance from HHS to take reasonable steps to provide meaningful access to Limited English Proficient (LEP) persons. Federal financial assistance includes grants, training, use of equipment, donations of surplus property, and other assistance. Recipients of HHS assistance may include hospitals, nursing homes, home health agencies, managed care organizations, universities and other entities with health or social service research programs, State, county, and local health agencies. It may also include State Medicaid agencies, State, county, and local welfare agencies, programs for families, youth, and children, Head Start programs, public and private contractors, subcontractors, and vendors, and physicians and other providers who receive Federal financial assistance from HHS.

DEFINITION OF LIMITED ENGLISH PROFICIENT INDIVIDUALS

Individuals who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance with respect to the particular service, benefit, or encounter.

FACTORS USED TO DETERMINE THE TITLE VI OBLIGATION TO ENSURE MEANINGFUL ACCESS FOR LEP PERSONS

Recipients are required to take reasonable steps to ensure meaningful access to their programs and activities by LEP persons. The Guidance explains that the obligation to provide meaningful access is fact-dependent and starts with an individualized assessment that balances four factors: (1) the number or proportion of LEP persons eligible to be served or likely to be encountered by the program or grantee; (2) the frequency with which LEP individuals come into contact with the program; (3) the nature and importance of the program, activity or service provided by the recipient to its beneficiaries; and (4) the resources available to the grantee/recipient and the costs of interpretation/translation services. There is no "one size fits all" solution for Title VI compliance with respect to LEP persons, and what constitutes "reasonable steps" for large providers may not be reasonable where small providers are concerned.

* USE OF FAMILY MEMBERS AND FRIENDS

Some LEP persons may feel more comfortable when a trusted family member or friend acts as an interpreter. When an LEP person attempts to access the services of a recipient of federal financial assistance, who upon application of the four factors is required to provide an interpreter, the recipient should make the LEP person aware that he or she has the option of having the recipient provide an interpreter for him/her without charge, or of using his/her own interpreter. Recipients should also consider special circumstances that may affect whether a family member or friend should serve as an interpreter, such as whether the situation is an emergency, and whether there are concerns over competency, confidentiality, privacy, or conflict of interest. Recipients cannot require LEP persons to use family members or friends as interpreters.

VITAL DOCUMENTS

Recipients can use the four factor analysis described above to determine if specific documents or portions of documents should be translated into the language of the various frequently-encountered LEP groups eligible to be served and/or likely to be affected by the recipient's program. Recipients should assess whether specific documents or portions of documents

are "vital" to the program, information, encounter, or service involved and the consequences to the LEP person if the information in question is not provided accurately or in a timely manner. As with the LEP Guidance of other Federal agencies, the HHS Guidance provides recipients with a "safe harbor" that, if undertaken, will be considered strong evidence that the recipient has satisfied its written translation obligations.

INTERPRETER/TRANSLATOR COMPETENCE

The Guidance provides additional guidance on what to consider in determining interpreter and translator competency in particular contexts.

ELEMENTS OF AN EFFECTIVE LANGUAGE ASSISTANCE PLAN

If, after completing the four-factor analysis, a recipient determines that it should provide language assistance services, a recipient may develop an implementation plan to address the identified needs of the LEP populations it serves. Recipients have considerable flexibility in developing this plan. The Guidance provides five steps that may be helpful in designing such a plan: (1) identifying LEP individuals who need language assistance; (2) language assistance measures (such as how staff can obtain services or respond to LEP callers); (3) training staff; (4) providing notice to LEP persons (such as posting signs); and (5) monitoring and updating the LEP plan.

VOLUNTARY COMPLIANCE EFFORT

The Office for Civil Rights and HHS are committed to assisting recipients of HHS financial assistance in complying with their obligations under Title VI of the Civil Rights Act of 1964. HHS is committed to engaging in outreach to its recipients and to being responsive to inquiries from its recipients. HHS provides a variety of practical technical assistance to recipients to assist them in serving LEP persons so they are in compliance with the Title VI regulations. The requirement to provide meaningful access to LEP persons is enforced and implemented by the HHS Office for Civil Rights through the procedures identified in the Title VI regulations. These procedures include complaint investigations, compliance reviews, efforts to secure voluntary compliance, and technical assistance.

FOR MORE INFORMATION

Anyone who believes that he/she has been discriminated against because of race, color or national origin may file a complaint with OCR within 180 days of the date on which the discrimination took place. The OCR Regional Offices are listed below:

Region I - CT, ME, MA, NH, RI, VT

Office for Civil Rights
U.S. Department of Health & Human Services
JFK Federal Building - Room 1875
Boston, MA 02203
(617) 565-1340; (617) 565-1343 (TDD)
(617) 565-3809 FAX

Region II - NJ, NY, PR, VI

Office for Civil Rights
U.S. Department of Health & Human Services
26 Federal Plaza - Suite 3313
New York, NY 10278
(212) 264-3313; (212) 264-2355 (TDD)
(212) 264-3039 FAX

Region III - DE, DC, MD, PA, VA, WV

Office for Civil Rights
U.S. Department of Health & Human Services
150 S. Independence Mall West - Suite 372
Philadelphia, PA 19106-3499
(215) 861-4441; (215) 861-4440 (TDD)
(215) 861-4431 FAX

Region IV - AL, FL, GA, KY, MS, NC, SC, TN

Office for Civil Rights
U.S. Department of Health & Human Services
61 Forsyth Street, SW. - Suite 3B70
Atlanta, GA 30323

Region VI - AR, LA, NM, OK, TX

Office for Civil Rights
U.S. Department of Health & Human Services
1301 Young Street - Suite 1169
Dallas, TX 75202
(214) 767-4056; (214) 767-8940 (TDD)
(214) 767-0432 FAX

Region VII - IA, KS, MO, NE

Office for Civil Rights
U.S. Department of Health & Human Services
601 East 12th Street - Room 248
Kansas City, MO 64106
(816) 426-7278; (816) 426-7065 (TDD)
(816) 426-3686 FAX

Region VIII - CO, MT, ND, SD, UT, WY

Office for Civil Rights
U.S. Department of Health & Human Services
1961 Stout Street - Room 1426
Denver, CO 80294
(303) 844-2024; (303) 844-3439 (TDD)
(303) 844-2025 FAX

Region IX - AZ, CA, HI, NV, AS, GU, The U.S. Affiliated Pacific Island Jurisdictions

Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100

(404) 562-7886; (404) 331-2867 (TDD)
(404) 562-7881 FAX

Region V - IL, IN, MI, MN, OH, WI

Office for Civil Rights
U.S. Department of Health & Human Services
233 N. Michigan Ave. - Suite 240
Chicago, IL 60601
(312) 886-2359; (312) 353-5693 (TDD)
(312) 886-1807 FAX

San Francisco, CA 94103
(415) 437-8310; (415) 437-8311 (TDD)
(415) 437-8329 FAX

Region X - AK, ID, OR, WA

Office for Civil Rights
U.S. Department of Health & Human Services
2201 Sixth Avenue - Mail Stop RX-11
Seattle, WA 98121
(206) 615-2290; (206) 615-2296 (TDD)
(206) 615-2297 FAX

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Montgomery County Department of Social Services (MCDSS) Resolution Agreement

RESOLUTION AGREEMENT

BETWEEN

U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE FOR CIVIL RIGHTS, REGION II

AND

MONTGOMERY COUNTY DEPARTMENT OF SOCIAL SERVICES

I. Introduction

This Resolution Agreement (Agreement) is entered into by the United States Department of Health and Human Services (USDHHS), Office for Civil Rights (OCR) and the Montgomery County Department of Social Services (MCDSS) located in Fonda, New York. This Agreement resolves a complaint, transaction number 08-79992, filed with OCR on February 28, 2008, by **[COMPLAINANT'S NAME REDACTED]** (the complainant), alleging that MCDSS did not provide the complainant with a Spanish interpreter during a home visit.

A. **Parties to Agreement**

1. United States Department of Health and Human Services, Office for Civil Rights.
2. Montgomery County Department of Social Services in Fonda, New York.

B. **Jurisdiction**

MCDSS receives Federal financial assistance from the USDHHS, and is subject to Title VI of the Civil Rights Act of 1964, 42 U.S.C. 2000d *et seq.*, (Title VI) and its implementing regulation, 45 C.F.R. Part 80. Title VI prohibits discrimination on the basis of race, color, or national origin in any program or activity receiving Federal financial assistance. The implementing regulations prohibit both intentional discrimination and policies and practices that appear neutral but have a discriminatory effect. Policies that have an adverse effect on the ability of national origin minorities to meaningfully access services may also constitute a violation of Title VI.

C. **Purpose of Agreement**

1. To resolve these matters expeditiously and without further burden or expense of investigation or litigation, MCDSS agrees to the terms stipulated in this Agreement and affirms its assurance of compliance with all provisions of Title VI and its implementing regulations. The promises, obligations or other terms and conditions set forth in this Agreement constitute the exchange of valuable consideration between MCDSS and OCR.
2. This Agreement shall not be construed as an admission or as evidence that MCDSS has not complied with those provisions of Title VI of the Civil Rights Act of 1964 or its implementing regulations that relate to language assistance services provided to persons with limited English proficiency with respect to the allegations in the subject complaint.

II. Definitions

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For the purpose of this Agreement, the terms listed below shall have the following meaning:

- A. Applicant** means any person who inquires about or submits an application for public assistance benefits under any MCDSS program or service.
- B. Bilingual/Multilingual Staff** means a MCDSS staff member who has demonstrated proficiency in English and at least one other language, and who can interpret accurately, impartially, and effectively to and from such language(s) and English using any specialized terminology necessary for effective communication, but whose main job responsibilities are other than interpretation. A MCDSS staff member who only has a rudimentary familiarity with a language other than English shall not be considered "Bilingual/Multilingual Staff" under this agreement.
- C. Contractor** means any entity that performs work or provides services on behalf of MCDSS under a contractual agreement with reimbursement, which includes monies allocated to MCDSS as Federal financial assistance from HHS.
- D. Frequently-Encountered Language** means any language spoken by a significant number or percentage of the population eligible to be served or likely to be directly affected by MCDSS's programs and services.
- E. Interpreter** means a person who has demonstrated proficiency in both spoken English and at least one other language; and who can interpret accurately, impartially, and effectively to and from such language and English using any specialized terminology necessary for effective communication; and who understands interpreter ethics and client confidentiality needs. A person who has rudimentary familiarity with a language other than English is not to be considered an "interpreter" under this agreement.
- F. Language Assistance** means all oral and written language services needed to assist LEP individuals to communicate effectively with MCDSS staff, sub-recipients and contractors to provide LEP individuals with meaningful access to, and an equal opportunity to participate fully in the services, activities, programs or other benefits administered by MCDSS.
- G. Limited-English Proficient (LEP) Individual** means an individual who does not speak English as his or her primary language and who has a limited ability to read, write, speak or understand English in a manner that permits him or her to communicate effectively with MCDSS and have meaningful access to and participate fully in the services, activities, programs, or other benefits administered by MCDSS.
- H. Participant** means any person who has applied for and is receiving public assistance benefits or services under any MCDSS program or service for which USDHHS funding is received.
- I. Primary Language** means the language that an LEP individual identifies as the language that he or she uses to communicate effectively, and is the language that the individual prefers to use to communicate with MCDSS.
- J. Staff Interpreter** means a MCDSS staff member whose job is to provide interpretation and translation services.
- K. Sub-recipients** means an entity that expends Federal assistance received as a pass-through from MCDSS to carry out a federally-funded program, in which the sub-recipient provides services to and has contact with applicants and participants in the same manner as MCDSS if MCDSS were to administer the program directly, but does not include an individual applicant or participant who is a beneficiary of the program.
- L. Vital Documents** shall include, but are not limited to: applications; consent forms; complaint forms; letters or notices pertaining to eligibility for benefits; letters or notices pertaining to the reduction, denial, or termination of services or benefits that require a response from the LEP person; written tests that evaluate competency for a particular license, job, or skill for which knowing English is not required; documents that must be provided by law; and notices regarding the availability of free language assistance services for LEP individuals.

III. General Provisions

- A. Facilities Covered by Agreement.** The agreement covers MCDSS and all programs and services it administers or provides directly or through sub-recipients or contractors. This includes, but is not limited to, programs and services such as cash assistance programs, Temporary Assistance for Needy Families, food stamps, Medicaid,

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emergency assistance relief, general relief, fraud prevention, children's medical security insurance, adoption, children's day care, foster care, services for welfare recipients and adults, adult protective services, home-based services and Consumer Directed Programs.

B. Effective Date and Duration of Agreement. This Agreement shall become effective on the date it is executed by OCR (Effective Date) and shall remain in effect for eighteen (18) months or until OCR's written acceptance of the final progress report, whichever date is later. At such time, the Agreement will terminate, provided MCDSS is in substantial compliance with the Agreement as determined by OCR in its sole judgment upon its review of the Compliance Reports and other relevant information. Notwithstanding the aforementioned time limitation, MCDSS acknowledges that it will comply with Title VI of the Civil Rights Act of 1964 for so long as it continues to receive Federal financial assistance.

C. MCDSS's Continuing Obligation. Nothing in this Agreement is intended to relieve MCDSS of its obligation to comply with other applicable non-discrimination statutes and their implementing regulations.

D. Effect on Other Compliance Matters. The terms of this Agreement do not apply to any other issues, investigations, reviews, or complaints of discrimination that are unrelated to the subject matter of this Agreement and that may be pending before OCR or any other Federal Agency. Any unrelated compliance matters arising from reviews or investigations will be addressed and resolved separately. OCR shall review complaints against MCDSS that are received on or after the Effective Date that concern the laws, regulations, issues and subject matter covered by this Agreement. Nothing in this Agreement shall be construed to limit or restrict OCR's statutory and regulatory authority to conduct complaint investigations and compliance reviews.

E. Prohibition Against Retaliation and Intimidation. MCDSS shall not retaliate, intimidate, threaten, coerce, or discriminate against any person who has filed a complaint, assisted, or participated in any manner in the investigation of matters addressed in this Agreement.

F. OCR's Review of MCDSS's Compliance with Agreement. OCR may, at any time, review MCDSS' compliance with this Agreement. As part of such review, OCR may require MCDSS to provide written reports, permit inspection of offices, interview staff members, and allow OCR to examine and copy documents. MCDSS agrees to retain records required by OCR to assess its compliance with the Agreement, as described in Section IV.T., and to submit reports to OCR as specified in Section IV.V.

G. Failure to Comply with the Terms of Agreement. If at any time OCR determines that MCDSS has failed to comply with any provision of this Agreement, OCR shall notify MCDSS in writing. The notice shall include a statement of the basis for OCR's determination and shall allow MCDSS thirty (30) calendar days to either: (a) explain in writing the reasons for its actions and describe the remedial actions that have been or shall be taken to achieve compliance with this Agreement; or (b) dispute the accuracy of OCR's findings. On notice to MCDSS, OCR may shorten the 30-calendar day period if it determines that a delay would result in irreparable injury to the complainant or to other affected parties. If MCDSS does not respond to the notice, or if, upon review of MCDSS's response, OCR determines that MCDSS has not complied with the terms of the Agreement, OCR reserves the right to reopen its investigation of MCDSS's compliance with Title VI. OCR may incorporate into its reopened investigation any relevant evidence of noncompliance with this Agreement, and any relevant evidence gathered by OCR prior to the signing of this Agreement.

H. Non-Waiver Provision. Failure by OCR to enforce this entire Agreement or any provision thereof with respect to any deadline or any other provision shall not be construed as a waiver of OCR's right to enforce other deadlines or any other provision of this Agreement.

I. Entire Agreement. This Agreement constitutes the entire understanding between MCDSS and OCR in resolution of Transaction Number 08-79992. Any statement, promise, or agreement not contained herein shall not be enforceable through this Agreement.

J. Modification of Agreement. This Agreement may be modified by mutual agreement of the parties in writing.

K. Effect of MCDSS Program Changes. MCDSS reserves the right to change or modify its programs, so long as MCDSS ensures compliance with Title VI and its implementing regulations, and other applicable state and federal laws, and the provisions of this Agreement. Significant program changes that may affect compliance with this Agreement or any applicable statutes and regulations within OCR's jurisdiction must be reported to OCR promptly.

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- L. Publication or Release of Agreement.** OCR places no restrictions on the publication of the terms of this Agreement. In addition, OCR may be required to release the Agreement and all related materials to any person upon request consistent with the requirements of the Freedom of Information Act, 5 U.S.C. 552, and its implementing regulations, 45 C.F.R. Part 5.
- M. Authority of Signer.** The individual who signs this document on behalf of MCDSS represents that he or she is authorized to bind MCDSS to this Agreement.
- N. Third Party Rights.** This Agreement can only be enforced by the parties specified in this Agreement, their legal representatives and assigns. This Agreement shall be unenforceable by third parties and shall not be construed to create third party beneficiary rights.
- O. Severability.** In the event that a court of competent jurisdiction determines that any provision of this Agreement is unenforceable, such provision shall be severed from this Agreement and all other provisions shall remain valid and enforceable; provided, however, that if the severance of any such provision materially alters the rights or obligations of the Parties, they shall, through reasonable, good faith negotiations, agree upon such other amendments hereto as may be necessary to restore the Parties as closely as possible to the relative rights and obligations initially intended by them hereunder.
- P. Technical Assistance.** OCR agrees to provide appropriate technical assistance to MCDSS regarding compliance with this Agreement, as requested and as reasonably necessary.

IV. Specific Provisions

- A. Recognition.** MCDSS recognizes that LEP individuals need language assistance services to access and fully participate in programs and activities operated by MCDSS. Pursuant to MCDSS policy, MCDSS is committed to providing competent language assistance at no cost and in a timely manner to LEP individuals to ensure meaningful access to and an equal opportunity to participate fully in the services, activities, programs or other benefits administered by MCDSS. This includes ensuring effective communication between MCDSS staff members, contractors, and/or sub-recipients and LEP individuals.
- B. Develop and Implement Policy.** Within sixty (60) calendar days of the Effective Date of this Agreement, MCDSS shall develop written policies and procedures to provide language assistance to LEP individuals pursuant to Section IV.A, of this Agreement, Title VI, and New York State Office of Temporary and Disability Assistance Administrative Directive 06-ADM-05 Revised [NYS Administrative Directive]. The NYS Administrative Directive identifies the responsibilities of local social services district staff to ensure access is provided to persons with disabilities and/or LEP who are inquiring about, applying for, or receiving benefits, programs and services from local social services districts.
- OCR shall review the policy and procedures within thirty (30) calendar days of receipt. The policy and procedures shall not be implemented by MCDSS without the approval of OCR. Within fifteen (15) calendar days of OCR approval, MCDSS shall disseminate the policy and procedures to MCDSS staff members, contractors, and sub-recipients and publish them in an appropriate MCDSS-wide communication piece.

C. **Assessment for Determining Linguistic Needs**

- 1. Determining the Language Needs of the Affected Population.** Within ninety (90) calendar days of the Effective Date of this Agreement, and annually thereafter, MCDSS shall assess the language needs of LEP individuals that are eligible for services and are likely to be directly affected by its programs. Such assessment shall identify the following:
- a. The non-English languages likely to be encountered in MCDSS' programs.
 - b. An estimate of the number of LEP individuals likely to be directly affected by MCDSS' programs and their languages by reviewing various sources including but not limited to:
 - i. Census data;

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- ii. Utilization data from LEP individuals' files;
 - iii. School system data;
 - iv. Data from state and local governments;
 - v. Data from community agencies and organizations; and
 - vi. Information from refugee/immigrant serving agencies.
- c. The points of contact within MCDSS' programs and MCDSS' contracted programs where language assistance is likely to be needed.
- d. The locations and availability of language assistance resources, and arrangements that must be made to access these resources in a timely manner. This shall include the number of bilingual/multilingual staff volunteers, staff interpreters, contracted interpreters, community volunteer interpreters and telephonic interpreting services required at each MCDSS office and the resources needed to translate documents, as required.
- e. Existing vital documents and a process for determining which later-created documents are vital documents.

2. Determining the Language Needs of Each LEP Individual. Within thirty (30) calendar days of the Effective Date of this Agreement, MCDSS shall develop and implement a system for determining the primary language of each LEP individual at the first point of contact.

a. In-person Communication. Upon a staff member's initial encounter with an LEP individual for whom the staff member cannot personally provide language assistance, the staff member will determine the individual's primary language utilizing one of the following:

- i. Multi-language identification cards or "I speak" cards;
- ii. Poster-size language list; or
- iii. If the LEP person does not read or recognize any of the languages included in one of the methods described above, MCDSS shall use a telephone interpreting service to identify the individual's primary language.

Upon identification of the LEP person's primary language, the MCDSS staff member will refer the individual to the pre-printed statement in the individual's primary language that reads, "Please wait while I obtain an interpreter."

b. Telephone Communication. When a staff person places or receives a telephone call and cannot determine the language spoken by the person on the line, a telephone interpreter services provider will be contacted to make an assessment of the language spoken by the other party and to assist the other party as necessary.

c. Documentation. The primary language of each LEP individual shall be documented in a conspicuous location in the individual's record to alert staff that language assistance services must be provided.

d. Coordination between MCDSS Departments. A system or process shall be developed by which information concerning the language assistance needs of applicants and participants are communicated between MCDSS departments and program areas.

D. Notifying LEP Individuals of the Availability of Free Language Assistance. Within thirty (30) calendar days of the Effective Date of this Agreement, MCDSS shall provide meaningful notice to LEP and community agencies serving LEP individuals in MCDSS' service area of the right to free language assistance and the process for filing and resolving complaints about such services with MCDSS. Such methods shall include:

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1. Posters and signs translated into frequently-encountered languages prominently displayed in each MCDSS office, in waiting rooms, reception areas, and other initial points of entry;
2. Brochures or flyers translated into frequently-encountered languages providing notice to community agencies and organizations;
3. Statements included on application forms and informational material disseminated to the public, including the MCDSS website.

E. Request for an Interpreter. If an LEP individual requests an interpreter, one shall be provided. Under no circumstances shall a staff member deny a request for an interpreter based solely on whether an LEP individual can answer short questions by nodding or through the use of questions to which the answers are simply "yes" or "no."

F. Oral Language Services (Interpretation)

1. Within thirty (30) calendar days of the Effective Date of this Agreement, MCDSS shall provide interpretation, pursuant to Section IV.H., of this Agreement, for LEP individuals who need such assistance to communicate effectively with MCDSS staff, and for all other MCDSS contracted programs and services. MCDSS may utilize any of the following language assistance resources, to the extent such resources result in effective communication:
 - a. Bilingual/multilingual staff;
 - b. Staff or contract interpreters;
 - c. MCDSS language phone banks staffed with bilingual/multilingual staff;
 - d. Interpreters from community organizations;
 - e. Telephone interpreter services procured under contract by MCDSS; or
 - f. Volunteer interpreter program.
2. MCDSS shall ensure that, pursuant to Section IV.L, of this Agreement, regardless of the type of language assistance provided, the language assistance provider is competent to interpret or translate.
3. Within thirty (30) calendar days of the Effective Date of this Agreement, MCDSS will develop, and ensure that each MCDSS office maintains a list identifying all available language interpreters, telephone language lines, and other services and resources. For each MCDSS office, the list shall identify all of the following:
 - a. The name and telephone number of every language assistance resource available to the office;
 - b. The location of the office to which the interpreter is assigned, if the interpreter is a staff member of MCDSS;
 - c. The languages for which each interpreter is qualified;
 - d. The hours and days the interpreter or resource is available to provide interpretation or other assistance; and
 - e. The procedure by which each interpreter or resource shall be accessed by staff.

G. Translation of Written Documents.

1. Within six (6) months after the Effective Date of this Agreement, MCDSS shall identify and review existing vital documents and shall establish a process for determining which later-created documents are "vital" to the meaningful access of the LEP populations served.
2. Within one (1) year after the Effective Date of this Agreement, MCDSS shall translate existing vital documents into any language spoken by five (5%) percent of the total population eligible to be served or likely to be directly affected or encountered by MCDSS' programs, or one thousand (1000) persons in that population, whichever is less;

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later-created vital documents shall be translated into the same languages within a reasonable time of being created, but not to exceed six (6) months of being created.

a. If there are fewer than fifty (50) persons in a language group that reaches the five (5%) percent trigger, MCDSS may, in lieu of translating the vital documents, elect to provide written notice in the primary language of the LEP language group of the right to receive competent oral translation of the vital documents, free of cost to the LEP individual.

b. MCDSS shall develop a process for ensuring that correspondence and other documents submitted by an LEP individual in the LEP individual's primary language are translated without undue delay.

H. Timely, Competent Language Assistance. MCDSS shall ensure that each LEP individual receives competent oral and written language assistance services necessary to ensure meaningful access to MCDSS programs, pursuant to Section IV.A. of this Agreement and Title VI.

MCDSS may offer to schedule appointments for LEP individuals at specified times in order to minimize waiting times and to ensure the availability of appropriate qualified language interpreters, provided that the use of an appointment facilitates the provision of language assistance and does not impede or delay the individual's access to benefits and/or services provided by MCDSS.

I. Language Assistance Resources. Based on the language needs assessment conducted pursuant to Section IV.C., of this Agreement, MCDSS shall annually determine what resources and arrangements are needed to provide sufficient language assistance services in a timely manner for oral and written communication. MCDSS shall hire appropriate staff and utilize outside agencies as required to provide necessary services.

J. Telephone Communication. MCDSS shall provide uniform procedures for timely and effective telephone communication between staff members and LEP individuals.

K. Home-Based Communication. MCDSS shall provide uniform procedures for timely and effective communication between staff members and LEP individuals during home visits and inspections.

L. Language Assistance Standards. MCDSS shall ensure that MCDSS staff interpreters and translators, bilingual/multilingual staff, interpreters from community organizations, and contractors providing language assistance services, including interpretation and translation, are capable of competently performing their duties. Competency of language assistance service providers may be established by a variety of means including self-attestation of the interpreter after having reviewed the interpreter competency standards listed below. Whether self-attestation or another means is used to establish competency, MCDSS shall take reasonable steps to ensure that the individuals providing the interpretation and translation are capable of facilitating effective communication between LEP persons and MCDSS in accordance with Section IV.A. of this Agreement.

Standards for interpreter competency shall include the following:

1. Communicate in both English and the LEP individual's primary language accurately and effectively;
2. Interpret to and from English and the LEP individual's primary language accurately and impartially;
3. Possess appropriate knowledge of specialized terms and concepts used frequently in the provision of the MCDSS' services and programs;
4. Understand and follow the obligation to maintain confidentiality;
5. Understand the roles of interpreters and the ethics associated with being an interpreter; and
6. For those providing written translations, have the ability to translate written documents effectively.

M. Use of Family or Friends as Interpreters. The parties recognize that LEP individuals may seek to use family members or friends as interpreters. Regardless, MCDSS shall not require an LEP individual to utilize family members or friends to provide interpretation or translation services, and must make the LEP individual aware that he or she has the option of MCDSS providing an interpreter free of charge. In addition:

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1. If an LEP individual, after the offer of free language assistance in his or her primary language, elects to use a family member or friend to provide interpretation, MCDSS shall take reasonable steps to determine whether the individual providing the interpretation is competent to provide this service. Further, MCDSS shall take reasonable steps to determine whether conflict of interest, confidentiality or other concerns make use of the friend or family member inappropriate. These concerns are heightened and require the exercise of significant caution, if the LEP individual asks to have a minor provide interpretation. If the family member or friend is not competent or appropriate under the circumstances, MCDSS shall provide interpreter services in place of or, if appropriate, in addition to the person selected by the LEP individual.
2. For each LEP individual who declines the offer for MCDSS to provide an interpreter free of charge, MCDSS staff shall document in the LEP individual's record:
 - a. that an offer was made for MCDSS to provide an interpreter free of charge;
 - b. that the offer was declined; and
 - c. the name of the family member or friend who provided language assistance at the LEP individual's request, if any.
3. MCDSS shall inform an LEP individual who has declined the offer for MCDSS to provide an interpreter free of charge that he or she may reconsider and request an interpreter at any time.

N. MCDSS Language Assistance Coordinator. Within thirty (30) calendar days of the Effective Date of this Agreement, MCDSS shall designate a senior staff person to serve as its Language Assistance Coordinator. The MCDSS Language Assistance Coordinator shall have overall responsibility for coordinating MCDSS' comprehensive language assistance services and directing compliance with this Agreement, including but not limited to:

1. Serving as a liaison between MCDSS and USDHHS, and other stakeholders serving LEP individuals who seek to access and fully participate in programs and activities operated by MCDSS; and
2. Performing other duties identified in MCDSS policies and procedures that will be implemented pursuant to Part IV.B. of this Agreement.

O. Language Assistance Personnel. Within sixty (60) calendar days of the Effective Date of this Agreement, MCDSS shall identify appropriate personnel at each level of the organization (i.e. division, branches, unit, etc.) who will coordinate language assistance services for their respective levels. The identified personnel shall have responsibility for directing compliance with Title VI and implementation of this Agreement at their respective levels, including but not limited to:

1. Distributing to the appropriate MCDSS staff members the policies and procedures regarding language assistance referenced in Section IV. B of this Agreement, and the list of available language assistance services referenced in Section IV.F. 3. of this Agreement;
2. Consulting with the MCDSS Language Assistance Coordinator on the development and implementation of staff training pursuant to Section IV. P. of this Agreement;
3. Collecting MCDSS internal data pursuant to Section IV.U. of this Agreement; and
4. Performing other duties as identified in MCDSS policies and procedures implemented pursuant to Section IV.B. of this Agreement.

P. Training. Within six (6) months of the Effective Date of this Agreement, MCDSS will develop and implement mandatory staff training for all supervisors as well as for staff members who have regular contact with applicants and participants on the MCDSS policies and procedures for communicating with and serving LEP individuals. The training will specifically address MCDSS's responsibility to provide interpreter services to LEP individuals during home visits to determine eligibility for services. Thereafter, training on these policies and procedures shall be conducted annually and at orientation for new employees, or at least within thirty (30) calendar days of employment. Training may be conducted online and be self-paced with acknowledgement of understanding by the trainees.

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1. The training program shall be of sufficient content and duration to cover the following:
 - a. The importance of effective communication with LEP individuals;
 - b. The policy and procedures outlined in this Agreement;
 - c. The method used to assess an individual's need for interpreter or other language assistance services;
 - d. The use of interpreters when staff members receive incoming calls from or make outgoing calls to LEP individuals;
 - e. The impact of ethnic and cultural differences on effective communication and the need for sensitivity to diversity issues;
 - f. The effective method of using an in-person and telephone interpreter; and
 - g. Applicable record-keeping procedures.
2. MCDSS shall maintain a training registry that records the names and dates of the staff members who have been trained.

Q. Complaint Procedures. Within thirty (30) calendar days of the Effective Date of this Agreement, MCDSS will develop and implement uniform procedures for receiving and responding to complaints and concerns from LEP individuals who need language assistance services. These complaints will be forwarded to the MCDSS Language Assistance Coordinator for review and response to questions and complaints regarding language assistance services.

R. Notice of Non-Discrimination Policy. Within thirty (30) calendar days of the Effective Date of this Agreement, MCDSS shall develop and post, in each area in which participants wait for service at each office, a notice of its non-discrimination policy.

S. MCDSS Sub-Recipients and Contractors. MCDSS shall ensure that all applicable sub-recipients and contractors are informed of the LEP requirements of Title VI and this Agreement. MCDSS shall further ensure that the applicable sub-recipients and contractors complete an individualized assessment and implement a written policy corresponding to the requirements herein, including, but not limited to, the provision of language assistance services, training for staff, and complaint procedures. MCDSS shall provide information to and oversee the applicable sub-recipients and contractors as necessary to monitor compliance with these requirements.

T. Monitoring. To ensure effective language assistance and access to services, MCDSS shall develop and implement a program to monitor the provision of language assistance services to LEP individuals and compliance with this Agreement. As part of the monitoring program, MCDSS may:

1. Review LEP individuals' case records to assess whether primary languages are properly recorded in all case records and whether such persons are provided adequate language assistance services;
2. Review complaints filed by LEP individuals to determine adequacy of language assistance services;
3. Assess MCDSS staff, and sub-recipients and contractors' knowledge about MCDSS' language assistance policies and procedures;
4. Review the accuracy of the list(s) containing the availability of bilingual staff, interpreters, and other resources;
5. Request feedback from LEP individuals and advocates;
6. Review the development and distribution of translated MCDSS documents and posting of signs in public assistance offices;

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- 7. Assist with the recruitment and assignment of bilingual staff, if applicable;
- 8. Analyze the impact of all procedural and policy changes affecting LEP individuals;
- 9. Reassess the linguistic needs of the affected population by conducting the Assessment for Determining Linguistic Needs described in Section IV.C.; and
- 10. Develop and conduct a self-assessment program to determine whether language assistance services are provided to LEP persons when they visit MCDSS offices or contact an office by telephone. The self-assessment program shall include:
 - a. Unannounced site visits to a sampling of randomly selected offices to be conducted every six (6) months, beginning within six (6) months of the Effective Date of this Agreement; and
 - b. Requests for public assistance information in languages other than English by testers.

U. MCDSS Internal Data Collection. MCDSS shall maintain a centralized record-keeping system that facilitates coordination between MCDSS programs, divisions, branches, and units and assures the ready availability of data regarding the provision of language assistance services to LEP individuals, in which:

- 1. MCDSS shall record the primary language spoken by each LEP person in its record keeping system.
- 2. MCDSS shall record in each LEP individual's case file the primary language of the individual, the type of language assistance provided during each encounter, if any, and if a family member or friend of the LEP individual provided interpretation, the name of the family member or friend, pursuant to Section IV. M. of this Agreement.
- 3. MCDSS shall identify, in consultation with OCR, any other data needed to ascertain compliance with this Agreement, which may include but is not limited to:
 - a. The number of LEP individuals served, by primary language; and
 - b. The number and type of language assistance services provided.

V. Reporting Requirements to OCR

- 1. Within sixty (60) calendar days of the Effective Date of this Agreement, MCDSS shall submit written policies and procedures pursuant to Section IV. B. of this Agreement for OCR's review and approval.
- 2. Within ninety (90) calendar days of the Effective Date of this Agreement, MCDSS shall submit to OCR, a preliminary report on the data collected pursuant to Section IV.U. of this Agreement.
- 3. Beginning within six (6) months of the Effective Date of this Agreement, MCDSS shall provide to OCR semi-annual progress reports, every six (6) months, concerning its compliance with the terms of this Agreement,
- 4. MCDSS, in consultation with OCR, shall determine the content and the form for each report submitted pursuant to this Section.

IV. Signatures

 William M. Cranker
 Commissioner
 Montgomery County Department of Social Services, New York

 Date

U.S. Department of Health & Human Services

Improving the health, safety, and well-being of America

Civil Rights

Michael R. Carter

Date

Regional Manager, Region II

U.S. Department of Health & Human Services

Office for Civil Rights

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how meaningful access will be assessed by OCR:

- A physician, a sole practitioner, has about 50 LEP Hispanic patients. He has a staff of two nurses and a receptionist, derives a modest income from his practice, and receives Medicaid funds. He asserts that he cannot afford to hire bilingual staff, contract with a professional interpreter service, or translate written documents. To accommodate the language needs of his LEP patients, he has made arrangements with a Hispanic community organization for trained and competent volunteer interpreters, and with a telephone interpreter language line, to interpret during consultations and to orally translate written documents. There have been no client complaints of inordinate delays or other service related problems with respect to LEP clients. Given the physician's resources, the size of his staff, and the size of the LEP population, OCR would find the physician in compliance with Title VI.
- A county TANF program, with a large budget, serves 500,000 beneficiaries. Of the beneficiaries eligible for its services, 3,500 are LEP Chinese persons, 4,000 are LEP Hispanic persons, 2000 are LEP Vietnamese persons and about 400 are LEP Laotian persons. The county has no policy regarding language assistance to LEP persons, and LEP clients are told to bring their own interpreters, are provided with application and consent forms in English and if unaccompanied by their own interpreters, must solicit the help of other clients or must return at a later date with an interpreter. Given the size of the county program, its resources, the size of the eligible LEP population, and the nature of the program, OCR would likely find the county in violation of Title VI and would likely require it to develop a comprehensive language assistance program that includes all of the options discussed in Section C. 3, above.
- A large national corporation receives TANF funds from a local welfare agency to provide computer training to TANF beneficiaries. Of the 2,000 clients that are trained by the corporation each month, approximately one-third are LEP Hispanic persons. The corporation has made no arrangements for language assistance and relies on bilingual Hispanic students in class to help LEP students understand the oral

instructions and the written materials. Based on the size of the welfare agency and corporation, their budgets, the size of the LEP population, and the nature of the program, OCR would likely find both the welfare agency and the corporation in noncompliance with Title VI. The welfare agency would likely be found in noncompliance for failing to provide LEP clients meaningful access to its benefits and services through its contract with the corporation, and for failing to monitor the training program to ensure that it provided, such access. OCR would likely also find the corporation in noncompliance for failing to provide meaningful access to LEP clients and would require it to provide them with both oral and written language assistance.

5. Interpreters.

Two recurring issues in the area of interpreter services involve (a) the use of friends, family, or minor children as interpreters, and (b) the need to ensure that interpreters are competent, especially in the area of medical interpretation.

(a) *Use of Friends, Family and Minor Children as Interpreters*—A recipient/covered entity may expose itself to liability under Title VI if it requires, suggests, or encourages an LEP person to use friends, minor children, or family members as interpreters, as this could compromise the effectiveness of the service. Use of such persons could result in a breach of confidentiality or reluctance on the part of individuals to reveal personal information critical to their situations. In a medical setting, this reluctance could have serious, even life threatening, consequences. In addition, family and friends usually are not competent to act as interpreters, since they are often insufficiently proficient in both languages, unskilled in interpretation, and unfamiliar with specialized terminology.

If after a recipient/covered entity informs an LEP person of the right to free interpreter services, the person declines such services and requests the use of a family member or friend, the recipient/covered entity may use the family member or friend, if the use of such a person would not compromise the effectiveness of services or violate the LEP person's confidentiality. The recipient/covered entity should document the offer and declination in the LEP person's file. Even if an LEP person elects to use a family member or friend, the recipient/covered entity should suggest that a trained interpreter

sit in on the encounter to ensure accurate interpretation.

(b) *Competence of Interpreters*—In order to provide effective services to LEP persons, a recipient/covered entity must ensure that it uses persons who are competent to provide interpreter services. Competency does not necessarily mean formal certification as an interpreter, though certification is helpful. On the other hand, competency requires more than self-identification as bilingual. The competency requirement contemplates demonstrated proficiency in both English and the other language, orientation and training that includes the skills and ethics of interpreting (e.g. issues of confidentiality), fundamental knowledge in both languages of any specialized terms, or concepts peculiar to the recipient/covered entity's program or activity, sensitivity to the LEP person's culture and a demonstrated ability to convey information in both languages, accurately. A recipient/covered entity must ensure that those persons it provides as interpreters are trained and demonstrate competency as interpreters.

6. Examples of Frequently Encountered Scenarios

Over the course of the past 30 years enforcing Title VI in the LEP context, OCR has observed a number of recurring problems. The following are examples of frequently encountered policies and practices that are likely to violate Title VI:

- A woman is brought to the emergency room of a hospital by her brother. The hospital has no language assistance services and requires her brother to interpret for her. She is too embarrassed to discuss her condition through her brother and leaves without treatment. Alternatively, she is forced to use her brother as the interpreter, who is untrained in medical terminology and through whom she refuses to discuss sensitive information pertaining to her medical condition.
- A health clinic uses a Spanish-speaking security guard who has no training in interpreting skills and is unfamiliar with medical terminology, as an interpreter for its Hispanic LEP patients. He frequently relays inaccurate information that results in inaccurate instructions to patients.
- A local welfare office uses a Vietnamese janitor to interpret whenever Vietnamese applicants or beneficiaries seek services or benefits. The janitor has been in America for six months, does not speak English well and is not familiar with the terminology that is used. He often

relays inaccurate information that results in the denial of benefits to clients.

- A state welfare agency does not advise a mother of her right to free language assistance and encourages her to use her eleven year old daughter to interpret for her. The daughter does not understand the terminology being used and relays inaccurate information to her mother whose benefits are jeopardized by the failure to obtain accurate information.
- A medical clinic uses a medical student as an interpreter based on her self-identification as bilingual. While in college, the student had spent a semester in Spain as an exchange student. The student speaks Spanish haltingly and must often ask patients to speak slowly and to repeat their statements. On several occasions, she has relayed inaccurate information that has resulted in misdiagnosis.
- A managed care plan calls the receptionist at an Ethiopian community organization whenever it or one of its providers needs the services of an interpreter for an Ethiopian patient. The plan instructs the receptionist to send anyone who is available as long as that person speaks English. Many of the interpreters sent to a provider either do not understand English well enough to interpret accurately or are unfamiliar with medical terminology. As a result, clients often misunderstand their rights and benefits.
- A local welfare office forces a Mandarin-speaking client seeking to apply for SCHIP benefits on behalf of her three year old child to wait for a number of hours (or tells the client to come back another day) to receive assistance because it cannot communicate effectively with her, and has no effective plan for ensuring meaningful communication. This results in a delay of benefits.
- An HMO that enrolls Medicaid beneficiaries instructs a non-English speaking client to provide his or her own interpreter services during all office visits.
- A health plan requires non-English speaking patients to pay for interpreter services.

D. Promising Practices

In meeting the needs of their LEP patients and clients, some recipient/covered entities have found unique ways of providing interpreter services and reaching out to the LEP community. As part of its technical assistance, OCR has frequently assisted, and will continue to assist, recipient/covered

entities who are interested in learning about promising practices in the area of service to LEP populations. Examples of promising practices include the following:

Simultaneous Translation—One urban hospital is testing a state of the art medical interpretation system in which the provider and patient communicate using wireless remote headsets while a trained competent interpreter, located in a separate room, provides simultaneous interpreting services to the provider and patient. The interpreter can be miles away. This reduces delays in the delivery of language assistance, since the interpreter does not have to travel to the recipient/covered entity's facility. In addition, a provider that operates more than one facility can deliver interpreter services to all facilities using this central bank of interpreters, as long as each facility is equipped with the proper technology.

Language Banks—In several parts of the country, both urban and rural, community organizations and providers have created community language banks that train, hire and dispatch competent interpreters to participating organizations, reducing the need to have on-staff interpreters for low demand languages. These language banks are frequently nonprofit and charge reasonable rates. This approach is particularly appropriate where there is a scarcity of language services, or where there is a large variety of language needs.

Language Support Office—A state social services agency has established an "Office for Language Interpreter Services and Translation." This office tests and certifies all in-house and contract interpreters, provides agency-wide support for translation of forms, client mailings, publications and other written materials into non-English languages, and monitors the policies of the agency and its vendors that affect LEP persons.

Multicultural Delivery Project—Another county agency has established a "Multicultural Delivery Project" that is designed to find interpreters to help immigrants and other LEP persons to navigate the county health and social service systems. The project uses community outreach workers to work with LEP clients and can be used by employees in solving cultural and language issues. A multicultural advisory committee helps to keep the county in touch with community needs.

Pamphlets—A hospital has created pamphlets in several languages, entitled "While Awaiting the Arrival of an Interpreter." The pamphlets are intended to facilitate basic

communication between inpatients/outpatients and staff. They are not intended to replace interpreters but may aid in increasing the comfort level of LEP persons as they wait for services.

Use of Technology—Some recipient/covered entities use their internet and/or intranet capabilities to store translated documents online. These documents can be retrieved as needed.

Telephone Information Lines—Recipient/covered entities have established telephone information lines in languages spoken by frequently encountered language groups to instruct callers, in the non-English languages, on how to leave a recorded message that will be answered by someone who speaks the caller's language.

Signage and Other Outreach—Other recipient/covered entities have provided information about services, benefits, eligibility requirements, and the availability of free language assistance, in appropriate languages by (a) posting signs and placards with this information in public places such as grocery stores, bus shelters and subway stations; (b) putting notices in newspapers, and on radio and television stations that serve LEP groups; (c) placing flyers and signs in the offices of community-based organizations that serve large populations of LEP persons; and (d) establishing information lines in appropriate languages.

E. Model Plan

The following is an example of a model language assistance program that is potentially useful for all recipient/covered entities, but is particularly appropriate for entities such as hospitals or social service agencies that serve a significant and diverse LEP population. This model plan incorporates a variety of options and methods for providing meaningful access to LEP beneficiaries:

- A formal written language assistance program;
- Identification and assessment of the languages that are likely to be encountered and estimating the number of LEP persons that are eligible for services and that are likely to be affected by its program through a review of census and client utilization data and data from school systems and community agencies and organizations;
- Posting of signs in lobbies and in other waiting areas, in several languages, informing applicants and clients of their right to free interpreter services and inviting them to identify themselves as persons needing language assistance;
- Use of "I speak" cards by intake workers and other patient contact

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ADA Best Practices Tool Kit for State and Local Governments

Chapter 3

General Effective Communication Requirements Under Title II of the ADA

In this chapter, you will learn about the requirements of Title II of the ADA for effective communication. Questions answered include:

- What is effective communication?
- What are auxiliary aids and services?
- When is a state or local government required to provide auxiliary aids and services?
- Who chooses the auxiliary aid or service that will be provided?

A. Providing Equally Effective Communication

Under Title II of the ADA, all state and local governments are required to take steps to ensure that their communications with people with disabilities are as effective as communications with others.¹ This requirement is referred to as “effective communication”² and it is required except where a state or local government can show that providing effective communication would fundamentally alter the nature of the service or program in question or would result in an undue financial and administrative burden.

What does it mean for communication to be “effective”? Simply put, “effective communication” means that **whatever is written or spoken must be as clear and understandable to people with disabilities as it is for people who do not have disabilities**. This is important because some people have disabilities that affect how they communicate.

How is communication with individuals with disabilities different from communication with people without disabilities? For most individuals with disabilities, there is no difference. But people who have disabilities that affect hearing, seeing, speaking, reading, writing, or understanding may use different ways to communicate than people who do not.



The effective communication requirement applies to ALL members of the public with disabilities, including job applicants, program participants, and even people who

simply contact state or local government agencies seeking information about programs, services, or activities.

¹ Department of Justice Nondiscrimination on the Basis of State and Local Government Services Regulations, 28 C.F.R. Part 35, § 35.160 (2005). The Department's Title II regulation is available at www.ada.gov/reg2.html.

² See Department of Justice Americans with Disabilities Act Title II Technical Assistance Manual II-7.1000 (1993). The Technical Assistance Manual is available at www.ada.gov/taman2.html.

1. Providing Equal Access With Auxiliary Aids and Services

There are many ways that you can provide equal access to communications for people with disabilities. These different ways are provided through "auxiliary aids and services." **"Auxiliary aids and services" are devices or services that enable effective communication for people with disabilities.**³

Title II of the ADA requires government entities to make appropriate auxiliary aids and services available to ensure effective communication.⁴ You also must make information about the location of accessible services, activities, and facilities available in a format that is accessible to people who are deaf or hard of hearing and those who are blind or have low vision.⁵


Generally, the requirement to provide an auxiliary aid or service is triggered when a person with a disability requests it.

³ 28 C.F.R. §§ 35.104, 35.160.

⁴ 28 C.F.R. Part 35.160(b)(1).

⁵ 28 C.F.R. § 35.163 (a).

2. Different Types of Auxiliary Aids and Services

 Here are some examples of different auxiliary aids and services that may be used to provide effective communication for people with disabilities. **But, remember, not all ways work for all people with disabilities or even for people with one type of disability. You must consult with the individual to determine what is effective for him or her.**

- qualified interpreters
- notetakers
- screen readers
- computer-aided real-time transcription (CART)
- written materials
- videotext displays
- description of visually presented materials
- exchange of written notes
- TTY or video relay service
- email

- telephone handset amplifiers
- assistive listening systems
- hearing aid-compatible telephones
- computer terminals
- speech synthesizers
- communication boards
- text telephones (TTYs)
- open or closed captioning
- closed caption decoders
- video interpreting services
- text messaging
- instant messaging
- qualified readers
- assistance filling out forms
- taped texts
- audio recordings
- Brailled materials
- large print materials
- materials in electronic format
(compact disc with materials in plain text or word processor format)

B. Speaking, Listening, Reading, and Writing: When Auxiliary Aids and Services Must be Provided

Remember that communication may occur in different ways. Speaking, listening, reading, and writing are all common ways of communicating. When these communications involve a person with a disability, an auxiliary aid or service may be required for communication to be effective. The type of aid or service necessary depends on the length and complexity of the communication as well as the format.

1. Face-to-Face Communications

For brief or simple face-to-face exchanges, very basic aids are usually appropriate. For example, exchanging written notes may be effective when a deaf person asks for a copy of a form at the library.

For more complex or lengthy exchanges, more advanced aids and services are required. Consider how important the communication is, how many people are involved, the length of the communication anticipated, and the context.

Examples of instances where more advanced aids and services are necessary include meetings, hearings, interviews, medical appointments, training and counseling sessions, and court proceedings. In these types of situations where someone involved has a disability that affects communication, auxiliary aids and services such as qualified interpreters, computer-aided real-time transcription (CART), open and closed captioning, video relay, assistive listening devices, and computer terminals may be required. Written transcripts also may be appropriate in pre-scripted situations such as speeches.

Computer-Aided Real-Time Transcription (CART)

Many people who are deaf or hard of hearing are not trained in either sign language or lipreading. CART is a service in which an operator types what is said into a computer that displays the typed words on a screen.

2. Written Communications

Accessing written communications may be difficult for people who are blind or have low vision and individuals with other disabilities. Alternative formats such as Braille, large print text, emails or compact discs (CDs) with the information in accessible formats, or audio recordings are often effective ways of making information accessible to these individuals. In instances where information is provided in written form, ensure effective communication for people who cannot read the text. Consider the context, the importance of the information, and the length and complexity of the materials.

When you plan ahead to print and produce documents, it is easy to print or order some in alternative formats, such as large print, Braille, audio recordings, and documents stored electronically in accessible formats on CDs. Some examples of events when you are likely to produce documents in advance include training sessions, informational sessions, meetings, hearings, and press conferences. In many instances, you will receive a request for an alternative format from a person with a disability before the event.

If written information is involved and there is little time or need to have it produced in an alternative format, reading the information aloud may be effective. For example, if there are brief written instructions on how to get to an office in a public building, it is often effective to read the directions aloud to the person. Alternatively, an agency employee may be able to accompany the person and provide assistance in locating the office.

Don't forget . . .

Even tax bills and bills for water and other government services are subject to the requirement for effective communication. Whenever a state or local government provides information in written form, it must, when requested, make that information available to individuals who are blind or have low vision in a form that is usable by them.

3. Primary Consideration: Who Chooses the Auxiliary Aid or Service?

When an auxiliary aid or service is requested by someone with a disability, you must provide an opportunity for that person to request the auxiliary aids and services of their choice, and you must give primary consideration to the individual's choice.⁶ "Primary consideration" means that the public entity must honor the choice of the individual with a disability, with certain exceptions.⁷ The individual with a disability is in the best position to determine what type of aid or service will be effective.

The requirement for consultation and primary consideration of the individual's choice applies to aurally communicated information (i.e., information intended to be heard) as well as information provided in visual formats.

The requesting person's choice does not have to be followed if:

- the public entity can demonstrate that another equally effective means of communication

is available;

- use of the means chosen would result in a fundamental alteration in the service, program, or activity; or
- the means chosen would result in an undue financial and administrative burden.

Video Remote Interpreting (VRI) or Video Interpreting Services (VIS)

VRI or VIS are services where a sign language interpreter appears on a videophone over high-speed Internet lines. Under some circumstances, when used appropriately, video interpreting services can provide immediate, effective access to interpreting services seven days per week, twenty-four hours a day, in a variety of situations including emergencies and unplanned incidents.

On-site interpreter services may still be required in those situations where the use of video interpreting services is otherwise not feasible or does not result in effective communication. For example, using VRI / VIS may be appropriate when doing immediate intake at a hospital while awaiting the arrival of an in-person interpreter, but may not be appropriate in other circumstances, such as when the patient is injured enough to have limited mobility or needs to be moved from room to room.

VRI / VIS is different from Video Relay Services (VRS) which enables persons who use sign language to communicate with voice telephone users through a relay service using video equipment. VRS may only be used when consumers are connecting with one another through a telephone connection.

⁶ 28 C.F.R. Part 35.160(b)(2).

⁷ See Title II Technical Assistance Manual II-7.1100.

4. Providing Qualified Interpreters and Qualified Readers

When an interpreter is requested by a person who is deaf or hard of hearing, the interpreter provided must be qualified.

A “qualified interpreter” is someone who is able to sign to the individual who is deaf what is being spoken by the hearing person and who can voice to the hearing person what is being signed by the person who is deaf. Certification is not required if the individual has the necessary skills. To be qualified, an interpreter must be able to convey communications effectively, accurately, and impartially, and use any necessary specialized vocabulary.⁸

Similarly, those serving as readers for people who are blind or have low vision must also be “qualified.”⁹ For example, a qualified reader at an office where people apply for permits would need to be able to read information on the permit process accurately and in a manner that the

person requiring assistance can understand. The qualified reader would also need to be capable of assisting the individual in completing forms by accurately reading instructions and recording information on each form, in accordance with each form's instructions and the instructions provided by the individual who requires the assistance.

Did You Know That There are Different Types of Interpreters?

Sign Language Interpreters

Sign language is used by many people who are deaf or hard of hearing. It is a visually interactive language that uses a combination of hand motions, body gestures, and facial expressions. There are several different types of sign language, including American Sign Language (ASL) and Signed English.

Oral Interpreters

Not all people who are deaf or hard of hearing are trained in sign language. Some are trained in speech reading (lip reading) and can understand spoken words more clearly with assistance from an oral interpreter. Oral interpreters are specially trained to articulate speech silently and clearly, sometimes rephrasing words or phrases to give higher visibility on the lips. Natural body language and gestures are also used.

Cued Speech Interpreters

A cued speech interpreter functions in the same manner as an oral interpreter except that he or she also uses a hand code, or cue, to represent each speech sound.

8 28 C.F.R. § 35.104.

9 28 C.F.R. § 35.104.

5. Television, Videos, Telephones, and Title II of the ADA

The effective communication requirement also covers public television programs, videos produced by a public entity, and telephone communications.¹⁰ These communications must be accessible to people with disabilities.

a. Public Television and Videos

If your local government produces public television programs or videos, they must be accessible. A common way of making them accessible to people who are unable to hear the audio portion of these productions is closed captioning. For persons who are blind or have low vision, detailed audio description may be added to describe important visual images.

b. Telephone Communications

Public entities that use telephones must provide equally effective communication to individuals with disabilities. There are two common ways that people who are deaf or hard of hearing and those with speech impairments use telecommunication. One

way is through the use of teletypewriters (TTYs) or computer equipment with TTY capability to place telephone calls. A TTY is a device on which you can type and receive text messages. For a TTY to be used, both parties to the conversation must have a TTY or a computer with TTY capability. If TTYs are provided for employees who handle incoming calls, be sure that these employees are trained and receive periodic refreshers on how to communicate using this equipment.

A second way is by utilizing telephone relay services or video relay services. Telephone relay services involve a relay operator who uses both a standard telephone and a TTY to type the voice messages to the TTY user and read the TTY messages to the standard telephone user. Video relay services involve a relay operator who uses both a standard telephone and a computer video terminal to communicate voice messages in sign language to the computer video terminal user and to voice the sign language messages to the standard telephone user.

Public employees must be instructed to accept and handle relayed calls in the normal course of business. Untrained individuals frequently mistake relay calls for telemarketing or collect calls and refuse to accept them. They also may mistakenly assume that deaf people must come into a government office to handle a matter in person even though other people are allowed to handle the same matter over the telephone.

¹⁰ 28 C.F.R. §§ 35.104, 35.160, 35.161.

C. Planning Ahead to Provide Effective Communication

Even before someone requests an auxiliary aid or service from your public entity, plan ahead to accommodate the communication needs of persons with disabilities. Prepare for the time when someone will request a qualified interpreter, Braille documents, video relay, or another auxiliary aid or service.

- **Identify local resources for auxiliary aids and services.** Even if you do not think there is anyone with a disability in your community, you need to be prepared.
- **Find out how you can produce documents in Braille or acquire other aids or services.** Technology is changing, and much of the equipment needed to ensure effective communication is less expensive than it once was. Consider whether it makes sense to procure equipment or obtain services through vendors. If your needs will be best met by using vendors, identify vendors who can provide the aids or services and get information about how much advance notice the vendors will need to produce documents or provide services.
- **Contract with qualified interpreter services and other providers so that interpreters and other aids and services will be available on short notice.** This is especially critical for time-sensitive situations, such as when a qualified interpreter is necessary to communicate with someone who is arrested, injured, hospitalized, or involved in some other emergency.

- **Use the checklist included in this Chapter to assess your agency's ability to provide effective communication and to figure out the next steps for achieving ADA compliance.**
 - **Train employees about effective communication and how to obtain and use auxiliary aids and services. All employees who interact with the public over the telephone or in person need to know their role in ensuring effective communication.**
-

ADA Tool Kit for State and Local Governments

ADA Home Page

February 27, 2007



DELAWARE PSYCHIATRIC CENTER
POLICY AND PROCEDURE DIRECTIVE

Division of Substance Abuse and Mental Health
Delaware Health and Social Services

FUNCTION PATIENT RIGHTS AND ORGANIZATIONAL ETHICS	REVISION/REVIEW DATES July 2, 1990 July 30, 1991
SUBJECT PAGE 1 OF 4 DEAF OR HARD OF HEARING PATIENTS	August 12, 1992 August 1, 1994 August 14, 1998 (revised) January 14, 2000 (revised)
POLICY NUMBER RI 30	May 19, 2003 September 7, 2006 (revised)
EFFECTIVE DATE July 1, 1989	
MEDICAL DIRECTOR/DESIGNEE DATE	HOSPITAL DIRECTOR DATE

DISCIPLINES INVOLVED: ___ Dietary X Business Office ___ Housekeeping
___ Maintenance X Medical X Nursing ___ Personnel ___ Pharmacy
___ Psychology ___ Rehab Services ___ Risk Management ___ Security X Social
Work X Training
Other: _____

PURPOSE:

This policy explains the procedures used in providing assistance in communication to patients who are deaf or hard of hearing.

STANDARDS:

Delaware Psychiatric Center (DPC) assures that no person, solely on the basis of deafness or hearing loss, is excluded from participation in treatment, is denied the benefits of services, or is subjected to discrimination. It is the practice of DPC to ensure that patients who are deaf or hard of hearing are identified at admission and are adequately informed in their primary mode of communication of their legal rights and are able to participate to the extent feasible in the formulation and review of their individual treatment plans. A patient's care and treatment includes the regular use of sign language when that is the patient's primary mode of communication. DPC staff also recognize and are sensitive to geriatric patients who have experienced hearing loss due to the natural aging process and have become hard of hearing.

RI.2.100 – The hospital respects the patient's right to and need for effective communication.

DEFINITIONS:

TDD – Telecommunication device for the deaf.

PROCEDURES:

I. DEAF AND HEARING LOSS PATIENTS AT ADMISSION AND DURING TREATMENT

- A. A list of qualified persons, their expressive and receptive sign language competence and their telephone numbers is provided by the Director of Social Services to the Admissions Director, to all Physicians and is posted in the Admissions Suite. A sign is posted in the Admissions Suite stating that DPC will provide sign language interpreters for patients requiring that service.
- B. The Admitting Physician recognizes when a patient has a communication problem associated with a hearing loss and alerts the Nurse and Admissions Clerk.
- C. Staff are sensitive to the patient's limited ability to communicate and understand the admissions process. Staff act in a way that demonstrates sensitivity to the patient's special needs, minimizes the patient's level of anxiety and calms the patient. Staff will utilize the following when communicating with a hard of hearing patient:

Communicating with the Hard of Hearing

- Face the patient directly; present a full face so lip movements may be readily seen
 - Get the patient's attention before speaking
 - Talk with a low, moderate voice; regulate pace rather than volume
 - Speak slightly louder, but do not shout
 - Use short, simple sentences
 - Reword your statement if needed
 - Minimize background noise
 - Use facial expressions and gestures to give useful clues
 - Do not hide your mouth; avoid chewing gum or eating while talking
 - Write down important instructions
 - Be patient, stay positive and relaxed
- D. Admitting staff attempt to find out whether the deaf patient can communicate through lip-reading, reading and writing.
 - E. If the patient indicates that he/she cannot understand and needs the services of an interpreter, the Admissions Clerk makes an immediate attempt to contact an interpreter from the list of qualified individuals.

DEAF OR HARD OF HEARING PATIENTS

- F. If a person trained or experienced in sign language is not immediately available, the telephone company's TDD machine/service is available for use for patient identification information.
- G. Upon the arrival of the interpreter, staff communicates all rights, notices, statements or explanations required by the Mental Health Code to the patient through the interpreter.
- H. Orientation of the deaf or hard of hearing patients includes the location and purpose of visual fire alarms.
- I. When interpreter services are provided, the name of the person by whom it was given, the fact that the services were provided and the time of services are documented in the Progress Notes in the patient's Medical Record.
- J. Throughout the patient's treatment stay, interpreter services are arranged by the Director of Social Services. The Director of Social Services works with the Physician who represents the Treatment Team in determining the amount of interpreter services required by the patient. In the event that additional services are arranged by the Treatment Team, the Physician notifies the Social Services Director to facilitate the authorization of payment. In order to authorize the payment, the Social Services Director notifies the Senior Fiscal Administrative Officer. The patient's access to services and progress in treatment is documented in the Progress Notes.
- K. The unit Social Worker monitors the interpreter's time and forwards that information to the Social Services Director to sign timecard. The Social Services Director must submit the timecard to the Business Office on a weekly basis.
- L. If assistance is not available to DPC treatment staff, the Hospital Director is contacted to obtain assistance.
- M. The Social Worker making the discharge plans is responsible for establishing firm linkage for any individual transferred to an alternative program.

II. TREATMENT OF GERIATRIC AND HARD OF HEARING PATIENTS

- A. Staff recognize that from 30% to 50% of persons >65 years of age have significant hearing loss leading to impairment in functioning and are alert to the following signs and symptoms:

DEAF OR HARD OF HEARING PATIENTS

Signs and Symptoms of Possible Hearing Loss

- Difficulty following and participating in conversation
- Poor attention span with distractibility
- Accusations of others not speaking clearly
- Changes in quality of voice; speech too loud or too soft
- Changes in personality; indifference, social withdrawal, insecurity
- Difficulty hearing high-pitched voices of women and children
- Offering noncommittal, ambiguous answers to questions that are misunderstood

- B. When clinically indicated, Medical staff order a hearing consultation. Based on the findings and recommendations of the consultant, the patient's treatment plan is revised to address any additional treatment needs.