



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Model Bill for State Licensure of Audiologists, Speech-Language Pathologists, and Audiology and Speech-Language Pathology Assistants — August 2014

Background

Since 1972, the American Speech-Language-Hearing Association (ASHA) has maintained a model bill for the state licensure of speech-language pathologists and audiologists. In 2012, ASHA added provisions relating to audiology and speech-language pathology assistants. The model bill is an example of licensure legislation that holds consumer protection paramount and is based on current licensure practices and existing ASHA policies. The model bill is presented as a prototype for state regulation of audiologists, speech-language pathologists, and audiology and speech-language pathology assistants. It is designed as an example to be modified to reflect individual state's needs. The current model bill replaces all previous versions and may be modified in the future.

The model bill consists of suggested statutory language appearing on the left side of each page and an explanation section appearing on the right side. The comments contained in the explanation section are intended to address the questions, concerns, and problems that generally arise, or which may arise, with the corresponding statutory provisions. References to ASHA policies and documents, outside sources, and common practices among the current state licensure programs for audiology, speech-language pathology, and audiology and speech-language pathology assistants are provided as a resource for users. The explanation section also advises users that states may have a prescribed manner for dealing with licensure legislation and licensure provisions. All new provisions are bolded.

Use

The explanation section contains alternate approaches to certain provisions. These options are presented with the recognition that many state licensure issues are complex, and that each state's political, geographical, and demographic needs and situations must be considered in resolving specific issues such as grandparenting, exemptions, and continued competency assurances.

ASHA acknowledges that complete uniformity among state licensure programs, although desirable, is unrealistic. States may choose to deviate from the ASHA model in whole, or in part, or may be required to deviate because of political or practical realities. However, the Association hopes that if state licensure laws, regulations, and procedures can become more similar, the similarity may ease some of the problems licensed individuals experience when academic and/or experience requirements vary from national standards, when relocation from one licensed state to another licensed state occurs, or when the continuing education requirements of neighboring states differ.

Contents

The model bill consists of five major sections or articles: General Provisions; Administration; Licenses; Disciplinary Actions and Severability. The following discussion highlights the major components of each section.

Article 1. General Provisions contains a statement of purpose, definitions describing various terms used in the document, provisions for speech-language pathology and audiology assistants and exclusions. Unique to this document is the provision that requires the informed consent of persons who are receiving services from speech-language pathology or audiology assistants.

Article 2. Administration deals with matters specific to a board of examiners such as appointment, composition, compensation, powers and duties. One of the responsibilities of the board is the reporting of disciplinary actions to relevant state and federal authorities and to other state speech-language pathology and audiology licensing authorities.

Article 3. Licenses delineates such components of licensure as qualifications; waivers for persons practicing at the time the law takes effect; persons who received their education in another country; persons holding licensure from another state or ASHA certification; restrictions for persons holding provisional licensure; and renewal and reinstatement stipulations.

Article 4. Disciplinary Actions includes the kinds of penalties that can be imposed and the actions for which penalties may be assigned. The model bill calls for a range of penalties to deal with a variety of grounds for disciplinary actions.

Article 5. Severability deals with matters related to the constitutionality, termination, and effective date of the language of the model bill.



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Table of Contents

Article 1. General Provision

- 1.01 Title
- 1.02 Purpose and Legislative Intent
- 1.03 Definitions
- 1.04 Audiology Assistants and Speech-Language Pathology Assistants
- 1.05 Persons and Practices Affected
- 1.06 Persons and Practices Not Affected
- 1.07 Fitting and Dispensing of Hearing Aids
- 1.08 Assessing, Selecting, Developing, and Fitting Products Related to Speech, Language, and Swallowing
- 1.09 Use of Endoscopy in Speech-Language Pathology
- 1.10 Use of Telepractice in Speech-Language Pathology and Audiology Services

Article 2. Administration

- 2.01 Board of Examiners
- 2.02 Composition
- 2.03 Appointments
- 2.04 Terms
- 2.05 Meetings
- 2.06 Compensation
- 2.07 Powers and Duties of the Board
- 2.08 Disposition of Funds

Article 3. Licenses

- 3.01 Qualifications
- 3.02 Waiver of Requirements
- 3.03 Provisional License
- 3.04 **Limited License/Registration**
- 3.05 License Renewal
- 3.06 Reinstatement of Expired Licenses
- 3.07 Inactive License
- 3.08 Reinstatement of Revoked License
- 3.09 Reciprocity
- 3.10 Internationally Educated Applicants

Article 4. Disciplinary Actions

- 4.01 Penalties
- 4.02 Grounds
- 4.03 Complaint Procedure in General
- 4.04 Complaint Investigation and Disposition
- 4.05 Due Process
- 4.06 Monitoring of Licensure Holder
- 4.07 Injunction
- 4.08 Jurisdiction Over Unlicensed Practice
- 4.09 Reporting of Violations

Article 5 Severability

- 5.01 Severability
- 5.02 Termination
- 5.03 Effective Date

Article 1. General Provisions

1.01 Title

This act may be cited as the "Licensure Act for Audiologists, Speech-Language Pathologists, and Audiology and Speech-Language Pathology Assistants."

1.02 Purpose and Legislative Intent

It is hereby declared to be a policy of this State that the practice of audiology and speech-language pathology is a privilege granted to qualified persons and that, in order to safeguard the public health, safety and welfare, protect the public from being misled by incompetent, unscrupulous, and unauthorized persons, and protect the public from unprofessional conduct

Explanation

NOTE: The format used in this document is one example of legislative format. States may require that a specific organizational style be used in developing this kind of legislation.

NOTE: Bill drafters need to be aware of statutory interpretation in their states. Some states are permissive, meaning that activities or functions are permitted unless specifically prohibited in statute. Other states are restrictive, meaning that unless the statute specifically allows a function or activity it is prohibited. For example, in a restrictive state cerumen removal by audiologists would be prohibited unless the scope of practice in the licensure law specifically includes it. Drafters in restrictive

by qualified audiologists, speech-language pathologists, and audiology and speech-language pathology assistants, it is necessary to provide regulatory authority over persons offering audiology and speech-language pathology services to the public.

1.03 Definitions

In general, unless otherwise indicated in this Act, these words and terms have the following meanings:

(1) **Act** is defined as the Licensure Act relating to the licensing and regulation of audiologists, speech-language pathologists, and audiology and speech-language pathology assistants.

(2) **Audiologist** is defined as any person who engages in the practice of audiology and who meets the qualifications set forth in this Act. A person represents himself/herself to be an audiologist when he/she holds himself/herself out to the public by any means, or by any service or function performed, directly or indirectly, or by using the terms “audiology,” “audiologist,” “audiometry,” “audiometrist,” “audiologic,” “audiological,” “audioprosthologist,” “audiometrics,” “hearing therapy,” “hearing therapist,” “hearing clinic,” “hearing clinician,” “hearing center,” “hearing aid audiologist,” or any variation, synonym, coinage or other word that expresses, employs, or implies these terms, names or functions.

(3) **Audiology Assistant** is defined as any person who assists in the practice of audiology and who meets the qualifications set forth in this Act. A person represents himself/herself to be an audiology assistant when he/she holds himself/herself out to the public by any means, or by any service, or function performed, directly or indirectly, or by using the terms “audiology assistant,” “audiologist assistant,” “audiometry assistant,” “audiometrist assistant,” “audiologic assistant,” “audiological assistant,” “audiology support personnel,” “audioprosthologist assistant,” “audiometrics assistant,” “hearing therapy assistant,” “hearing therapist assistant,” “hearing clinic assistant,” “hearing clinician assistant,” “hearing center assistant,” “hearing aid audiologist assistant,” or any variation, synonym, coinage, or other word that expresses, employs, or implies these terms, names, or functions.

(4) **Board** is defined as the State Board of

states need to be more concerned about specific language.

1.03 Definitions

Definitions are listed in alphabetical order.

(3) Many terms can be used to designate individuals who provide support services in audiology. The term, “assistant,” is used in the American Speech-Language-Hearing Association. (2011). *Audiology support personnel: preparation, supervision, and ethical considerations* [Guidelines, Position Statement]. Available from www.asha.org/policy.

Examiners for Audiology and Speech-Language Pathology.

(5) **Department** is defined as (insert name of state agency responsible for administering the Act).

(6) **Instruction** is defined as (a) providing audiology or speech-language pathology services or teaching in infant/toddler, preschool, elementary or secondary school programs; or (b) teaching students in institutions of higher education.

(7) **Person** is defined as any individual, partnership, organization, or corporation, except that only individuals can be licensed under this Act.

(8) **Practice of Audiology** is defined as the application of principles, methods, and procedures related to hearing, balance and the disorders of hearing and to related language and speech disorders, including but not limited to, (a) facilitating the conservation of auditory system function; developing and implementing environmental and occupational hearing conservation programs; (b) screening, identifying, assessing and interpreting, diagnosing, preventing and rehabilitating peripheral and central auditory system and balance system disorders; (c) providing and interpreting behavior and electro-physiological measurements of auditory and vestibular functions; (d) selecting, fitting, programming and dispensing of hearing aids and cochlear implants (and other implantable devices), large area amplification systems, and other hearing assistive technologies and providing training in their use; (e) providing audiologic/auditory rehabilitation and related counseling services to individuals with hearing impairments and their families; (f) providing vestibular rehabilitation; (g) cerumen management; (h) providing tinnitus evaluation and management; (i) Measurement and interpretation of sensory and motor evoked potentials, electromyography, and other electrodiagnostic tests for purposes of neurophysiologic intraoperative monitoring and cranial nerve assessment; and (j) screening of speech-language and other factors affecting communication disorders provided that judgments and descriptive statements about the results of such screenings are limited to pass/fail determinations.

(4) In some states Boards for Audiology and Speech-Language Pathology may be separated.

(5) () parentheses refers to items of state discretion

(7) This model bill is intended to license individuals and is not intended to license business entities.

(8) This definition is taken from the American Speech-Language-Hearing Association. (2004). *Scope of Practice in Audiology* [Scope of Practice]. Available from www.asha.org/policy.

(8) The aspects of speech-language pathology that may be included in the practice of audiology are based on interpretations of the Board of Ethics of the Association.

(8) This definition reflects a Board of Ethics Issues in Ethics Statement. American Speech-Language-Hearing Association. (2004). *Clinical Practice by Certificate Holders in the Profession in Which They Are Not Certified* [Issues in Ethics]. Available from www.asha.org/policy.

(8) The practice of audiology is defined in accordance with LC 53-83, which provides that "ASHA adopt the position that state laws establishing licensure standards for audiology and speech-language pathology should provide for the licensure of all qualified individuals...." The report of the Ad Hoc Committee on Professional Autonomy, accepted by the ASHA Executive Board, states, "It is ultimately in the best interests of all consumers of audiology and speech-language pathology services and of the profession that provides those services if no exemptions are granted in licensure laws..." Therefore, the practice of audiology is defined in the broadest sense and is inclusive of the various endeavors in which members of the profession may be engaged.

(9) Practice of Speech-Language Pathology

is defined as the application of principles, methods and procedures related to the development, disorders and effectiveness of human communication and related functions including but not limited to providing prevention, screening, consultation, assessment/evaluation, diagnosis, treatment/intervention/management, counseling, collaboration, and referral services for disorders of speech, fluency, resonance voice, language, feeding and swallowing; and cognitive aspects of communication. The practice of speech-language pathology also includes establishing augmentative and alternative communication techniques and strategies, including developing, selecting and prescribing of such systems and devices (e.g., speech generating devices); providing services to individuals with hearing loss and their families (e.g., auditory training, speech reading, speech and language intervention secondary to hearing loss); screening individuals for hearing loss or middle ear pathology using conventional pure-tone air conduction methods (including otoscopic inspection), otoacoustic emissions screening, and/or screening tympanometry; using instrumentation (e.g., videofluoroscopy, endoscopy, stroboscopy) to observe, as well as collect data and measure parameters of communication and swallowing; selecting, fitting and establishing effective use of prosthetic/adaptive devices for communication, swallowing or other upper aerodigestive functions (does not include sensory devices used by individuals with hearing loss); and providing services to modify or enhance communication performance (e.g., accent modification, personal/professional communication efficacy).

(8) Terms in this definition may be clarified in the rules and regulations to delineate specific components of service delivery, e.g., screening, as an aspect of identification; counseling as an aspect of consultation; and referral and case management as aspects of habilitation and rehabilitation.

(9) This definition is from the American Speech-Language-Hearing Association. (2007). *Scope of Practice in Speech-Language Pathology* [Scope of Practice]. Available from www.asha.org/policy. Further delineation of the practice of speech-language pathology can be found in the document described above.

(9) Terms contained in this and other definitions of the model bill can be clarified in the rules and regulations.

(9) Normal communication and its disorders form the knowledge base of the discipline. Consequently, the development of normal communication also is an integral component of this knowledge base. The term "development and disorders of communication," therefore, appears in this definition and in the definition of speech-language pathology in most licensure laws

(9) Services provided by speech-language pathologists and audiologists are not limited to the evaluation and treatment of human communication disorders. This is supported by the inclusion of prevention in the continuum of services comprising the practices of audiology and speech-language pathology which are described in sections 1.03 (6) and (9). LC 45-81 approved the definition of prevention as it relates to communication disorders: "In a general sense, prevention of communicative disorders is defined as the elimination of those causes which interfere with the normal acquisition and development of communication skills." The inclusion of prevention as a legitimate professional activity is justified by the fact that it is an application of principles, methods and procedures related to both development and disorders of human communication

(9) Terms in this definition may be clarified in

the rules and regulations to delineate specific components of service delivery, e.g., screening as an aspect of identification; counseling as an aspect of consultation and referral; and case management as an aspect of habilitation and rehabilitation.

(9) The aspects of audiology which may be included in the practice of speech-language pathology are based on a Board of Ethics Issues in Ethics Statement.

American Speech-Language-Hearing Association. (2004). *Clinical Practice by Certificate Holders in the Profession in Which They Are Not Certified* [Issues in Ethics]. Available from www.asha.org/policy.

(9) The practice of speech-language pathology is defined in accordance with LC 53-83, which provides that "ASHA adopt the position that state laws establishing licensure standards for audiology and speech-language pathology should provide for the licensure of all qualified individuals...." The report of the Ad Hoc Committee on Professional Autonomy, accepted by the ASHA Executive Board, states, "It is ultimately in the best interests of all consumers of speech-language pathology and audiology services and of the profession that provides those services if no exemptions are granted in licensure laws..." Therefore, the practice of speech-language pathology is defined in the broadest sense and is inclusive of the various endeavors in which members of the profession may be engaged.

(10) Provisional License is defined as the license issued to an applicant who is practicing speech-language pathology while completing the supervised postgraduate professional experience after a master's degree in speech-language pathology or an audiologist after completing the required coursework and a specified number of supervised clinical practicum experiences from the educational institution or its cooperating programs, in furtherance of a doctoral degree in audiology.

(10) This definition of provisional license takes into account the fact that there may be some individuals who have moved from a bachelor's degree to a doctoral degree without a master's degree in between. For those individuals the supervised professional experience will be completed pre-degree rather than post-degree. The content of this supervised professional experience is to be approved by the Board and further delineated in corresponding regulations.

(11) Speech-Language Pathologist is defined as any person who engages in the practice of speech-language pathology and who

meets the qualifications set forth in this Act. A person represents himself/herself to be a speech-language pathologist when he/she holds himself/herself out to the public by any means, or by any service or function performed, directly or indirectly, or by using the terms "speech pathology," "speech pathologist," "speech therapy," "speech therapist," "speech teacher," "speech correction," "speech correctionist," "speech clinic," "speech clinician," "language therapy," "language therapist," "language pathology," "language pathologist," "language specialist," "voice therapy," "voice therapist," "voice pathologist," "logopedics," "logopedist," "communicology," "communicologist," "communication specialist," "aphasiology," "aphasiologist," "phoniatriest," **"swallowing specialist,"** or any variation, synonym, coinage, or other word that expresses, employs or implies these terms, names, or functions.

(12) Speech-Language Pathology Assistant is defined as any person who assists in the practice of speech-language pathology and who meets the qualifications set forth in this Act. A person represents himself/herself to be a speech-language pathology assistant when he/she holds himself/herself out to the public by any means, or by any service or function performed, directly or indirectly, or by using the terms "speech pathology assistant," "speech pathologist assistant," "speech language pathology support personnel," "speech therapy assistant," "speech therapist assistant," "speech teacher assistant," "speech correction assistant," "speech correctionist assistant," "speech clinic assistant," "speech clinician assistant," "language therapy assistant," "language therapist assistant," "language pathology assistant," "language pathologist assistant," "language specialist assistant," "voice therapy assistant," "voice therapist assistant," "voice pathologist assistant," "logopedics assistant," "logopedist assistant," "communicology assistant," "communicologist assistant," "communication specialist assistant," "aphasiology assistant," "aphasiologist assistant," "phoniatriest assistant," or any variation, synonym, coinage, or other word that expresses, employs, or implies these terms, names, or functions.

(12) Many terms can be used to designate individuals who provide support services in speech-language pathology. The term, "assistant," is used in the American Speech-Language-Hearing Association. (2004). *Guidelines for the Training, Use, and Supervision of Speech-Language Pathology Assistants* [Guidelines]. Available from www.asha.org/policy.

(13) **Telepractice** is defined as telespeech, teleaudiology, teleSLP, telehealth, or telerehabilitation when used separately or together. Telepractice service means the application of telecommunication technology to deliver speech-language pathology and/or audiology services at a distance for assessment, intervention and/or consultation. Services delivered via telespeech and/or teleaudiology must be equivalent to the quality of services delivered face-to-face.

(14) **Endoscopy** is defined as an imaging procedure included within the scope of practice for speech-language pathologists in which a speech-language pathologist uses a flexible/nasal endoscopy, rigid/oral endoscopy, and/or stroboscopy for the purpose of evaluating and treating disorders of speech, voice, resonance, and swallowing function.

1.04 Audiology Assistants and Speech-Language Pathology Assistants

(1) Audiologists and speech-language pathologists supervising audiology assistants or speech-language pathology assistants shall:

- (a) Register with the Board the name of each assistant working under their supervision;
- (b) Be responsible for the extent, kind, and quality of service provided by the assistant, consistent with the Board's designated standards and requirements; and
- (c) Ensure that persons receiving services from an assistant receive prior written notification that services are to be provided, in whole or in part, by an audiology assistant or a speech-language pathology assistant.

(2) Supervising audiologists must hold a valid state license and hold a Certificate of Clinical Competence in Audiology from the American Speech-Language-Hearing Association. Supervising speech-language pathologists must hold a valid state license and hold a Certificate of Clinical Competence in Speech-Language Pathology from the American Speech-Language-Hearing Association. Each such supervisor shall not accept more than two full-time assistants.

(13) This definition was adapted from the American Speech-Language-Hearing Association (2005). *Speech-Language Pathologists Providing Clinical Services via Telepractice: Position Statement*. Available from <http://www.asha.org/docs/html/PS2005-00116.html> and ASHA's Model Regulations for Telepractice. Available from www.asha.org/uploadedFiles/ModRegTelepractice.pdf

(14) This definition was taken from the American Speech-Language-Hearing Association. (2008). *Use of Endoscopy by Speech-Language Pathologists: Position Statement* [Position Statement]. Available from www.asha.org/policy.

(2) Guidance is available from American Speech-Language-Hearing Association. (2011). *Audiology support personnel: preparation, supervision, and ethical considerations* [Guidelines, Position Statement] and American Speech-Language-Hearing Association. (2004). *Training, Use, and Supervision of Support Personnel in Speech-Language Pathology* [Position Statement]. Available from www.asha.org/policy.

1.05 Persons and Practices Affected

(1) Licensure shall be granted either in audiology or speech-language pathology independently. A person may be licensed in both areas if that person meets the respective qualifications. No person shall practice audiology or speech-language pathology or represent himself/herself as an audiologist or speech-language pathologist in this state, unless such person is licensed in accordance with this Act.

(2) On or after [date], an individual hired by a public school system, State approved nonpublic school for children with disabilities, or chartered educational institution of the State or the State Department of Education to practice speech-language pathology shall be licensed in accordance with this Act.

(3) On [date], an individual employed by a public school system, State approved nonpublic school for children with disabilities, or chartered educational institution of the State or the State Department of Education to practice speech-language pathology who does not otherwise meet the qualifications set forth in this Act, may be licensed to practice speech-language pathology as long as they are practicing continuously on and after [date] while performing the duties of that employment.

(4) Any person not eligible for licensure as an audiologist or not eligible for authorization to practice as an intern, who assists in the practice of audiology under the supervision of a licensed audiologist must be licensed as an audiology assistant. No person shall practice as an audiology assistant or represent himself/herself as an audiology assistant in this state, unless such person is licensed in accordance with this Act.

(5) Any person not eligible for licensure as a speech-language pathologist or not eligible for authorization to practice as an intern, who assists in the practice of speech-language pathology under the supervision of a licensed speech-language pathologist must be licensed as a speech-language pathology assistant. No person shall practice as a speech-language pathology assistant or represent himself/herself

1.05 Persons and Practices Affected

(1) Services and activities delineated in 1.03(8) and 1.03(9) constitute the scope of practice of audiology and the scope of practice of speech-language pathology, respectively. Licensure is considered to be the most restrictive form of professional regulation because it generally limits both title use and scope of practice

Explanation: The intention of the last sentence is to require all persons providing audiology/speech-language pathology services, regardless of setting, to be licensed. It is one form of a standard legal provision that is typically used in legislation of this type and appears in most licensure laws for audiology and speech-language pathology. It means that it is unlawful for a person not licensed under this Act to conduct activities or provide services that comprise audiology or speech-language pathology, regardless of the way the person represents him/herself or the title(s) he/she uses. The provision also means that it is unlawful for a person not licensed under this law to use any of the titles prohibited by the law, regardless of the services being provided or activities conducted by the unlicensed person. Therefore, the conjunction "or" makes the prohibition doubly limiting in that illegal practice and illegal title use do not have to occur concomitantly; the presence of one or the other is sufficient to be considered unlawful. However, interpretations regarding the use of "and" or "or" may be state specific.

This has the same effect of prohibiting title use by unlicensed persons but not practice.

as a speech-language pathology assistant in this state, unless such person is licensed in accordance with this Act.

1.06 Persons and Practices Not Affected

Nothing in this Act shall be construed as preventing or restricting:

(1) A person licensed, certified, registered, or otherwise credentialed by this State in professions other than audiology and speech-language pathology, including a person licensed in the practice of medicine or osteopathic medicine and surgery, from practicing the profession for which he/she is licensed, certified, registered or credentialed.

(2) A person duly credentialed by this state as a teacher of the deaf.

(3) The activities and services of persons pursuing a course of study leading to a degree in audiology or speech-language pathology at a college or university provided that:

(a) These activities and services constitute a part of a planned course of study at that institution;

(b) Such persons are designated by a title such as intern, trainee, student, or by other such title clearly indicating the status appropriate to their level of education; and

(c) Such persons work under the supervision of a person licensed by this state to practice audiology or speech-language pathology

(4) The activities of persons who are nonresidents of this state from engaging in the practice of audiology or speech-language

1.06 Persons and Practices Not Affected

(1) The terms used in this provision, licensed, certified, registered, or otherwise credentialed, are not intended to include persons practicing audiology or speech-language pathology. Attempts may be made to classify individuals providing audiology or speech-language pathology services under an alternative occupation, such as special education instructor. The intent of an effective licensure or registration requirement is to guarantee that the public receives services from appropriately qualified personnel. This goal is subverted when states do not apply licensure or registration requirements which are appropriate to the services provided.

(1) The scope of practice for one profession does not necessarily restrict the practice of other professionals who may perform the same or similar services under the scope of practice authorized under their own practice act. For example, while section 1.03(8) authorizes audiologists to dispense amplification devices and remove cerumen, hearing aid dealers and physicians, respectively, can also provide such services under their practice acts.

(4) While most licensure laws have generous provisions for temporary practice by qualified nonresidents, initial comments to the model bill

pathology as long as the activities of such persons do not exceed five days in any calendar year and provided that:

- (a) Such persons meet the qualifications of this Act;
- (b) Such persons register with the Board in accordance with procedures specified in the rules and regulations; and
- (c) Agree to abide by the standards of professional conduct contained in this Act and rules and regulations.

(5) The activities of a licensed hearing aid dealer. Nothing in this Act shall be construed to limit or otherwise affect the practice of selling and fitting hearing aids.

(6) The performing of routine hearing screening, limited to a pass/fail determination, for the purpose of identifying and referring individuals suspected of having hearing disorders.

(7) Nothing in this Act shall be construed to prevent an audiologist or speech-language pathologist from employing any individual in non-clinical capacities.

1.07 Fitting and Dispensing of Hearing Aids

(1) A person who meets the requirements of this Act for licensure as an audiologist who fits and dispenses hearing aids must:

- (a) Register with the Board of Examiners for Audiology and Speech-Language Pathology the individual's intent to fit and dispense hearing aids;
- (b) Adhere to the professions code of ethics;
- (c) Comply with federal, state and local laws and regulations;
- (d) Provide a written contract for services that contains the name, mailing address, and telephone number of the board;
- (e) Follow guidelines for either a 30-day or 45-day trial on every hearing aid purchase.

(2) If audiometric testing is not conducted in a stationary acoustical enclosure, sound level measurements must be conducted at the time of the testing to ensure that ambient noises levels meet permissible standards for testing threshold to 20 dB based on the most recent American National Standards Institute "ears covered" octave band criteria for permissible ambient noise levels during audiometric testing. A dB

were highly supportive in suggesting that such provisions were not in the best interest of the public and that the ASHA model bill should not reflect current practice. The dilemma is to find a solution that enables the licensure board to monitor practice without imposing unnecessary requirements on persons engaging in short-term or temporary practice.

1.07 Fitting and Dispensing of Hearing Aids

LC 24-78 established ASHA policy to foster the legal right of audiologists to dispense hearing aids under that licensing or registration authority which controls audiological rehabilitation activities. As of December 2011, there are 38 states that allow audiologists to dispense hearing aids under an audiology license.

The practice of audiology includes selecting, fitting, programming and dispensing of amplification, assistive listening and alertive devices and other systems (e.g., implantable devices) and providing training in their use. (American Speech-Language-Hearing Association. (2004). *Scope of Practice in Audiology* [Scope of Practice]. Available from www.asha.org/policy.)

This section was expanded to include additional regulations. For example, the restrictions on advertising and door-to-door sales are found in regulations promulgated by the Federal Trade Commission and state law.

As of December, 2011, 27 states and the District of Columbia impose a mandatory trial period for

equivalent level may be used to determine compliance. The board shall adopt rules necessary to enforce this subsection.

hearing aids.

Product Dispensing, states that dispensing by audiologists is limited to products related to hearing, e.g., hearing aids, assistive listening systems/devices, sensory aids. (American Speech-Language-Hearing Association. (2006). *Preferred Practice Patterns for the Profession of Audiology* [Preferred Practice Patterns]. Available from www.asha.org/policy.)

1.08 Assessing, Selecting, Developing, and Fitting Products Related to Speech, Language, and Swallowing

A person who meets the requirements of this Act for licensure as a speech-language pathologist, who assesses, selects, develops, and fits products related to speech, language, or swallowing, must:

- (a.) Adhere to the profession's code of ethics;
- (b.) Comply with federal, state and local laws and regulations;
- (c.) Provide a written contract for services that contains the name, mailing address, and telephone number of the board.

1.09 Use of Endoscopy in Speech-Language Pathology

A person who meets the requirement of this Act for licensure as a speech-language pathologist may perform assessment, treatment, and procedures related to speech, voice, resonance, and swallowing function using non-medical endoscopy.

A licensed speech-language pathologist shall not perform an endoscopic procedure unless he or she has received training and is competent to perform these procedures.

A licensed speech-language pathologist must have protocols in place for emergency medical backup when performing procedures using an endoscope.

1.10 Use of Telepractice in Speech-Language Pathology and Audiology services

1.09 Use of Endoscopy in Speech-Language Pathology

State language on the performance of non-medical endoscopy varies. The model language used here is based on ASHA's official position that endoscopy may be utilized by speech-language pathologists to evaluate swallowing function and that medical personnel should be available in case of emergency. (American Speech-Language-Hearing Association. (2005). *The Role of the Speech-Language Pathologist in the Performance and Interpretation of Endoscopic Evaluation of Swallowing: Position Statement* [Position Statement]. Available from www.asha.org/policy.)

1.10 Use of Telepractice in Speech-Language Pathology and Audiology services

- (1) An individual licensed by this Act may provide speech-language pathology or audiology services via telepractice.
- (2) An individual licensed as a speech-language pathologist or audiologist in another state may not engage in the practice of speech-language pathology or audiology across state lines, hold himself or herself out as qualified to do the same, or use any title, word, or abbreviation to indicate to or induce others to believe that he or she is licensed to practice speech-language pathology or audiology across state lines unless he or she has been issued a limited **license/registration** in this state to practice telepractice in accordance with this Act.
- (3) An individual must hold a full license in another state in order to be eligible for a limited **license/registration**.

ASHA defines telepractice as the application of telecommunications technology to delivery of professional services at a distance by linking clinician to client, or clinician to clinician, for assessment, intervention, and/or consultation. ASHA's position is that telepractice is an appropriate model of service delivery for the professions of speech-language pathology [and audiology]. Telepractice may be used to overcome barriers of access to services caused by distance, unavailability of specialists and/or subspecialists, and impaired mobility.

Some states may not have enabling language in their statute to allow them to adopt a limited **license/registration** provision. Those states would require a statutory change.

Article 2. Administration

2.01 Board of Examiners for Audiology and Speech-Language Pathology

(1) There is hereby created a Board of Examiners for Audiology and Speech-Language Pathology under the jurisdiction of the Department.

(2) The Board shall consist of nine members who are appointed by the Governor, are residents of this state, and have been residents of this state for at least one year prior to their appointments.

2.02 Composition

(1) The Board shall consist of three audiologists who are currently practicing audiology and who have had five years'

2.01 Board of Examiners for Audiology and Speech-Language Pathology

(1) & (2) Because the model bill specifically identifies audiologists who dispense hearing aids and speech-language pathologists who assess, select, develop, and fit products related to speech, language, and swallowing, states may want to specify that the composition of the board include an audiologist who dispenses hearing aids and a speech-language pathologist who provides products related to speech, language, and swallowing. Additionally, some states may want to ensure that at least one school-based practitioner is on the board.

(2) An odd number of members are suggested. However, Board size may be dictated by the administrative policy of each state for Board size and/or by the number of licensees who will be licensed under the Act.

2.02 Composition

experience practicing audiology and who hold active and valid licensure for the practice of audiology in this state, except for the first audiologists appointed who shall meet the eligibility requirements for licensure as specified in this Act.

(2) The Board shall consist of three speech-language pathologists who are currently practicing speech-language pathology and who have had five years' experience practicing speech-language pathology and who hold active and valid licensure for the practice of speech-language pathology in this state, except for the first speech-language pathologists appointed who shall meet the eligibility requirements for licensure as specified in this Act.

(3) The Board shall consist of three representatives of the public who do not have a financial interest in the practice or business of audiology or speech-language pathology.

2.03 Appointments

(1) Within () days after enactment of this Bill, the first Board shall be appointed by the Governor from a list of names of at least 10 audiologists, 10 speech-language pathologists, and 10 public representatives submitted by the State Speech-Language Hearing Association.

(2) Each subsequent appointment may be made from recommendations submitted by the State Speech-Language Hearing Association which may submit at least three names per appointment or from recommendations submitted by other interested organizations or persons in the state. No member of the Board shall at the same time serve in an elected, appointed or employed position in any national, state or local-level organization representing audiologists and speech-language pathologists, which presents or may present a conflict of interest situation.

2.04 Terms

(1) Appointments to the Board shall be for a period of three years except for the initial appointments, which shall be of staggered terms. Members shall serve until the expiration of the term for which they have been appointed or until their successors have been appointed

(3) The number of consumer members on the board may be dictated by state administrative policy and/or the number of persons licensed by the Act. This number should be adjusted to ensure an odd number of members to the board.

2.03 Appointments

(1) State administrative policy may specify the nomination procedures to be followed in suggesting persons for Board appointments. Some states may prohibit organizations, including professional associations, from submitting nominations.

(2) State administrative policy may determine appointment procedures.

2.04 Terms

(1) This provision includes the qualification process involved in selecting board members. Without it, a board may lose board member representation if a replacement member is appointed but is not qualified to serve on the board.

and are deemed to be qualified to serve on the board. In the event of a vacancy in the office of a member of the Board other than by expiration of a term, the Governor shall appoint a qualified person to fill the vacancy for the unexpired term. No member may serve more than two consecutive 3-year terms.

(2) The Governor may remove any member of the Board for unprofessional conduct, incompetence or neglect of duty.

2.05 Meetings

(1) The Board shall meet during the first month of each calendar or fiscal year to select a chairperson and vice chairman and to conduct other appropriate business. At least () additional meetings shall be held before the end of each calendar or fiscal year. In order for the Board to conduct its business in a timely manner, further meetings may be convened at the call of the chairperson or at the request of two or more board members. The Board shall conduct its meetings and keep records of its proceedings in accordance with the provisions of the Administrative Procedure Act of this state.

(2) Six members of the Board shall constitute a quorum to do business, provided that the majority of members present are audiologists or speech-language pathologists and that at least one audiologist, one speech-language pathologist, and one public representative are present.

2.06 Compensation

Members of the Board shall receive monetary remuneration and reimbursement of expenses consistent with state administrative policy.

(2) State administrative policy may determine termination procedures. Some states may choose or be required to specify that failure to attend a specified number of board meetings is considered neglect of duty.

2.05 Meetings

(1) Some states may require the governor to appoint the chair and vice chair. Although it may not be necessary to select a vice-chair, a provision must be made in law or rules for the conduct of meetings in the absence of the chair. It also may be advisable to allow board members to call meetings to avoid situations where a board chairman refuses to call a meeting to discuss a controversial topic.

(1) If no state-defined procedures exist for conducting meetings or recording meeting proceedings, such information should be specified in the rules and regulations.

(1) Liaison with licensees and with the state association regarding Board proceedings, although not specified in the model bill is encouraged.

(2) State administrative policy may specify how a quorum is to be determined.

2.06 Compensation

The parameters for compensation of Board members generally are specified in state administrative policy. Financial remuneration may be in the form of hourly compensation or per diem allowance and also may include compensation for subsistence and travel.

2.07 Powers and Duties of the Board

The powers and duties of state regulatory

2.07 Powers and Duties of the Board

(1) The Board shall:

- (a) Administer, coordinate and enforce the provisions of this Act, establish licensure fees, evaluate the qualifications of applicants, supervise the examination of applicants and issue and renew licenses;
- (b) Issue subpoenas, examine witnesses, administer oaths, conduct hearings and, at its discretion, investigate allegations of violations of this Act and impose penalties if such violations of this Act have occurred;
- (c) Adopt responsible rules and regulations subject to the approval of the responsible agency including but not limited to regulations that delineate qualifications for licensure; specify requirements for the renewal of licensure; promulgate rules and regulations relative to the delivery of services via telepractice; establish standards of professional conduct; and any other rules and regulations necessary to carry out the provisions of this Act; and to amend or repeal the same. Following their adoption, the rules and regulations shall govern and control the professional conduct of every person who holds a license to practice audiology or speech-language pathology in this state;
- (d) Have available the names and addresses of persons currently licensed and registered under the provision of this Act;
- (e) Employ such personnel as determined by its needs and budget;
- (f) Request legal advice and assistance, as needed, from the Attorney General's office or other appropriate state legal officer;
- (g) Enter into such contracts as necessary to carry out its responsibilities under this Act;
- (h) Hire legal counsel, if deemed necessary;
- (i) Establish a budget;
- (j) Submit reports of its operations and finances as requested by the (supervising agency);
- (k) Adopt an official seal by which it shall authenticate its proceedings, copies or proceedings, records, acts of the Board, and licensees;
- (l) Communicate disciplinary actions to

boards, including enforcement responsibilities, may be specified by state administrative policy.

(1)(c) Standards of professional conduct are to be included in the rules and regulations and may include standards of ethical conduct identical or similar to ASHA's Code of Ethics; standards of care; and standards for the retention of records.

(1)(d) Some states do not release the names and addresses of licensees to the public.

(1) States with privacy laws may have limited disclosure authority. Specific language may be needed to amend the privacy law to facilitate the

relevant state and federal authorities and to other state speech-language pathology and audiology licensing authorities.

(2) The conferral or enumeration of specific powers elsewhere in this Act shall not be construed as a limitation of the general functions conferred by this section.

(3) No member of the Board shall be liable for civil action for any act performed in good faith in the performance of his/her duties as prescribed by law.

2.08 Disposition of Funds

(1) Upon enactment of this Act, the State is hereby authorized to establish and maintain a continuous, non-lapsing fund in accordance with (cite state law) to be known as the Audiology and Speech-Language Pathology Licensing Fund. This fund is created for the purpose of carrying out the provisions of this Act.

(2) Each month the Board shall report to the state (appropriate official) the amount and source of all revenue received by it pursuant to this Act during the previous month and shall at that time pay the entire amount into the Audiology and Speech-Language Pathology Licensing Fund.

(3) The Board shall be financed from income accruing to it from fees, licenses, and other charges and funds collected by the Board, as well as monies appropriated by the state to establish and maintain the Board and its operations. The board shall retain all fees and other monies received by it for deposit into the Audiology and Speech-Language Pathology Licensing Fund. Such funds may be expended by the board without appropriation for costs of administration and other expenses.

Additionally, such funds may be used for the establishment and operation of continuing education programs relating to speech, language, or hearing disorders. Any funds remaining unexpended and unencumbered at the end of each fiscal year shall be retained by the board for expenditure in succeeding years and no part thereof shall revert to the general fund of the state. All civil monetary penalties collected for the violation of any provisions of this Act or its rules and regulations shall be paid to the state's general fund.

(4) All employee salaries and other expenses

disclosure of additional information to other state or national authorities.

2.08 Disposition of Funds

(1) The creation of a revolving fund may require specific language as determined by each individual state. Without specific language, funds may be automatically deposited into the state's general fund.

(4) Civil monetary penalties should be deposited into the state's general fund to avoid giving the board the opportunity to finance its

shall be paid as budgeted after budgets are approved by the Comptroller (or appropriate official) or within the limitations of any appropriation or funds available for that purpose. All appropriate expenses incurred by the Board in the administration of the provisions of this Act shall be paid by the Comptroller (or appropriate official) when vouchers relating to such expenses are exhibited as having been approved by the Board.

activities through its civil penalties. Criminal penalties are generally assessed by the courts and are deposited into the general fund.

Article 3. Licenses

3.01 Qualifications

3.01 Qualifications

(1) To be eligible for licensure by the Board as an audiologist, the applicant shall:

- (a) Make application to the Board, upon such a form prescribed by the Board;
- (b) Pay to the Board the appropriate application fee;
- (c) Possess a doctoral degree with an emphasis in audiology from a program accredited by the accrediting agency of the American Speech-Language-Hearing Association;

(1)(c) This requirement reflects a shift in the profession toward doctoral entry into the field of audiology. For the ASHA CCC, from January 1, 2007 through January 1, 2012, a transitional standard will be required which consists of 75 semester credit hours of post-baccalaureate study that culminates in a doctoral or other recognized degree. The ASHA CCC will require a doctoral degree beginning in 2012.

(d) Complete supervised clinical practicum experiences from an educational institution or its cooperating programs;

(1)(d) ASHA CCC requires 1,820 hours of supervised clinical practicum. See: <http://www.asha.org/Certification/2012-Audiology-Certification-Standards/>

(e) Pass the Praxis II examination in audiology, or its successor;

(1)(e) When an individual moves from a bachelor's degree to a doctoral degree without a master's degree in between, the clinical fellowship is completed pre-degree rather than post-degree.

(f) Have committed no acts described in section 4.02 for which disciplinary action may be justified.

(1)(f) The National Examination in Audiology and the National Examination in Speech-Language Pathology are used by ASHA to

satisfy the examination requirement for the Certificates of Clinical Competence and by all currently existing licensure boards to satisfy the examination requirement for state licensure. The National Examinations are administered by the Educational Testing Service of Princeton, New Jersey.

(2) To be eligible for licensure by the Board as a speech-language pathologist, the applicant shall:

- (a) Make application to the Board, upon such a form prescribed by the Board;
- (b) Pay to the Board the appropriate application fee;
- (c) Possess a master's or doctoral degree from an educational institution accredited by the accrediting agency of the American Speech-Language-Hearing Association and from an educational institution approved by the state
- (d) Complete supervised clinical practicum experiences from an educational institution or its cooperating programs, the content of which shall be approved by the Board and delineated in the rules and regulations;
- (e) Complete a supervised postgraduate professional experience
- (f) Pass the Praxis II examination in speech-language pathology, or its successor
- (g) Have committed no acts described in section 4.02 for which disciplinary action may be justified.

(3) To be eligible for licensure by the Board as an audiology assistant, the applicant shall:

- (a) Submit a signed and notarized application to the Board, upon such form as prescribed by the Board;
- (b) Pay to the Board the appropriate application fee;
- (c) Possess a high school diploma, or its equivalent;
- (d) Have committed no acts described in section 4.02 for which disciplinary action may be justified.

(4) To be eligible for licensure by the Board as a speech-language pathology assistant, the applicant shall:

- (a) Submit a signed and notarized application to the Board, upon such form as prescribed by the Board;

(3) Guidance is available from American Speech-Language-Hearing Association. (2011). Audiology support personnel: preparation, supervision, and ethical considerations [Guidelines, Position Statement].

- (b) Pay to the Board the appropriate application fee;
- (c) Possess an associate's degree or bachelor's degree with an emphasis in speech-language pathology from an accredited educational institution approved by the Board;
- (d) Submit a bona fide official transcript or a written notification from the chair or program director of an academic institution verifying that the applicant attended the academic institution and completed the academic course work requirement.
- (e) Complete a minimum of 100 clock hours of supervised clinical experience at the educational institution approved by the Board or during the first year of employment.
- (f) Have committed no acts described in section 4.02 for which disciplinary action may be justified.
- (5) Within 30 days of employment, the supervising audiologist or supervising speech-language pathologist must submit a notarized statement to the Board explicitly indicating that the supervisor agrees to supervise the assistant's practice and that the supervisor accepts full and complete responsibility for that practice.

3.02 Waiver of Requirements

- (1) The Board may waive the education, practicum and professional experience requirements for applicants who
 - (a) Provide proof of employment in the practice of audiology or speech-language pathology in this state on the effective date of this Act;
 - (b) Pass an examination, if requested by the Board; and
 - (c) Apply for a license in audiology or speech-language pathology within one year after the effective date of this Act, providing that the provisions of clause (1) of this section shall have no further force and effect after (date).
- (2) The Board may, at its discretion, waive the

3.02 Waiver of Requirements

- (1)(a) Some states may wish to adopt a more stringent "grandparent" policy and waive requirements for persons who can demonstrate employment of a longer duration, such as "3 years out of the 5 years immediately preceding the effective date of this Act," rather than the more generous employment requirement, "...on the effective date of this Act.," which is included in this document.
- (1)(b) This requirement gives the Board the discretion to require an examination, if it deems necessary, after reviewing the credentials of an applicant requesting to be "grandparented."
- (1)(c) The grandparenting provision should be sunsetted after a reasonable time has elapsed.

education, practicum and professional experience requirements for applicants who:

- (a) Received their professional education in another country provided that the Board is satisfied that equivalent education and practicum requirements have been met; and
- (b) Meet the examination requirement of section 3.01(1)(f) or 3.01(2)(f).

(3) The Board shall waive the qualifications in 3.01 (1)(c) (d), (e), and (f) and 3.01(2)(c), (d), (e), and (f) for applicants who:

- (a) Present proof of current licensure in a state that has standards that are at least equivalent to those of this state; or
- (b) Hold a current Certificate of Clinical Competence from the American Speech-Language-Hearing Association in the area for which they are applying for licensure.

(4) Persons who hold current licensure from another state with equivalent standards or who hold the Certificate of Clinical Competence from the American Speech-Language-Hearing Association are permitted to practice audiology or speech-language pathology in this state, pending Board disposition of their applications, provided that:

- (a) They are practicing in the area, audiology or speech-language pathology, in which their licensure or Certificate of Clinical Competence was granted;
- (b) They have filed an application with the Board and paid the appropriate application fee; and
- (c) They have not committed any of the act described in section 4.02 for which disciplinary action may be justified.

3.03 Provisional License

(1) The Board shall issue a provisional license in speech-language pathology to an applicant who:

- (a) Except for the postgraduate professional experience, meets the academic, practicum, and examination requirements of this Act;
- (b) Submits an application to the Board, upon a form prescribed by the Board, including a plan for the content of the postgraduate professional experience;
- (c) Pays to the Board the appropriate application fee for a provisional license; and

(2) Some states may not want to waive the professional experience requirement, but rather, may wish to leave the imposition of this requirement to the Board's discretion.

(4) Some states may object to allowing any persons to practice until the Board has processed their applications, decided on their ability to meet licensure standards, and granted licensure.

- (d) Has not committed any of the acts described in section 4.02 for which disciplinary action may be justified.
- (2) The purpose of a provisional license is to permit an individual to practice speech-language pathology while completing postgraduate professional experience in speech-language pathology as required by this Act. A person holding a provisional license is authorized to practice speech-language pathology only while working under the supervision of a person fully licensed by this state in accordance with this Act.
- (3) The term for provisional licenses and the conditions for their renewal are to be determined by the Board and delineated in the rules and regulations.

3.04 Limited License/Registration for Telepractice

- (1) Upon completed application including all required documentation, verification of licensure or certification and payment of fees, the Board may issue a limited **license/registration** for interstate telepractice, if the following conditions are met:
 - (a) The speech-language pathologist or audiologist **possesses an unrestricted and unencumbered license or certification** to practice in the state from which the speech language pathologist or audiologist provides telepractice services **and that the license or certification is comparable to its corresponding license or certification in this state as determined by the Board;**
 - (b) The speech-language pathologist or audiologist has not had a license to practice speech-language pathology or audiology revoked or restricted in any state or jurisdiction;
 - (c) In the event of a previous disciplinary action against the applicant, the board may issue a limited **license/registration** to practice across state lines if it finds that the previous disciplinary action does not indicate that the speech-language pathologist or audiologist is a potential threat to the public.

3.04 Limited License/Registration for Telepractice

A limited **license/registration** for telepractice is included to ensure that any provider outside of the state who provides services inside the state have the education and qualifications to do so.

Some states may not have enabling language in their statute to allow them to adopt a limited **license/registration** provision. Those states would require a statutory change.

- (d) The speech-language pathologist or audiologist does not have an office in this state and does not provide service in the physical presence of a client in this state.
- (e) The speech-language pathologist or audiologist agrees to be subject to the state laws, the state judicial system and the Board with respect to providing speech language pathology or audiology services to this state's residents.
- (f) Telepractitioners shall comply with all laws, rules and regulations governing the maintenance of client records, including client confidentiality requirements, regardless of the state where the records of any client within this state are maintained.

3.05 License Renewal

(1) Licenses issued under this Act shall expire at a time specified by the Board. Every person licensed under this Act shall:

- (a) Pay an amount established by the Board in order for his/her license to be renewed;
- (b) Submit an application for renewal on a form prescribed by the Board;
- (c) Complete 30 contact hours or three CEUs of continuing education per three-year renewal period
 - (i) CEUs or contact hours may be earned from the American Speech-Language-Hearing Association (ASHA) and ASHA approved providers, the state speech-language-hearing association as well as additional providers approved by the Board;

3.05 License Renewal

(1)(c) Currently, the vast majority of public and private credentialing bodies which intend to ensure continuing competence have continuing education requirements. In 1979, ASHA's Code of Ethics was amended to include under Principle of Ethics II, Rule of Ethics C., "Individuals shall continue their professional development throughout their careers." ASHA's Council for Clinical Certification reiterated the importance of continuing professional development for maintenance of the ASHA certificates of clinical competence by implementing new requirements for continuing professional development for the CCC-A beginning in 2003 and the CCC-SLP beginning in 2005.

Some states consider continuing education to be a reasonable expectation and a legitimate demonstration of concern for consumer protection as evidenced by the fact that approximately 80% of the audiology and

speech-language pathology licensure boards have continuing education requirements. Other state governments are opposed to continuing education requirements because of the expense and time involved in enforcing them.

The exact details of the continuing competency requirements are typically delineated in the rules and regulations because of the difficulty in changing the law via the legislature if changes in the requirements are desired at a later date.

(1)(c) The board should determine the number of continuing education hours or units that should be earned during the renewal period. Typically, a high percentage (50-100%) of the hours should be directly related to clinical practice and patient/client care.

(1)(c) Each board should decide the criteria and content that a provider should adhere to in order for that organization's courses to be accepted for licensure renewal. Some boards have provider approval processes. Other boards approve individual courses offered by providers. Most boards recognize the established approval processes of such organizations as the American Speech-Language-Hearing Association (ASHA).

- (d) Show proof of maintenance of ASHA Certificate of Clinical Competence; and
- (e) Meet any other requirements the Board establishes as conditions for license renewal.

(2) Licensees are granted a grace period of 30 days after the expiration of their licenses in which to renew retroactively if they meet statutory requirements for renewal fee and any late fee set by the Board.

(3) A suspended license is subject to expiration and may be renewed as provided in this Act, but such renewal shall not entitle the licensee, while the license remains suspended and until it is reinstated, to engage in the licensed activity, or any other conduct or activity in violation of the order of judgment by which the license was suspended.

(4) A license revoked on disciplinary grounds is subject to expiration as provided in this Act, but it may not be renewed. If such license is reinstated after its expiration, the licensee as a condition of reinstatement shall meet license requirements for new licensees and shall pay a

reinstatement fee that shall equal the renewal fee in effect on the last regular renewal date immediately preceding the date of reinstatement, plus any additional fees set by the Board.

3.06 Reinstatement of Expired Licenses

(1) Persons who fail to renew their licenses by the end of the 30-day grace period may have their licenses reinstated as long as they:

- (a) Submit an application for reinstatement to the Board within () years after the expiration date of the license;
- (b) Provide documentation of having completed the continuing education requirements for the period in which the license has lapsed; and
- (c) Pay to the Board a reinstatement fee that shall equal the renewal fee in effect on the last regular renewal date immediately preceding the date of reinstatement, plus any late fee set by the Board.

(2) Persons who fail to renew their licenses within 5 years after the expiration date may not have their licenses renewed, and they may not be restored, reissued, or reinstated thereafter, although such persons may apply for and obtain a new license if they meet the requirements of this Act at the time of renewal and pay to the Board the appropriate fee.

3.07 Inactive License

The Board may adopt rules permitting inactive licensure. The rules shall specify the requirements and procedures for placing a license on inactive status, the length a license may remain on inactive status and the requirements and procedures to activate an inactive license. Except as otherwise specified by rule, an inactive license has no right or privilege to engage in the practice of audiology or speech-language pathology.

3.06 Reinstatement of Expired Licenses

The reinstatement of expired licenses can be a difficult procedure to implement because of the various circumstances presented by persons requesting reinstatement. The specific procedures and requirements for reinstatement should be clearly delineated in the rules and regulations.

3.07 Inactive License

Some states may wish to allow licensees to place their license on inactive status. Essentially, this means that a licensee has agreed not to practice but wishes to maintain licensure so that they may return to practice in the future. Typically, the fees associated with an inactive license are substantially lower than those for an active license. Usually, if a license is not reactivated within a certain time frame (e.g., five to eight years), a new application for licensure must be made.

States that require licensees to demonstrate continuing competence for license renewal may elect to impose a similar requirement on persons who elect an inactive status for their license. To reactivate an inactive license, a licensee would have to meet the same continuing competence

3.08 Reinstatement of Revoked License

The Board may adopt rules permitting the reinstatement of a revoked license. The rules shall specify the requirements and procedures for reinstating a license.

3.09 Reciprocity

The Board, subject to the provisions of this chapter and the rules and regulations of the Board promulgated thereunder prescribing the qualifications of a speech-language pathologist and/or audiologist, may permit, at its discretion any person who has successfully complied with the requirements of the American Speech-Language-Hearing Association (ASHA), and is a holder of a Certificate of Clinical Competence in speech-language pathology or audiology, and who holds a current license in another state in speech-language pathology or audiology may be granted a license according to the following conditions:

- (a) That the other state maintains a system and standard of qualifications and examinations for speech-language pathologists or audiologists which meet or exceed the current requirements for licensure in this state.
- (b) Payment of the current fee established by the Board for other licensees.
- (c) Submission of evidence satisfactory to the Board, i.e., proof of current out-of-state license.

3.10 Internationally Educated Applicants

The Board may grant a license to practice speech-language pathology or audiology to an applicant who completed an educational program in a college or university in another country if the applicant submits one of the following:

- (a) Proof satisfactory to the Board that the applicant has received a Master's degree or higher for speech-language pathology or a Doctoral degree for audiology from a international institution which was accredited, at the time the degree was conferred, by an accrediting body recognized by the national government of the country in which the institution is located; or
- (b) A certification from a private education evaluation service approved by the

requirements as persons who maintained current licensure.

3.09 Reciprocity

ASHA's Certificate of Clinical Competence is recognized in 34 states for the purposes of reciprocity or interim practice and, for that reason, may aid the practitioner who moves or wishes to work in another state. In recognizing the CCC for the purposes of reciprocity or interim practice, states appreciate the scientific validity and high standards of the credential.

- Board that the applicant's international education is equivalent to the education provided by an accredited program; or
- (c) A certification from the American Speech-Language-Hearing Association, or its successor organization.

Article 4. Disciplinary Actions

4.01 Penalties

- (1) The Board may impose separately, or in combination, any of the following disciplinary actions on a licensee after formal or informal disciplinary action as provided in this Act:
 - (a) Refuse to issue or renew a license;
 - (b) Issue a letter of reprimand or concern;
 - (c) Require restitution of fees;
 - (d) Impose probationary conditions;
 - (e) Impose a fine not to exceed (\$), either total or per violation;
 - (f) Require the licensee to reimburse the board for costs of the investigation and proceeding;
 - (g) Suspend or revoke a license;
 - (h) Impose practice and/or supervision requirements;
 - (i) Require licensees to attend continuing education programs specified by the Board as to content and hours;
 - (j) Impose other disciplines as deemed appropriate by the Board.
- (2) If the Board imposes suspension or revocation of license, application may be made to the Board for reinstatement, subject to the limits of section 3.05(3). The Board shall have discretion to accept or reject an application for reinstatement and may require an examination for reinstatement.
- (3) If a licensee is placed on probation, the Board may require the license holder to:
 - (a) Report regularly to the Board on matters that are the basis of probation;
 - (b) Limit practice to the areas prescribed by the Board; or
 - (c) Continue or review continuing education until the license holder attains a degree of skill satisfactory to the Board in those areas that are the basis of the probation.

4.01 Penalties

Provisions pertaining to disciplinary action are usually subject to the administrative policy governing the professional licensure boards in each state. Consequently, such provisions generally must adhere to a certain format and include specific content.

Because licensure laws differ across states, it is impossible to list all potential grounds for disciplinary action. The listing in the model bill of unlawful or unprofessional acts was selected from various licensure laws and is representative of the "typical grounds" for discipline cited by Randolph Reeves in The Law of Professional Regulation and Certification. Because of each state's idiosyncrasies, the administrative policy of each state should be consulted to determine the required content or format, if any, for the law and items which may or should be included in rules and regulations.

4.02 Grounds

(1) Disciplinary actions may be taken by the Board for conduct that may result from but not necessarily be limited to:

- (a) Fraudulently or deceptively obtaining or attempting to obtain a license or a provisional license for the applicant, licensee, holder or for another;
- (b) Fraudulently or deceptively using a license or provisional license;
- (c) Altering a license or provisional license;
- (d) Aiding or abetting unlicensed practice;
- (e) Selling, bartering, or offering to sell or barter a license or provisional license;
- (f) Committing fraud or deceit in the practice of audiology or speech-language pathology, including but not limited to:
 - (1) Willfully making or filing a false report or record in the practice of audiology or speech-language pathology;
 - (2) Submitting a false statement to collect a fee;
 - (3) Obtaining a fee through fraud or misrepresentation;
- (g) Using or promoting or causing the use of any misleading, deceiving, improbable, or untruthful advertising matter, promotional literature, testimonial, guarantee, warranty, label, brand insignia or any other representation;
- (h) Falsely representing the use or availability of services or advice of a physician;
- (i) Misrepresenting the applicant, licensee, or holder by using the word "doctor" or any similar word, abbreviation, or symbol if the use is not accurate or if the degree was not obtained from a regionally accredited institution;
- (j) Committing any act of dishonesty, immoral or unprofessional conduct while engaging in the practice of audiology or speech-language pathology;
- (k) Engaging in illegal or incompetent or negligent practice;
- (l) Providing professional services while:
 - (1) Mentally incompetent;
 - (2) Under the influence of alcohol;
 - (3) Using any narcotic or controlled dangerous substance or other drug that

4.02 Grounds

- (11) Standards of professional conduct should be included in the rules and regulations and may include standards of ethical conduct, standards of care, and standards for record retention

is in excess of therapeutic amounts or without valid medical indication.

- (m) Providing services or promoting the sale of devices, appliances or products to a person who cannot reasonably be expected to benefit from such services, devices, appliances or products;
 - (n) Violating any provision of this Act, any lawful order given or rule or regulation adopted by the Board;
 - (o) Being convicted or pleading guilty or nolo contendere to a felony or to a crime involving moral turpitude, whether or not any appeal or other proceeding is pending to have the conviction or plead set aside;
 - (p) Being disciplined by a licensing or disciplinary authority of any other state, country or nationally recognized professional organizations or convicted or disciplined by a court of any state or country for an act that would be grounds for disciplinary action under this section;
 - (q) Exploits a patient for financial gain or sexual favors;
 - (r) Failing to report suspected cases of child abuse or vulnerable adult abuse in accordance with state law;
 - (s) Diagnosing or treating individuals for speech or hearing disorders by mail or telephone unless the individual has been previously examined by the licensee and the diagnosis or treatment is related to such examination; or
 - (t) Violating federal, state or local laws relating to the profession;
- (2) The Board shall adopt by rule a schedule of sanctions to be imposed as the result of formal or informal disciplinary activities conducted by the Board.

4.03 Complaint Procedure in General

(1) The Board shall keep an information file about each complaint filed with the board. The information in each complaint file shall contain complete, current and accurate information including, but not limited to:

- (a) all persons contacted in relation to the complaint;
- (b) a summary of findings made at each step of the complaint process;
- (c) an explanation of the legal basis and reason for a complaint that is dismissed;

and

(d) other relevant information.

(2) If a written complaint is filed with the board within the Board's jurisdiction, the board, at least as frequently as quarterly and until final disposition of the complaint, shall notify the parties to the complaint of the status of the complaint unless the notice would jeopardize an ongoing investigation.

(3) The board by rule shall adopt a form to standardize the information concerning complaints made to the board. The board by rule shall prescribe information to be provided to a person when the person files a complaint with the board.

(4) The board shall provide reasonable assistance to a person who wishes to file a complaint with the board.

(5) The board shall list along with its regular telephone number the toll-free telephone number that may be called to present a complaint about a health professional if the toll-free number is established under other state law.

4.04 Complaint Investigation and Disposition

(1) The board shall adopt rules concerning the investigation of a complaint filed with the board. The rules adopted under this subsection shall:

- (a) distinguish between categories of complaints;
- (b) ensure that complaints receive appropriate consideration;
- (c) adopt regulations to communicate with and monitor the disciplinary action if it is handled by another authority;
- (d) notify the complainant in writing of the reasons for the dismissal of a complaint;
- (e) ensure that the person who filed the complaint has an opportunity to explain the allegations made in the complaint;
- (f) prescribe guidelines concerning the categories of complaints that require the use of a private investigator and the procedures for the board to obtain the services of a private investigator.

(2) The board shall dispose of all complaints in a timely manner. The board shall establish a schedule for conducting each phase of a complaint that is under the control of the board

4.04 Complaint Investigation and Disposition

All states except Kentucky have Administrative Procedures Acts which specify the procedures to be followed in settling contested cases. Some states also have an intermediate hearings board before judicial appeal.

not later than the 30th day after the date the complaint is received by the board. The schedule shall be kept in the information file for the complaint and all parties shall be notified of the projected time requirements for pursuing the complaint. A change in the schedule must be noted in the complaint information file and all parties to the complaint must be notified not later than the seventh day after the change is made.

(3) The director of the board shall notify the board of a complaint that extends beyond the time prescribed by the board for resolving the complaint so that the board may take necessary action on the complaint.

4.05 Due Process

(1) Before the Board imposes disciplinary actions, it shall give the individual against who the action is contemplated an opportunity for a hearing before the Board. The Board shall give notice and hold a hearing in accordance with the state's Administrative Procedures Act. Any person aggrieved by a final decision of the Board may appeal in accordance with the Administrative Procedures Act.

The individual shall be entitled to be heard in his or her own defense, alone or with counsel, and may produce testimony and testify in his or her own behalf.

4.06 Monitoring of Licensure Holder

(1) The board by rule shall develop a system for monitoring license holders' compliance with the requirements of this Act. Rules adopted under this section shall include procedures for monitoring a license holder who is ordered by the board to perform certain acts and to identify and monitor license holders who present a risk to the public.

4.07 Injunction

(1) The Board is empowered to apply for relief by injunction, without bond, to restrain any person, partnership, or corporation from engaging in any act or practice which constitutes an offense against this Act. It shall not be necessary for the Board to allege and prove that there is no adequate remedy at law in order to obtain the relief requested. The

members of the Board shall not be individually liable for applying for such relief.

(2) If a person other than a licensed audiologist or speech-language pathologist has engaged in any act or practice which constitutes an offense under this Act, a district court of any county on application of the board may issue an injunction or other appropriate order restraining such conduct.

4.08 Jurisdiction Over Unlicensed Practice

Section ___ of this Act makes it unlawful for any unlicensed person to engage in the practice of audiology or speech-language pathology, and enables the Board to exact penalties for unlawful practice. Any individual who, after a hearing, shall be found by the Board to have unlawfully engaged in the practice of audiology or speech-language pathology shall be subject to a fine to be imposed by the Board not to exceed \$ _____ for each offense. Each such violation of this Act or the rules promulgated hereunder pertaining to unlawfully engaging in the practice of audiology or speech-language pathology shall also constitute a misdemeanor punishable upon conviction as provided in criminal code of the state.

4.09 Reporting of Violations

All actions taken by the Board against a person licensed as an audiologist or speech-language pathologist shall be reported to the National Practitioners Databank and a formal complaint filed with the American Speech-Language-Hearing Association Board of Ethics.

4.08 Jurisdiction Over Unlicensed Practice

Unlicensed practice is a problem across the country. This clause allows the Board specific jurisdiction to stop the practice and the issuance of penalties.

Article 5. Severability

5.01 Severability

If any part of this Act is for any reason held unconstitutional, inoperative or void, such holdings of invalidity shall not affect the remaining portions of the Act; and it shall be construed to have been the legislative intent to pass this Act without such unconstitutional, invalid or inoperative part therein; and the remainder of this Act, after the exclusion of such part or parts, shall be valid as if such parts were not contained therein.

5.02 Termination

Unless reenacted by the legislature, the provisions of this Act shall be without effect after ().

5.02 Termination

Not all states have legislation governing the termination of licensure legislation. States that have such legislation, known as sunset laws, require licensure laws to be repealed on a specified date unless, after review by the legislature, they are reenacted.

5.03 Effective Date

This Act is effective ().



AMERICAN
SPEECH-LANGUAGE-
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Speech-Language Pathology Assistants

Overview

- Informing Consumers
- Affiliation with ASHA

Support personnel assist speech-language pathologists (SLPs) in providing a variety of services in different work settings. Titles used to identify speech-language pathology support personnel vary by state and include, but are not limited to, speech-language pathology assistant (SLPA), SLP-Assistant, paraprofessional, speech aide, therapy assistant, and communication aide.

Differing levels of support personnel (e.g., aide, assistant, associate) may exist within and across work settings, states, or organizations. ASHA uses the term *SLPA* to refer to one category of support personnel with a specific scope of practice as detailed below. The SLPA Scope of Practice defines aides/technicians and assistants; these may not be consistent with the definitions used in individual states.

While ASHA endorses the use of trained and supervised support personnel, ASHA does not require the use of support personnel. SLPs should not be expected to use support personnel, particularly if they feel that quality of service may be compromised. ASHA expects SLPs to use support personnel in accordance with the ASHA Code of Ethics and may impose sanctions on SLPs if assistants are used inappropriately.

SLPAs and supervising SLPs are required to determine the specific requirements in their respective work settings and states. See ASHA's State-by-State page for the Summary of State Requirements for Support Personnel. ASHA's Model Bill for State Licensure (2012) [PDF] includes provisions relating to audiology and speech-language pathology assistants.

Expert Opinion

SLPs should consider the following when hiring or working with an SLPA:

- Appropriate training and supervision of SLPAs is to be provided by SLPs who hold ASHA's Certificate of Clinical Competence (CCC) in Speech-Language Pathology.
- An SLP should not supervise or be listed as a supervisor for more than two full-time (FTE) SLPAs in any setting or combination thereof.
- Activities may be assigned only at the discretion of the supervising SLP and should be constrained by the Scope of Practice for SLPAs.

- The best interest and protection of the consumer should be paramount at all times.
- The purpose of the SLPA should not be to increase or reduce the caseload size for SLPs, but rather to assist SLPs in managing their existing caseloads. SLPAs should not have full responsibilities for a caseload or function autonomously. (ASHA, 2013)

Informing Consumers

SLPs must inform consumers when services are provided by support personnel. SLPs may delegate certain tasks to support personnel, but the SLP retains the legal and ethical responsibility for all services provided or omitted.

Affiliation with ASHA

ASHA has established an Associate's Affiliation Program for support personnel in speech-language pathology and audiology open to individuals who

- are currently employed in support positions providing audiology or speech-language pathology services and working under the supervision of an ASHA-certified audiologist (CCC-A) or SLP (CCC-SLP) or have obtained the signature of the program director (or training program instructor) certifying that they are qualified to provide services under the direction of an ASHA-certified audiologist or speech-language pathologist; and
- are qualified to work as audiology or speech-language pathology support personnel in the state and follow the state licensure, registration, or certification rules (if any) that are applicable to them.

Applicants are required to obtain the signature of their ASHA-certified supervisors in order to become ASHA Associates.

Key Issues

Resources

References

Content Disclaimer: The Practice Portal, ASHA policy documents, and guidelines contain information for use in all settings; however, members must consider all applicable local, state and federal requirements when applying the information in their specific work setting.

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State Licensure Trends and Quarterly Updates

ASHA tracks trends in the states related to audiology and speech-language pathology. Following is a list of the most common trends we see in states. To see where your state stands on these trends, please view the trend chart. This chart is updated at the end of each year.

State-by-State Comprehensive Trends Charts

These charts provide an overall view of trends tracked for each state.

- State Licensure Trends [PDF]
- Support Personnel Requirements in School Settings [PDF]
- Support Personnel Requirements Excluding School Settings [PDF]
- Hearing Aid Dispensing [PDF]
- State Teacher Requirements Licensing Trends: SLP [PDF]
- State Teacher Requirements Licensing Trends: Audiology [PDF]
- State Hearing Screening Requirements [PDF]

Quarterly Report Updates

Provides updates on pending legislation and regulatory actions related to various issues, including: autism, telemedicine, Medicaid, and hearing aid coverage.

- Third quarter, 2016 [PDF]
- Second quarter, 2016 [PDF]
- First quarter, 2016 [PDF]
- Fourth quarter, 2015 [PDF]

Support Personnel Excluding School Settings

This chart is a summary of state legislative/regulatory trends which is updated annually. For more detailed information, go to ASHA state-by-state webpage at www.asha.org/advocacy/state/, and check the support personnel requirements under each state.

| State/Trends | 1. States that License Support Personnel | 2. States that Register Support Personnel | 3. States that Certify Support Personnel | 4. States that Regulate in School Settings Only | 5. States that Do Not Regulate Support Personnel | 6. Bachelors Degree (or Equivalent) Required for Support Personnel | 7. Bachelors Degree (or Equivalent) + Graduate Hours | 8. Associates Degree (or Equivalent) Required for Support Personnel | 9. High School Diploma (or Equivalent) Required for Support Personnel | 10. Non-conforming Educational Requirements | 11. No. of Full-time Support Personnel per Supervisor | 12. No. of Part-time Support Personnel per Supervisor | 13. Continuing Ed for Support Personnel (hours/year) |
|----------------|--|---|--|---|--|--|--|---|---|---|---|---|--|
| Missouri | X | | | | | SLPA or Audi/Asst | | | SLP & Audi/Aides | | 3 | | 0 |
| Montana | X | | | | | SLP/Aide or Asst I | SLP/Aide or Asst I | | | SLP Aide or Asst III & Audi Aide or Asst | 3 | | 20 units/10 hours/yr |
| Nebraska | X | | | | SL Technicians Endorsement only | SLPA, Audi, Asst, or Speech Language Technician | | SLPA or Audi Asst | | | 2 | | 10/1 |
| Nevada | | | X | | X | | | SLPA | | | 3 | | 0 |
| New Hampshire | | | | | X | | Apprentices in SL | | | | 3 | | 0 |
| New Jersey | X | | | | | | | | | | 3 | | 20/2 |
| New Mexico | X | | | | X | | | | | | 3 | | 0 |
| New York | | | | | X | | | | | | 2 | 1 | 0 |
| North Carolina | | X | | | | SLPA | | SLPA | | Audiometric Technician | 2 | | 0 |
| North Dakota | | | | X | | | | | SLPA & Audi Aides | | 2 | | 0 |
| Ohio | X | | | | | | | | | | 2 | | 0 |
| Oklahoma | X | | | | | | | SLPA (after June 2013) | SLPA (until June 19 2013) & Audi/Asst | X | 2 | | 20/2 |
| Oregon | | | | | | | | | | X | 2 | | 15/2 |
| Pennsylvania | | | | | | | | | | 30 hrs for equivalent | 3 | | 0 |
| Rhode Island | | X | | | | | Support Personnel Speech Language | | Audiometric Aide | | 1/3 | | 0 |
| South Carolina | X | | | | | SLPA | | SLPA | | | 2 | | 0/2 |
| South Dakota | X | | | | | SLPA | | SLPA | | | 3 | | 0 |
| Tennessee | | | | | | 60 semester credit hours | | | | | 2 | | 5/1 |
| Texas | X | | | | | SLPA & Audi/Asst | | | | | 4 | | 20/2 |
| Utah | | X | | | | | | | SLP Aide & Audi Aide | | 3 | | 0 |
| Vermont | | | | | X | | | | | | | | 0 |

Support Personnel Excluding School Settings

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| State/Trends | 1. States that License Support Personnel | 2. States that Register Support Personnel | 3. States that Certify Support Personnel | 4. States that Regulate Support Personnel in School Settings Only | 5. States that Do Not Regulate Support Personnel | 6. Bachelors Degree (or Equivalent) Required for Support Personnel | 7. Bachelors Degree (or Equivalent) + Graduate Hours | 8. Associates Degree (or Equivalent) Required for Support Personnel | 9. High School Diploma (or Equivalent) Required for Support Personnel | 10. Non-conforming Educational Requirements | 11. No. of Full-time Support Personnel per Supervisor | 12. No. of Part-time Support Personnel per Supervisor | 13. Continuing Ed for Support Personnel (hours/year) |
|---------------|--|---|--|---|--|--|--|---|---|---|---|---|--|
| Virginia | | | | | | | | | | | | | |
| Washington | | | SLPA | | | X | | | | | | | 0 |
| West Virginia | | X | | | SLPA or Aud. Asst | SLPA or Aud. Asst | | | | | 3 | | 51 |
| Wisconsin | | | | | | | | | | | 2-SLPA 5/10-Aud | | 0 |
| Wyoming | | X | | | | | | | | | 3 | | 0 |
| TOTAL | 13 | 20 | 5 | 4 | 10 | 19 | 4 | 18 | 15 | 7 | 35 | 8 | 22 |

* Exceptions

- CA (6) Bachelors degree in SLP or communication disorders fulfills equivalency standard for assistants. Board may consider 9 mo FT experience in lieu of field or bachelor's clinical experience.
- (10) Aides do not need formal academic or clinical training and must be directly supervised.
- (11) A supervisor may not supervise more than two SLPAs, but may supervise a total of three support personnel, including SLPAs and aides.
- CO (4) See school trends chart for detailed requirements for schools.
- CT (5) Unlicensed but in laws.
- DE (10) Aud. Aide- Certification By Council of Accreditation of Occupational Hearing Conservationists or equivalent.
- GA (13) Continuing education for audiology aides only.
- HI (4) See school trends chart for detailed requirements for schools.
- IA (5) Unlicensed but in rules.
- IL (13) Continuing education requirements differ for school-based paraprofessionals.
- KY (4) See school trends chart for detailed requirements for schools.
- LA (1) Offers a provisional license. Aides are not licensed.
- (13) Continuing education requirements apply only to assistants. Continuing education is recommended for aides.
- MO (11) Not specified for Aides.
- MT (10) Does not specify degree requirement.
- (13) 20 limits apply to slp aides and assistants; ten hours apply to slp aides, or assistants II and III and audiology aides and industrial aides or assistants.
- NC (11) & (12) Does not apply to audiometric technician.
- (13) As assigned by supervising SLP.
- ND (4) See school trends chart for detailed requirements for schools.
- NE (11) Not specified for Speech-language Technician.
- NH (3) Not required in schools.
- OH (13) Amount and frequency not specified.
- OK (13) CEU applies only to SLPAs.
- OR (10) Administrative rules specify course hours and contact hours of clinical interaction.
- (11) Supervision exemptions apply allowing up to four full-time.
- RI (11) SLP 1; Aud 3.
- TX (11) An exception may be made allowing supervision of more than four individuals if the supervisor submits documentation demonstrating their ability to manage the entire caseload.

Support Personnel Excluding School Settings

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| 1. States that License Support Personnel | 2. States that Register Support Personnel | 3. States that Certify Support Personnel | 4. States that Regulate Support Personnel in School Settings Only | 5. States that Do Not Regulate Support Personnel | 6. Bachelor's Degree (or Equivalent) Required for Support Personnel | 7. Bachelor's Degree (or Equivalent) + Graduate Hours | 8. Associates Degree (or Equivalent) Required for Support Personnel | 9. High School Diploma (or Equivalent) Required for Support Personnel | 10. Non-conforming Educational Requirements | 11. No. of Full-time Support Personnel per Supervisor | 12. No. of Part-time Support Personnel per Supervisor | 13. Continuing Ed. for Support Personnel (hours/year) |
|--|---|--|---|--|---|---|---|---|---|---|---|---|
| VA (3) Use of SLPA and Audiology Assistant Certification not required but supervision requirements must be met WA (8) Associates degree, or bachelor's degree, or board approved work experience WI (5) Not licensed, registered, or certified but in licensure law WV (8) SLPA or Audiology Assistant may have an associate's degree or a bachelor's degree WY (11) Provides a waiver on supervision limits | | | | | | | | | | | | |

Support Personnel Requirements in School Settings

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|---------------|--|---|--|--|--|--|--|---|---|---|---|---|--|
| Alabama | | | X | | | SLPA I | SLPA II | | | | | | 50/5 |
| Alaska | | X | | | | SLPA | | SLPA | | | 2 | | 15/2 |
| Arizona | X | | | | | SLP Technician | | SLPA | | | 2 | 3 | 10/1 or 180/6 |
| Arkansas | | X | | | | SLPA | | SLPA | SLP Aide | | 2 | 3 | SLPA & Aide 12/yr |
| California | | X | | | | X | | SLPA | | SLP & AID Aide | 2-3 | | SLPA 1/2/2 |
| Colorado | | | | SLPA | | SLPA | | | | | | | 0 |
| Connecticut | | | | | X | | | | | | | | 0 |
| DC | | | | | X | | | | | | | | 0 |
| Delaware | | | | | | | | | | | | | 0 |
| Florida | | | X | | | SLPA | | | Aid/Asst | | 2 | 3 | 20/2 |
| Georgia | | | | | | | | Paraprofessional | SLP Aide | Paraprofessional | 1-2 | | 0 |
| Hawaii | | | | | | | | Communication Aide | Communication Aide | | | | 0 |
| Idaho | | | | | | | | Paraprofessional | Paraprofessional | | | | 0 |
| Illinois | X (SLPAs only) | | | | | SLP Paraprofessional (schools only) | | SLPA | | | 2 (SLPAs) | 1 (SLPAs) | 0 |
| Indiana | | | | | | SLP Assistant | | SLP Associate | SLP Aide | | 2 | | 0 |
| Iowa | | | | | X | | | | SLPA I & II | | 3 | | 0 |
| Kansas | | X | | | | | | | SLP Asst & AID Asst | | | | 0 |
| Kentucky | X | | | | | SLPA (school settings only) | | | | | 2 | | 20/2 |
| Louisiana | X | | | | | SLPA (schools only) | | | | | 3 | | 10/1 |
| Maine | | X (SLPAs only) | | | | SLPA | | SLPA Ed/Tech II and III* | Ed Tech I | | 2 (SLPAs) | | 0 |
| Maryland | X | | | | | SLPA | | SLPA | | | 2 | 3 | 10/2 |
| Massachusetts | | | | | | | | | | | | | 0 |
| Michigan | | | | | X | | | | | | | | 0 |
| Minnesota | | | | | | | | | | | | | 0 |

Support Personnel Requirements in School Settings

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| State/Trends | 1. States that License Support Personnel | 2. States that Support Personnel | 3. States that Certify Support Personnel | 4. States that Regulate in School Settings Only | 5. States that Do Not Regulate Support Personnel | 6. Bachelors Degree (or Equivalent) Required for Support Personnel | 7. Bachelors Degree (or Equivalent) + Graduate Hours Required for Support Personnel | 8. Associates Degree (or Equivalent) Required for Support Personnel | 9. High School Diploma (or Equivalent) Required for Support Personnel | 10. Non-conforming Educational Requirements | 11. No. of Full-time Support Personnel per Supervisor | 12. No. of Part-time Support Personnel per Supervisor | 13. Continuing Ed for Support Personnel (hours/year) |
|----------------|--|----------------------------------|--|---|--|--|---|---|---|---|---|---|--|
| Mississippi | | | | | | | | | | | | | 0 |
| Missouri | | X | | | | Speech Implementer | | | | | | | 0 |
| Montana | | | | | | | | | SLP/Ass/Aide & Audi Aide | | | | 0 |
| Nebraska | | | X | | | Speech Language Technician | | | | | | | 0 |
| Nevada | | | | | X | | | | | | | | 0 |
| New Hampshire | | | | | | | | | | | | | 0 |
| New Jersey | | | | | X | | | | | | | | 0 |
| New Mexico | | | | | | | | | | | | | 0 |
| New York | | X | | | X | | SLPA | | | | 2 | 1 | 0 |
| North Carolina | | | | X | | SLP para professional | | | | | 2 | | 0 |
| North Dakota | | | | | | | | | | | | | 0 |
| Ohio | | | | | | | | | | | | | 0 |
| Oklahoma | | | X | | | | | SLPA (beginning June, 2013) | | | 2 | | 207 |
| Oregon | | | SLPA | | | | | | | X | 2 | | 152 |
| Pennsylvania | | | | | | | | | | | | | 0 |
| Rhode Island | | | | | | | | | | | | | 0 |
| South Carolina | | | | | | | | | | | | | 0 |
| South Dakota | | | | | | | | | | | | | 0 |
| Tennessee | X | | | | | SL Teacher | | | | | | | 0 |
| Texas | | | | | | | | | | | | | 0 |
| Utah | X | | | | | SL Technician | | | | | | | 0 |
| Vermont | | | | | X | | | | | | | | 0 |
| Virginia | | | | | | | | | | | | | 0 |
| Washington | | | | | | | | | | | | | 0 |
| West Virginia | | | | | | Speech Assistant | | | | | | | 0 |
| Wisconsin | X | | | | | | | | | | | | 0 |
| Wyoming | | | | | | | | | | | | | 0 |
| TOTAL | 8 | 8 | 8 | 2 | 8 | 19 | 2 | 14 | 9 | 7 | 18 | 6 | 15 |

Support Personnel Requirements in School Settings

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| State/Trends | 1. States that License Support Personnel | 2. States that Register Support Personnel | 3. States that Regulate in School Settings Only | 4. States that Regulate Support Personnel | 5. States that Do Not Regulate Support Personnel | 6. Bachelors Degree (or Equivalent) Required for Support Personnel | 7. Bachelors Degree (or Equivalent) + Graduate Hours Required for Support Personnel | 8. Associates Degree (or Equivalent) Required for Support Personnel | 9. High School Diploma (or Equivalent) Required for Support Personnel | 10. Non-conforming Educational Requirements | 11. No. of Full-time Support Personnel per Supervisor | 12. No. of Part-time Support Personnel per Supervisor | 13. No. of Continuing Ed for Support Personnel (hours/year) |
|--------------|--|---|---|---|--|--|---|---|---|---|---|---|---|
|--------------|--|---|---|---|--|--|---|---|---|---|---|---|---|

* Exceptions

The information in the chart indicates the requirements specified for school settings only either by the state licensure board and/or the state Department of Education.

- AL 13) Applies only to Level II SLPAs
- AZ 6) Speech Language Technicians have no supervisor requirements.
- AZ 13) Speech language technicians must complete 180 clock hours of graduate level coursework every six years.
- CA 6) Bachelors degree in SLP or communication disorders fulfills equivalency standard for assistants. Board may consider 9 mo FT experience in lieu of field or bachelor's clinical experience.
- CA 10) Aides do not need formal academic or clinical training and must be directly supervised.
- CA 11) A supervisor may not supervise more than two SLPAs, but may supervise a total of three support personnel including SLPAs and aides. No more than two aides may be supervised by one credentialed language, speech, and hearing specialist.
- CO 4) Department of Education provides an authorization.
- CT 5) Unlicensed but in laws.
- GA 2) Registration for SLP Aides is not required in schools if no fees are charged for services.
- GA 10) As an alternative to an Associate's degree, a paraprofessional may have two years of college coursework or passed a PSC approved paraprofessional assessment (with a high school diploma or GED).
- IA 5) Unlicensed but in rules.
- ID 10) Requires high school diploma and two years of study at institution of higher education or an associate's degree or higher.
- IL 13) Choices are provided for continuing education fulfillment. Continuing education requirements differ for outside of school settings.
- LA 1) Offers a provisional license.
- LA 3) Valid for three years only. SLPAs in schools must be licensed and have ancillary certification.
- ME 8) Educational technicians Level III require more post-secondary hours than Level II. Educational Technicians receive an authorization from the Department of Education.
- MO 6) Speech implementers must have a Bachelor's Degree in Elementary or Secondary Education or Communication Disorders and a current MO teaching certificate.
- MT 13) Must attend specific training activities as determined by the supervisor.
- NC 13) As assigned by supervising SLP.
- ND 4) SLP Paraprofessional for school settings only. Certificate of completion for SLP or SLP licensed issued by Audiology and SLP Board required.
- NE 3) Requires an endorsement under a Provisional Special Services Certificate.
- OR 10) Administrative rules specify course hours and contact hours of clinical interaction. Supervision exemptions apply allowing up to four full-time.
- WI 10) Experience and coursework requirements are established by the school district.
- WV 6) Authorization required for a Speech Assistant.
- WV 13) Professional development required but hours and frequency are not specified.
- WY 10) School districts determine requirements for these positions.

Support Personnel Excluding School Settings

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| State Trends | 1. States that License Support Personnel | 2. States that Register Support Personnel | 3. States that Certify Support Personnel | 4. States that Regulate in School Settings Only | 5. States that Do Not Regulate Support Personnel | 6. Bachelors Degree (or Equivalent) Required for Support Personnel | 7. Bachelors Degree (or Equivalent) + Graduate Hours | 8. Associates Degree (or Equivalent) Required for Support Personnel | 9. High School Diploma (or Equivalent) Required for Support Personnel | 10. Non-conforming Educational Requirements | 11. No. of Full-time Support Personnel per Supervisor | 12. No. of Part-time Support Personnel per Supervisor | 13. Continuing Ed for Support Personnel (hours/year) |
|---------------|--|---|--|---|--|--|--|---|---|---|---|---|--|
| Alabama | X | | | | | SLPA or Aud/Asst | | | | | | | 0 |
| Alaska | | X | | | | SLPA | | SLPA | | | 2 | | 152 |
| Arizona | X | | | | | | | SLPA | | | 2 | 3 | 101 |
| Arkansas | | X | | | | SLPA | | SLPA | SLP Aide | | 2 | 3 | SLPA 10/yr max |
| California | | X | | | | X | | SLPA | SLP & AUD Aide | | 2-3 | | SLPA 12/2 |
| Colorado | X | | | X | | | | | Hearing Aid Provider Trainees and Associates | | | | 0 |
| Connecticut | | | | | X | | | | | | 3 | | 0 |
| DC | | | | | X | | | | | | | | 0 |
| Delaware | | Aud/Aide only | | | | | | | SLP Aide | AUD Aides | 2 | 3 | 20/2 |
| Florida | | | X | | | SLPA | | Aud/Asst | SLP Aide | | 2 | | 10/2 |
| Georgia | | | | | | | | Aud/Asst | SLP Aide | | 2 | | 0 |
| Hawaii | | | | X | | | | | | | | | 0 |
| Idaho | X | | | | | SLP Aide | | SLPA | | | | | 10/1 |
| Illinois | X | | | | | | | SLPA | | | | | 10/2 |
| Indiana | | X | | | | | SLP Assistant | SLP Associate | SLP Aide | | 2 (SLPAs) | 1 (SLPAs) | 0 |
| Iowa | | | | | X | | | | SLP & Aud Asst. I & II | | 3 | | 0 |
| Kansas | | X | | | | | | | SLP Asst. & Aud Asst. | | | | 0 |
| Kentucky | | | | X | | | | | SLP of Aid/Aide | | | | 0 |
| Louisiana | X | | | | | SLPA | | | SLP of Aid/Aide | | 3 (SLPAs) | | 10/1 |
| Maine | | X | | | | SLPA | | SLPA | | | 2 | | 0 |
| Maryland | X | | | | | SLPA or Aud/Asst | | SLPA | | | 2 | | 10/2 |
| Massachusetts | X | X | | | | SLPA or Aud/Asst | | SLPA or Aud Asst. | | | 3 | | 0 |
| Michigan | | | | | X | | | | | | | | 0 |
| Minnesota | | | | | | SLPA | | SLPA | | | 1 | | 0 |
| Mississippi | | X | | | | SLP & Aud/Aides | | | SLP & Aud/Aides | | 3 | | 0 |



AMERICAN
SPEECH-LANGUAGE-
HEARING
ASSOCIATION

Maryland Support Personnel Requirements

The following information includes speech-language pathology and audiology support personnel requirements in educational and other practice settings. The information is reviewed on an annual basis. Please be advised that regulations and policy may change at any time, so always check with your state for the most up-to-date information.

Speech-Language Pathology

School Setting Requirements

Individuals hired after October 1, 2007 by a Maryland local public school system, state approved nonpublic school for children with disabilities, or chartered educational institution of the state to provide speech and language services must be licensed by the State Board of Examiners for Audiologists, Hearing Aid Dispensers, and Speech-language Pathologists.

Statutory and Regulatory Requirements

1. To be licensed, a speech-language pathology assistant must have completed one of the following requirements within the past five years:
 - a. an associate's degree from an approved program for speech-language pathology assistants at an accredited institution;
 - b. an associate's degree in an allied health field from an accredited institution, with minimum coursework that includes at least three credit hours in each of the following areas—normal speech-language development, speech disorders, anatomy and physiology of speech systems, language disorders and phonology; or
 - c. a baccalaureate degree in speech-language pathology or communication science disorders from an accredited institution.
2. A speech-language pathology assistant must demonstrate completion of 25 hours of clinical observation and 75 hours of clinical assisting experience obtained within an associate, bachelor, or master's program. If an applicant has not completed these hours, the applicant may file with the Board a written plan for an alternative method to obtain the hours.
3. A full-time supervising speech-language pathologist may not supervise more than two full-time speech-language pathology assistants. A part-time supervising speech-language pathologist may not supervise more than one full time speech-language pathology assistant. A supervising speech-language pathologist must have a minimum of three years of work experience and maintain ongoing contact with all clients seen by the assistant as directed in regulation.
4. Speech-language pathology assistants must complete a minimum of 10 CEUs every two years to renew their license.

Limited License

1. An assistant shall have a limited license before beginning supervised practice and shall practice only under a licensed speech-language pathologist.
2. An assistant must complete nine months of supervised practice under a limited license and submit a competency checklist completed by the supervisor, to the State Board of Examiners.

Waivers

An individual may be eligible for a waiver if they have been working as a speech-language pathology assistant for two years, have completed the associate's or bachelor's educational program, submit an speech-language pathology assistant competency skills checklist, and complete a delegation agreement for each supervising speech-language pathologist; or via reciprocity if the other state has equivalent qualifications.

Audiology

School Setting Requirements

Audiology support personnel are not regulated in this setting.

Statutory and Regulatory Requirements

Audiology support personnel are not regulated by the state.

Resources

For further information on laws and regulations for speech-language pathology and audiology support personnel in educational and other practice settings, please visit this website:

- [Laws and Regulations for Speech-Language Pathology Assistants \[PDF\]](#)

To see where your state stands on support personnel licensure trends, please view the trends charts which are updated annually:

- [Support Personnel in Schools Settings \[PDF\]](#)
- [Support Personnel Excluding Schools Settings \[PDF\]](#)

Questions regarding state advocacy issues? Call ASHA at 800-498-2071 and ask for the State Advocacy Team.

Your Search...



Phone Numbers

Mobile

Help

Size

Print

Email

Delaware General Assembly : Delaware Regulations : Administrative Code : Title 14 : 1500

HOME

- Agency Information
- Office Locations
- Contact Information
- Related Links
- Site Map

SERVICES

- Register of Regulations
 - Current Issue
 - Previous Issues
- Regulatory Flexibility Act
- Administrative Code
- Delaware Code
- Laws of Delaware
- City & Town Charters
- Style Manual
- Cumulative Table
- Subscription Services
- Tour of Legislative Hall

INFORMATION

- Citizen Participation

TOP A

**Title 14 Education
1500 Professional Standards Board**

- [1501 Knowledge, Skills, and Responsibility Based Salary Supplements for Educators](#)
- [1502 Graduate Level Salary Increments](#)
- [1503 Educator Mentoring](#)
- [1505 Standard Certificate](#)
- [1506 Emergency Certificate](#)
- [1507 Alternative Routes to Teacher Licensure and Certification Program](#)
- [1508 Special Institute for Teacher Licensure and Certification](#)
- [1509 Meritorious New Teacher Candidate Designation](#)
- [1510 Issuance of Initial License](#)
- [1511 Issuance and Renewal of Continuing License](#)
- [1512 Issuance and Renewal of Advanced License](#)
- [1513 Denial of Licenses](#)
- [1514 Revocation, Limitation, or Suspension of Licenses](#)
- [1517 Paraeducator Permit](#)
- [1520 Early Childhood Teacher](#)
- [1521 Elementary Teacher](#)
- [1522 Elementary School Counselor](#)
- [1531 Middle Level English Language Arts Teacher](#)
- [1532 Middle Level Mathematics Teacher](#)
- [1533 Middle Level Science Teacher](#)
- [1534 Middle Level Social Studies Teacher](#)
- [1539 Health Education Teacher](#)
- [1540 Secondary English Language Arts Teacher](#)
- [1542 Secondary Mathematics Teacher](#)
- [1543 Secondary Science Teacher](#)
- [1544 Secondary Social Studies Teacher](#)
- [1545 Secondary School Counselor](#)
- [1549 Dance Teacher](#)
- [1550 AgriScience Teacher](#)
- [1551 Business Education Teacher](#)
- [1553 Driver Education and Traffic Safety Education Teacher](#)
- [1554 Family and Consumer Sciences Teacher](#)
- [1555 Marketing Education Teacher](#)
- [1556 School To Work Transition Teacher](#)
- [1557 Technology Education Teacher](#)
- [1558 Theater Teacher](#)
- [1559 Skilled and Technical Sciences Teacher](#)
- [1560 Art Teacher](#)
- [1561 Bilingual Teacher](#)
- [1562 Teacher of English Learners](#)
- [1563 Music Teacher](#)

- [1564 Physical Education Teacher](#)
- [1565 World Language Teacher](#)
- [1570 Early Childhood Exceptional Children Special Education Teacher](#)
- [1571 Special Education Teacher of Students with Disabilities](#)
- [1572 Teacher of Students Who Are Gifted and Talented](#)
- [1573 Teacher of Students with Autism or with Severe Intellectual Disabilities](#)
- [1574 Teacher of Students Who Are Deaf or Hard of Hearing](#)
- [1575 Teacher of Students with Visual Impairments](#)
- [1580 School Library Media Specialist](#)
- [1581 School Reading Specialist](#)
- [1582 School Nurse](#)
- [1583 School Psychologist](#)
- [1584 School Social Worker](#)
- [1590 Delaware Administrator Standards](#)
- [1591 School Principal and Assistant School Principal](#)
- [1592 Certified Central Office Personnel](#)
- [1593 Superintendent or Assistant Superintendent](#)
- [1594 Special Education Director](#)
- [1595 Certification Programs for Leaders in Education](#)
- [1597 Delaware Professional Teaching Standards](#)
- [1598 Delaware Professional Development Standards](#)
- [1599 Delaware Educational Technology Standards](#)

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UDaily



In addition to the course work, the graduate students will begin by working with clients at the Speech-Language-Hearing Clinic, which has gained tremendous popularity since its doors opened late last year.

Grad program accredited

New speech-language pathology master's program to launch this fall

8:18 a.m., March 24, 2016--The University of Delaware College of Health Sciences' newest degree program, a master of arts in speech-language pathology, is officially ready to launch.

With a massive shortage of speech-language pathologists (SLPs), the First State desperately needed a graduate program so the University tapped Aquiles Iglesias to bring it to life.

"Up until now, there was no master's level program in Delaware," says Iglesias, director of the Communication Sciences and Disorders Program. "People were forced to study out of state; therefore, the great majority stayed out of state, creating a dead zone of services for Delawareans."

Iglesias received the official accreditation letter from the Council on Academic Accreditation in Audiology and Speech-Language Pathology (CAA) of the American Speech-Language-Hearing Association.

But the applications had already flooded in well before the accreditation news ever arrived. More than 300 applied for 25 spots in the inaugural cohort, which embarks this fall. Housed in the Health Sciences Complex on UD's Science, Technology and Advanced Research (STAR) Campus, the program is full-time — two years in duration, it includes two winter and one summer session. Students will take classes such as Neurogenic Disorders of Language, Language Disorders in School-Age Children, and Voice and Resonance Disorders.

"The curriculum offers professional scholarship through clinical work and collaborative research," says Jacquie Truluck, director of clinical education.

In addition to the courses, the graduate students will work with clients at the Speech-Language-Hearing Clinic, which has gained tremendous popularity since its doors opened late last year. The clinic's clients range in age from toddler to elderly. And they've come to STAR Health from across the state — North Wilmington, Middletown, and even Seaford — to work with top-tier SLPs, who are already in place and seeing clients even before the students arrive. These SLPs will serve as mentors for the maiden group of students.

In the students' second year, they will take their knowledge out into the community, completing externships in hospitals, agencies, sub-acute nursing facilities and schools.

In addition to teaching the next generation of SLPs, the fresh-faced program is attracting communication sciences and disorders researchers to its STAR Campus home. The program will research everything from neural underpinning of language learning to effective treatments approaches for individuals with aphasia or Parkinson's disease.

"Our faculty and students will use research to improve the quality of care for Delawareans with speech, language and hearing disorders," says Iglesias, whose own research interests include language development of dual language learners and assessment of language disorders in bilingual children.

Another group of people who stand to benefit from the new program are SLPs practicing across the region. The College of Health Sciences site was designed as a resource hub for SLPs, helping them keep up on the latest developments, methodologies and research.

"Our facility is meant to be an information center – a training site for others. Whether it's learning about new assessment tools or intervention approaches, we want SLPs to reach out and visit. We want to make their jobs easier," Iglesias says.

Upon completion of their degree, students will apply for certification in speech-language pathology from the American Speech-Language-Hearing Association and licensure as an SLP in Delaware.

Article by Dante LaPenta

Photo by Evan Krape



Dare to be first.



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ARE YOU IN
RECOVERY FROM
ALCOHOL OR
DRUG PROBLEMS?

Know
your
Rights



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov

This brochure provides general guidance on the legal rights of individuals with alcohol and drug problems. It is not intended to serve as legal advice for any particular case involving or potentially involving discrimination. If you believe that you have been or are being subjected to illegal discrimination, you should immediately consult an attorney or seek assistance from the Federal agency responsible for addressing discrimination complaints or administering the program or benefits at issue.

ARE YOU IN
RECOVERY FROM
ALCOHOL OR
DRUG PROBLEMS?

Know *your* Rights

This brochure will help you:

- KNOW YOUR RIGHTS UNDER FEDERAL LAWS THAT PROTECT YOU FROM DISCRIMINATION IN –
 - Employment and job training
 - Housing
 - Government services and programs
 - Health care and other public accommodations
 - Education.

- KNOW THE LEGAL CONSEQUENCES OF SUBSTANCE USE-RELATED CONDUCT THAT MAY LIMIT YOUR RIGHTS AND OPPORTUNITIES IN AREAS SUCH AS –
 - Public housing and other federally assisted housing
 - Federally funded public assistance and food stamps
 - Federal student loans and aid.

- KNOW WHAT YOU CAN DO TO –
 - Prevent or remedy violations of your rights under Federal non-discrimination laws
 - Overcome legal barriers that other laws may impose due to past or current substance use-related conduct, including convictions for substance use offenses.

THE FEDERAL NON-DISCRIMINATION LAWS THAT PROTECT YOU

Q: I am in recovery from substance abuse, but I still face discrimination because of my addiction history. Does any law protect me?

A: Yes. Federal civil rights laws prohibit discrimination in many areas of life against qualified “individuals with disabilities.” Many people with past and current alcohol problems and past drug use disorders, including those in treatment for these illnesses, are protected from discrimination by:

- The Americans with Disabilities Act (ADA)
- The Rehabilitation Act of 1973
- The Fair Housing Act (FHA) and
- The Workforce Investment Act (WIA).

WHO IS PROTECTED?

The non-discrimination laws discussed in this brochure protect individuals with a “disability.” Under these Federal laws, an individual with a “disability” is someone who –

- has a current “physical or mental impairment” that “substantially limits” one or more of that person’s “major life activities,” such as caring for one’s self, working, etc.
- has a record of such a substantially limiting impairment
or
- is regarded as having such an impairment.
- Whether a particular person has a “disability” is decided on an individualized, case-by-case basis.
- Substance use disorders (addiction) are recognized as impairments that can and do, for many individuals, substantially limit the individual’s major life activities. For this reason, many courts have found that individuals experiencing or who are in recovery from these conditions are individuals with a “disability” protected by Federal law.
- To be protected as an individual with a “disability” under

Federal non-discrimination laws, a person must show that his or her addiction substantially limits (or limited, in the past) major life activities.

- People wrongly believed to have a substance use disorder (in the past or currently) may also be protected as individuals “regarded as” having a disability.

WHO IS NOT PROTECTED?

- People who currently engage in the illegal use of drugs are not protected under these non-discrimination laws, except that individuals may not be denied health services (including drug rehabilitation) based on their current illegal use of drugs if they are otherwise entitled to those services.
- People whose use of alcohol or drugs poses a direct threat—a significant risk of substantial harm—to the health or safety of others are not protected.
- People whose use of alcohol or drugs does not significantly impair a major life activity are not protected (unless they show they have a “record of” or are “regarded as” having a substance use disorder—addiction—that is substantially limiting).

WHAT IS, AND IS NOT, ILLEGAL DISCRIMINATION?

- Discriminating against someone on the basis of his or her disability—for example, just because he has a past drug addiction or she is in an alcohol treatment program—may be illegal discrimination. Discrimination means treating someone less favorably than someone else because he or she has, once had, or is regarded as having a disability.
- Acting against a person for reasons other than having a disability is not generally illegal discrimination, even if the disability is related to the cause of the adverse action.

For instance, it is not likely to be ruled unlawful discrimination if someone in substance abuse treatment or in recovery is denied a job, services, or benefits because he –

- does not meet essential eligibility requirements
- is unable to do the job
- creates a direct threat to health or safety by his behavior, even if the behavior is caused by a substance use disorder
- violates rules or commits a crime, including a drug or alcohol-related one, when that misconduct is cause for excluding or disciplining anyone doing it.

Since the basis for the negative action in these cases is not (or not solely) the person's disability, these actions do not violate Federal non-discrimination laws.

EMPLOYMENT

Q: Are people in treatment for or in recovery from substance use disorders protected from job discrimination?

A: The answer in many cases is "yes." The Americans with Disabilities Act and the Rehabilitation Act prohibit most employers from refusing to hire, firing, or discriminating in the terms and conditions of employment against any qualified job applicant or employee on the basis of a disability.

- The ADA applies to all State and local governmental units, and to private employers with 15 or more employees.
- The Rehabilitation Act applies to Federal employers and other public and private employers who receive Federal grants, contracts, or aid.

Rights In general, these employers –

- May not deny a job to or fire a person because he or she is in treatment or in recovery from a substance use disorder, unless the person's disorder would prevent safe and competent job performance.
- Must provide "reasonable accommodations," when needed, to enable those with a disability to perform their job duties. Changing work hours to let an employee attend treatment

is one kind of a reasonable accommodation. (But if an accommodation would cause the employer undue hardship—significant difficulty or expense—it is not required.)

- Must keep confidential any medical-related information they discover about a job applicant or employee, including information about a past or present substance use disorder.

Limits The non-discrimination laws protect only applicants and employees qualified for the job who currently are not engaging in the illegal use of drugs.

- “Qualified” means that a person meets the basic qualification requirements for the job, and is able to perform its essential functions—fundamental duties—with or without a reasonable accommodation.
- Remember: people who pose a direct threat to health or safety, or have committed misconduct warranting job discipline, including termination, are not protected.

Medical Inquiries & Examinations

As a general rule, employers:

- May not use information they learn about an individual’s disability in a discriminatory manner. They may not deny or treat anyone less favorably in the terms and conditions of employment if he or she is qualified to perform the job.
- Must maintain the confidentiality of all information they obtain about applicants’ and employees’ health conditions, including addiction and treatment for substance use disorders.

Before making a job offer, employers may not ask:

- Questions about whether a job applicant has or has had a disability, or about the nature or severity of an applicant’s disability. Pre-offer medical examinations also are illegal.
- Whether a job applicant is or has ever abused or been

addicted to drugs or alcohol, or if the applicant is being treated by a substance abuse rehabilitation program, or has received such treatment in the past.

Employers may ask job applicants:

- Whether the applicant currently is using drugs illegally
- Whether the applicant drinks alcohol
- Whether the applicant can perform the duties of the job.

After making a job offer, employers may:

- Make medical inquiries and require an individual to undergo a medical examination (including ones that reveal a past or current substance use disorder), as long as all those offered the position are given the same exam.
- Condition employment on the satisfactory results of such medical inquiries or exams.

After employment begins, employers may make medical inquiries or require an employee to undergo a medical examination, but only when doing this is job-related and justified by business necessity.

Such exams and inquiries may be permitted if the employer has a reasonable belief, based on objective evidence, that an employee has a health (including substance use-related) condition that impairs his or her ability to perform essential job functions, or that poses a direct threat to health or safety.

Workplace Drug Testing

- Employers are permitted to test both job applicants and employees for illegal use of drugs, and may refuse to hire—or may fire or discipline—anyone whose test reveals such illegal use.
- Employers may not fire or refuse to hire any job applicant or employee solely because a drug test reveals the presence

of a lawfully used medication (such as methadone).

- Employers must keep confidential information they discover about an employee's use of lawfully prescribed medications.

Medical Leave

Q: Do I have the right to take medical leave from my job if I need it for substance abuse treatment?

A: Yes, in many workplaces, you do.

Rights The Family and Medical Leave Act (FMLA) gives many employees the right to take up to 12 weeks of unpaid leave in a 12-month period when needed to receive treatment for a "serious health condition" —which, under the FMLA, may include "substance abuse." The leave must be for treatment; absence because of the employee's use of the substance does not qualify for leave.

- The FMLA covers Federal, State and local Government employers, public and private elementary and secondary schools, and private employers with 50 or more employees.
- To be eligible for leave under FMLA, you must have been employed by a covered employer for at least 12 months, worked at least 1,250 hours during the 12 months immediately before the leave, and work at a worksite where there are at least 50 employees or within 75 miles of that site.
- FMLA makes it illegal for employers to deny leave to or take action against an employee for requesting or taking leave.
- In some circumstances, denying an employee leave for substance use treatment may constitute a violation of the ADA or the Rehabilitation Act.

Limits Neither the FMLA nor Federal non-discrimination laws make it illegal for an employer to fire or discipline an employee for a legitimate non-discriminatory reason, even when the employee is granted or entitled to leave under these laws or under the employer's personnel policy. This means an employee who

violates workplace rules or who uses drugs illegally still can be fired for those reasons.

Job Training

Q: I need job training and placement services. Can I be denied that help because of my substance use history?

A: No, not in public (governmental) job training and placement programs, nor in private job placement services that receive Federal financial assistance.

The Workforce Investment Act (WIA) provides financial assistance for job training and placement services for many people through the One-Stop Career Center system. Section 188 of WIA and the other non-discrimination laws discussed in this brochure prohibit most job training and placement service providers from denying services to, or discriminating in other ways against, qualified applicants and recipients on the basis of disability—including people with past or current substance use disorders—who otherwise:

- meet the eligibility requirements for these services
and
- are currently not using drugs illegally.

HOUSING

Q: Am I also protected from discrimination when it comes to renting or buying housing?

A: The Fair Housing Act (FHA) makes discrimination in housing and real estate transactions illegal when it is based on a disability. The FHA protects people with past and current alcohol addiction and past drug addiction—although other Federal laws sometimes limit their rights. The FHA does not protect people who currently engage in illegal drug use.

Rights Landlords and other housing providers may not refuse to rent or sell housing to people in recovery or who have current alcohol disorders, and may not discriminate in other ways against them in housing transactions solely on the basis of their dis-

ability. It is also illegal to discriminate against housing providers (such as sober or halfway houses for people in recovery) because they associate with individuals with disabilities.

Limits on Public Housing Eligibility Federal law limits some people's eligibility for public and other federally assisted housing because of past or current substance use-related conduct. The Quality Housing and Work Responsibility Act:

- requires public housing agencies, Section 8, and other federally assisted housing providers to exclude:
 - Any person evicted from public, federally assisted, or Section 8 housing because of drug-related criminal activity (including possession or sale). This bar ordinarily lasts for 3 years after the individual's eviction. A public housing agency can lift or shorten that time period if the individual successfully completes a rehabilitation program.
 - Any household with a member who is abusing alcohol or using drugs in a manner that may interfere with the health, safety, or right to peaceful enjoyment of the premises by other residents. Exceptions can be made if the individual demonstrates that he or she is not currently abusing alcohol or using drugs illegally and has successfully completed a rehabilitation program.
- permits applicants for public housing to be denied admission if a member of the household has engaged in any drug-related criminal activity (or certain other criminal activity) within a "reasonable time" of the application.

GOVERNMENT SERVICES AND PROGRAMS

Q: Government benefits and services are crucial to my getting treatment and staying in recovery. Do Federal laws protect me from discrimination in these areas?

A: Yes. The Americans with Disabilities Act and Rehabilitation Act prohibit disability-based discrimination by Federal, State, or local governmental agencies in any of their "services, programs, or activities." These include Government –

- services (such as health or social services and education and training programs)
- benefit programs (such as welfare or child-care assistance) and other forms of financial assistance (such as student loans)
- other Government activities, such as zoning or occupational licensure.

Rights If you are “qualified”—that is, you meet the essential eligibility requirements of the service, program, or activity—you may not be denied the opportunity to participate in or receive benefits from these and other public services, benefit programs, or governmental activities because of your disability.

Limits on Rights and Opportunities Due to Drug Convictions

1. **Public Assistance and Food Stamps: Drug Felony Ban**
 - The Federal welfare law (the Personal Responsibility and Work Opportunity Act of 1996) imposes a lifetime ban on Federal cash assistance and food stamps for anyone convicted of a drug-related felony (including possession or sale) after August 22, 1996. However, States may “opt out” of or modify this Federal rule:
 - 12 States do not impose this ban.
 - 21 other States have modified the ban, and allow people who get treatment, show they are rehabilitated, or meet other requirements to become eligible again.
2. **Education: Student Loans and Aid** – The Higher Education Act of 1998 makes students convicted of drug offenses (including possession or sale) ineligible for federally funded student loans, grants, or work assistance.
 - Ineligibility lasts for varying lengths of time, depending on the type of drug offense and if it is a repeat offense.
 - This bars students from getting federally funded education loans or aid in college, and in many other educa-

tional and training programs.

- States cannot “opt out” of or otherwise modify this Federal rule.

3. Driver’s Licenses – The Department of Transportation (DOT) Appropriation Amendment offers Federal financial incentives to States that agree to revoke or suspend, for at least 6 months, the driver’s license of anyone convicted of a drug offense (including not only drug-related driving offenses, but also those involving drug possession or sale).

- Many States choose not to opt out of this law.

PRIVATE EDUCATIONAL, HEALTH CARE, AND OTHER FACILITIES

Q: Do private educational institutions, service providers, and other facilities also have to comply with Federal non-discrimination laws protecting people with disabilities?

A: A large number do.

- The Americans with Disabilities Act requires “public accommodations” as well as Government agencies to comply with its non-discrimination requirements. Public accommodations are private facilities that provide goods or services to the public. They include:
 - schools and universities
 - hospitals, clinics, and health care providers
 - social service agencies such as homeless shelters, day care centers, and senior centers.
- Private service providers that receive Federal grants, contracts, or aid must comply with the same non-discrimination requirements under the Rehabilitation Act and the Workforce Investment Act, when it applies.

Rights In offering or providing their goods or services, public accommodations (and other private entities covered by the Rehabilitation Act or WIA) must not discriminate against individuals

on the basis of their past, current, or perceived disability. This means they must ensure that individuals with disabilities:

- enjoy the equal opportunity to participate in or benefit from the facility's goods and services
- receive goods or services in the most integrated setting possible. Segregating or providing different services to people with disabilities generally is not allowed.

HOW YOU CAN PROTECT YOUR RIGHTS

Q: Is there anything I can do to protect my rights under these Federal non-discrimination laws?

A: Yes. If you believe you are being or have been discriminated against because of your past or current alcohol disorder or past drug use disorder, you can challenge the violation of your rights in two ways:

- You may file a complaint with the Office of Civil Rights, or similar office, of the Federal agency(s) with power to investigate and remedy violations of the disability discrimination laws. Key ones are listed below. You do not need a lawyer to do this. Filing with the Government can be faster and easier than a lawsuit and get you the same remedies. However, the deadline for filing these complaints can be as soon as 180 days after the discriminatory act – or even sooner, with Federal employers – so always check. The Federal agencies listed can tell you the deadlines and other requirements for filing discrimination complaints.
- In most (but not all) cases, you also may file a lawsuit in Federal or State court, in addition to or instead of filing an administrative complaint. Deadlines for lawsuits vary from 1 to 3 years following the discriminatory act.
- You must file employment discrimination claims under the ADA with the U.S. Equal Opportunity Employment Commission (EEOC). You may not file a lawsuit first or instead of filing with the EEOC.

If your complaint is upheld, the persons or organizations that discriminated against you may be required to correct their actions and policies, compensate you, or give you other relief.

Here is contact information for the key Federal agencies that accept complaints alleging disability-based discrimination:

Employment: U.S. Equal Employment Opportunity Commission: (EEOC). Call (800) 669-4000 (voice) or (800) 669-6820 (TTY) or visit <http://eeoc.gov/facts/howtofil.html>.

Medical leave rights (FMLA): U.S. Department of Labor, Wage and Hour Division. Call (866) 487-9243 (voice) or (877) 889-5627 (TTY) or visit <http://www.dol.gov/esa/whd/fmla/>.

Job training and related services provided through the One-Stop Career Center system (WIA): either the State or local Equal Opportunity Officer (contact information should be available through the program or service involved), or the U.S. Department of Labor Civil Rights Center (CRC). To reach CRC, call (202) 693-6500 (voice) or the toll-free Federal Information Relay Service at (800) 877-8339 (TTY) or visit <http://www.dol.gov/oasam/programs/crc/complaint.htm>.

Housing: U. S. Department of Housing and Urban Development (HUD), Office of Fair Housing and Equal Opportunity. Call (800) 669-9777 (or local office for TTY service) or visit <http://www.hud.gov/complaints/housediscrim.cfm>.

Public accommodations: U.S. Department of Justice (DOJ). Call (800) 514-0301 (voice) or (800) 514-0383 (TTY) or visit www.usdoj.gov/crt/ada/t3compfm.htm.

Government services, programs, and activities: Contact the Federal agency that gives financial assistance to, provides, or regulates the program or activity. You can look up how to contact the agency in your local phone book or public library, or look for the agency's Web site online.

Know
your
Rights

§ 35.131 Illegal use of drugs*(a) General.*

- (1) Except as provided in paragraph (b) of this section, this part does not prohibit discrimination against an individual based on that individual's current illegal use of drugs.
- (2) A public entity shall not discriminate on the basis of illegal use of drugs against an individual who is not engaging in current illegal use of drugs and who—
 - (i) Has successfully completed a supervised drug rehabilitation program or has otherwise been rehabilitated successfully;
 - (ii) Is participating in a supervised rehabilitation program; or
 - (iii) Is erroneously regarded as engaging in such use.

(b) Health and drug rehabilitation services.

- (1) A public entity shall not deny health services, or services provided in connection with drug rehabilitation, to an individual on the basis of that individual's current illegal use of drugs, if the individual is otherwise entitled to such services.
- (2) A drug rehabilitation or treatment program may deny participation to individuals who engage in illegal use of drugs while they are in the program.

(c) Drug testing.

- (1) This part does not prohibit a public entity from adopting or administering reasonable policies or procedures, including but not limited to drug testing, designed to ensure that an individual who formerly engaged in the illegal use of drugs is not now engaging in current illegal use of drugs.
- (2) Nothing in paragraph (c) of this section shall be construed to encourage, prohibit, restrict, or authorize the conduct of testing for the illegal use of drugs.

§ 35.132 Smoking

[Previous Page](#)

[Next Page](#)

CHAPTER 189
FORMERLY
HOUSE BILL NO. 42
AS AMENDED BY

HOUSE AMENDMENT NO. 2

AN ACT TO AMEND TITLE 14 OF THE DELAWARE CODE RELATING TO THE POWERS AND DUTIES OF THE DEPARTMENT OF EDUCATION.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF DELAWARE:

Section 1. Amend Title 14, Chapter 1, §122(b) by adding a new subsection to read as follows:

"(24) Establishing, for purposes of student discipline, uniform definitions for student conduct which may result in alternative placement or expulsion, uniform due process procedures for alternative placement meetings and expulsion hearings, and uniform procedures for processing Attorney General's reports. Such regulations shall apply to all districts and charter schools. This subsection shall not be interpreted to restrict the ability of district and charter schools to determine which student conduct shall result in expulsion or an alternative placement."

Approved August 22, 2011



149th GENERAL ASSEMBLY
FISCAL NOTE

BILL: SENATE BILL NO. 49
SPONSOR: Senator Townsend
DESCRIPTION: AN ACT TO AMEND TITLE 6 OF THE DELAWARE CODE RELATING TO HOMELESS PERSONS.

Assumptions:

1. This Bill would become effective 90 days after its enactment.
2. This Bill creates a "Homeless Individuals Bill of Rights", providing for the protection for individuals experiencing homelessness from discrimination while in public places, while seeking access to housing, employment, or temporary shelter.
3. This Bill empowers the State Division of Human Relations and the State Human Relations Commission authority to investigate and enforce the Bill of Rights.
4. The Division estimates a one-time fiscal impact of \$26,000 for a Contract attorney (equivalent to a State Deputy Attorney General III position whose average salary and benefits total \$52 per hour) for 500 hours, to assist in drafting regulations related to the Bill of Rights and \$3,000 in ongoing training and educational costs for Human Relations Representatives on the new law.

Cost:

| | |
|------------------|---------------------|
| Fiscal Year 2017 | \$26,000 (one-time) |
| Fiscal Year 2018 | \$3,000 |
| Fiscal Year 2019 | \$3,000 |

Prepared by Art Jenkins
Office of the Controller General

Homeless Bill of Rights

From Wikipedia, the free encyclopedia

The **Homeless Bill of Rights** (also **Homeless Person's Bill of Rights** and **Acts of Living bill**) refers to legislation protecting the civil and human rights of homeless people. These laws affirm that homeless people have equal rights to medical care, free speech, free movement, voting, opportunities for employment, and privacy. Legislation of this type has become law in Rhode Island, Connecticut and Illinois and is under consideration by several other U.S. states.

Contents

- 1 Controversy over Legislation Affecting the Homeless
- 2 Legislation in the United States
 - 2.1 Rhode Island
 - 2.2 Connecticut
 - 2.3 Illinois
 - 2.4 California
- 3 See also
- 4 References
- 5 External links

Controversy over Legislation Affecting the Homeless

At issue in homeless bills of rights are local codes that outlaw loitering, vagrancy, sitting or lying on the sidewalk, begging, eating in public, and other behaviors. These codes disproportionately affect homeless people.^[1]

The National Law Center on Homelessness and Poverty concludes its report on the "criminalization of homelessness" with an exhortation to change the laws:^[1]

Laws that criminalize visible homelessness are immoral and offend our basic human instincts. They are contrary to the fundamental religious and political principals from which the American people seek guidance, and their existence demonstrates that we have fallen vastly short of our religious and foundational aspirations.

Business interests, represented by the California Chamber of Commerce, have called Assemblymember Tom Ammiano's Homeless Person's Bill of Rights^[2] a "job killer" which would create "costly and unreasonable mandates on employers."^{[3][4]} Some municipalities and local politicians also oppose the laws, which impose state authority to overturn local regulations. San Francisco Supervisor Scott Wiener commented:^[5]

Our local laws against forming encampments, passing out and blocking sidewalks, and otherwise monopolizing public spaces would be wiped off the books. Think we have a street behavior problem now? Just wait until this passes.

The *Los Angeles Times* suggested in an editorial that the Homeless Bill of Rights does not go far enough unless accompanied by economic resources allocated to provide housing.^[6] Joel John Roberts, CEO of People Assisting the Homeless, argued similarly that the Homeless Bill of Rights may be toothless and even enabling. Roberts writes:^[7]

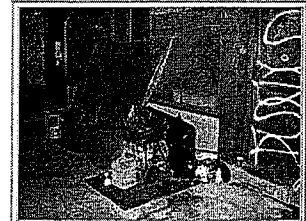
There needs to be a balance between criminalizing homelessness with ordinances that persecute people who are forced to live on the street, and giving those same people the right to do whatever they want without any consequences.... A more powerful Bill of Rights for people who are homeless, however, would consist of one simple right: the right to housing.

Legislation in the United States

The idea of a "Homeless Bill of Rights" has been discussed periodically in the U.S., and was presented formally by a group of New York City ministers on Martin Luther King, Jr. Day, 1992.^[8] City Councilperson Peter Vallone introduced several versions of such a Bill in 1998, despite strong opposition from Mayor Rudy Giuliani.^[9]

Puerto Rico and some states have passed laws adding homeless people to their lists of groups protected against hate crimes.^[10]

Rhode Island



Homeless Bill of Rights laws affirm that people living on the street have a reasonable expectation of privacy in their property.



The "Beds Not Bars" slogan suggests that society must help homeless people instead of outlawing their behavior.



Skid Row in Los Angeles is sometimes mentioned as an area that would deteriorate if homelessness was not regulated

Rhode Island was the first state in the U.S. to pass a "Homeless Bill of Rights". John Joyce, who was homeless for a period in his life, is responsible for the initial introduction of the bill. The Rhode Island law, S-2052, was ratified in the state of Rhode Island on June 21, 2012 and signed into law by Governor Lincoln Chafee on June 27.^[11] It amends the Rhode Island Fair Housing Act with wording intended to protect the rights of homeless people and prevent discrimination against them. It is the first U.S. state-level law designed to protect the rights of homeless people.

Excerpt from Rhode Island bill S-2052

- 34-37.1-3. Bill of Rights. – No person's rights, privileges, or access to public services may be denied or abridged solely because he or she is homeless. Such a person shall be granted the same rights and privileges as any other resident of this state. A person experiencing homelessness:
 1. Has the right to use and move freely in public spaces, including, but not limited to, public sidewalks, public parks, public transportation and public buildings, in the same manner as any other person, and without discrimination on the basis of his or her housing status;
 2. Has the right to equal treatment by all state and municipal agencies, without discrimination on the basis of housing status;
 3. Has the right not to face discrimination while seeking or maintaining employment due to his or her lack of permanent mailing address, or his or her mailing address being that of a shelter or social service provider;
 4. Has the right to emergency medical care free from discrimination based on his or her housing status;
 5. Has the right to vote, register to vote, and receive documentation necessary to prove identity for voting without discrimination due to his or her housing status;
 6. Has the right to protection from disclosure of his or her records and information provided to homeless shelters and service providers to state, municipal and private entities without appropriate legal authority; and the right to confidentiality of personal records and information in accordance with all limitations on disclosure established by the Federal Homeless Management Information Systems, the Federal Health Insurance Portability and Accountability Act, and the Federal Violence Against Women Act; and
 7. Has the right to a reasonable expectation of privacy in his or her personal property to the same extent as personal property in a permanent residence.

The well-established Rhode Island Coalition for the Homeless (and a newer subgroup called Rhode Island Homeless Advocacy Project) collaborated with the more radical Occupy Providence group to lobby successfully for the Bill.^{[12][13]}

The law does not guarantee positive rights such as housing or food, and some homeless advocates are concerned that it has not had enough impact.^[14]

Connecticut

On June 5, the Connecticut Assembly passed a Homeless Bill of Rights (SB 896) with seven protections similar to those passed in Rhode Island. Pending signature by Governor Dan Malloy, the bill would take effect on October 1, 2013. The Connecticut law significantly includes freedom from police harassment in its first section.^[15]

Excerpt from Connecticut bill SB 896

(a) There is created a Homeless Person's Bill of Rights to guarantee that the rights, privacy and property of homeless persons are adequately safeguarded and protected under the laws of this state. The rights afforded homeless persons to ensure that their person, privacy and property are safeguarded and protected, as set forth in subsection (b) of this section, are available only insofar as they are implemented in accordance with other parts of the general statutes, state rules and regulations, federal law, the state Constitution and the United States Constitution. For purposes of this section, "homeless person" means any person who does not have a fixed or regular residence and who may live on the street or outdoors, or in a homeless shelter or another temporary residence.

(b) Each homeless person in this state has the right to:

1. Move freely in public spaces, including on public sidewalks, in public parks, on public transportation and in public buildings without harassment or intimidation from law enforcement officers in the same manner as other persons;
2. Have equal opportunities for employment;
3. Receive emergency medical care;
4. Register to vote and to vote;
5. Have personal information protected;
6. Have a reasonable expectation of privacy in his or her personal property; and
7. Receive equal treatment by state and municipal agencies.

(c) Each municipality shall conspicuously post in the usual location for municipal notices a notice entitled "HOMELESS PERSON'S BILL OF RIGHTS" that contains the text set forth in subsection (b) of this section.

Illinois

On August 22, 2013 Illinois became the second state to adopt a homeless bill of rights.^[16]

Excerpt from Illinois bill SB 1210

Section 10. Bill of Rights.

(a) No person's rights, privileges, or access to public services may be denied or abridged solely because he or she is homeless. Such a person shall be granted the same rights and privileges as any other citizen of this State. A person experiencing homelessness has the following rights:

1. the right to use and move freely in public spaces, including but not limited to public sidewalks, public parks, public transportation, and public buildings, in the same manner as any other person and without discrimination on the basis of his or her housing status;
2. the right to equal treatment by all State and municipal agencies, without discrimination on the basis of housing status;
3. the right not to face discrimination while seeking or maintaining employment due to his or her lack of permanent mailing address, or his or her mailing address being that of a shelter or social service provider;
4. the right to emergency medical care free from discrimination based on his or her housing status;

5. the right to vote, register to vote, and receive documentation necessary to prove identity for voting without discrimination due to his or her housing status;
6. the right to protection from disclosure of his or her records and information provided to homeless shelters and service providers to State, municipal, and private entities without appropriate legal authority; and the right to confidentiality of personal records and information in accordance with all limitations on disclosure established by the federal Homeless Management Information Systems, the federal Health Insurance Portability and Accountability Act, and the federal Violence Against Women Act; and
7. the right to a reasonable expectation of privacy in his or her personal property to the same extent as personal property in a permanent residence.

(b) As used in this Act, "housing status" has the same meaning as that contained in Section 1-103 of the Illinois Human Rights Act.

California

State Assemblymember Tom Ammiano (D-San Francisco) introduced a Homeless Person's Bill of Rights^[2] to the California Assembly in December 2012.^[17] In May 2013, the Appropriations Committee postponed debate until January 2014.^[5] Assemblymember Ammiano said in a statement that his bill was suspended largely because of the costs of setting up new infrastructure and enforcing the new rules.^[5] A report by the Chair of the Assembly Appropriations Committee estimates that setting up hygiene centers across the state would cost \$216 million, with ongoing operating costs of \$81 million annually.^[2] The report also estimates that setting up facilities for annual law enforcement reports would cost \$8.2 million, with ongoing operating costs of \$4.1 million annually.^[2] Without providing estimates, the report notes that other costs, some potentially significant, include those associated with the right to counsel conferred to the homeless for defending against infractions, and those associated with defending against lawsuits brought against cities by the homeless alleging violations of rights conveyed under the bill.^[2]

California's Homeless Bill of Rights(Right2Rest Act), SB 608, was introduced by Senator Carol Liu (D) in February 2015. The "Right to Rest Act," would, among other things, protect the rights of homeless people to move freely, rest, eat, perform religious observations in public space as well as protect their right to occupy a legally parked motor vehicle. Also refer to UC Berkeley's Policy Advocacy Clinic Presents: California's New Vagrancy Laws a New Report on the Growing Criminalization of Homeless People in California.

A vote was not rendered during the 2015 process in the Housing and Transportation Committee and was asked to come back for a vote in the next California legislation session with amendments in order to get the necessary votes and pass to the next house.

See also

- Bill of Rights
- Human rights in the United States
- Aggressive panhandling

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2. Assem. Bill No. 5 (2013-2014 Reg. Sess.) (http://leginfo.ca.gov/faces/billNavClient.jspx?bill_id=201320140AB5)
3. "Updated homeless 'bill of rights' passes CA legislative committee (<http://blogs.sacbee.com/capitolalert/latest/2013/04/updated-homeless-bill-of-rights-passes-committee.html>)"; *Sacramento Bee*, 23 April 2013.
4. White, Jeremy B. (April 24, 2013). "California Homeless Bill Of Rights Bill Narrows, Advances In State Assembly" (http://www.huffingtonpost.com/2013/04/homeless-bill-of-rights_n_3147926.html). *Sacramento Bee*.
5. T.J. Johnston, "State Homeless 'Bill of Rights' Put on Hold Until Next Year (<http://sfpublicpress.org/news/2013-05/state-homeless-bill-of-rights-put-on-hold-until-next-year>)"; *San Francisco Public Press*, 30 May 2013.
6. Editorial: "Homeless rights bill is wrong: There's no point in criminalizing homelessness. But a proposed 'bill of rights' is not the answer either. What the homeless really need are resources (<http://www.latimes.com/news/opinion/editorials/la-ed-homeless-bill-of-rights-20130111,0,1281934.story>)", *Los Angeles Times*, 11 January 2013.
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8. Hatchett, David. "Homeless 'Bill of Rights' to revive Dr. King's 'fading voice'", *New York Amsterdam News*, 11 January 1992; accessed via ProQuest (<http://search.proquest.com/docview/226364509>), 11 July 2013.
9. Glenn Thrus, "Vallone Plans to Beat Rudy on Homeless Rights Bill (<http://www.citylimits.org/news/articles/504/vallone-plans-to-beat-rudy-on-homeless-rights-bill#Ud7tBb8mz34>)", *City Limits*, 31 August 1998.
10. "Hate Crimes Against the Homeless: An Organizing Manual for Concerned Citizens (<http://www.nationalhomeless.org/publications/hatecr National Coalition for the Homeless>, January 2012.
11. "Hundreds celebrate signing of Homeless Bill of Rights" (<https://web.archive.org/web/20120629182824/https://www.630wpro.com/Article.asp?id=2483553&spid=38785>). WPRO. 2012-06-27. Archived from the original (<http://www.630wpro.com/Article.asp?id=2483553&spid=38785>) on 2012-06-29.
12. Robert Wengronowitz, "Lessons From Occupy Providence", *The Sociological Quarterly* 54(2), March 2013. Accessed via Wiley (<http://onlinelibrary.wiley.com/doi/10.1111/tsq.2013.3> July 2013. "OP would not have been able to negotiate the deal with the City without the decades-long effort by RICH and later RIHAP to create organizational infrastructure—for example, communication networks, development of coalitional relationships, and media contacts. In fact, RICH's infrastructure itself significantly supported the founding of RIHAP. Rhode Island became the first state to pass a Homeless Bill of Rights in late June 2012, an action less likely without RICH, RIHAP, OP, and their ability to work across differences. For instance, some RICH members were concerned that OP was "too radical," but OP was fortunate in that RICH considers seriously the concept of coalition building. Ryczek (2011, capitalization in original) defended the collaboration this way to RICH members: 'Coalitions rarely see eye to eye on each and every single factor concerning their common interests... We certainly...will not agree on all issues. Yet, where common ground and common goals DO exist it must be our role to move on such commonalities.'"
13. Mallory Moretti, "Occupy Prov. marches for homelessness: Governor allows tents on State House law (http://www.wpri.com/dpp/news/local_news/providence-march-rally-for-homelessness-affordable-housing-in-rhode-island)"; *WPRI*, 10 December 2011.
14. Jake Grovum, "Nation's 1st Homeless Bill of Rights Slow to Cause Change in Rhode Island (<http://www.governing.com/news/state/si-first-homeless-bill-of-rights.html>)", 12 November 2012.

15. Scott Keyes, "Connecticut Passes Landmark 'Homeless Person's Bill Of Rights' Law (<http://thinkprogress.org/justice/2013/06/12/2139181/homeless/?mobile=nc>)", *ThinkProgress*, 12 June 2013.
16. <http://www.chicagohomeless.org/illinois-becomes-2nd-state-to-enact-a-homeless-bill-of-rights/>
17. Kevin Fagan, "Tom Ammiano backs homeless rights bill (<http://www.sfgate.com/news/article/Tom-Ammiano-backs-homeless-rights-bill-4091599.php>)"; *San Francisco Chronicle*, 4 December 2012.

External links

- Text (<http://webserver.rilin.state.ri.us/PublicLaws/law12/law12356.htm>) of the Rhode Island bill
- Text (<http://www.ilga.gov/legislation/fulltext.asp?DocName=09500HB1878eng&GA=95&SessionId=51&DocTypeId=HB&LegID=30714&DocNum=1878&GAID=9&Session=>) of the Illinois bill
- Interview (<http://occupiedprovidencejournal.wordpress.com/tag/homeless-bill-of-rights/>) with late Rhode Island homeless advocate John Joyce

Retrieved from "https://en.wikipedia.org/w/index.php?title=Homeless_Bill_of_Rights&oldid=778863916"

Categories: Homelessness in the United States | Rhode Island law | Human rights instruments | Homelessness and law

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Ending Discrimination for Delaware's Homeless

Protecting the Rights of Our Most Vulnerable Citizens

This report brings attention to the families and individuals in Delaware experiencing homelessness, or at risk of homelessness, who face discrimination due to their housing status, source(s) of income, and/or disability status while on the streets and when seeking access to housing, employment, and temporary shelter.

Prepared by the Policy Committee on Ending Homelessness in Delaware, a Working Group of the Homeless Planning Council of Delaware

March 2013

Policy Committee on Ending Homelessness in Delaware

A Working Group of the Homeless Planning Council of Delaware

Committee Membership:

- Rachel Beatty
 - Research Assistant, University of Delaware, Center for Community Research and Service

- Lonnie Edwards
 - Chairman, Family Resource Coalition

- Rosemary Haines
 - Delaware Interagency Council on Homelessness

- Charles Johnson
 - Founder of H.A.R.P., Homeless People Are Real People Too

- Kate LeFranc
 - Head of Christiana Presbyterian Church

- Karen G. Matteson
 - Director of Strategy for Post-Secondary Education - Stand By Me (Delaware Financial Empowerment Partnership)

- Susan Starrett
 - Executive Director, Homeless Planning Council of Delaware

- DeBorah Gilbert White
 - Ph.D., Diversity and Inclusion Consultant

Table of Contents

| | | |
|------|---|----|
| ➤ | Executive Summary..... | 3 |
| I. | Homelessness | |
| | A. System Goals..... | 5 |
| | B. The Current State of Homelessness..... | 6 |
| | C. Rhode Island’s Homeless Persons’ Bill of Rights..... | 7 |
| | D. Equal Access to Temporary Shelter..... | 8 |
| | E. The Criminalization of Homelessness..... | 9 |
| II. | Housing | |
| | A. The United States and The Human Right to Housing..... | 11 |
| | B. Delaware’s Affordable Housing Crisis..... | 12 |
| | C. Fair Housing: Housing Status and Source of Income..... | 13 |
| | D. Equal Employment Opportunity..... | 15 |
| III. | Policy Recommendations..... | 17 |
| | Appendices | |
| | Appendix A: Definitions..... | 22 |
| | Appendix B: Housing Discrimination Chart..... | 23 |
| | Appendix C: Employment Discrimination Chart..... | 24 |
| | Appendix D: Criminalization Charts..... | 25 |

Ending Discrimination for Delaware's Homeless

Protecting the Rights of Our Most Vulnerable Citizens

February 2013

EXECUTIVE SUMMARY

This report aims to bring the attention of Delaware legislators to the families and individuals experiencing homelessness, or at risk of homelessness, who face discrimination due to their housing status, source of income, and disability status while on the streets and when seeking access to housing, employment, and temporary shelter.¹ In July 2012, Rhode Island passed the first Homeless Persons' Bill of Rights in the nation, providing protections for all citizens of their State regardless of their housing status.

Discriminatory practices aggravate the problem by unnecessarily prolonging experiences of homelessness and burdening the State's criminal justice, homeless services, and human services systems. As part of a comprehensive strategy to prevent and end homelessness in Delaware we must ensure that persons experiencing and at risk of homelessness receive equal treatment under the law, and have equal access to the goods and services necessary to end their homelessness.

HOMELESSNESS, DISCRIMINATION, AND CRIMINALIZATION

➤ ***DISCRIMINATION IN ACCESS TO TEMPORARY SHELTER:*** Temporary shelters in Delaware discriminate against persons due to their disability status, whether physical or psychiatric disability. Unlike other citizens in Delaware, disabled persons experiencing or at risk of homelessness are subject to overt housing discrimination by the very system meant to serve them.

POLICY RECOMMENDATIONS:



- Develop a Homeless Persons' Bill of Rights for the State of Delaware that requires all shelter providers to comply with the American Disabilities Act and Delaware's Fair Housing Act.

➤ ***CRIMINALIZATION ON THE STREET:*** Persons living on the streets are vulnerable to policies that target the homeless for performing necessary life-sustaining activities (e.g. eating, sleeping, sitting, standing) that they have no option but to perform in public places. Laws that make it illegal to do things that persons experiencing homelessness must do as a result of their homeless status criminalize homelessness. Persons experiencing homelessness are frequently treated unequally by authorities with regards to their use of public space in our communities. This criminalization of homelessness

¹ See APPENDIX A: Definitions

Ending Discrimination for Delaware's Homeless

Protecting the Rights of Our Most Vulnerable Citizens

February 2013

places unnecessary burdens on Delaware's criminal justice system. It also saddles the homeless with fines they cannot afford, and criminal records that inhibit their ability to access housing, employment, and the essential human services they need to end their homelessness.

POLICY RECOMMENDATIONS:

- Develop a Homeless Persons' Bill of Rights for the State of Delaware that ensures equal treatment under the law, equal access to and use of public space for all Delaware citizens, regardless of their housing status.
- Pursue alternative justice system strategies to criminalization such as police training, human services and police department collaborations, police department homeless liaisons, and homeless diversion or community courts.
- Review municipal and state codes, and their enforcement, to ensure that laws do not unfairly target the homeless due to their housing status.

HOUSING AND EMPLOYMENT DISCRIMINATION

➤ **FAIR HOUSING AND EQUAL EMPLOYMENT OPPORTUNITY:** Persons experiencing or at risk of homelessness are frequently denied access to housing and employment for which they would otherwise be eligible due to practices by landlords and employers that discriminate against applicants based on their housing status and/or source(s) of income. These practices aggravate the problem by denying individuals and families equal opportunities to access the housing and income they need to end their homelessness.

POLICY RECOMMENDATIONS:

- Develop a Homeless Persons' Bill of Rights for the State of Delaware that protects all individuals and families in Delaware experiencing or at risk of homelessness from discrimination based on their housing status and source of income.
- Add "housing status" and "source(s) of income" to Delaware's Fair Housing Act and Delaware's Equal Opportunity Law.

Ending Discrimination for Delaware's Homeless

Protecting the Rights of Our Most Vulnerable Citizens

February 2013

In this Bill they define the term "housing status" as "the status of having or not having a fixed or regular residence, including the status of living on the streets or in a homeless shelter or similar temporary residence."⁸

D. EQUAL ACCESS TO TEMPORARY SHELTER

The Fair Housing Amendments Act of 1988 (FHAA) prohibits discrimination in the sale or rental of housing on the basis of disability. As a result of the Olmstead settlement with the Department of Justice in July 2011, Delaware has made significant progress towards ensuring that individuals with a diagnosed psychiatric disability have access to permanent community-based housing. However, it is also necessary to ensure that psychiatrically and physically disabled persons experiencing or at risk of homelessness are protected from discrimination with regards to equal access to temporary shelter in situations of crisis. In this report, "temporary shelter" means any emergency, transitional, or temporary shelter provided to individuals and/or families experiencing homelessness by any federal, state, faith-based, non-profit, or private agency.

Eight hundred and forty-six (37%) of the adults served by Delaware's homeless services system in FY 2011 reported having a disability of long duration⁹. Approximately 10% of Delaware's homeless in 2011 were physically disabled.¹⁰ During Delaware's Registry Week in June 2012 for the 100,000 Homes Campaign, volunteers located and interviewed a total of 186 homeless individuals living on the streets in Delaware over the course of 3 mornings. Of those persons, 78% reported one or more behavioral health issue, while 40% reported a dual diagnosis of mental illness and substance abuse disorder.¹¹ In Delaware's 2012 Point in Time survey, 27% of individuals reported having a diagnosed mental illness, and 24% reported having a substance abuse problem.

Homeless individuals diagnosed with physical and psychiatric disabilities, including co-occurring disorders (recurring mental illness *and* recurring substance abuse disorder), are at greater risk of being denied access to shelter than the general homeless population in Delaware due to their disability

⁸ Rhode Island Homeless Persons' Bill of Rights, 34-37-3, 27-29

⁹ Homeless Planning Council of Delaware. (2012). Delaware HMIS FY2011 Data Report.

¹⁰ Homeless Planning Council of Delaware (2011). Point In Time Data.

¹¹ Homeless Planning Council of Delaware. (2012). Delaware Registry Week Community Brief Back Fact Sheet.

Legislation proposed on equal protection



DELAWARE LEGISLATIVE SESSION
MATTHEW ALBRIGHT

Some General Assembly members want to place protections against discrimination in the Delaware Constitution.

They want to add one sentence to the document that has been Delaware's highest law since 1897: "Equal protection under the law shall not be denied or abridged because of race, sex, age, religion, creed, color, familial status, disability, sexual orientation, gender identity or national origin."

"We would make a statement of Delaware's values that we treat everyone equally, no matter who they are," said state Sen. Karen Peterson, D-Stanton, sponsor of the bill to make the amendment.

The bill comes amid national calls to amend the U.S. Constitution to stop gender discrimination and legislation in Arkansas and Indiana that allows businesses to refuse service to gay people, citing religious reasons. The U.S. Justice Department is suing North Carolina over its law requiring transgender people to use public restrooms and showers corresponding to the gender on their birth certificate.

Delaware has created various laws aimed at banning discrimination in things like employment and housing over the past few years. Most recently, began enforcing rules barring insurance companies from charging higher rates to transgender people or denying coverage for trans-related health care.

Peterson argues there are still plenty of holes in the laws of state and local governments that could be exploited. State agencies could decide to charge more for fishing permits than men, set age limits on driver's licenses or refuse to provide certain accommodations for prisoners with disabilities, she said.

"There are a thousand other things covered by Delaware code where none of those protections exist," Peterson said. "Rather than pick them off one by

Equal

Continued from Page 1A

one, this is an umbrella."

The bill was unveiled earlier this month in the midst of a busy legislative session, so it's not clear yet how many lawmakers support the change. All 12 Democrats are listed as co-sponsors, and Peterson said at least one Republican, state Sen. Cathy Cloutier, R-Heathbrooke, asked to be added after the bill was listed. The session ends June 30.

Republican Senate Minority Leader Gary Simpson, of Milford, said he is skeptical. "I think this legislation is unnecessary since all the classes mentioned in the bill are already covered under existing law," Simpson said. "What are we gaining except election-year pandering?"

Democrats will need some Republican support because constitutional amendments require a two-thirds vote. In the Senate, for example, Democrats hold 12 of 21 seats, so they would need two Republicans.

A constitutional amendment would be both symbolically and practically powerful, said Widener Law School professor Erin Daly.

"From a general perspective, it's hugely important, because what the constitution does is embody the state's values," Daly said. "It confirms that this is a fundamental value of Delaware and

its citizens that we don't arbitrarily discriminate."

If anti-discrimination rules were placed in the constitution, Daly said, judges will be required to apply "strict scrutiny," the highest level of judicial rigor, when hearing discrimination cases. The state would have to prove an overwhelmingly important interest if it were to take any kind of action that treats one category of resident differently from another.

A constitutional amendment also would mean that laws protecting equal rights would be much harder to overturn. "Laws can be repealed. They can be narrowed. They can fail to give the full measure of protection," Daly said. "It entrenches the values we are seeking to protect."

Daly said most state constitutions have equal protection clauses, though who exactly is protected varies from state to state.

Daly and Peterson are both in a group called DelawareERAnow, dedicated to passing the federal Equal Rights Amendment, which would expand the U.S. Constitution's equal protection clause to state that women have the same rights as men.

Peterson said the idea for her Delaware amendment came when she was looking at how the equal protection clause of the Delaware Constitution stacked up to the U.S. Constitution.

"Lo and behold, Delaware doesn't have one," Peterson said. "Our thought is, we absolutely should have one."

EQUAL PROTECTION AMENDMENT

Move to ban bias stalls in Del. Senate

JAMES FISHER

THE NEWS JOURNAL

A precedent-setting amendment to the state constitution that would bar discrimination in the law based on sexual orientation, gender identity, race, sex, age and several other factors was tabled Tuesday before it could come up for a vote in the Senate.

"There were some people who thought it was moving too fast, although it was introduced a month ago," said Sen. Karen Peterson, D-Stanton, the sponsor of SB 190. "If I had taken it to a vote today, the votes would not have been there."

As constitutional amendments go, Peterson's is short, adding one sentence: "Equal protection under the law shall not be denied or abridged because of race, sex, age, religion, creed, color, familial status, disability, sexual orientation, gender identity or national origin."

See MEASURE, Page 4A

Measure

Continued from Page 1A

Sen. Ernie Lopez, R-Lewes, one of the moderate Republicans in Dover, said in a statement he'd be recorded as "not voting" on the bill if a vote was held Tuesday because the amendment's protections are already enshrined in state laws. He praised the amendment for trying to "create more of an atmosphere of equality and protection for those among us who feel most vulnerable," but said it was a "false choice" and redundant.

Peterson referenced the shooting at an Orlando gay nightclub over the weekend. "Violence against women has reached epidemic proportions and hatred and intolerance of gays and transgenders is still very much with us, as Sunday's events have shown," she said.

But Lopez, in a statement, said the Orlando shooting should have delayed a vote on SB 190. "In the wake of Orlando, there should have been a pause and time for reflection," he said.

Many states, including Delaware, have passed laws widening legal protections for gay, lesbian, bisexual and transgender people. But enshrining those nondiscriminatory norms in state constitutions requires even more votes than passing a bill does.

Thirty-one states had passed constitutional amendments banning gay marriage, but the Supreme Court's 2015 decision finding that the U.S. Constitution grants same-sex couples the right to marry invalidated those amendments.

"Much is left uncovered by legislation," said Peterson, who stunned colleagues in the Senate Tuesday when she announced she would not run for a fifth term. "I've seen bills sail through the General Assembly in less than a week. That's how fast laws can change and protections can disappear unless they're in the state constitution."

Every Senate Democrat is a sponsor of the amendment, but Democrats need some Republican allies because constitutional amendments require a two thirds vote. In the Senate, the 12 Democrats need two Republicans to support the amendment for a total of 14 favorable votes; Peterson told reporters there is currently support from "13 and a half" members.

In the 41-member House, 28 votes are necessary. And to succeed, two General Assemblies in a row will have to support the amendment by two thirds margins.

Rodney A. Smolla, dean of the Delaware Law School, testified in favor of the amendment, saying the rights people consider most crucial, like freedom of speech and freedom of religion, are locked in by constitutional definition.

"They have more presence and more resiliency" than regular statutes, Smolla said.

The Delaware Family Policy Council, which unsuccessfully fought the process that made same-sex marriage legal in Delaware, opposes the amendment. "The idea that laws should be fair to all citizens, regardless of who they are, should unite us on common ground. But SB 190 singles out specific classes to protect, while excluding others," said the group's director, Nicole Theis, in a statement. "This is not true equality."

Peterson, the state's first openly gay state lawmaker, was a leading champion of the same-sex marriage law that passed in 2013. She announced her decision not to run again after noting her wife, Vikki Bandy, was in the Senate chamber.

"I wanted her to be with me as I announce my retirement. I will not be running for re-election this year," Peterson said as several colleagues gasped in surprise. "You just know in your heart when it's time. And it's true. For me, it's time."

Sen. F. Gary Simpson, R-Milford, praised Peterson.

"Sen Peterson and I probably disagree on a few things that have come before us this year," Simpson said. "I could always count on what she said to me to be her heartfelt analysis of the issue before us and I always respected her for that."

No other candidate has filed for Peterson's seat in either party. Candidates have until July 12 to declare an intent to run. Peterson's decision puts pressure on the Democratic caucus to find a candidate who can hold the seat and not erode the Democrat's three-vote majority in the Senate.

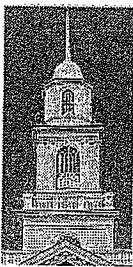
Sen. Karen Peterson, D-Stanton, tells reporters why she tabled a constitutional amendment guaranteeing equal protection on Tuesday.

JAMES FISHER/THE NEWS JOURNAL

DELAWARE

5-4-12 NJ

Doctor-assisted suicide law offered



DELAWARE LEGISLATIVE SESSION
MATTHEW ALBRIGHT

A Delaware lawmaker has proposed legislation that would allow doctors to help terminally people end their own lives.

"This is an issue about allowing adults facing a terminal illness to make critical decisions about their life," said Rep. Paul

Baumbach, D-Newark. "Many people in the last stages of life wish to retain their dignity, including the ability to make decisions regarding their life and their suffering."

Baumbach says his "Delaware End of Life Options Act" includes numerous safeguards that would prevent someone from ending their lives "haphazardly." The option would be open only to those who have been diagnosed with an incurable and irreversible disease that has been "medically confirmed" to have six months or less to live.

"This is not a life or death decision. This is a death or death decision," Baumbach said.

A person who is considering ending their life would need to be presented with all other end-of-life options, including comfort care, hospice care and pain control. They would need medical confirmation by two physicians and psychiatric/psychological counseling when indicated.

There would be two waiting periods. First, a physician would have to wait 15 days after the patient re-

quests the lethal drugs. Then, after the patient makes a request in writing, another 48 hours would have to elapse before the prescription could be written.

Baumbach proposed similar legislation in 2015, but that bill did not make it out of committee. The new bill has four co-sponsors.

The issue of physician-assisted suicide — some supporters prefer the term "death with dignity" — is an issue of national controversy. Five states have legalized the practice, but some national organizations oppose it.

AMA's code of ethics

"Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks," the American Medical Association's code of ethics says. "Euthanasia could readily be extended to incompetent patients and other vulnerable populations."

Some religious groups, like the Catholic Church, also oppose the practice.

"A choice to take one's life is a supreme contradiction of freedom, a choice to eliminate all choices," a statement from the U.S. Conference of Catholic Bishops. "And a society that devalues some people's lives, by hastening and facilitating their deaths, will ultimately lose respect for their other rights and freedoms."

Contact Matthew Albright at malbright@delawareonline.com or (302) 324-2428.

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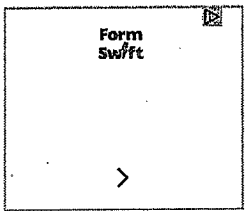
'Death With Dignity' Laws by State

125

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Watching a loved one suffer through an agonizing illness or medical condition can be very difficult, especially when it's terminal. But when all hope is lost and the patient no longer has the will to live, does she have the right to end her life

(<http://healthcare.findlaw.com/patient-rights/is-there-a-constitutional-right-to-physician-assisted-suicide.html>)? It depends. Federal law doesn't specifically protect the act of mercy killing or euthanasia (<http://dictionary.findlaw.com/definition/euthanasia.html>), nor does it prohibit the practice altogether. Instead, the right to assisted suicide (also sometimes known as 'death with dignity') is established by state law.



The vast majority of states do not allow patients to end their lives, either on their own or through the aid of a doctor. However, in 1990 the U.S. Supreme Court did rule (<http://caselaw.lp.findlaw.com/scripts/getcase.pl?court=us&vol=497&invol=261>) that patients or their designated health care agents may refuse life-preserving medical treatment, including feeding tubes. A health care agent is an individual named by the patient to make health care decisions on their behalf, usually through a durable power of attorney (<http://dictionary.findlaw.com/definition/durable-power-of-attorney.html>). Health care agents typically follow a patient's wishes laid out in a living will or "do not resuscitate" form.

So while all states allow patients to withhold treatment (<http://estate.findlaw.com/estate-planning-help/advance-directives-and-living-wills-state-specific-forms.html>), only a few states allow doctors to take an active role in assisting a patient's death. Most of these laws require the patient to:

- Be expected to die within a certain period of time
- Be a certain age
- Follow certain consent guidelines

If a patient is unable to make this request orally, they may do so through their health care agent.

The following is a breakdown of the states that allow assisted suicide or 'death with dignity':

California

Gov. Jerry Brown signed the End of Life Option Act (https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201520160SB128) into law in 2015, allowing physicians to prescribe lethal drugs to certain terminally ill patients. The law is modeled after similar laws in Oregon, Washington, and Vermont. Patients who are expected to die

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(<http://healthcare.findlaw.com/patient-rights/planning-long-term-care.html>)

within the next six months, provide informed consent, have a medically confirmed diagnosis, and who request assistance three times may obtain a prescription for lethal drugs.

- *How it was Legalized:* Legislature
- *Number of Months Until Expected Death:* 6
- *Minimum Age:* 18
- *Number of Doctor Requests:* 2 oral (at least 15 days apart); 1 written

Montana

The Montana Supreme Court issued a ruling in late 2009 (http://www.patientsrightscouncil.org/site/wp-content/uploads/2011/03/Montana_Opinion_12_31_09.pdf) that broadened the state's Rights of the Terminally Ill Act (<http://codes.lp.findlaw.com/mtcode/50/9>) to include physician-assisted suicide. However, Montana statute does not provide a regulatory framework for doctor-assisted suicide. Instead, the ruling shields doctors from prosecution as long as they have the patient's request in writing. Several attempts to pass euthanasia-related bills, which would establish rules and procedures for assisted suicide, were made since the ruling, but none have passed.

- *How it was Legalized:* Montana Supreme Court decision
- *No additional regulations on assisted suicide*

New Mexico

Although New Mexico's statutes continue to list assisted suicide as a fourth-degree felony, the practice was made legal through the courts in early 2014. The 2nd District Court in Albuquerque ruled that New Mexico doctors may legally prescribe lethal drugs to assist terminally ill people with suicide. The state's attorney general declined to challenge the ruling, letting it stand. As with Montana, the ruling provides a defense for doctors who help eligible patients die but doesn't provide a regulatory framework.

- *How it was Legalized:* 2nd District Court decision
- *No additional regulations on assisted suicide*

Note: The New Mexico Court of Appeals ruled against the 2014 decision that legalized physician-assisted suicide in September of 2015. The practice is now illegal in the state, but a challenge in the New Mexico Supreme Court is likely.

Oregon

Oregon voters passed the Death with Dignity Act (<http://public.health.oregon.gov/providerpartnerresources/evaluationresearch/deathwithdignityact/Pages/index.aspx>) in 1994 with 51 percent of the vote, which allows terminally ill patients to obtain a prescription for lethal drugs. A ballot measure attempting to repeal the law lost (with 60 percent of voters opposed) in 1997, and was upheld by the U.S. Supreme Court in 2006 (<http://caselaw.lp.findlaw.com/scripts/getcase.pl?navby=case&court=us&vol=546&page=243>). To be eligible, patients must wait 15 days after making an oral request to a doctor, and then make another oral and written request, followed by a 48-hour waiting period before medications are made available.

- *How it was Legalized:* Ballot initiative
- *Number of Months Until Expected Death:* 6
- *Minimum Age:* 18
- *Number of Doctor Requests:* 2 oral (at least 15 days apart); 1 written

Vermont

Vermont lawmakers passed the Patient Choice and Control at End of Life Act (http://healthvermont.gov/family/end_of_life_care/patient_choice.aspx) in 2013. The law protects doctors who follow the steps outlined in the Act from liability. Doctors are then able to prescribe lethal drugs to terminally ill patients. The state also requires patients to make two separate oral requests -- plus one in

writing -- separated by a 15-day waiting period before doctors are allowed to prescribe lethal drugs. The initial diagnosis must be certified by a consulting physician and the patient must be of sound mind.

- *How it was Legalized:* Legislation
- *Number of Months Until Expected Death:* 6
- *Minimum Age:* 18
- *Number of Doctor Requests:* 2 oral (at least 15 days apart); 1 written

Washington

Voters approved the Washington Death with Dignity Act (<http://www.doh.wa.gov/YouandYourFamily/IllnessandDisease/DeathwithDignityAct>) in 2008 with 58 percent of the vote. The law permits eligible patients with a terminal illness to request lethal drugs to end their lives. Individual hospitals may prohibit participation in euthanasia, but must clearly state their policy. Washington law is very similar to assisted suicide laws in Oregon and Vermont. The statute requires a series of requests and waiting periods, while requiring the patient to be of sound mind and capable of clear communication.

- *How it was Legalized:* Ballot initiative
- *Number of Months Until Expected Death:* 6
- *Minimum Age:* 18
- *Number of Doctor Requests:* 2 oral (at least 15 days apart); 1 written

This is an emerging area of the law and only a handful of states permit physician-assisted suicide. If you have additional legal questions about this issue, including euthanasia and advanced directives, contact a [health care attorney](http://lawyers.findlaw.com/lawyer/practice/health-health-care-law) (<http://lawyers.findlaw.com/lawyer/practice/health-health-care-law>) in your state.

125

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104

Next Steps

Contact a qualified health care attorney to help navigate legal issues around your health care.

(<http://lawyers.findlaw.com/lawyer/state.jsp>) (e.g., Chicago, IL or 60611)

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Death With Dignity Wins and Loses in Several States

A push for doctor-assisted “death with dignity” has begun in several state legislatures, as well as the District of Columbia.

NEWS ([/CATEGORY/NEWS](#))

MELISSA BROWN ([HTTPS://REFINEDRIGHT.COM/AUTHOR/MELISSA_BROWN/](https://refinedright.com/author/melissa_brown/)) • MONDAY, MARCH 6, 2017 ([HTTPS://REFINEDRIGHT.COM/2017/03/NEWS/DEATH-DIGNITY-WINS-LOSES-SEVERAL-STATES/](https://refinedright.com/2017/03/news/death-dignity-wins-loses-several-states/))

All across the country, three words are creating a buzz that is changing the conversation on end-of-life options: Death with Dignity.

According to the 501(c)4 that shares the same name as the [term](https://www.deathwithdignity.org/terminology/) (<https://www.deathwithdignity.org/terminology/>), it is a law allowing “mentally competent, terminally ill adults to request a prescription medication from their physician for the purpose of hastening their death.” It is completely voluntary and can only happen

if the person choosing (https://refinedright.com). These requirements include (https://www.deathwithdignity.org/learn/access/) being a legal adult, having mental competency, and being a resident of a state where death with dignity is legal. Two additional, and major requirements include being diagnosed with a terminal illness with less than six months to live, and be able to administer the prescription yourself.

Several states are currently debating on whether or not to make this an option for terminally ill adults.

In Hawaii (<http://www.hawaiinewsnow.com/story/34516905/death-with-dignity-bill-advances-in-state-legislature>), Senate Bill 1129 advanced out of the Senate Consumer Protection and Health Committee in February and is being referred to the Senate Committee on Judiciary and Labor. Three hundred people signed up to testify on the bill.

Minnesota State Senator Chris Eaton and Representative Mike Freibert introduced (<http://www.kare11.com/news/renewed-push-to-legalize-medically-assisted-death/417340892>) the End-of-Life Options Act of 2017 in both legislative chambers. The representatives do not expect the acts to get hearings in the Republican controlled legislature, but they want to continue the conversation on this issue.

Terminally ill residents (<http://www.washingtontimes.com/news/2017/feb/18/dc-physician-assisted-suicide-law-goes-effect/>) of Washington, D.C. are now able to choose death with dignity after Congressional Republican efforts to block the legislation failed. The legislation was signed into law by D.C. mayor Muriel Bowser last December.

Maryland legislators withdrew (<http://www.baltimoresun.com/news/maryland/politics/bs-md-aid-in-dying-withdrawn-20170303-story.html>) legislation for an end-of-life option act last week. The two Democratic sponsors claimed that the cross-filed bills wouldn't have enough support to pass in either chambers of the General Assembly.

Currently, six states and the District of Columbia have death with dignity laws. Twenty-four states are currently debating legislation on whether or not to enact death with dignity laws. Opponents of death with dignity claim (<http://notdeadyet.org/assisted-suicide-talking-points>) that these laws could lead to abuse of the elderly and disabled through coercion. Supporters believe (<https://www.compassionandchoices.org/who-we-are/>) that this legislation will give people more control over their lives, and possibly comfort, when they enter the final stages of their life.



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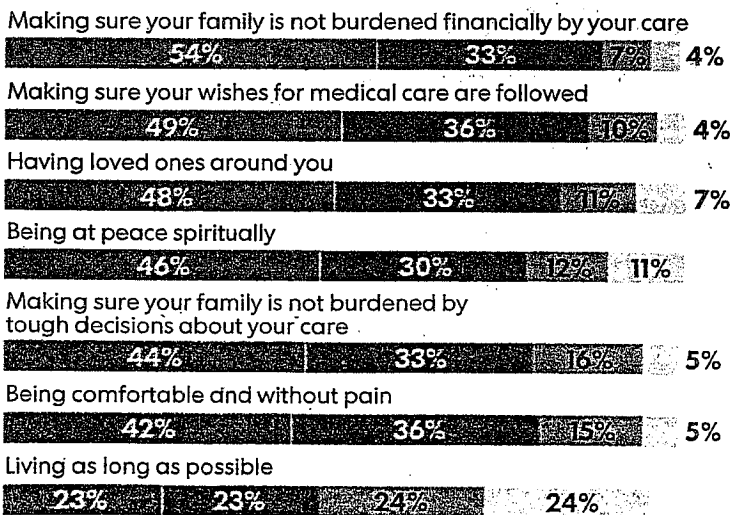
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SURVEY: WHAT'S IMPORTANT AT DEATH?

The Kaiser Family Foundation did a survey in 2016 asking about end-of-life medical care. Here is the response to one question:

Thinking about your own death, how important is each of the following to you?:

Extremely important
 Very important
 Somewhat important
 Not too important



NOTE Not applicable and not sure/no answer responses are not shown
SOURCE Kaiser Family Foundation/The Economist Four-Country Survey of Aging and End of Life Medical Care (conducted March 30-May 29, 2016)

JANET LOEHRKE, USA TODAY

and communicating your values to your loved ones is a good step toward making certain your quality of life requirements are followed by your health care surrogate," McClanahan says.

A DIFFICULT TASK

Opening an end-of-life conversation is not easy, says Bob Maurerstock, author of *Passing the Torch, Critical Conversations with Your Adult Children*.

Others agree.

"As a society, we are reticent to have these conversations," says Jim McCabe, president of Elder-care Resources. "What's more, don't be surprised if you're adult children don't want to discuss the topic. I have had elderly clients who wanted to talk about end of life, but it was the adult children who resisted."

FIND THE RIGHT DOCTOR

There are three kinds of doctors — paternalistic, informational and collaborative — according to Atul Gawande, author of *Being Mortal*. "The best doctor is collaborative," McClanahan says. "They take the time to understand your values and goals to help you make the choices that are right for you."

Unfortunately, there are so few of these doctors now, she says. Most doctors are informational, according to McClanahan. Given that, she provides her clients with a form to give their health care surrogate that outlines their quality of life measures.

"So, when a doctor says, 'We can do surgery, put in a feeding tube, provide antibiotics and the like' the health care surrogate says, 'Will this allow my ... to regain her ability to communicate' or whatever it is that is important?" McClanahan asks. "If the doctor says no, the surrogate does not allow the doctor to move forward and requests palliative care."

According to McCabe, end-of-life treatments such as hospice and palliative care face a good number of myths about what they do and how they operate.

"For instance, many folks don't know that they can get hospice at home," he says. "They think that they need to go to a nursing home for treatment so will not have that conversation."

Powell is editor of *Retirement Weekly* and contributes regularly to *USA TODAY*, *The Wall Street Journal*, *TheStreet* and *MarketWatch*. Email rpowell@allthingsretirement.com.

5-21-17 USA Today

Polling on Voter Support for Medical Aid in Dying for Terminally Ill Adults

National Polling

LifeWay Research online survey, Sept. 27-Oct. 1, 2016¹

- » Two thirds of Americans (67%) agree that: "When a person is facing a painful terminal disease, it is morally acceptable to ask for a physician's aid in taking his or her own life."
- » Majority support included most faith groups, including Christians (59%), Catholics (70%), Protestants (53%), those of other religions (70%) and those who identify as non-religious (84%)
- » Majority support included Americans with some college education (71%) or with graduate degrees (73%) and with high school diplomas or less (61%), Americans age 18 to 24 (77%), 35 to 44 (63%) and 55 to 64 (64%), White Americans (71%) and Hispanic Americans (69%), In addition, more than half of Black, Non-Hispanics (53%) agreed that: "Physicians should be allowed to assist terminally ill patients in ending their life."

Gallup's Poll Social Series: Values and Beliefs, May 2016²

- » Nearly 7 of out 10 Americans (69%) said they agreed that: "When a person has a disease that cannot be cured...doctors should be allowed by law to end the patient's life by some painless means if the patient and his or her family request it."
- » Gallup concluded: "Bottom Line...California, often a bellwether for change throughout the U.S., may persuade other states to consider passing legislation permitting physicians to allow terminally ill people to end their lives."

The American public consistently supports medical aid in dying by large majorities in both independent national and state surveys. Polling outlets such as Gallup and Harris both report strong support for medical aid in dying. Similarly, state-by-state polling also indicates majority support across demographic groups.

Gallup's Values and Beliefs Survey, May 2015³

- » Nearly 7 in 10 Americans (68%) agreed that "Individuals who are terminally ill, in great pain and who have no chance for recovery have the right to choose to end their own life."
- » Gallup noted that support "has risen nearly 20 points in the last two years and stands at the highest level in more than a decade," and support among young adults aged 18 to 34 "climbed 19 points this year, to 81%."

Medscape Poll, December 2016⁴

- » This online survey of more than 7500 physicians from more than 25 specialties demonstrated a significant increase in support for medical aid in dying from 2010. Today well over half (57%) of the physicians surveyed endorse the idea of medical aid in dying, agreeing that "Physician assisted death should be allowed for terminally ill patients."

Medscape Poll, December 2014⁵

- » This online survey of 17,000 U.S. doctors representing 28 medical specialties demonstrated that physicians agreed by a 23-percent margin (54% vs. 31%) that: "I believe terminal illnesses such as

metastatic cancers or degenerative neurological diseases rob a human of his/her dignity. Provided there is no shred of doubt that the disease is incurable and terminal, I would support a patient's decision to end their life, and I would also wish the same option was available in my case should the need arise."

- » The previous Medscape survey on this issue in 2010 showed physicians support medical aid in dying by a 5-percent margin (46% vs. 41%)

Harris Poll, November 2014⁶

- » Three out of 4 Americans (74%) polled after Brittany Maynard utilized Oregon's Death With Dignity Act agreed that: "Individuals who are terminally ill, in great pain and who have no chance for recovery, have the right to choose to end their own life."
- » Only 14 percent disagreed with this position.
- » Support for this position cut across all generations and educational groups, both genders, and even political affiliation: millennials (75%), Gen X (76%), baby boomers (74%), matures (68%), high school (75%), some college (74%), college grad (72%), post grad (76%), Rep. (64%), Dem. (78%), ind. (78%).

Gallup Survey, May 2014⁷

- » Nearly 7 out of 10 Americans (69%) think that doctors should be allowed by law to end the life of a patient who has a disease that cannot be cured "by some painless means if the patient and his or her family request it."

Pew Research Poll, November 2013⁸

- » Two out of 3 Americans (66%) "say there are at least some situations in which a patient should be allowed to die" and "the share saying they would stop their treatments so they could die has remained about the same over the past 23 years."

State Polling

Arizona Polling

Behavior Research Center's Rocky Mountain Poll, November 2015⁹

- » By a 25-point margin (56% vs. 31%), adult heads of households surveyed in Arizona support a "proposed law that would allow terminally ill persons to end their own lives provided that two doctors certify that the person is terminally ill and is mentally competent. The new law would also require that the ill person administer the lethal drug themselves orally or via injection. In this way the patient would be in total control of their end of life decision."
- » Adults in the 55-and-over age bracket support the legislation by more than 2-to-1 (63% vs. 25%). Younger respondents favored the plan by smaller margins.

California Polling

Journal of Palliative Medicine online survey, July-Oct. 2015: Multi-Ethnic Attitudes Toward Physician-Assisted Death in California and Hawaii¹⁰

- » "Majority of study participants in California (72.5%) were supportive of PAD [physician-assisted death]."
- » "...all ethnic groups were equally supportive of PAD."
- » "Even in the subgroups least supportive of PAD, the majority supports PAD."
- » "In California, 75.6% of non-Hispanic whites, 74.3% of Asians, and 71.6% of Hispanics were in support of PAD compared to 59.6% of African Americans."
- » "Within Asian Americans, Chinese were most favorably disposed toward PAD (82.7% in California), followed by Japanese (74.6% in California) and the Filipino Americans (67.7% in California)."

- » "It is remarkable that in both states, even participants who were deeply spiritual, a majority of 52%, were still in support of PAD."
- » "The effects of gender and ethnicity did not reach statistical significance in terms of attitudes toward PAD."

Field Poll, September-October 2015¹¹

- » Two out of 3 California voters (65%) say they support "a bill [End of Life Option Act] that allows California residents who are terminally ill and declared mentally competent, and who have been evaluated by two physicians and have submitted written requests to receive a lethal prescription, which they themselves would administer to end their own lives."
- » Support for the legislation includes both Democrats and no-party-preference registrants (70%), Republicans (55%), male voters (67%), female voters (64%), "majorities of voters across all age and racial/ethnic voter segments, and spans all religious subgroups," including Protestants (58%) and Catholics (55%).
- » The survey found 71 percent of voters in favor of granting incurably ill patients this right [to medical aid in dying], "very similar to levels of support found in each of five previous polls dating back to 1995."

Institute of Governmental Studies, University of California, Berkeley, August 2015¹²

- » Three out of 4 Californians (76%) support "a bill under consideration before the California State Legislature [that] would allow terminally ill people to be able to voluntarily end their own lives by taking drugs prescribed by a physician."
- » This support includes 82 percent of Democrats, 79 percent of independents and 67 percent of Republicans.

- » Support was at least 75 percent among whites, Latinos and Asian Americans, and 52.3 percent among African Americans.
- » Support levels of at least 69 percent were registered across all other demographic categories, from gender to educational, income and age levels.

Goodwin Simon Strategic Research & Probolsky Research Poll, June 2015¹³

- » By a 49-point margin, California voters (69% vs. 20%) support "the End-of-Life Option Act [that] would allow a terminally ill adult who is mentally competent the option to request and receive aid-in-dying medication from a physician."
- » Support was significant among every voter subgroup, including: Catholics (60%), non-evangelical Protestants (65%), evangelical Christians (57%), whites (69%), African-Americans (67%), Latinos (70%), Asian-Pacific Islanders (69%), men (70%), women (67%), younger voters (69% ages 18-54), older voters (68% ages 55+), Democrats (73%), independents (80%) and Republicans (55%), particularly Republicans over the age of 55 (58%).

Goodwin Simon Strategic Research Poll, July 2014¹⁴

- » By nearly a 3-1 margin (64% vs. 24%), California voters support "giving a terminally ill person, who is mentally competent, the right to request and receive a prescription for life-ending medication from a physician."

Colorado Polling

Colorado Presidential Election, November 8, 2016¹⁵

- » By a 30-point margin (65% vs. 35%), Colorado voters approved the medical aid-in-dying ballot initiative, Prop. 106
- » Voters across a broad demographic range supported Prop 106, according to exit polling con-

ducted for the Associated Press and television networks in Colorado.

- » Both men and women, Hispanics and whites, people with and without college degrees said they backed the proposal.
- » Prop 106 received more Yes votes than any other measure or candidate on the Colorado ballot.

Colorado Mesa University, Rocky Mountain PBS, and Franklin & Marshall College, Sept. 14-18, 2016¹⁶

- » Seven out of 10 Colorado voters (70%) either "strongly favor" (46%) or "somewhat favor" (24%) medical aid in dying ballot initiative, Prop. 106, vs. only 22 percent who oppose it.

Colorado Medical Society Member Survey, February 2016¹⁷

- » Overall, 56% of CMS members are in favor of "physician-assisted suicide, where adults in Colorado could obtain and use prescriptions from their physicians for self-administered, lethal doses of medications,"
- » 31% "strongly" supported this end of life care option.

Talmey-Drake Research and Strategy Inc. omnibus poll, Jan. 2016¹⁸

- » By a 40 percent margin (65% vs. 24%), Colorado voters said they support legislation to allow "those who are terminally ill a reliable and peaceful way to end their lives if and when they want to" by self-administering aid-in-dying "medications prescribed by a doctor.

Strategies 360 Poll, May 2014¹⁹

- » By a 34 percent margin (62% vs. 28%), Colorado voters support "mentally competent, terminally ill patients with less than six months to live be able to end their life using prescription medications they can self-administer."

- » This majority support includes: 76% of Democrats, 68% of unaffiliated voters, 50% of Republican primary voters, 68% of millennial voters (18-34 years-old), 56% of seniors (65+ years old), 55% of Christians, and 52% of Catholics.

Connecticut Polling

Quinnipiac University Poll, March 2015²⁰

- » By more than a 2-1 margin (63% vs. 31%), Connecticut voters support "allowing doctors to legally prescribe lethal drugs to help terminally ill patients end their own lives."
- » All party, age and gender groups support the idea, including voters over 55 years old, who support it 59 percent to 34 percent.

Quinnipiac University Poll, March 2014²¹

- » By nearly a 2-1 margin (61% vs. 32%), Connecticut voters support death-with-dignity legislation "allowing doctors to legally prescribe lethal drugs to help terminally ill patients end their own lives" (see question 49).
- » The poll showed majority approval of a death-with-dignity bill among Republicans (51%), Democrats (66%), independents (63%), men (63%), women (58%) and all age groups (18-29: 63%, 30-49: 65%, 50-64: 62%, 65+: 54%).
- » A majority of these same groups (except Republicans and 30-39 year olds) also agreed that if death-with-dignity legislation "became law in Connecticut, and [they] were diagnosed with a terminal illness and had less than 6 months to live and were living in severe pain ... [they] would probably ask a doctor to help [them] end [their] life" (see question 51a).

Purple Insights Poll, February 2014²²

- » Two out of 3 Connecticut voters (66%) support a proposal to allow "mentally competent, terminally ill patients with less than six months to live be

able to end their life in a humane and dignified manner, using prescription medications they can self-administer."

- » This majority support holds across all age groups (<50: 73%, 50-64: 64%, 65+: 62%), among Catholics (61%), Republicans (59%) and disabled voters (65%).

Momentum Analysis Survey, June 2012²³

- » Two out of 3 Connecticut voters (67%) favor allowing "mentally competent, terminally ill patients with less than six months to live to be able to end their life in a humane and dignified manner, using prescription medications they can self-administer."

Hawai'i Polling

Anthology Marketing Group (formerly QMark Research) survey, Nov. 2016²⁴

- » Eight out of 10 Hawaii voters (80%) agreed that "a mentally capable adult [who] is dying of a terminal disease that cannot be cured...definitely (55%) or probably (25%) should have the legal option to request prescription medicine from their doctor, and use that medication to end their suffering in their final stages of dying."
- » Only 12 percent of survey respondents were opposed to this legal option and 8 percent were unsure.
- » A majority of Catholics (82%) and those associated with the Christian Fellowship (83%) said terminally ill adults definitely or probably should have this legal option.

Journal of Palliative Medicine online survey, July-Oct. 2015: Multi-Ethnic Attitudes Toward Physician-Assisted Death in California and Hawaii²⁵

- » "Majority of study participants in California (72.5%) were supportive of PAD [physician-assisted death]."

- » "...all ethnic groups were equally supportive of PAD."

- » "Even in the subgroups least supportive of PAD, the majority supports PAD."

- » "In California, 75.6% of non-Hispanic whites, 74.3% of Asians, and 71.6% of Hispanics were in support of PAD compared to 59.6% of African Americans."

- » "Within Asian Americans, Chinese were most favorably disposed toward PAD (82.7% in California), followed by Japanese (74.6% in California) and the Filipino Americans (67.7% in California)."

- » "It is remarkable that in both states, even participants who were deeply spiritual, a majority of 52%, were still in support of PAD."

- » "The effects of gender and ethnicity did not reach statistical significance in terms of attitudes toward PAD."

Qmark Research Survey, January 2012²⁶

- » Three out of 4 Hawai'i doctors (76%) support "allowing a mentally competent adult, who is dying of a terminal disease, the choice to request and receive medication from his/her physician to bring about their own peaceful death, if there were appropriate safeguards in place to protect against abuse."

Maryland Polling

Maryland State Medical Society (MedChi) survey, June-July 2016²⁷

- » Six out of 10 Maryland physicians (60%) supported changing the Maryland State Medical Society's position on Maryland's 2016 aid-in-dying legislation from opposing the bill to supporting it (47%) or adopting a neutral stance (13%).

- » Among the physicians surveyed who were current members of the Maryland State Medical Society,

65 percent supported changing the organization's position to supporting the aid in dying bill (50.2%) or adopting a neutral stance (14.6%).

Momentum Analysis poll, Feb. 2016²⁸

- » Nearly two out of three Maryland voters (65%) said they "support allowing a mentally capable adult, who is dying of a terminal disease with no hope of recovery, the option to ask for medication to bring about their own death"
- » Support for medical aid in dying included a majority of African-Americans (59%), Republicans (56%), Catholics (53%), and a plurality of voters who attend religious services weekly (46%).
- » A majority (54%) also said they would "want a legal option to end my own life," including a majority of Catholics (50%), nearly half of conservatives (48%), a plurality of seniors (47%), and about 4 in 10 frequent service-goers (39%).

Goucher Poll, February 2015²⁹

- » By a 60 to 35 percent margin, Maryland residents support death-with-dignity legislation that would allow mentally competent, terminally ill patients with less than six months to live to obtain a prescription for a fatal dose of drugs that they could self-administer.

Massachusetts Polling

Purple Insights Survey, February 2014³⁰

- » Seven out of 10 Massachusetts voters (71%) support a proposal to allow "mentally competent, terminally ill patients with less than six months to live be able to end their life in a humane and dignified manner, using prescription medications they can self-administer."
- » This majority total support holds across all age groups (<50: 73%, 50-64: 73%, 65+: 67%), among Catholics (64%), Republicans (61%) and disabled voters (74%).

Momentum Analysis Survey, May 2012³¹

- » Seven out of 10 Massachusetts voters (70%) favor allowing "mentally competent, terminally ill patients with less than six months to live to be able to end their life in a humane and dignified manner, using prescription medications they can self-administer."

Minnesota Polling

Minnesota State Senate Fair Poll, August.-September 2016³²

- » By more than a 3-1 ratio (68% vs. 22%), Minnesotans who completed the state Senate's questionnaire at the annual state fair agreed that: "When a mentally competent adult is dying from an incurable and irreversible medical condition that is expected to end the individual's life within six months...this individual should be allowed to obtain from a physician a prescription for medication that may be self-administered to end that person's life."

Minnesota House of Representatives State Fair Poll, August.-September 2016³³

- » By nearly a 3-1 ratio, (67% vs. 23%), Minnesotans who completed the state House of Representatives' questionnaire at the annual state fair agreed that: "When a mentally capable adult is dying from a terminal illness...this adult should be allowed to receive a prescription for life-ending medication they may self-administer."

Montana Polling

Global Strategy Group Survey, April 2013³⁴

- » Seven out of 10 Montana voters (69%) support allowing a mentally competent adult who is dying of a terminal disease and in extreme pain to choose to end his or her life in a humane and dignified way.

New Jersey Polling

Rutgers-Eagleton Poll, February 2015³⁵

- » By more than a 2-1 margin (63% to 29%), New Jersey residents support a state Legislature aid-in-dying bill that "would allow terminally ill patients to obtain a prescription to end their lives."
- » "This is not really a partisan issue in New Jersey," said Ashley Koning, manager of the Rutgers-Eagleton Poll. "Though a difficult subject for many, the issue has widespread support and acceptance here. Public opinion is mainly on the bill's side."
- » A majority of New Jerseyans of all denominations and levels of religiosity would prefer to relieve pain and discomfort, even if that meant shortening their life, including Protestants (73%), Catholics (64%) and other non-Protestant residents (59%).

Fairleigh Dickinson University's PublicMind Poll, July 2014³⁶

- » A double-digit majority of New Jersey adults (51% vs. 38%) agreed that the state legislature should pass "a bill that would allow people with fewer than six months to live to end their life with a lethal dose of prescription drugs and the assistance of a doctor."
- » The last time this question was polled, in October 2012, when the legislature considered similar legislation, 46 percent said it should pass the bill.
- » "... the consensus seems to be for personal autonomy in deciding how and when to end one's life when a terminal illness brings the end sooner rather than later," said Krista Jenkins, director of PublicMind and professor of political science at Fairleigh Dickinson University.

Purple Insights Survey, February 2014³⁷

- » Six out of 10 New Jersey voters (62%) support a proposal to allow "mentally competent, terminally ill patients with less than six months to live be

able to end their life in a humane and dignified manner, using prescription medications they can self-administer."

- » This majority total support holds across all age groups (<50: 65%, 50-64: 69%, 65+: 55%), among Catholics (57%), Republicans (58%) and disabled voters (63%).

Momentum Analysis Survey, April 2013³⁸

- » Six out of 10 New Jersey voters (63%) "favor allowing a mentally competent adult, who is dying of a terminal illness with no hope of recovery, the choice to bring about their death."

New Mexico Polling

Research & Polling Survey, April 2012³⁹

- » Two out of 3 New Mexico voters (65%) favor "allowing a mentally competent adult, who is dying of a terminal disease, with no hope of recovery, the choice to request and receive medication from his/her physician which could bring about their own death, if there were appropriate safeguards in place to protect patients against abuse..."

New York Polling

Eagle Point Strategies Survey, September 2015⁴⁰

- » Three of 4 New York voters (77%) think "when a mentally competent adult is dying from a terminal illness that cannot be cured, the adult should be allowed the option to request a prescription for life ending medication from their doctor, and decide whether and when to use that medication to end their suffering in their final stages of dying."
- » "Clear majorities extend across lines based on respondents' religious affiliation, level of education, political party enrollment, gender, age and region of the state."
- » When respondents learned more about New York's medical aid-in-dying legislation, including

opponents' arguments against it, support increased to 4 out of 5 voters (81%).

Tennessee Polling

Princeton Survey Research Associates International/Vanderbilt University, May 2015⁴¹

- » Tennessee voters agreed by a 17-point margin (55% vs. 38%) that doctors should be permitted to assist people with painful, incurable diseases to painlessly end their lives.
- » Nearly two-thirds of voters (65%) supported some sort of option for ending one's life due to health concerns.

Utah Polling

Dan Jones & Associates survey, Nov. 2015⁴²

- » Nearly six of 10 adult Utahns (58%) favor "some kind of 'right to die' law, where licensed medical personnel could help a terminally-ill, mentally-competent person die with allowed drugs if that person chooses."
- » Republicans are divided on the issue with 41% saying they favor "right-to-die" legislation and 50% opposed. Democrats and independents overwhelmingly prefer the idea with 90% of Democrats and 67% of independents supporting.
- » There was not much of a religious divide on the question: 94% of those who say they don't ascribe to any religion, self-described "not active" Latter Day Saints (LDS) Church members, 80% of Protestants, 79% of "somewhat active" Mormons, and 76% of Catholics favored the idea.
- » The only religious group opposed to the idea were "very active" LDS Church members by a 54-38% margin.

Vermont Polling

Momentum Analysis Survey, June 2012⁴³

- » Three out of 4 Vermont voters (74%) favor allowing "mentally competent, terminally ill patients with less than six months to live to be able to end their life in a humane and dignified manner, using prescription medications they can self-administer."

Washington, D.C., Polling

Lake Research Survey, July 2015⁴⁴

- » Two-thirds (67%) of District of Columbia residents support — and 51 percent strongly support — the right of terminally ill adults with less than six months to live to legally obtain medication to end their lives.

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Developmental Disabilities Council

2016 Position on Assisted Suicide

The Developmental Disabilities Council opposes the legalization of any action that legally supports medical assistance of one's death regardless of prognosis, including "medical aid in dying", "assisted suicide", "assisted death", "death with dignity" or other terms not specifically listed. Equal rights must include equal suicide prevention.

Oregon, Washington, Vermont and, recently, California have statutes legalizing assisted suicide. The Montana Supreme Court has declared that the victim's consent to assisted suicide can be a defense to homicide charges, and a New Mexico district court has declared assisted suicide a state right, but the state is appealing that ruling.

In Oregon and Washington, data indicates that people request assisted suicide for reasons directly related to disability-based oppression, such as feelings of loss of autonomy and dignity, and feelings of being a burden on others. These factors are the direct result of both negative stereotypes and public policies that deny people the consumer-controlled long-term services and supports that they need to feel respected and valued throughout life to a natural death. Assisted suicide laws set up a double standard whereby most people who are suicidal get suicide prevention services and support while certain others get suicide assistance. For those who are old, ill, or "disabled enough", society will not only agree that suicide is appropriate but will provide the lethal means to complete the act. This form of discrimination violates the ADA and must be opposed.

During 2015, disability rights and independent living advocates were instrumental in defeating assisted suicide legislation in Alaska, Colorado, Connecticut, Delaware, Maine, Nevada, Rhode Island and Tennessee, with efforts continuing in New Jersey, Maryland and the District of Columbia. The Developmental Disabilities Council believes there is a clear danger that individuals with intellectual and developmental disabilities and other disabilities

will not be advised of other options but instead steered toward the least expensive options rather than the supports individuals may need. This is due to the current climate in a profit driven healthcare system and environment of cost containment.

Recommendations:

1. Options other than suicide need to be offered and provided to terminally ill patients and their families by medical and social work professionals. Medical interventions such as hospice, palliative care, and pain management have been shown to provide comfort while the individual is dying. In addition, these services are typically covered by medical insurances.
2. Medical professionals need to be provided information such as disability etiquette and disability rights, and demonstrate that individuals can have a quality life despite any disabling



conditions. Groups such as Not Dead Yet, the National Council on Independent Living, ADAPT, and Disability Rights and Educational Defense Fund can provide this.

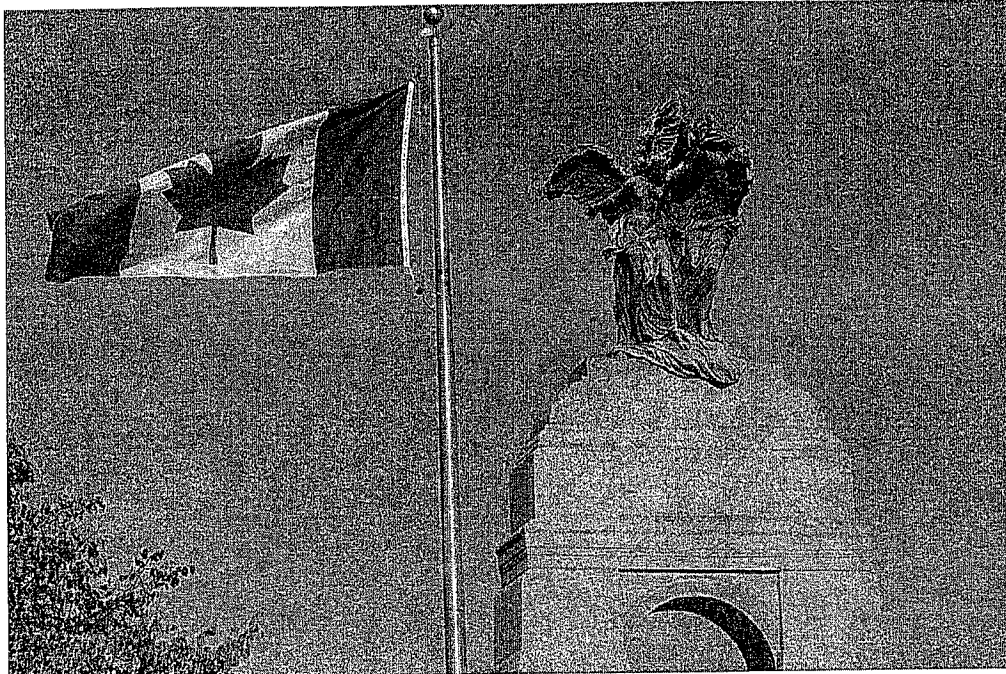
3. To assure quality of life issues are valued, local Centers for Independent Living need to work on individual and systemic advocacy. Working with the individual with a disability and his/her family on how to identify supports needed so the individual and the family can have a quality life that is appropriate for him/her.

4. Groups that also oppose assisted suicide include the National Association of Nurses and several medical schools. Disability advocacy organizations and nonprofits need to work with these groups to demand that assisted suicide laws do not get passed.

Sources for this statement include: The National Council for Independent Living, The Arc of Maryland, and Not Dead Yet.

Canada legalizes physician-assisted suicide

Updated by Sarah Kliff | sarah@vox.com | Feb 6, 2015, 3:40pm EST



Mike Carroccetto/Getty Images

1. On Friday, Canada's Supreme Court legalized physician-assisted suicide.
2. This makes Canada one of a small handful of countries — the others are Belgium, the Netherlands, Luxembourg and Switzerland — that allow doctors to hasten the deaths of terminally-ill patients.
3. Canada's law will take effect in one year, after the country's provinces have had time to set up rules and regulations of how new aid-in-dying laws will work.

A huge decision for advocates of physician-assisted suicide

In a **landmark decision**, Canada's Supreme Court ruled that physicians should be allowed to aid a patient in dying so long as "the person affected clearly consents to the termination of life" and is suffering from ""grievous and irremediable medical condition."

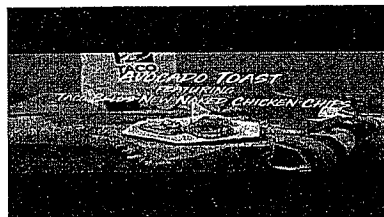
The ruling centered on the case of 89-year-old Gloria Taylor, a resident of British Columbia who suffered from late-stage Amyotrophic Lateral Sclerosis, or ALS, which causes progressive muscle weakness.

*"I DO NOT WANT TO WASTE AWAY," THE PLAINTIFF
IN THE CASE WROTE*

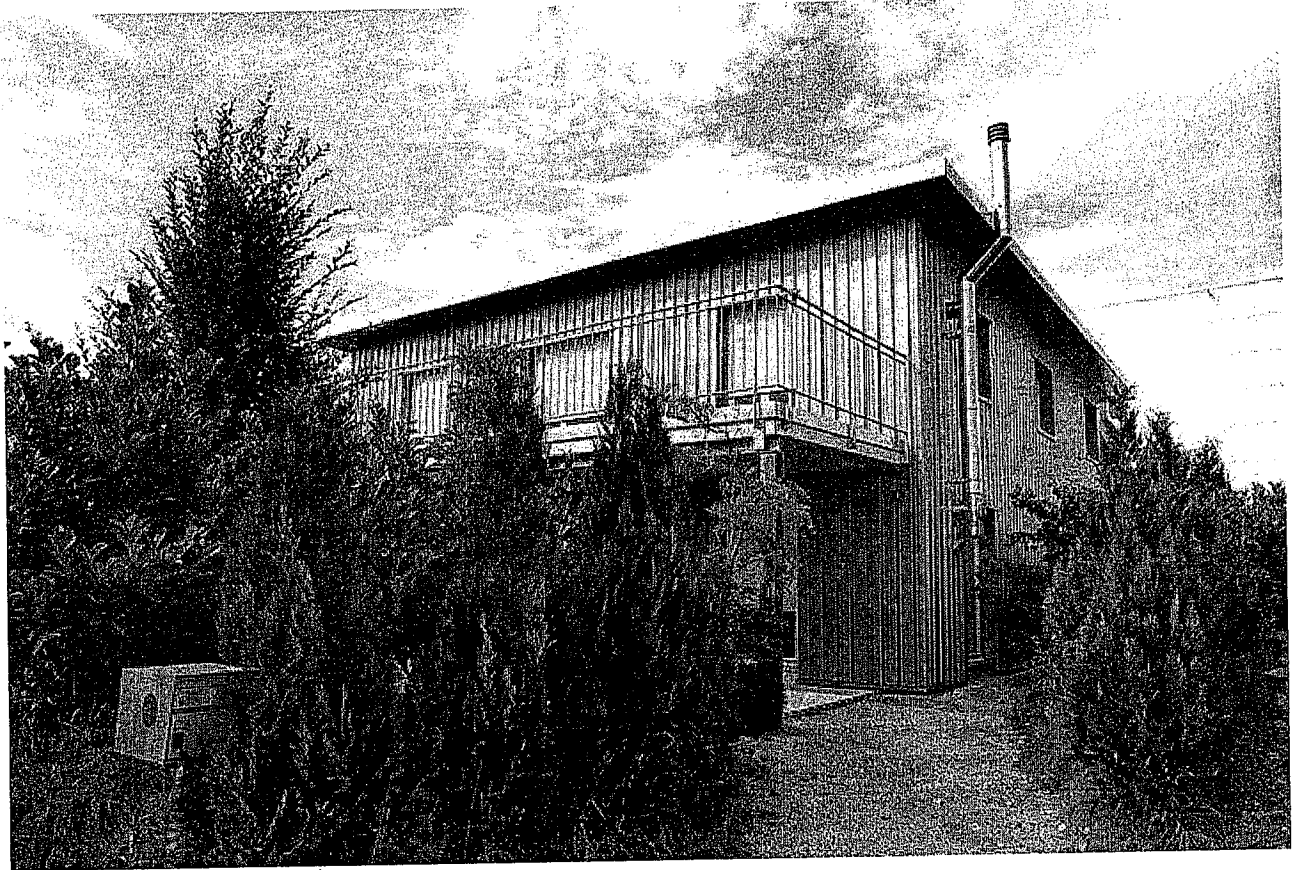
"What I fear is a death that negates, as opposed to concludes, my life," Taylor wrote of her wish for physician-assisted suicide in documents the Supreme Court quoted. "I do not want to die slowly, piece by piece. I do not want to waste away unconscious in a hospital bed. I do not want to die wracked with pain."

Canada's law will take effect in one year, after the country's provinces have had time to set up rules and regulations of how new aid-in-dying laws will work.

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Canada joins a handful of European countries with legal physician-assisted suicide



An assisted suicide clinic in Switzerland run by Zurich-based group Dignitas (AFP via Getty News Images) Three countries have passed legislation that allows doctors to hasten the deaths of terminally-ill patients: Belgium, the Netherlands, and Luxembourg. Switzerland has an even more liberal aid-in-dying policy, which allows non-doctors to assist suicide, that stems from the country's **criminal code**.

The Netherlands was the first country to legalize physician-assisted suicide with a 2002 law, although the country has informally permitted such activities for approximately three decades. The Dutch law also legalized euthanasia, which the country defines as death from a medication administered by a physician to

hasten death (whereas physician-assisted suicide includes cases where the patient gets a prescription for a deadly dosage, but administers it him or herself).

1.8 PERCENT OF ALL DEATHS IN THE NETHERLANDS ARE THE RESULT OF PHYSICIAN AID-IN-DYING

A **2007 study** found that, in 2005, 1.8 percent of all deaths in the country were the result of euthanasia or physician-assisted suicide.

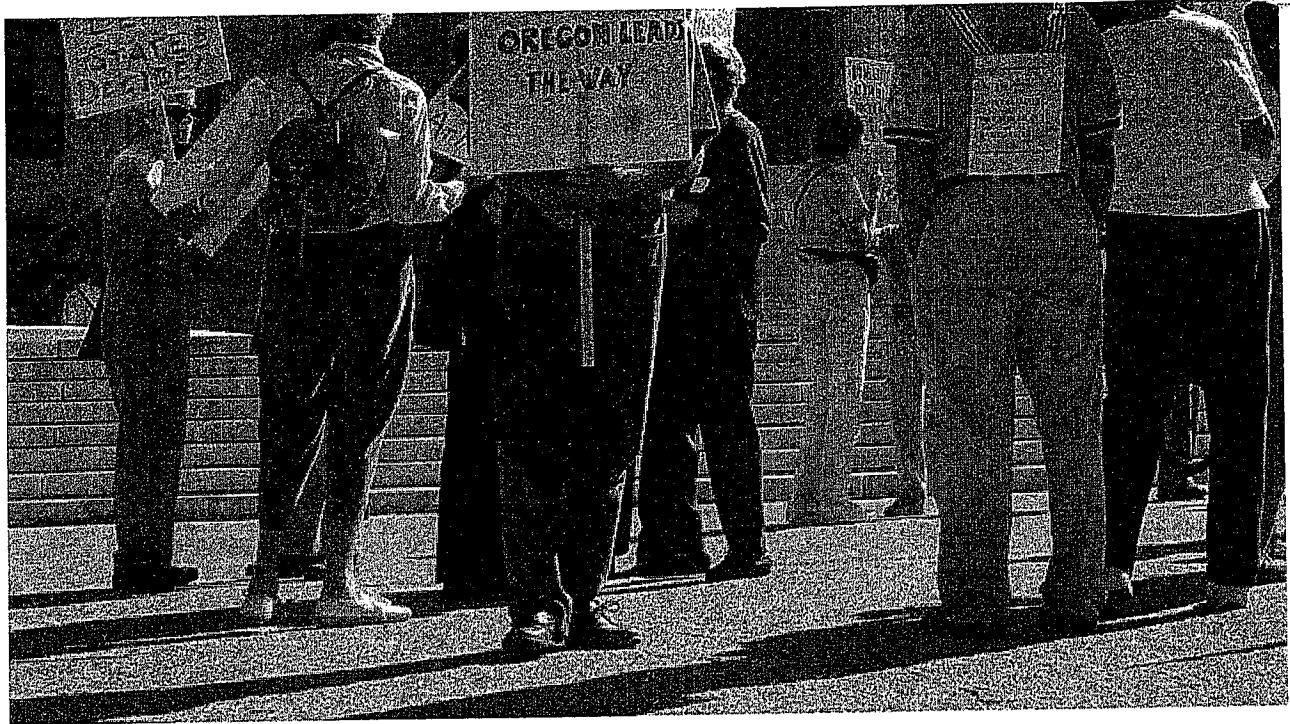
Belgium also **passed** its aid-in-dying law in 2002, and it also permits both euthanasia and physician-assisted suicide. In 2014, Belgium **extended** its law to apply to children of any age living with terminal illness (the Netherlands' law is not available to children under 12 and, for teens using it, requires parental consent). **Luxembourg** was the third country to legalize euthanasia in 2009.

In Switzerland, physician-assisted suicide is legal so long as the doctor is not motivated by "selfish" interests. Euthanasia, however, is not allowed. Switzerland is **unique** in that it allows non-doctors to assist in suicides as well and does not limit access to life-ending drugs to patients with terminal illness.

The ruling from the Canadian Supreme Court says that provinces there cannot "prohibit physician-assisted death." Whether this means they will allow physician-assisted suicide (where doctors prescribe fatal drugs for patients to take) or euthanasia (where the doctor himself administers the deadly medication).

Five states in America have right-to-die laws





Protesters rally at the Supreme Court before arguments in *Gonzalez v. Oregon*, a 2005 decision that allowed Oregon's aid-in-dying law to continue (The Washington Post via Getty News Images)

No states in America allow for euthanasia. The five states with right-to-die laws — Oregon, Washington, New Mexico, Montana, and Vermont — all require the patient to administer their own deadly medications.

In Oregon, which passed its Death with Dignity law in 1997, patients must make their request for a lethal medication in writing and then, 15 days later, make an oral request. Another 15 days must pass before the patient can fill the prescription — and they could decide never to fill it at all.

"If a doctor is allowed to give a patient a lethal injection, the doctor is the last actor," says Alan Meisel, a bioethicist at the University of Pittsburgh who has written extensively on right-to-die laws. "In Oregon and Washington, the patient is the last actor. And that lets them reserve the right not to act at all."

Will Canada's new law lead to suicide tourism in North America?

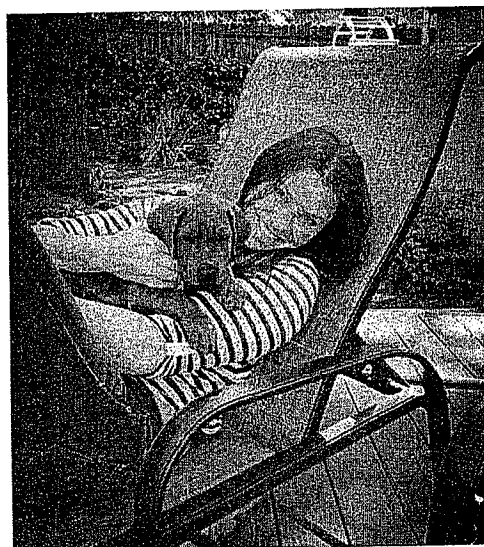
Switzerland's law is best known for attracting suicide tourism: those who travel from abroad to end their own lives, because they cannot do where they live.

Suicide tourism to Switzerland, particularly among those who are not terminally-ill, appears to have increased in recent years. **One study** found that 611 non-Swiss citizens from 31 countries used the country's aid-in-dying laws between 2008 and 2012.

There are two reasons to think Canada will not have nearly as much suicide tourism as Switzerland. First, Canada's law is much more restrictive than Switzerland's. While Switzerland allows those who are not terminally ill to end their lives, Canada's laws will restrict access to those who have an "irremediable" condition that causes "enduring and intolerable suffering."

Second, aid-in-dying has been available in the United States since 1997, when Oregon passed its death with dignity law. The Oregon law does require those wishing to end their lives to be residents of the state. This is certainly an obstacle, but not an impossible one: 29-year-old **Brittany Maynard** famously moved to Oregon in 2014 to end her life after being diagnosed with terminal brain cancer.

It's unclear, at this point, whether the Canadian law will have residency requirements — that's up to the provinces there as they interpret the new court ruling. If it does, that will likely be a significant deterrent to Americans traveling there seeking to end their lives.



Brittany Maynard ended her life on November 1 (Courtesy of Compassion and Choices)

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Distinctions Between Domicile and Residence

Distinctions Between Domicile and Residence

Domicile is a person's permanent place of dwelling. It is a legal relationship between a person and a locality. It may or may not be of same meaning as the term 'residence'.

The concept of domicile has different meanings in different context. For purposes of jurisdiction, "domicile" means a legal residence which is the place where a person has fixed dwelling with an intention of making it his/her permanent home[i].

Domicile is a combination of two factors namely, residence and intent to remain. As the term domicile includes residence, the scope and significance of the term domicile is larger than the term residence. An individual may have several residences whereas; s/he will have only one domicile. Domicile is more used in reference to personal rights, duties and obligations[ii].

Generally residence is referred to a place, where one person lives. It is also a building used as home. Residence is of a more temporary nature compared to domicile. An individual's present physical location of stay is residence [iii]. It may be one among several places where a person may be present. Residence can also be referred to a person's fixed place of stay without any intention to move from there.

Domicile involves intent of an individual whereas, residence is something objective. A person may have his/her residence in one place and his/her domicile in another[iv].

Whether the term 'residence' used in a statute will be construed as having the meaning of 'domicile', or vice versa, depends on the purpose of the statute. Also, the nature of the subject matter as well as the context in which the term is used would be taken into consideration[v].

The terms are given equivalent meaning when used in connection with subjects of domestic policy. These terms are given equal meaning where a statute stipulates residence as a qualification for the enjoyment of a privilege or the right of voting in an election[vi].

Residency is a more flexible concept than domicile, and permanency is not a requirement for residency. Even a temporary and transient place of dwelling can qualify as residence. In addition, a minor is legally unable to establish a residence separate and apart from their parents[vii].

Residence takes meaning from the context in the term is found. A definition which fits one situation will not be apt

when used in another context or in a different sense[viii].

[i] *Snyder v. McLeod*, 971 So. 2d 166 (Fla. Dist. Ct. App. 5th Dist. 2007).

[ii] *McIntosh v. Maricopa County*, 73 Ariz. 366 (Ariz. 1952).

[iii] *George Zulakis, Personal Representative of the Estate of Charles M. Decker v. Auto-owners ins. Co.*, 2001 Mich. App. LEXIS 1874 (Mich. Ct. App. Nov. 20, 2001).

[iv] *Missouri Pacific R. Co. v. Lawrence*, 215 Ark. 718, 223 S.W.2d 823, 12 A.L.R.2d 748 (1949).

[v] *McIntosh v. Maricopa County*, 73 Ariz. 366 (Ariz. 1952).

[vi] *Id.*

[vii] *McLeod v. Allstate Ins. Co.*, 789 So. 2d 806 (Miss. 2001).

[viii] *State v. Tustin*, 322 S.W.2d 179, 180 (Mo. App. 1959).

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