



DISABILITIES LAW PROGRAM

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MEMORANDUM

To: SCPD Policy & Law Committee
From: Brian J. Hartman
Re: Legislative & Regulatory Initiatives
Date: June 16, 2014

I am providing my analysis of thirteen (13) legislative and regulatory initiatives. Given time constraints, the commentary should be considered preliminary and non-exhaustive.

1. S.B. No. 219 (Opioid Overdose Intervention)

This legislation was introduced on May 8, 2014. It passed the Senate and was released from the House Health & Human Development Committee on June 11. As of June 16, it awaited a House vote. Background is contained in the attached May 14, June 4, and June 8, 2014 Delaware News Journal articles.

As background, Naloxone is a drug used to counter the effects of an opioid overdose, including heroin and morphine-related overdoses. Consistent with the articles, Naloxone is available as a nasal spray and an autoinjector device. A prescription can be written for a person with the addiction and purchased by friends and family to have available in the event of an overdose. However, training in its use is important since "people who are administered Naloxone can wake up violent and/or go into respiratory failure" (lines 20-21).

S.B. No. 219 would require the Department of Health & Social Services to promote the safe use of Naloxone through education and training programs. The legislation also contemplates DHSS establishment of a community-based Naloxone program funded through grant money. At a minimum, individuals soliciting Naloxone from the program would be required to complete a training and education program.

I did not identify any technical concerns with the bill. The legislation reasonably addresses the growing problem of opioid addiction and concomitant overdoses and merits endorsement.

2. H.B. No. 347 (School Safety Construction & Renovations Features)

This legislation was introduced on May 15, 2014. It is earmarked with an incomplete fiscal note. As of June 16, it had been released by the House Education Committee and awaited action by the full House.

The bill would have two effects. First, it would require newly constructed or renovated school buildings to contain certain design features, including bulletproof glass, certain door locks, and an intruder alert system. Second, it would require the OMB Facilities Management Section to ensure Dept. Of Homeland Security review of such sites to address compliance with both the above standards and "Crime Prevention through Environmental Design (CPTED) contemporary practices."

I identified one principal concern with the legislation. Adoption of safety features can create barriers and result in violations of the ADA. In the past, I believe at least one public school installed safety features which were later uninstalled due to non-conformity with accessibility standards. I therefore recommended an amendment to add the following sentence at the end of line 12: "Such review shall be coordinated with the Architectural Accessibility Board established by Chapter 73 of this title to ensure compatibility of safety and architectural accessibility features." The AAB is already charged with reviewing school construction and renovations to ensure ADA compliance. However, if the "safety" review occurred after the AAB review, changes could supersede and contravene the AAB-approved accessibility features. After consultation with the AAB, the SCPD shared the proposed amendment with the prime sponsor on June 5 and received a favorable response.

I recommend following up to promote adoption of the amendment.

3. H.B. No. 344 (Criminal Mental Health Code)

This bill was introduced on May 15, 2014. As of June 16, it had been released by the House Health & Human Development Committee and awaited a vote by the House. The legislation was prepared to implement the recommendations of a mental health code study group established by HJR 17.

The legislation revises Delaware statutes which address procedural issues related to competency to stand trial, not guilty by reason of insanity, and guilty but mentally ill. The effects of the bill are listed in the synopsis. They would include the following:

A. Individuals determined not guilty by reason of insanity would be authorized to petition the Superior Court to address their status and potential discharge from the Delaware Psychiatric Center. The Court would also enjoy discretion to authorize the individual's participation in "off campus" treatment, employment, and other activities.

B. The procedures for competency evaluations are specified. If the accused does not agree with the results of a court-ordered evaluation, the accused could solicit approval of a second competency evaluation. Individuals determined incompetent to stand trial may be confined at DPC until their competency is restored. If DPC determines after two years that competency is not likely to be restored, a court hearing would be scheduled to determine if the individual should be released or detained for further treatment.

I shared some discrete proposed revisions with the drafters on June 10. One revision would authorize DPC to solicit a court review of competency prior to expiration of the 2-year period if it certified that the individual's condition and competency were immutable. I have been advised that the proposed revisions will be incorporated into an omnibus amendment to be placed with the bill.

I recommend endorsement of the legislation as amended.

4. H.B. No. 337 (Public School Choice Program Enrollment)

This legislation was introduced on May 13, 2014. It passed the House with one amendment and was released from the Senate Education Committee on June 11. As of June 16 it awaited a Senate vote.

Background is provided in the attached May 16 edition of the Delaware House Democrats newsletter. In a nutshell, the bill would result in uniformity in school choice enrollment deadlines for local and vocational school districts, charter schools, and magnet schools. An application could be filed between the first Monday in November and second Wednesday in January for the following school year (lines 22-24). Applications could be accepted after the deadline by charter schools, vocational-technical school districts, and magnet schools "to fill remaining availability" (lines 29-31). The bill does not affect the current authorization for receiving agencies to process late applications for "good cause" (lines 32-34). The receiving agencies would take action on the application by the last day of February for grades 1-12 and parents would have to accept an offer in writing by the third Friday in March (lines 45-48 and 55-56).

I recommend endorsement.

5. DMMA Final Medicaid Coverage of Prescribed Drugs Reg. [17 DE Reg. 1189 (6/1/14)]

The SCPD and GACEC commented on the proposed version of this regulation in April, 2014. A copy of the April 30 SCPD letter is attached for facilitated reference.

In a nutshell, the Councils endorsed the initiative since it conformed to CMS guidance on compliance with the Affordable Care Act (ACA). The ACA disallows restrictions on access to a broad range of drugs used in smoking cessation and the Delaware Medicaid plan had some limits.

The Division of Medicaid and Medical Assistance has now acknowledged the endorsements and adopted a final regulation with no additional changes. I recommend no further action.

6. DMMA Final HCBS/DD Renewal Application Reg. [17 DE Reg. 1179 (6/1/14)]

DMMA, in concert with DDDS, solicited comments on its application to renew its waiver administered by DDDS. The SCPD and GACEC submitted comments in both March and April, 2014. The Division submitted its waiver on March 10, 2014 and the Councils were advised that it was approved through a May 30, 2014 email. The Council comments and DDDS responses to the comments are compiled in the final regulation published. The following is a summary which conforms to the numbering in the regulation:

1. In March, the Councils expressed a concern with the limited opportunity to comment.

Response: An additional opportunity to comment was provided in April.

2. The Councils encouraged inclusion of a participant direction option in the waiver.

Response: DDDS noted that it “does not have the infrastructure to support participant directed services.”

3. The Councils objected to the omission of references to waiver eligibility of individuals with brain injury.

Response: DDDS asked CMS “to add the term ‘brain injury’ to the waiver application to make it clear that this population is included.”

4. The Councils objected to changing the initial age of eligibility from 4 to 12.

Response: Based on claims data, no one under age 12 has received services under the DDDS waiver. It is common to include age limits in waivers. DHSS will be seeking an amendment to its enabling statute [29 Del.C. §7909(c)(3)] to delete its duty to provide early intervention services since they are being provided by DPH and DMS.

5. The Councils shared a concern with the limit in number supported living units an individual could receive.

Response: No individual currently receives more than the established limit of 35 hours per week of supported living services.

6. The Councils questioned whether the waiver included a residential habilitation cap on provider payment based on the ICAP.

Response: "The limit on ICAP hours per day is twenty-four (24) if the client is supported in a 1:1 arrangement."

7. The Councils noted that the waiver described neighborhood homes as providing a separate bedroom for each resident unless the resident requested a roommate. This was not supported by the neighborhood home regulation.

Response: Waiver participants have a choice of their own bedroom even if not required by the neighborhood home regulation.

8. The Councils supported an authorization to allow guardians to serve as shared living and supported living providers.

Response: DDDS is willing to work with families in anticipation of amending the waiver in the future.

9. The Councils identified an inconsistency in the authorization for a parent to serve as a prevocational services provider.

Response: Only agencies are authorized to provide prevocational services under the waiver. Such agencies could hire relatives to provide services.

10. The Councils noted that the qualifications for a DDDS case manager are meager and do not even require a high school diploma.

Response: The qualifications are based on a State Merit classification. Case managers receive specialized training.

11. The Council suggested that DDDS consider adding a second (NF) level of care apart from ICF/IDD.

Response: DDDS will retain the single level of care standard, ICF/IDD. States can only have a single level of care in a waiver.

12. The Councils identified a potential conflict with the IDEA.

Response: DDDS is relying on a CMS template.

13. The Councils noted that references to Mandt protocols may not be accurate.

Response: DDDS will ask CMS to amend the references in this context.

14. The Councils observed that the description of ELP preparation activities appeared inflated.

Response: The description is based on a process being tested and expected to be operational effective July 1, 2014.

15. The Councils expressed concern that reporting to CMS on the offer of choice between institutional and waiver services was being discontinued.

Response: CMS has removed the measure from its standard reporting form.

16. The Councils expressed concern that the number of projected waiver participants was ostensibly too low.

Response: DHSS has asked CMS to add 50 slots to each year in the 5-year waiver.

17. The Councils encouraged inclusion of "satisfaction with services and quality of life" measures in "quality" measures.

Response: DDDS plans to include National Core Indicators measures to the waiver in the future.

18. The Councils noted that DDDS might have to amend its waiver standards to address leases and protections from discharge/eviction to conform to recent CMS regulations.

Response: The CMS regulations were effective March 17, 2014. The waiver amendment was submitted prior to the effective date (March 12). Therefore, there is additional time to comply with the regulation.

19. The Councils encouraged consideration of adoption of a higher income standard (300% of the SSI Federal Benefit Rate).

Response: Delaware has chosen the 250% FBR standard for all of its HCBS waivers.

Since the regulation is final, I recommend no further action. The Councils should monitor attempts to revise the DDDS enabling statute to delete a duty to provide early intervention services. See Par. 4.

7. DSS Prop. Food Supplement Program Household Definition Reg. [17 DE Reg. 1145 (6/1/14)]

This is a "housekeeping" amendment to Delaware's Food Supplement Program regulations.

As background, legislation (H.B. No. 75) was enacted in 2013 which resulted in adoption of the following statute:

§129. Equal Treatment of Marital Relationships.

(a) All laws of this State applicable to marriage or married spouses or the children of married spouses, whether derived from statutes, administrative rules or regulations, court rules, governmental policies, common law, court decisions, or any other provisions or sources of law, including n equity, shall apply equally to same-gender and different-gender married couples and their children.

Title 13 Del.C. §129.

The existing federal [7 C.F.R. 273.1] and State regulations covering eligibility for the Food Supplement Program define a “household” as including “spouses” who live together regardless of whether they customarily purchase food and prepare meals together. The current State regulation contains the following provision excluding “same-sex” couples from being considered “spouses”:

Same sex couples, for food stamp purposes, are not considered spouses and the presumption of purchasing food and preparing meals together would not apply to them.

At 1146.

Given the above §129, DSS is deleting this provision so same-gender spouses would be treated the same as different-gender spouses for purposes of eligibility for benefits under the Food Supplement Program.

Since the revision is necessary to conform to statute, I recommend endorsement.

8. DSS Prop. Food Supp. Program Unearned Income Verification Reg. [17 DE Reg. 1140 (6/1/14)]

The Division of Social Services (DSS) proposes to amend its Food Supplement Program standards for verification of unearned income.

As background, DSS recites that federal regulations give state agencies the option of using an Income and Eligibility Verification System “IEVS”) to verify income when determining eligibility for and the amount of benefits. DSS is opting to not use the IEVS system to obtain information on unearned income. Instead, “DSS will continue to use alternative methods to document and verify unearned income.” At 1140. Both earned and unearned income are considered when assessing eligibility. See 16 DE Admin Code 9054-9057.

The rationale for opting to use “alternative methods” to verify unearned income is not provided. The justification could be based on cost, accuracy of information, or difficulty in acquiring information.

I recommend that the SCPD comment that it reviewed the regulation but is unable to offer comments (pro or con) given lack of information on the justification for using unearned income verification sources other than the federal IEVS.

9. DSS/DMMA Prop. Case Processing Procedures Regulation [17 DE Reg. 1138 (6/1/14)]

The DLP is responsible for prompting this initiative. On January 29, 2014 I emailed the Delaware Medicaid Director and identified the following inconsistency in regulations covering the time frames for processing initial Medicaid applications:

Section 14100.5.1 was amended in November, 2013. It provides “90 day” and “45 day” time periods for processing Medicaid applications. However, Section 2000 also covers applications for “medical assistance” and Section 2000.5 establishes a “30 day” time frame for processing the application. These sections are ostensibly inconsistent.

The Director responded that the reference in §2000 is incorrect and would be removed to clarify that §2000.5 is inapplicable to Medicaid.

The proposed regulation implements the above consensus. In a nutshell, §2000 is amended to clarify that policies specific to Medical Assistance applications are compiled in §14100. However, the regulation could be improved. For example, the 2000 series still contains some references to Medical Assistance (e.g. §§2002.1.1 and 2012) and there is no exclusion in §2000.5 for Medical Assistance cases. Therefore, ambiguity is still present.

DHSS could consider the following:

1) Amend the new reference in §2000 as follows: “Policies specific to Medical Assistance applications and processing time lines are found in DSSM policy section 14100.”

2) Amend the title to §2000.5 as follows: “Non-Medical Assistance Filing Dates and Processing Standards”. This approach is consistent with other headings which are more program-specific. See, e.g. §§2002, 2007, and 2008.

I recommend sharing the above observations with DSS and DMMA.

10. DOE Prop. High School Graduation Requirements & Diploma Reg. [17 DE Reg. 1127 (6/1/14)]

The Department of Education proposes to adopt some discrete amendments to its standards related to graduation and diploma eligibility. The DOE notes that the significant changes are in the following contexts: 1) requiring an advisement process to the student success planning; 2) modifying definitions; 3) revising the date for which diplomas may be awarded to the previous graduating class; and 4) addressing students in the custody of the DSCY&F. At 1127.

I identified the following concerns.

First, the Department maintains a requirement (§4.1.4) that a credit in Mathematics shall be earned during the senior year. I question the justification for the requirement. Students must achieve 4 credits in math (§4.1) so why should it matter when the credits are obtained? There is no analogous requirement that an English or Science credit be obtained in the senior year. If a student were to earn a 4th credit through on-line learning or a summer program prior to the onset of the senior year, the student should not be penalized.

Second, §5.1 establishes the need for a Student Success Plan for students in grades 8-12. It would be preferable to clarify that grade 12 encompasses students through the end of their eligibility for education. See Title 14 Del.C. §1703(d) which recites as follows: "Grade 12 is defined as enrollment until receipt of a regular high school diploma or the end of the school year in which the student attains the age of 21, whichever occurs first, as defined in Chapter 31 of this title." This clarification could be accomplished through the addition of a definition of "twelfth grade student".

Third, §5.1 requires the Student Success Plan to incorporate the transition plan required by 14 DE Admin Code 925. The transition plan must also be incorporated in the IEP. See 14 DE Admin Code 925, §20.2. These competing directives may result in confusion. Do educators place the transition plan in the IEP or the SSP?

Fourth, §9.3 provides as follows: "Diplomas from one school year shall not be issued after ~~December 31~~ September 15 of the next school year." I recommend retaining the existing standard. What harm results from retention of the existing standard? Moreover, it's unclear what happens if a student completes credit requirements between September 16-December 31. Does the student receive a diploma in the Fall or have to wait until the following calendar year? Delaying receipt of a diploma can affect job qualifications, qualifications to enter the military, and qualifications to enter post-secondary education.

Fifth, in §10.2, it would be preferable to add an explicit standard that the districts and charter schools will defer to any full and partial awards of credit by DSCY&F educational settings. For example, the Ferris School for Boys [Title 31 Del.C. §5112] is a public school and the DSCY&F should be able to award credits which would be honored by other schools. Other DSCY&F settings also provide comprehensive full day education by certified teachers. See attached p. 44 from December 19, 2013 MOU among DSCY&F and the public school system. Parenthetically, the attached p. 18 of the same MOU directs schools receiving transfer students to "immediately apply full credits" while also encouraging the receiving schools to "accept partial credits to benefit the student". It would be preferable to include similar guidance in §10.0.

I recommend sharing the above observations with the DOE, SBE, and DSCY&F.

11. DOE Prop. Limitations on Use of Seclusion & Restraint Reg. [17 DE Reg. 1133 (6/1/14)]

The SCPD and GACEC submitted comments on an initial, pre-publication version of this regulation. The May 8 SCPD letter, which contains 39 comments, is attached for facilitated reference. The GACEC letter included the same comments while adding several comments from individual Council members. My current analysis includes references to the earlier SCPD commentary by number.

I have the following observations.

First, consistent with earlier Comment #1, §1.1 omits any reference to “chemical” restraint. Compare §2.0, definition of “chemical restraint”; and §3.1.1. The first sentence could be amended as follows: “The purpose...physical restraint, chemical restraint, mechanical restraint...”

Second, consistent with earlier Comment #2, add a reference to 14 Del.C. §3110.

Third, consistent with earlier Comment §5, in §2.0, definition of “mechanical restraint”, second bullet, insert “or” between “movement” and “stability”.

Fourth, in §3.2.9, strike “; and” and substitute a period.

Fifth, consistent with earlier Comment #11, the training standards in §4.1 are too weak. The reference to “nationally recognized training programs” is an insufficient standard. The term “approved by the Department” should be inserted after “programs”. Compare 14 DE Admin Code 910 (DOE must approve alternatives to GED testing).

Sixth, in §6.1.2, first line, convert “Written” to low case. Compare §6.1.3.

Seventh, consistent with earlier Comment #22, insert “duration” of restraint. This is a very important component of a restraint, i.e., did it last 5 minutes or an hour. Compare §8.3.3 and Title 16 Del.C. §5162(a).

Eighth, in §8.1.2.1, delete the word “and” at the end.

Ninth, in §8.2, the 60 day period for the review committee to issue a decision would be followed by a review period for the Secretary to “consider the whole record of the case and the committee’s recommendations” (§8.4) followed by mailing of a decision. If a student is manifesting extreme behaviors during this period, a quicker review may be in everyone’s interests. At a minimum, consider the following revision to §8.2: “All requests.....shall be rendered as soon as practicable but in no event more than 60 days from receipt of the waiver request.”

I recommend sharing the above observations with the DOE and SBE.

12. DFS Emergency Camp Personnel Criminal Background Check Reg. [17 DE Reg. 1124 (6/1/14)]

The Division of Family Services (DFS) issued an emergency regulation which was effective May 19, 2014.

As background, the Division notes that the Governor issued Executive Order No. 42 in January, 2014 which created a task force to examine Delaware's criminal background and child protection registry check requirements related to individuals working with children. The task force report is not expected to be issued until the end of 2014. In the meantime, there is no statutory or regulatory requirement that persons employed or volunteering in summer camps undergo background checks. The regulation attempts to "close the loophole" by requiring checks of criminal convictions and the Child Protection Registry.

The concept underlying the regulation is laudable. Checks of prospective employees should be undertaken. However, some provisions in the regulation are "overbroad".

First, §3.3.1.1 recites as follows:

No employee, owner, operator or volunteer may work or volunteer in a youth summer camp if convicted of a sexually related offense(s) or other offenses against children.

I recognize that DFS has adopted similar language in other regulations. See, e.g., 17 DE Reg. 332, 335, §6.1 (September 1, 2013). However, the categorical ban against employment of anyone with a conviction of an offense against a child is too sweeping. There is no time limit so a conviction occurring 50 years ago bars employment. Convictions can be minor and present negligible evidence of a danger to children. Consider the following examples:

A. A parent allowed his 17 year old to ride a bike without a helmet resulting in a conviction under Title 21 Del.C. 4198K(b).

B. An 18 year old had an altercation with a 17 year old in high school 30 years ago resulting in a conviction for offensive touching.

C. A store clerk sold a pack of cigarettes to a 17 year old 30 years ago resulting in a conviction for a violation of Title 11 Del.C. §1121.

Such convictions which are either minor and/or remote in time implicate negligible risk of harm if the individual applies to work in a summer camp. Therefore, DFS should consider adopting a more restrained and discriminating standard. At a minimum, DFS could adopt a definition of an "offense against a child" which focuses on crimes implicating abuse, neglect, or exploitation.

Second, as applied to camps operated by local governments (e.g. NCC; City of Newark), the categorical ban on employing individuals with a conviction of any offense against a child violates the public policy established by newly enacted State law. H.B. No. 167 disallows public employers from disqualifying an individual from employment based on criminal history unless the exclusion is job related for the position and consistent with business necessity. The employer is admonished to consider the nature of the offense, the time that has passed since the offense, and nature of the job. Although the new law is not effective until November, it provides useful public policy guidance. The DFS approach of categorically excluding anyone from employment in a camp for minor and stale convictions is simply inconsistent with the deliberative approach espoused by the newly enacted State law.

Finally, the arbitrary nature of the DFS standard is underscored by considering who is not covered by the DFS categorical ban on camp employment. Individuals with convictions for arson, weapons offenses, assaults with adult victims, homicide of adults, etc. can work or volunteer in camps with no regulatory restriction.

I recommend sharing the above observations with DFS.

13. DFS Prop. Early Care & Education & School-Age Center Reg. [17 DE Reg. 1156 (6/1/14)]

The Division of Family Services proposes to adopt a wholesale revision of its standards applicable to early care and education and school-aged centers. Given the length of the document, I only had time to skim the proposed standards.

I have the following observations.

First, I was unable to identify any general non-discrimination provision, including a provision barring discrimination based on disability. I noted only isolated and oblique references (e.g. §25.1.3). Compare 14 DE Admin Code 225 for DOE equivalent. In the 1990s the Division's regulations routinely contained such provisions. See, e.g., attached excerpts from former regulations. In its December 19, 2007 commentary on proposed DFS regulations covering child care homes, the SCPD offered the following recommendation:

2. Although there are a few cryptic references to "nondiscrimination" (e.g. §29.1.2), the regulations do not mention or proscribe discrimination based on race, disability, or other protected classes. At a minimum, §7.2.3 could be renumbered §7.2.4 and the following new §7.2.3 inserted:

7.2.3 Commitment to comply with applicable non-discrimination laws, including the Americans with Disabilities Act [42 U.S.C. 12101] and Delaware Equal Accommodations Law [Title 6 Del.C. Ch. 45].

Attached please find a December 2, 1991 Delaware Attorney General's Opinion holding that day care centers are covered by both the ADA and Delaware Equal Accommodations law.

Indeed, consistent with the attached Attorney General's Opinion, DFS offered training on daycare center compliance with the ADA in the past. See attached May 9, 1996 excerpt from "DayCare Centers and the Americans with Disabilities Act".

The bottom line is that the current regulation would benefit from an affirmative requirement that providers comply with the ADA and Equal Accommodations law in their programs. Concomitantly, there are a number of provisions in the proposed regulation which may be "at odds" with the Attorney General's opinion and the ADA. See, e.g., §§59.1 (children excluded if unspecified illness limits child's comfortable participation or extra care needs compromise health and safety of other children); 17.4.1 (implication that programs may discourage enrollment based on special needs).

Second, §13.0 lists several "events" requiring reporting to DFS. There is no mention of reporting extended physical restraint which is ostensibly not limited by §§64.4 and 65.4. Compare Title 16 Del.C. §5162(a)(2) and 17 DE Reg. 1133, 1137, §6.1.2 (June 1, 2014). DFS may wish to consider requiring the reporting of physical restraint above a certain threshold (e.g. 10 minutes).

Third, §41.0 requires children to wear helmets if riding a bike with wheels of 20 or more inches. The State law requiring children to wear helmets [Title 21 Del.C. §4198K] does not exempt children riding on bikes with smaller wheels. The "20 inch" standard for bikes should be deleted.

I recommend sharing the above observations with the Division.

Attachments

E:leg/614bils
F:pub/bjh/leg/2014p&l/614bils

Bill would permit possession of heroin overdose drug

Jon Offredo, The News Journal 9:38 p.m. EDT May 14, 2014

Bill would get counter drug in the hands of more people likely to come across overdoses



(Photo: GARY EMEIGH/THE NEWS JOURNAL)

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CONNECT

<https://twitter.com/intent/tweet?url=http://delonline.us/1gpn9nU&text=Bill%20would%20permit%20possession%20of%20heroin%20overdose%20drug>

TWEET

The Delaware Senate will consider a bill that makes a drug available without a prescription that supporters argue will save the life of someone overdosing on heroin or other opioids.

The legislation, which cleared a Senate committee Wednesday, allows Delaware's Department of Health and Social Services to distribute Naloxone without a prescription and at little or no cost to anyone who completes a training program. Officials say the legislation is a tool to combat the growing heroin and opioid epidemic facing the state.

"This legislation will save lives," said the bill's sponsor Sen. Bethany Hall-Long, D-Middletown.

Delaware law currently allows friends and family members to purchase the drug when a prescription is written for a person with the addiction. One brand of the drug, Narcan, is available as a nasal spray. In April, the Food and Drug Administration approved an autoinjector-like device for administration of the drug, but the cost of it is unknown.

It could have saved David Humes's son, Greg, who died of an overdose in 2012. Humes remembers police telling him that his son could have survived if the state had a 911 Good Samaritan or Narcan law.

He lives those words every day of his life, he told the Senate Health and Social Services Committee on Wednesday. Gov. Jack Markell signed the Samaritan law last year.

"Time matters. Give other parents a life-saving tool that I didn't have," he said.

It's not clear how the community-based training program would work, but officials from DHSS are looking at best practices across the nation, said Debbie Gottschalk, the department's chief policy adviser.

The idea is to get the drug in the hands of more people who are likely to come across overdoses, whether they are community group members, friends or family members, Gottschalk said. Training is needed to help people understand how to administer the medicine, she added.

For Diann Jones, of Middletown, the legislation offers peace of mind.

Her daughter, 22, has been in and out of treatment for heroin and opioid addiction in the past two years. It's a constant struggle to fight the disease, but the legislation would allow her to help immediately, even if her daughter didn't seek a prescription, she said.

They recently took a drive to North Carolina, but she would have been powerless if the worst had happened.

"I have no idea what I would have done," she said.

Emergency Medical Service units in Delaware have administered Naloxone for several years now and 900 unresponsive people were given the drug in 2013. Three hundred were revived, but it is unknown how many had overdosed on opioids.

A pilot project started in March that allows Basic Life Support units to carry the drug in high heroin use areas has already seen results. Units have administered it five times, reviving three people. The drug is administered before police officers arrive at the scene in the vast majority of instances where emergency responders use it.

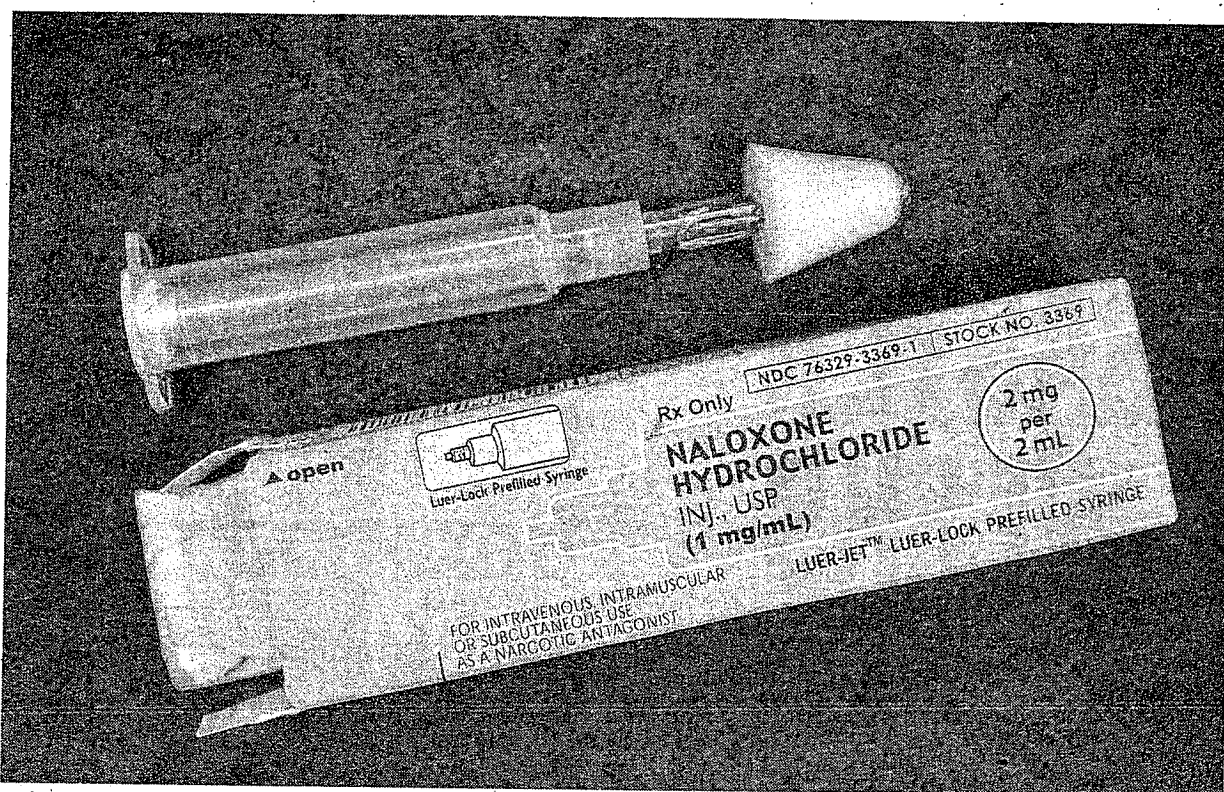
The legislation provides a front-line defense to a heroin and opioid epidemic, said Joe Connor, president of Addictions Coalition Delaware. Treatment for addiction comes in many forms: abstinence, medicine, education.

"This is kind of the 911 of treatment," he said. "It brings someone back from an overdose and gives them another opportunity to get treatment."

<http://www.delawareonline.com/story/news/local/2014/05/14/bill-permit-possession-heroin-overdose-dr...> 5/19/2014

6-4-14
NJ

Del. Senate eases way for usage of OD drug



Naloxone is a heroin antidote that can reverse the effects of an opioid overdose. GETTY IMAGES

After training, people could buy Naloxone at low rate

By Jon Offredo The News Journal

Senate lawmakers unanimously passed legislation Tuesday that could make overdose-reversing medication available without a prescription and at a low rate.

The bill, now heading to the House, allows Delaware's Department of Health and Social Services to establish a training program that would allow individuals to obtain Naloxone upon completion, said Sen. Bethany Hall-Long, a Middletown Democrat and the bill's sponsor.

How the training operates and the regulations allowing the distribution still is being worked out, but officials are studying best practices across the nation, she added.

A wider availability of Naloxone will save lives, Hall-Long said.

"I think all of us know that heroin and opiate addiction crosses economic classes," Hall-Long said. "It is prevalent."

Current state law allows friends and family members to purchase the medication when a prescription is written for the person struggling with addiction. But few, if any, doctors have prescribed the medication and pharmacies generally don't carry it, said David Mangler, director of the state's Division of Professional Regulation. Medical professionals just didn't know they could prescribe it under current law, he added.

The division is preparing to send out advisories to doctors and pharmacies explaining how the medication is used, administered and how to prescribe it, Mangler said.

Naloxone comes in several forms, including Narcan, a nasal spray. It would cost pharmacies roughly \$46 to order the medication, but the cost to patients is unknown and many insurance companies don't cover its purchase, Mangler said.

Contact Jon Offredo at (302) 678-4271 or at joffredo@delawareonline.com or on Twitter @jonoffredo.

'Narcan' vote is a vote against death

Our View 7:40 p.m. EDT June 4, 2014



(Photo: Spencer Platt)

Here is an appreciative nod to the Delaware Senate. The legislative body unanimously approved a medication that could save the lives of heroin addicts.

It is now up to the Delaware House to follow suit and for the governor to sign the bill into law.

Naloxone is an overdose-reversal medication. The bill allows it to be available with a prescription. Sen. Bethany Hall-Long, the prime sponsor of the bill, said a wider availability of Naloxone would save lives.

She is right.

EDITORIAL: [A closed bridge and an inconvenient commute \(/story/opinion/editorials/2014/06/03/closed-bridge-inconvenient-commute/9927461/\)](#)

EDITORIAL: [New Jersey's state's rights: Anything for a jackpot \(/story/opinion/editorials/2014/06/04/new-jerseys-state-rights-anything-jackpot/9981505/\)](#)

The medicine comes in a variety of forms. It can be used to reverse the affects of a heroin overdose. The medicine is known as "narcan" and it takes seconds to administer. Emergency officials and family members, for example, could quickly administer the medicine to someone who overdoses on heroin and help the victim revive.

The Delaware Department of Health and Social Services will be required to start training programs. It is hoped publicity attached to the bill let medical professionals know the medicine already is available through prescriptions. The bill will carry that to the next step.

Heroin is hitting Delawareans across all cultures, races and economic levels. The time for smart thinking about this scourge is now. Too many people are dying from overdoses or destroying their lives.

Passage of the bill does not get it into the hands of those who need it. However, Wednesday's action is a good start.

Read or Share this story: <http://delonline.us/1mUJWhn>

to Senate

Weekly video wrap

Legislative round-up

Our Leadership

Peter C. Schwartzkopf
Speaker of the House

Valerie Longhurst
Majority Leader

John Viola
Majority Whip

Keep In Touch



5-16-14

DE
HOUSE
DECA CARDS
NEWS LETTER

Flowering Leadership in Delaware



Students from high school career and technical clubs across the state descended on Legislative Hall this week to present lawmakers with their annual batch of... annuals (geraniums, to be exact). The students are representative of the 66,000-plus students who participate in groups such as FFA, Business Professionals of America, Delaware DECA and Skills USA. The groups are part of Delaware Career and Technical Student Organizations.

School Choice Enrollment Bill Filed

Parents would be able to weigh all school choice options for their children before making a final selection under legislation filed Tuesday that would align all school choice enrollment acceptance deadlines.

Sponsored by Rep. Kim Williams, House Bill 337 would require all school choice enrollment deadlines for public school districts, charter schools, magnet schools and career and technical education schools to line up, which would give parents uniformity and allow them to make decisions about which school their child will attend. Parents whose child wishes to attend a different public, charter, magnet or vo-tech school would have to apply between the first Monday in November and the second Wednesday in January for the following school year.

The bill would set a uniform deadline of the third Friday in March for parents and students to notify the school if they accept the school choice enrollment offer. Currently, there are no uniform deadlines for schools to extend an enrollment offer to a student, or for parents to accept an enrollment offer.

To read the full release, click [here](#).



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES
MARGARET M. O'NEILL BUILDING
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MEMORANDUM

DATE: April 30, 2014

TO: Ms. Sharon L. Summers, DMMA
Planning & Policy Development Unit

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

RE: 17 DE Reg. 951 [DMMA Proposed Medicaid Coverage of Prescribed Drugs Regulation]

The State Council has reviewed the Department of Health and Social Services/Division of Medicaid & Medical Assistance's (DMMA's) proposal to amend the Delaware Medicaid State Plan regarding prescribed drug coverage. The proposed regulation was published as 17 DE Reg. 955 in the April 1, 2014 issue of the Register of Regulations. SCPD endorses the proposed regulation and has the following observations.

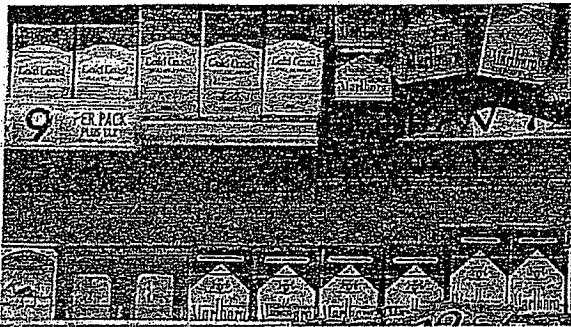
Effective January 1, 2014 the Affordable Care Act (ACA) disallows restricting access to barbiturates, benzodiazepines, and agents used to promote smoking cessation. DMMA is therefore proposing a technical amendment to conform to the ACA. The anomaly is that the current restrictions were just added last year. See 16 DE Reg. 1028 (4/1/13) (proposed); 16 DE Reg. 1270 (6/1/13) (final)]. Consistent with the attached March 30, 2014 article, Medicaid beneficiaries are more likely to smoke than the general population and the CDC recommends Medicaid coverage of all proven cessation treatments.

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

cc: Mr. Stephen Groff
Mr. Brian Hartman, Esq.
Governor's Advisory Council for Exceptional Citizens
Developmental Disabilities Council

examiner.com

Uneven progress in state Medicaid coverage for smoking cessation



Getty Images



Barbara Mader
General Education Examiner
| Follow:

March 30, 2014

More smokers would quit if state Medicaid programs covered more cessation treatments and removed barriers to coverage, according to a CDC study published in today's **Morbidity and Mortality Weekly Report**. All 50 states and the District of Columbia cover cessation treatments for at least some Medicaid enrollees. Efforts to expand state Medicaid coverage for all smoking cessation treatments and the removal

of coverage barriers have shown mixed progress over the past five years.

Americans enrolled in Medicaid are more likely to smoke than the general population, and smoking-related disease is a major contributor to increasing Medicaid costs. Insurance coverage of proven cessation treatments leads to more smokers using the treatments and successfully quitting smoking. A recent study from the American Journal of Preventive Medicine found that more comprehensive state Medicaid coverage was associated with increased quit rates among smokers enrolled in Medicaid.

Seven states cover all approved medications and in-person counseling cessation treatments for all Medicaid recipients. All states have some barriers to getting these

treatments. The most common barriers are limits on how long treatment is covered and how much is covered per year; prior authorization requirements; and copayments.

"States can save lives and reduce costs by providing Medicaid coverage for all proven cessation treatments, removing barriers to accessing these treatments, and promoting the expanded coverage," said Tim McAfee, M.D., M.P.H., Director of the CDC's Office on Smoking and Health. "Reducing the number of smokers will save lives and reduce health care costs."

The study compares 2008 with 2014 data and found that 41 states made changes to the treatments they covered for at least some plans or populations. Nineteen states added treatments to coverage without removing any treatments from coverage and eight states removed treatments from coverage without adding any treatments to coverage. Fourteen states both added and removed coverage.

During this same period, 38 states made changes to barriers to accessing treatments for at least some plans or populations. Nine states removed barriers without adding new barriers, 12 states added new barriers without removing existing ones, and 17 states both removed and added barriers.

"There's evidence suggesting that smokers enrolled in Medicaid, like other smokers, want to quit and will take advantage of covered cessation treatments to help them quit for good," said Stephen Babb, M.P.H., co-author of the article.

Some of the strongest evidence comes from Massachusetts, which expanded its Medicaid cessation coverage in 2006.

"Massachusetts heavily promoted its new Medicaid cessation coverage to Medicaid enrollees and health care providers, and saw a drop in the smoking rate among Medicaid enrollees from 38 percent to 28 percent," said Babb. There was also an almost 50 percent drop in hospital admissions for heart attacks among those who used the benefit. It is important that all smokers who want help quitting, including smokers enrolled in Medicaid, have access to proven cessation treatments and services."

Fifty years after the first Surgeon General's Report linking cigarette smoking to lung cancer, smoking remains the leading cause of preventable death and disease in the

United States, killing nearly half a million Americans every year. More than 16 million Americans live with a smoking-related disease. Smoking-related diseases cost Americans \$132 billion a year in direct health care expenses, much of which comes in taxpayer-supported payments. The most recent Surgeon General's Report, released in January 2014, recommends providing barrier-free access to proven cessation treatments, and expanding cessation services for all smokers in primary and specialty care settings.

Follow all the news about Green Living, American Made, Pets, Education, and Child Health by subscribing to my articles. Click on the "Subscribe" button, or here: <http://www.examiner.com/user-bmader>. Visit my blog for a chuckle at: <http://barb-says.blogspot.com>.

EXCEPT:
12-19-13 MSU
AMSC DOE
DSCYF &
DISTRICTS


children. Services may include in-home services, placement, family reunification, or other permanency options including adoption, guardianship, and independent living.

Division of Management Support Services (DMSS)

Education Programs

1. **Ferris School** - Education is provided on site by certified school personnel to youth in the secure treatment facility. Students transitioning through Mowlds Cottage either continue in the Ferris Program or return to the home school. Regular and special education courses are offered through a schedule which mirrors any local public high school. Electives include art, technology, media literacy, school to work and JDG classes.
2. **New Castle County Detention Center** - All students attend a full day of courses which include all the Core Courses. GED is available to youth meeting criteria for entry into the Program. Special education services are provided in accordance with state and federal law.
3. **Grace and Snowden Cottages** - This program is a residential treatment program for adjudicated males and females. Students are typically between the ages of 12-18. The program, located on the Wilmington Campus, is operated directly by the Division of Youth Rehabilitative Services. Education is provided on site by certified school personnel who are employed by DSCYF.
4. **Terry Children's Psychiatric Center** - This DPBHS program is a Residential Treatment Center providing inpatient and day hospital services for youth under the age of 14. Education is provided on-site by certified school personnel. Special education services are provided in accordance with state and federal law.
5. **Northeast Treatment** - This program is operated by Northeast Treatment Centers, LKEC (Delaware) Inc. under contract to the DPBHS. Students ages 12-17 receive a full day of education by certified teachers. Special education services are provided in accordance with state and federal law.
6. **Silver Lake Treatment Center** - This DPBHS program provides day treatment and educational services to youth ages 12-17. Full complement of core courses is provided by teachers certified by Delaware Department of Education. Special education services are provided in accordance with state and federal law.
7. **Stevenson House Detention Center** - All students attend a full day of courses which include all the Core Courses. GED is available to youth meeting criteria for entry into the Program. Special education services are provided in accordance with state and federal law.
8. **People's Place II** - Peoples' Place II is a non-secure detention environment for non-adjudicated males and females ages 12-18. While in placement youth are required to attend school. The certified educator employed by Department of Services for Children, Youth, and Their Families, Education Unit works closely with the youth's "home school" to make sure the on-site education provided while in placement is aligned with the child's "home school" class assignments. The DSCYF teacher also ensures compliance with special education regulations as required and assists in arranging a smooth return to a more conventional school environment upon discharge from the non-secure detention placement. Education is provided year round, on site, and in compliance with state and federal regulations. Peoples' Place II is located in Milford, DE
9. **Seaford House Treatment Center** - This program provides day treatment and educational services at the treatment center operated by Children and Families First under contract with DPBHS. Students ages 12-17 receive a full day of education by certified teachers. Special education services are provided in accordance with state and federal law.
10. **Delaware Day Treatment Center** - There are two Delaware Guidance programs: one in Kent County and one in Sussex County. Both programs are operated by Delaware Guidance Inc. under contract to the DPBHS. Students ages 6-15 are provided with day treatment and educational services. Education is provided on site by certified teachers

their school of origin and be provided transportation to the school of origin when a change in foster care placement occurs, when in the best interest of the child.

- b. Enroll a child in foster care (based on the results of the Best Interest Meeting) within two school days of referral in a new school even if DSCYF is unable to produce records, or the sending school has not yet transferred the records, such as previous academic records, medical records, proof of residency, and/or other documentation if all parties (child, school, parent/legal guardian/Relative Caregiver, Guardian ad litem, CASA, and DSCYF staff) agree that it is in the best interest of the child to change schools according to the McKinney-Vento Act.
- c. Ensure that the receiving school promptly obtains school and medical records from the sending school for a newly enrolled child in foster care.
- d. Transfer school and medical records from the sending school immediately (within three school days during the school year, or five working days in the summer) to a new school for a child in foster care who is transferring schools.
- e.  The receiving school shall immediately apply full credits and is encouraged to accept partial credits to benefit the student. The receiving and sending schools should determine, for transferring seniors, which school will provide the diploma.
- f. Accept a DSCYF letterhead statement as proof of residency of a child in foster care with the placement resource identified.
- g. Accept registration materials from DSCYF case managers via fax and schedule a meeting or a teleconference with the caseworker for a later date, within five business days, to discuss other educational information that may not have been shared.
- h. Host meetings with necessary parties to develop the best educational plan for a child or youth in foster care, as may be needed from time to time.
- i. Host a meeting in May or June, with all involved parties (district/school liaison, caseworker, parent, Guardian ad litem, CASA, and child) to determine whether it is in the best interest of the child to remain in the school of origin or be transferred to the district in which they are now living for the subsequent year. The school liaison will schedule the meeting and be responsible for scheduling other school personnel.



STATE OF DELAWARE
STATE COUNCIL FOR PERSONS WITH DISABILITIES

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May 8, 2014

Ms. Susan K. Haberstroh, Ed.D.
Department of Education
35 Commerce Way – Suite 1
Dover, DE 19904

RE: DOE Pre-Publication Draft Regulation on Restraints and Seclusion (April 7, 2014)]

Dear Ms. Haberstroh:

The State Council for Persons with Disabilities (SCPD) has reviewed the Department of Education's (DOE's) pre-publication draft regulation on restraints and seclusion. SCPD certainly appreciates the opportunity to review this prepublication draft and has the following observations.

1. In §1.0, the first sentence is "underinclusive" since the regulation a) establishes standards for chemical and mechanical restraint; b) addresses parental notice and due process; and c) addresses data collection and reporting. Council recommends substituting the following: "The purpose of these regulations is to implement state law and federal guidance concerning the use of seclusion and restraint by public school personnel." The reference to "federal guidance" would encompass the U.S. DOE Restraint and Seclusion: Resource Document (May, 2012) as well as other policy interpretations.

2. In §2.0, consider an amendment to read "...in accordance with 14 Del..C. §4112F and 14 Del.C. §3110." There are many "special education" aspects to the regulations and it is preferable to base the regulations on both the authority in §4112F and §3110.

3. Council suggests inserting the following preface to §3.0: "The following words and terms, when used in this regulation, shall have the following meaning unless the context clearly indicates otherwise." See Delaware Administrative Code Drafting and Style Manual [hereinafter "Manual"], §3.1.2.

4. In §3.0, the definitions of "mechanical restraint", "physical restraint", and "public school personnel" have subparts. Council recommends not capitalizing the first word in each subpart. The Manual (§3.1.2) offers the following guidance:

Uppercase the first letter of the first word in each definition. All subsequent words in each definition should be lowercase, unless words are proper nouns.

In the same sections, although the Manual (§3.1.2.1) recites that individual definitions are not numbered, the subparts would benefit from some numbers or letters to make it easier to read. Compare 14 DE Admin Code 103, §1.2, definition of "persistently low achieving school"; and 14 DE Admin Code 614, §3.0, definition of "bullying".

5. In §3.0, definition of "mechanical restraint", insert "or" between "movement" or "stability".

6. In §3.0, definition of "private program", consider the following amendment - "...a school district or charter school, including, without limitation, a private alternative program or a setting approved pursuant to 14 Del.C. §3124. This would explicitly clarify that the definition covers Interagency Collaborative Treatment Team (ICT)-approved placements and private "alternative programs". The amendment would also facilitate appropriate references in §7.1.2.
7. In §3.0, definition of "written report", substitute "means" for "includes".
8. In §4.2.3, substitute "neck" for "heck".
9. Section §4.2.10 copies the statute. It is confusing to recite that the restraint will conform to applicable regulations when these are the regulations. Consider substituting the following: "The physical restraint and consequent activity conform to §§5.0 - 9.0." This would encompass parental reporting, student interview, and reporting to DOE.
10. In §5.1, the term "employee" may be overly limiting since it would exclude a contractual worker (e.g. physical therapist). Likewise, the term "public school employee" would not cover private placement personnel. Compare §3.0, definition of "public school personnel". In §5.1, Council recommends substituting "public school or private program personnel who have..." for "a public school employee who has...".
11. In §5.1.1, for consistency with §5.1, Council recommends deleting the words "public school". Also, the reference to "nationally-recognized training program" is too weak a standard. There may be some "nationally recognized" programs which are used in adult or juvenile corrections or Judge Rotenberg-type settings. Council recommends the following substitute: "Such ~~public school~~ personnel shall receive annual training in the use of emergency safety interventions consistent with a nationally-recognized training programs approved by the Department which meets the following minimum requirements:". By comparison, Council would like to point out that §5.2 includes a requirement of reporting personnel completion of "training approved by the Department". Council has been informed that programs may differ widely in emphasis. For example, one program may devote 70% of time to restraint techniques and 30% of time to de-escalation and positive behavioral techniques. Another program may "reverse" this emphasis, i.e, devoting 70% of time to de-escalation and positive behavior techniques and 30% of time to restraint techniques.
12. In §5.1.1.2, substitute "public school or private program personnel" for "public school employees".
13. In §5.1.2, substitute "personnel" for "each public school employee".
14. Section 5.0 could be improved by including the concept of demonstration of competency rather than simply participation in the training. Some programs have "certifications" based on assessment of competency.
15. Section 6.1 could be improved by adding the following second sentence: "The school shall maintain written documentation of successful and unsuccessful attempts to notify a parent." Parenthetically, since many children are enrolled by guardians, custodians, and relative caregivers, it would be preferable to include a definition of "parent" in §3.0 to encompass such parental surrogates. See Title 14 Del.C. §§3101(7) and 202(e).
16. The text of §6.2.1 could be simply included as a second sentence in §6.2.
17. Amend §6.3 as follows: "...student's IEP or §504 plan, the parents and IEP or multidisciplinary team shall determine....".
18. In §7.1.1, consider substituting "public school or private program personnel" for "public school personnel".

19. In §7.1.2, if the DOE adopts the amendment suggested in Par. 6 above, the term “contracted private or alternative program” could be shortened to “contracted private program”.
20. In §7.0, it would be preferable for the DOE to require submission of the report based on a uniform format/form. Otherwise, schools will be providing an assortment of information to the DOE which will be difficult to aggregate into statistics for the DOE annual report. Section 7.1.3.1 already contains an outline of expected content which could be used to develop a standard form. Senate Bill No. 100 (lines 114-115) contemplates adoption of a “uniform reporting document”.
21. In §7.1.2, the DOE envisions private programs reporting to the public contracting school which then submits the report to the DOE. The DOE should consider an alternative, i.e., the private program could submit the report directly to both the contracting public school and DOE. This requirement could be included in the standard “boilerplate” for students placed through the ICT or placed in private alternative schools. This would reduce delayed submissions to the DOE.
22. Section 7.1.3.1 omits the “duration” of the physical restraint which would be useful information.
23. Section 7.1.3.2 requires reports to include information on age, race, ethnicity and disability category. Consistent with the recommendation in Par. 20, it would be preferable to have a standard form with uniform terms. Some schools will report race and ethnicity differently which will complicate DOE aggregation of data for its annual report. Moreover, the DOE should review the Office of Civil Rights (OCR) Civil Rights Data Collection so the data submitted to OCR and the DOE are based on the same definitions and schools can have a single data collection system for both the federal and state DOE. It would be dysfunctional to have schools reporting data to OCR and the DOE which adopt different definitions and criteria. The U.S. DOE Restraint and Seclusion: Resource Document (May, 2012) notes that OCR compiles seclusion/restraint data disaggregated based on race/ethnicity, sex, limited English proficiency status, and disability. At p. 5. Since schools are reporting data to OCR which includes limited English proficiency status, the DOE should also consider adding this data to reporting requirements.
24. Section 7.1.3.4.1 omits some “plans” covered by Senate Bill No. 100 (lines 92-94).
25. Sections 7.1.3.4.1 and 7.1.3.4.2 use the term “and/or”. The Manual (§6.6.1) recites that this term “should never be used.”
26. Section 8.1 should simply be the text of §8.0. Since there is no §8.2, there is no need for a §8.1.
27. Apart from renumbering, §8.1 is “underinclusive” since it refers to “LEA”. It also omits some key concepts, including “rates of usage by individual school (not LEA), identification of trends, and analysis of significant results.” These annual report components are not discretionary. They are mandatory. See Senate Bill No. 100 (lines 116-118).
28. In §9.1, substitute “or” for “and/or”. See Manual, §6.6.1. Delete “review of” which is surplusage. Substitute “Secretary’s” for “his/her”. See Manual, §3.3.2.1. Substitute “request” for “action”.
29. Section 9.1.1 is very confusing. It literally characterizes educational records, behavioral plans, etc. as “medical” documentation. The sentence is very complicated and difficult to follow.
30. In §9.0, it would be preferable for the DOE to develop a form for submission of a waiver since this would promote inclusion of all information considered necessary for review.
31. In §9.1.2.2, the reference to “consistent with Section 6.0” is problematic since §6.0 does not cover mechanical restraint or seclusion. Substitute “which conforms to the procedure compiled in Section 6.0 for reporting physical restraint” for “consistent with Section 6.0”.

32. In §9.1.3, substitute “or” for “and/or”. See Manual, §6.6.1. If the DOE adopts a definition of “parent” as recommended in Par. 15, the reference to “or guardian” could be deleted. Substitute “Department” for “committee” since the Secretary and designee will be reviewing confidential information and are not members of the committee. This approach is also consistent with §9.1.4 which refers to maintenance of confidentiality by the “Department”.

33. Section 9.2, the committee that is appointed by the Secretary of the Department of Education should include a representative from the Governor’s Advisory Council for Exceptional Citizens (GACEC).

34. Section 9.3 would benefit from adding a subsection covering “specific conditions and safeguards”. See Senate Bill No. 100 (line121). For example, the committee might recommend: a) durational limits; b) approval of only certain forms of mechanical restraint; or c) use of seclusion or restraint only after other interventions (e.g. redirection; positive engagement) have failed.

35. Section 9.3 would benefit from a requirement of a student interview equivalent to the post-physical restraint interview envisioned by §7.1.3.3.

36. Section 9.3 would benefit from a subsection addressing the committee’s recommendation on data collection. The committee could insist on data collection on antecedents, frequency, duration, etc.

37. In §9.4, substitute “a” for “his or her”. See Manual, §3.3.2.1.

38. In §9.4, the capitalization of “Committee’s” is inconsistent with prior lowercase references to “committee”.

39. In §9.4, it would be preferable to contemporaneously send a copy of the Secretary’s decision to the parent.

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

Sincerely,



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

cc: The Honorable Mark Murphy, Secretary of Education
Dr. Donna Mitchell, Professional Standards Board
Dr. Teri Quinn Gray, State Board of Education
Ms. Mary Ann Mieczkowski
Ms. Paula Fontello, Esq.
Ms. Terry Hickey, Esq.
Ms. Ilona Kirshon, Esq.
Mr. Brian Hartman, Esq.
Developmental Disabilities Council
Governor’s Advisory Council for Exceptional Citizens

Regs./doe draft r&s reg 5-8-14

DEACARE

REQUIREMENTS FOR DAY CARE CENTERS

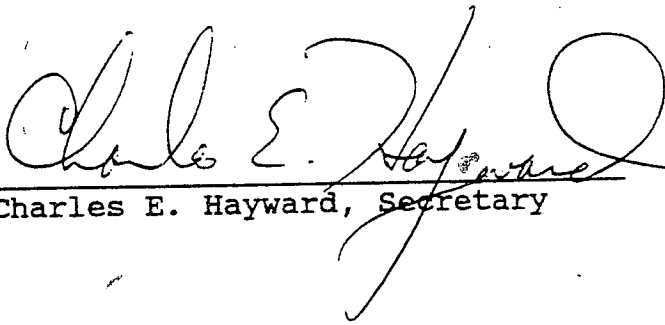


State of Delaware

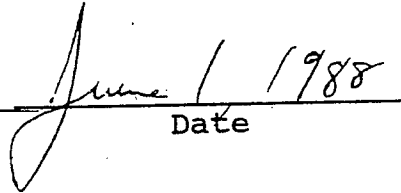
*The Department of Services
for Children, Youth, and
Their Families*

NOTICE OF RESCISSION AND PROMULGATION


The Division of Program Support, Department of Services for Children, Youth and Their Families adopts and promulgates the following requirements for day care centers as authorized in the Delaware Code, Title 31, Subchapter II, Subsections 341-344 and Title 29, Chapter 90, Subsection 9003(7). All previous rules, regulations and standards pertaining to such facilities are null and void. These requirements shall take effect on September 1, 1988.



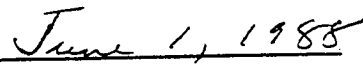
Charles E. Hayward, Secretary



Date



Virginia D. Miller, Director
Division of Program Support



Date

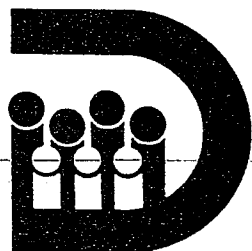
19. "Meal" means breakfast, lunch or dinner.
20. "Night Care" means care for any child between the hours of 7:00 P.M. and 7:00 A.M. when the period includes any portion of the child's normal sleeping hours.
21. "Parent(s)" means the child's natural or adoptive mother or father or other legally responsible person.
22. "Preschool Child" means a child two (2) through four (4) years of age.
23. "Program Director" means the employee of the Center with direct responsibility for developing, implementing and supervising the total program of services provided to children.
24. "Regularly or on a regular basis" means day care services which are available and provided at a Center on more than one (1) day in any one (1) week.
25. "School-age Care" means care for school-age children before and/or after school and full-time during school holidays and summer months.
26. "School-age Child" means a child five (5) years of age or older in a public or private school.
27. "Snack" means supplemental food served between meals.
28. "Specialized Day Care" means care to children with special needs which necessitate more than usual personal care and/or special equipment or architectural features in the facility.
29. "Toddler" means a child between the ages of twelve (12) and twenty-four (24) months of age.
30. "Training" means participation in any formal activity related to improvement in an employee's skills or knowledge related to job performance excluding routine supervision and including participation at conferences, workshops, relevant courses and in-service training sessions.

GENERAL REQUIREMENTS

31. No person shall operate, establish, manage, conduct, assist in or maintain a Day Care Center, or hold out, advertise or represent by any means to do so, without first obtaining a license from the Department pursuant to 31 Del.C., Chapter 3. Any person so involved shall be subject to criminal or civil penalties in accordance with State Law.
32. A license shall be issued only to the Center for which application is made and for the address on the application, and shall not be transferable, assignable or subject to sale.
33. When a Center is sold, leased or discontinued or the operation has moved to a new location or the license has been revoked, the current license immediately becomes null and void and shall be returned to the Department.
- * 34. A Center shall comply with the applicable provisions of Titles VI and VII of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, Executive Order No. 11246 of September 24, 1965, and any other Federal or State anti-discriminatory act, law, statute, regulation or policy, along with all amendments and revisions of such laws.

DELAWARE

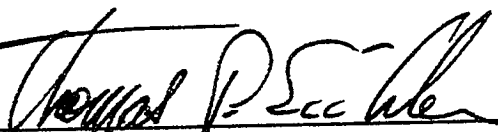
REQUIREMENTS FOR LARGE FAMILY CHILD CARE HOMES



**STATE OF DELAWARE
DEPARTMENT OF SERVICES FOR CHILDREN,
YOUTH AND THEIR FAMILIES
OFFICE OF CHILD CARE LICENSING**

NOTICE OF RESCISSION AND PROMULGATION

The Division of Family Services, Department of Services for Children, Youth and Their Families, adopts and promulgates the following licensing requirements for large family child care homes as authorized in The Delaware Code, Title 31, Subchapter II, Subsections 341 - 344. All previous rules, regulations and standards pertaining to such facilities are null and void. These requirements take effect on June 1, 1994.



Thomas P. Eichler, Secretary
Department of Services for Children
Youth and Their Families

12/21/93

Date



Gail B. Womble, Director
Division of Family Services

12/20/93

Date

- A. No person working directly with children in a LFCCH shall take any substance or medication which would impair his/her ability to care for children.

PROVISION OF OTHER REGULATED SERVICES

72. The LFCCH shall not be licensed or approved to care for convalescent, aged or patients requiring nursing care.
73. The LFCCH shall not provide foster care for children or adults without the prior written approval of the Department.
- A. The decision for dual service shall be made by the Administrator based upon the recommendation of the licensing specialist and foster home finder of the placing agency. The recommendation shall consider the specific needs of potential child care children and foster care placements.
- B. The written approval shall include the number and ages of children/adults to be cared for in each program in accordance with requirements.
- C. The decision for dual service shall be reviewed periodically.
- D. Foster children of preschool age and younger shall be counted in the capacity of the LFCCH.

DISCRIMINATION

74. The LFCCH shall not discriminate on the basis of sex, race, religion, cultural heritage, disability, marital status, or economic status.

INFORMATION PROVIDED TO PARENTS AND ACCESS TO THE LFCCH

75. The LFCCH shall give the parent of each child enrolled in the LFCCH a copy of "Licensing Information for Parents" as furnished by the Department. The LFCCH shall have written verification that each parent has received a copy.
76. The LFCCH shall have written verification that each parent of an enrolled child has received a copy of:
- A. Procedures related to the release of children.
- B. Policy and procedures on discipline and guidance of children.
- C. Policy on health and prevention of communicable diseases, injuries and child abuse.
- D. Policy on pets, if pets will be present in the LFCCH.
77. The LFCCH shall have a regular system of communication with parents concerning:
- A. The child's daily activities and routines.
- B. The child's developmental progress and concerns about the child's development and behavior.
- C. Accidents, injuries, illnesses, and other critical incidents.
78. Parents shall have free access to areas of the LFCCH used for child care while their children are in care.

RELEASE OF CHILDREN

79. The LFCCH shall release children only to persons authorized by the parent(s) who has placed the child(ren) in care.
80. The LFCCH shall have and use written policy and procedures for the release of children including:
- A. Procedures for emergency release of children.
- B. Procedures regarding the release of the child to any person not known to the Caregiver.
- C. Procedures for handling situations in which a noncustodial parent attempts to claim the child without the consent of the custodial parent.
- D. Procedures to be followed when a person not authorized to receive a child, or a person who is intoxicated or otherwise incapable of bringing the child home safely, requests release of a child.



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577-2500

December 2, 1991

The Honorable Terry R. Spence
House of Representatives
State of Delaware
Legislative Hall
Dover, DE 19903

Re: Applicability of the Americans with
Disabilities Act (ADA) to Daycare Providers
Informal Opinion No. 91-C005

Dear Representative Spence:

You have asked this office to provide an advisory opinion with respect to the applicability of the Americans with Disabilities Act (ADA) to daycare providers. In particular, you have asked:

1. Can a home daycare provider request each child receive a blood test to detect any communicable disease including the HIV virus and Hepatitis B?

2. If a parent refuses to have the child receive a blood test, can a home daycare provider then refuse care for their child?

3. If the test is returned positive for HIV or Hepatitis B, can the home daycare provider refuse care for that child without violating the law?

4. (a) Are family daycare homes covered under the Americans with Disabilities Act or other applicable federal or state law governing the right to deny services to individuals carrying contagious diseases?

(b) Are daycare centers covered or not covered under ADA?

5. Can a daycare provider have a parent sign a release form, which states that if their child has HIV virus the parent of the child will be held responsible for all liability should the HIV virus be transmitted within the child-care setting?

6. Presently, can a daycare provider refuse care for a "special needs" child for any reason without violating any laws or regulations?

We answer by way of this informal opinion.

The ADA was enacted by Congress to provide comprehensive civil rights protections to individuals with disabilities in the areas of employment, public accommodations, State and local government services, and telecommunications. It is subchapter III of the Act, "Public Accommodations and Services Operated by Private Entities," which governs the questions you raised. This subchapter of the ADA and the regulations promulgated thereunder become effective on January 26, 1992.

In response to Question 4, both daycare centers and family daycare homes are covered by the ADA. Title 42 U.S.C. sec. 12181(7)(K) specifically refers to daycare centers as places of public accommodation. Family daycare homes become subject to the ADA provisions in accord with the definitions of "public accommodation" and "private entity." A "public accommodation" means a private entity that owns, leases [or leases to], or operates a place of public accommodation; a "private entity" includes an individual. 28 C.F.R. sec. 36.104. The ADA regulations further provide that the ADA applies to a place of public accommodation located in a private residence, except for those portions of the residence utilized exclusively as a residence. 28 C.F.R. sec. 36.207(a). It should be noted that

religious organizations and entities controlled by religious organizations are specifically exempted from the application of subchapter III relating to public accommodations. 42 U.S.C. sec. 12187.

The term "disability" is defined by the ADA to mean:

(A) a physical or mental impairment that substantially limits one or more of the major life activities of such individual;

(B) a record of such an impairment; or

(C) being regarded as having such an impairment.

42 U.S.C. sec. 12102(2). The regulations include, without limitation, contagious and non-contagious diseases as physical or mental impairments, specifically listing HIV disease, whether symptomatic or asymptomatic. 28 C.F.R. sec. 36.104. Hepatitis B would also fall within the definition of disability. The ADA precludes the denial of an individual's participation in or benefit from services, facilities or accommodations of an entity, as well as the imposition or application of eligibility criteria which screen out or tend to screen out an individual with a disability. 42 U.S.C. sec. 12182(b).

The use of a blood test to detect HIV or hepatitis B is an eligibility criterion which screens out or tends to screen out individuals with a disability, and would be a violation of the ADA if requested by a daycare provider. To use the results of such a test, or the refusal to have a test done, as a basis to

refuse to provide services to a child would constitute discrimination on the basis of, or perception of, a disability in direct violation of the ADA. Therefore, the answer to questions 1, 2 and 3 is in the negative.

You have asked whether a daycare provider can require a parent to sign a "release form" which would hold the parent responsible for all liability in the event HIV is transmitted within the child care setting from their child. Again the answer is no, as it would be a direct violation of the ADA. Requiring parents to sign a "release form" would constitute the use of a method of administration which would have the effect of discriminating on the basis of the child's disability. 42 U.S.C. sec. 12182(b)(1)(D). Such a document would have questionable legal validity, and would most likely not serve to eliminate the provider's liability.

Your final question is whether daycare providers can refuse to care for a "special needs" child for any reason without violating any laws or regulations. In addition to the ADA, daycare providers are subject to the State Equal Accommodations statute (6 Del. C. ch. 45) and, if they receive Federal funds, Section 504 of the Rehabilitation Act of 1973. The definition of "handicap" in these two statutes closely parallels or has been interpreted to parallel the definition of "disability" found in the ADA. Therefore, if the child's special needs fall within the definition of "disability" or

"handicap," the provider would be violating these laws in the event services were refused due to the special needs. This general rule applies in all but the narrowest circumstances.

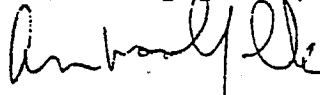
There are two exceptions in the ADA to the requirement that places of public accommodation provide their services or facilities to disabled persons. First, if the entity is able to show that making reasonable modifications to its policies, practices or procedures would fundamentally alter the nature of the goods, services, facilities, privileges, advantages, or accommodations offered, it would not constitute discrimination to refuse to serve a disabled person. 42 U.S.C. sec. 12182(b)(2)(A)(ii). Second, if the entity can show that the individual poses a direct threat to the health or safety of others, it would not constitute discrimination to refuse to serve a disabled person. 42 U.S.C. sec. 12182(b)(3). Policies and procedures currently required by the Office of Child Care Licensing and the Division of Public Health would ensure good infection control if utilized. The existence of these requirements would make it unlikely that a provider could show that reasonable modifications would fundamentally alter the provision of services. If the daycare provider is unable to show that a particular situation falls within one of these two exceptions, the entity would be in violation of the ADA and subject to enforcement action.

The Honorable Terry R. Spence
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For these reasons, it is our opinion that daycare providers are subject to the provisions of the ADA, that they would be in violation of the ADA if they utilized blood tests to identify and/or screen out individuals who are disabled, and that daycare providers cannot refuse to provide care for children with "special needs" unless reasonable modifications cannot be made or the child poses a direct threat to the health or safety of others.

If we can be of any further assistance, or if you have any questions, please do not hesitate to call us.

Very truly yours,



A. Ann Woolfolk
Deputy Attorney General



Janice R. Tigani
Deputy Attorney General

AAW/JRT/rt

APPROVED:



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DAYCARE CENTERS
AND THE AMERICANS WITH DISABILITIES ACT

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MAY 9, 1996

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IMPLICATIONS OF ADA ON CHILD CARE FACILITIES

WHAT IS ADA? AMERICANS WITH DISABILITIES ACT

- Broadest law ever covering disabilities
- Provides civil rights protections to individuals with disabilities
- Various parts of law:
 - Section protecting employment rights
 - Section requiring nondiscrimination by local and state governments.
 - Section requiring nondiscrimination by public accommodations - part of this on transportation
 - Section requiring improvements in telecommunications for hearing impaired.

Public accommodations includes family child care homes and child care centers which are also covered by employment section.

WHO IS COVERED?

- Children and adults with a physical or mental impairment that substantially limits the child from a "major life activity".
 - Caring for her/himself - sleeping, eating, breathing, communication, walking, seeing, hearing, speaking, learning.
 - Disabilities vary from simple allergies, moderate retardation, diabetes, cerebral palsy to terminal illness.
 - Includes emotional or mental illness - even a child with a severe behavioral problem.
- People who have a history of these impairments although are not currently impaired (e.g., child with cancer in remission).
- People regarded to have impairments even if they really do not - e.g., severe facial burn scars, history of psychotherapy.
- People associated with those with disabilities both relatives and non-relatives - child whose parent uses wheelchair, brother with HIV.

IMPORTANT PRINCIPLES -

- There is no one single approach to caring for child with disabilities.
- Anyone can become disabled.
- Children with disabilities are more like other children than they are different.
- Children with disabilities, as with any child, should be encouraged to help themselves as much as they can.

Also

- Many children with special needs can be integrated into child care programs without changes in routine or environment.
- Support services exist to help care for children with disabilities.
- The experience of working with children with special needs can be rewarding for everyone.

CAN A PROVIDER DENY CARE BECAUSE OF DISABILITY?

- No, a provider may not automatically deny admission simply because child or person close to child is disabled -
- May not have such a written policy.

ADA requires a new way of thinking

- Each child's needs and conditions must be evaluated on an individual basis.
- Once admitted, each child is entitled to equal, non-segregated inclusion in the program to the extent appropriate to child's needs.
- Since 1/26/93 all programs, regardless of size, can be sued if they don't comply.
- If a provider is sued and loses, provider must:
 - Comply with statute immediately
 - Can be ordered to pay attorneys fees

- If determined to be reckless violation, can be ordered to pay the child's family monetary compensation and/or public fine up to \$50,000.00 for first violation and up to \$100,000.00 for additional violations.

- Provider must assess needs of a child & balance those against size of program budget, staff and resources, to determine if the child's needs can be accommodated. Provider must take necessary steps to accommodate special needs of child before denying care.

• REASONS FOR DENIAL - (ONLY 4)

1. Accommodation (added equipment and/or services) imposes undue burden on provider or would fundamentally alter nature of program and no alternative steps can be taken.
2. Accommodation requires architectural changes not readily achievable and no reasonable alternative exists.
3. Child's condition poses a direct threat to health and safety of any of the other children or staff and no reasonable way exists to eliminate threat through changes.
4. Taking the child would fundamentally alter the nature of program and there are no reasonable alternatives.

ACCOMMODATIONS

- Modifications in policies, procedures, practices.
- Auxiliary aids and service.
 - e.g., interpreters, audio tapes, large print materials, etc.
- Removal of physical barriers which are readily achievable - rearrange tables or play areas, ramps, grab bars in toilet stall.

Examples of Accommodations:

1. Problem:

A child with severe mobility problems requiring wheelchair plus other limitations such as loss of bladder/bowel control and inability to feed self requiring special attention from provider.

Response:

Family Child Care Provider may not be able to provide adequate care without having additional staff which would pose undue burden - but child care center with large building and staff might have to shift staff coverage or hire staff as long as the care did not pose an undue burden.

2. **Problem:**

Child with less severe mobility impairment, crutches or leg brace, or wheelchair without required additional extraordinary care.

Response:

Less likely to pose undue burden on provider of any size or budget. As long as the child can be integrated into the program and his/her needs reasonably met provider must take the child. Examples of accommodation(s) needed are:

- Remove braces as needed
- Incorporate activities for child, ensuring access to facilities, adult assistance as needed.
- Or similar simple accommodation.

WHAT IS "UNDUE BURDEN"

- Defined as "a significant difficulty or expense".
- There are no clear-cut standards to measure.
- Provider must assess each situation considering:
 - Nature and cost of accommodation
 - Overall financial resources of program
 - Number of employees
 - Legitimate safety regulations at site
 - If part of larger corporation - financial resources, size and location of parent corporation
 - If accommodation poses significant difficulty or expense, whether reasonable alternatives exists, that do not pose a burden

Example:

- If child needs books in Braille or audio-recorded books to participate, family child care provider will be responsible to furnish.
 - If child needs full-time interpreter may pose undue burden for family child care but centers may be able to accommodate.
 - However, before claiming undue burden family child care must explore alternatives to expensive interpreters first.
- Generally, providers of larger programs will have greater obligation under the law than family child care providers to meet the needs.
 - Parents can provide accommodation or fee or provider may be able to borrow from toy lending library.
 - It is suggested that resource centers be stocked with loaners.

FEEES FOR ACCOMMODATIONS/SERVICES

- Provider may not pass higher cost of accommodations to parent of child unless all parents are charged.
 - Provider must absorb cost or charge all
 - Provider is encouraged to seek outside funds to defray cost before refusing child for an undue burden.
 - Tax deductions and credits are available to help defray cost.

WHAT IS "DIRECT THREAT"

- Exception is narrow, not easy to determine
- Provider must base determination on current medical information or "best available objective evidence" and consider:
 - Nature of child's condition that poses risk
 - Probable duration of condition that poses risk
 - Severity of risk
 - Probability of actual harm to others by the condition

- If risk can be eliminated by modifying policies, practices or procedures to not fundamentally alter nature of progress.
- Factors must be considered in light of accepted medical information and knowledge, not on public perceptions.
- Behavioral disorder can only be considered a direct threat if safely accommodating child's behavior creates an undue burden e.g., providing adequate supervision would significantly decrease necessary support of other children compromising their safety - but provider needs objective evidence and encourage parents to get professional help.

ADMISSION CRITERIA INVOLVING HEALTH CONCERNS

- May establish if imposed on all children - examples-
 - Require immunizations for all children, not just for some children.
 - Toilet training regulations can not exclude children whose disabilities prevent toilet training.
 - Children with HIV can not be excluded.

FEEES AND DOCUMENTATION

- Parent(s) never under obligation to cover the cost.
- Provider must carefully document process of assessing undue burden and inform parent of his/her right not to cover cost (if parent offers, provider does not have to refuse funds).
 - Exception - cost of professional services such as physical therapy which parent wants during hours of care can be passed on to parent.

IS PARENT REQUIRED TO DISCLOSE SPECIAL NEEDS IF NOT OBVIOUS?

- No, parent is not obligated to disclose
- However, provider not expected to accommodate needs which are not obvious or disclosed
 - Ask for good health records as per licensing regulations
 - If provider is concerned parent has not fully disclosed information, may ask for clarification.

- Only generic information about limitations or needs & risks associated with condition may be sought.
- It is illegal to require additional health tests or information solely to screen out or deny child, but provider can ask for these to better evaluate reasonable care.

FLOW CHART:

- Review to walk through the process to determine an individual child's needs.

* ACCOMMODATING CHILD IN SPECIAL NEEDS:

- Entitled to participate as equals in the "most integrated setting appropriate to child's needs"
- Provider must assess what is appropriate in consultation with parents, physician, public health and other special need resources.
- If parent does not disclose disability, provider not under obligation to provide accommodations.
- If child's disability becomes apparent, parent is unwilling to have child evaluated, Provider can not provide adequate, safe care without accommodations and after taking reasonable steps, care becomes unduly burdensome - Provider is under no obligation to continue.

PHYSICAL CHANGES TO HOME OR CENTER:

- Provider must remove accessibility barriers where "readily achievable" - means "easily accomplishable and able to be carried out without much difficulty or expense":

Example:

Family child care home front door has steps, but there is a side door at ground level - making it accessible is achievable (even if it means removing weeds, overgrown brush, lawn furniture or building small ramp for one step) - but permanent ramp to front door may not be readily achievable due to cost.

However, provider must first seek alternatives.

- Changes not required if change would involve a fair amount of difficulty or expense "as measured by size and budget." (reasonableness)
- Architectural changes to homes only required for parts of homes used for child care. New construction or additions to facility or home after 1/26/93 must be made accessible regardless of cost.

Tax Benefits Available

- NOT AVAILABLE TO NON-PROFITS.
- IRS Code Section 190 - Provider can deduct cost of "qualified architectural and transportation barrier removal expenses: - meet own, or lease facility or vehicle to qualify - capped at \$15,000.00.
- IRS - Section 44 - allows small businesses to take tax credit for expenses connected with ADA compliance includes architectural barrier removal, cost of interpreters, readers, taped texts, modification of equipment and devices, etc. Credit is 50% of any amount between \$250.00 and \$10,250.00 paid for a given expenditure. Eligibility requires gross receipts less than one million dollars or employment of 30 or fewer full-time employees.

Changes to Car or Van?

- If barriers can be removed with out too much difficulty or expense, required if transportation is part of program. (Required if readily achievable).
- Changes may be more readily achievable by larger programs than small centers or family child care homes, e.g., accommodating a wheelchair - even if vehicle can not be altered, provider is obligated to look for alternatives such as assisting child to the car and storing wheelchair in trunk.
- Private providers transporting in vehicles that seat more than 16 and who transport on fixed route (regular daily) must have accessible vehicles with hydraulic lifts.

Need Special Equipment or Toys?

- Called "auxiliary aids and services" - must provide unless would pose "undue burden" or would "fundamentally alter nature of program or facility".
- Equipment such as interpreter, phones compatible with hearing aids, etc - large centers may be better able to buy high tech equipment.
 - Sometimes cost is more reasonable than thought
 - Or family child care home may be able to borrow equipment.
 - Must check out options before claiming "undue burden" and check for alternative aids, e.g., magnifying glass instead of large print reading material.
 - Cost can not be passed onto parent of child.

What if Rent Home?

- ADA holds both provider and landlord responsible for compliance - does not specify who is responsible for which accommodations.
- ADA recommends each landlord and tenant enter ADA into contract specifying responsibilities. ADA suggests division of responsibilities as follows.
 - Landlord - Architectural barriers and providing auxiliary aids in any common area of multi unit structure (apartment or community building.)
 - Tenant responsible for auxiliary aids and architecture barriers in rental unit. Check local laws/ordinances.
 - Tenants must obtain landlord's permission for permanent changes.

Rent from Church

- Religious organizations that operate their own child care and those that rent to private programs are exempt from ADA unless state law requires compliance. However, §504 which predates ADA and applies to programs which receive federal funds, also applies to religious programs that operate own program (and receive federal funds).

- The private provider located in a church must comply with ADA-responsibility rests with that program as tenant.

Liability Insurance Impart

- ADA does not adequately address issue
- ADA says a program can not refuse a child because insurance coverage won't permit but =>
- ADA does not prohibit insurers from canceling or not renewing liability insurance based on program providing care for disability

- However, ADA may provide a remedy to program if insurer raises rates or discontinues policy - (insurer can not use this as an attempt to avoid insuring a program caring for disabled) -- check with State Insurance Commission about unfair business practice regulations which may apply.

Special Record Keeping?

- May be important for providers to keep good records on absences for all children.
- Providers should keep records on health status, special needs, physical conditions, etc., on all children.
- Provider may have a uniform policy requiring payment for children's absences, regardless of reason - then non-payment for any reason may be grounds for termination.

Role of Licensing

- To educate providers - to make them aware of the ADA law and their responsibilities.
- To assure licensing does not cause providers to be in violation of ADA.

SUMMARY OF ADA PROVISIONS

The Americans with Disabilities Act (ADA) is a federal law passed by Congress. It contains three parts, called Titles. The entire Act is published in the United States Code at 42 U.S.C. §§ 12101 - 12213.

Title I 42 U.S.C. §§ 12111 - 12117 : **EMPLOYMENT**

Title II 42 U.S.C. §§ 12131 - 12165 : **GOVERNMENTAL SERVICES**

Title III 42 U.S.C. §§ 12181 - 12189 : **PUBLIC ACCOMMODATIONS**

Miscellaneous Provisions 42 U.S.C. §§ 12201 - 12213

Purpose and Definitions 42 U.S.C. §§ 12010 - 12102

Private (as opposed to governmentally owned) daycare centers are governed by Title III of the ADA in the operation of the center. Daycare Centers are also covered by the Delaware Equal Accommodations Act (6 Del. C. Ch. 45) and those centers that receive federal funding are also covered by Section 504 of the Rehabilitation Act of 1973.