Part C Services and Homeless/Highly Mobile Children and Families:

There is a high probability that H/HM children 0-3 will experience a developmental delay and are therefore eligible for supports as provided by federal Part C Grants for Infants and Families Program within the Individuals with Disabilities and Education Act Minnesota Administrative Rules Chapter 3525, Children with a Disability.

Prepared by:

Kevin Overson and Scott McConnell
CEED@UROC
Center for Early Education and Development & Urban Research and Outreach/Engagement Center
University of Minnesota

February 6, 2015
Author’s Note

This report was produced by Kevin Overson and Scott McConnell. Opinions expressed here are those of the authors only, and no official endorsement of the University of Minnesota or any of its administrative or programmatic units should be inferred.

The team at CEED@UROC shares the ongoing commitment by the University of Minnesota to engage in the communities we serve; the University has "always shared its knowledge, the fruits of its discoveries, and the talents of its faculty, staff, and students with the communities it exists to serve." Many in the community and in the state are working to expand capacity to provide access to high-quality early care and education settings for young children experiencing homelessness and high mobility.

You are free to download this pdf file and use it, either in its current form or by adapting it for your use. We only ask that you attribute any parts you use to CEED@UROC at the University of Minnesota, and that any adaptations are used for noncommercial purposes. This work is licensed under Creative Commons – CC BY-NC 4.0.

For more information, please contact the authors at ceeduroc@umn.edu or 612-624-9381.

Recommended citation


Note to Readers

This report is essentially five parts, starting with a statement and each successive section providing more detail about the previous part.

1. The title of the report is the summative, declarative statement - what is the issue and what should be done about it. A 30-second summary, or "elevator speech", if you will.
2. The Executive Summary presents four points elaborating this; this is the "you have two minutes to tell me what you mean by that" section.
   (1) There is a United States law.
   (2) The State of Minnesota accepts the mandate and interprets the law.
   (3) Homelessness and High Mobility (H/HM) meets the state threshold for support provision under this law.
   (4) Minnesota must provide supports to H/HM children and families.
3. The Overview and following four sections explain each of the main points: What is the federal program, how does the State of Minnesota interpret and apply the mandate, what is the population in need of early intervention services, and what evidence supports the proposal that these children and families meet the state threshold for service provision?
4. The report concludes with a short summary and recommendation.
5. Appendices provide additional material if someone wishes to go into this further.
Executive Summary

The Individuals with Disabilities Education Act Grants for Infants and Families program (called "Part C") mandates that children 0-3 in the United States with conditions with a high probability of resulting in a developmental delay are eligible for "appropriate early intervention services", even if the child is not currently demonstrating a need or delay (U.S. Department of Education, CFDA Number: 84.181; State of Minnesota, March 3, 2014; Hadadian & Koch, 2013) (italics the authors').

The State of Minnesota Departments of Education, Health, and Human Services administer these services and define "high probability" conditions as those where "current research findings indicate that at least 50% of children with a given condition will experience a developmental delay in one or more areas of development at school age" (Minnesota Department of Health, High Probability, undated).

"Available research suggests that 50% of homeless children 0-3 years old have developmental delays; three to four times that of children in the general population" (Froehlish, Montauk & Tucker, June 2009).

Homeless and Highly Mobile children 0-3 are eligible for Part C services as provided under Minnesota state requirements definition, and the State of Minnesota must act to provide these services.
Overview

This report examines information that establishes Homeless and Highly Mobile (H/HM) status or experiences as eligibility for Part C services, or early intervention for infants and toddlers (0-3) with disabilities and their families, as provided under requirements of the Federal Individuals with Disabilities Education Act and Minnesota Administrative Rules Chapter 3525.

Under federal law, children in the United States who have conditions with a high probability of resulting in a developmental delay are eligible for “appropriate early intervention services”, even if the child is not currently demonstrating a need or delay (U.S. Department of Education, CFDA Number: 84.181; State of Minnesota, March 3, 2014; Hadadian & Koch, 2013). This law, The Individuals with Disabilities Education Act, requires states to create “statewide systems of coordinated, comprehensive, multidisciplinary, interagency programs and mak(e) early intervention services available to children with disabilities, aged birth through 2, and their families.” This program, the Grants for Infants and Families program, is also known as “Part C” of the United States programs of special education and related services (Appendix A).

Infants and toddlers with disabilities are defined federally as children who:

1. are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures, in one or more of the following five areas: cognitive development, physical development, communication development, social or emotional development, or adaptive development; or
2. have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay (Appendix A).

States are given leeway to interpret how to determine eligibility and “developmental delay”, and Minnesota’s departments of Education, Health, and Human Services, together responsible for administration of these supports, attempt to define clearly some parameters (Appendix B). In Minnesota, “high probability” means that current research findings indicate that at least 50% of children with a given condition will experience a developmental delay in one or more areas of development at school age (Minnesota Department of Health, High Probability, undated).

Young children who are homeless are at increased risk of developmental delay – and there is evidence that supports the stance that H/HM children 0-3 are at substantial risk. “While homelessness has lasting consequences for children at any age, the effects are especially harmful in the earliest years of life” (Wilder Research, May 2014, p.5). Indeed, “The impact of homelessness on the children, especially young children, is devastating and may lead to changes in brain architecture that can interfere with learning, emotional self-regulation, cognitive skills, and social relationships” (Bassuk, DeCandia & Beach, November 2014; Masten, et al, 1993).

We find substantial evidence that H/HM fits Minnesota’s “50% probability” threshold to be a determinant criterion for receiving Part C interventions. Minnesota must include H/HM as meeting eligibility criteria for Part C services, or early intervention for infants and toddlers with disabilities and their families, as provided under requirements of the Federal Individuals with Disabilities Education Act.
Part C Design

The Individuals with Disabilities Education Act Grants for Infants and Families program, also known as Part C, is a federal law requiring states to implement...

...statewide systems of coordinated, comprehensive, multidisciplinary, interagency programs and make(e) early intervention services available to children with disabilities, aged birth through 2, and their families. ...Infants and toddlers with disabilities are defined as children who:
1. are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures, in one or more of the following five areas: cognitive development, physical development, communication development, social or emotional development, or adaptive development; or
2. have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay (Appendix A).

Part C services are designed to:
- Enhance the development of infants and toddlers with disabilities.
- Reduce future educational costs by minimizing special education through early intervention.
- Minimize institutionalization and maximize independent living.
- Enhance the capacity of families to meet their child’s needs (Minnesota Department of Health, Infant and Toddler, Undated).

Within federal statutory limits, "developmental delay" has the meaning given the term by each state, and in Minnesota (Appendix B) “high probability” means that current research findings indicate that at least 50% of children with a given condition will experience a developmental delay in one or more areas of development at school age (Minnesota Department of Health, High Probability, undated).

Part C Service Availability in Minnesota

Appendix B offers an overview of Minnesota’s current approach, in early 2015, to Part C eligibility and implementation. The State of Minnesota has determined a “list of diagnosed conditions that result in automatic eligibility for Minnesota’s Infant and Toddler Intervention services” (Minnesota Department of Health, High Probability Conditions, Undated). Sample conditions:

1. Chromosomal / genetic (e.g., Angelman Syndrome, Fragile X Syndrome, Tay–Sachs Disease, Sickle Cell Disease).
2. Neuro–developmental disorders (e.g., Autism Spectrum Disorders, cerebral palsy).
3. Certain prenatal / perinatal conditions (e.g., disorders secondary to exposure to toxic substances, such as fetal alcohol syndrome, Very Low Birth Weight: Infants born at <1500 grams).
4. Physical conditions (e.g., Neuro–muscular disorders such as Muscular Dystrophies, and Complex Health Conditions which are conditions impacting multiple organs or systems such as CHARGE Syndrome).
5. Sensory (e.g., hearing loss or vision impairment, within diagnostic parameters).
6. Social or Emotional Conditions (e.g., Adjustment Disorders, Disorders of Affect, Feeding Behavior Disorders, Mixed Disorder of Emotional Expressiveness, Post–Traumatic Stress Disorder (PTSD), Disorders of Relating and Communicating) (Minnesota Department of Health, High Probability Conditions, Undated).

However, the absence of a specific diagnosis or condition listed by the state does not automatically rule out a child’s eligibility status (Minnesota Department of Health, High Probability Conditions, Undated); “children with conditions with a high probability of resulting in a delay are eligible for services even if the child is not currently demonstrating a need or delay. (Minnesota Department of Health, High Probability Conditions, Undated).

In Minnesota, these three items are key for determining Part C eligibility in the absence of a specific diagnosis or condition:
1. “’High probability’ means that current research findings indicate that at least 50% of children with a given condition will experience a developmental delay in one or more areas of development at school age” (Minnesota Department of Health, High Probability, undated).
2. “The absence of a specific diagnosis or condition listed on this web page does not automatically rule out a child’s eligibility status” (Minnesota Department of Health, High Probability Conditions, Undated).
3. “It is important to remember that children with conditions with a high probability of resulting in a delay are eligible for services even if the child is not currently demonstrating a need or delay” (Minnesota Department of Health, High Probability Conditions, Undated).
Homelessness and High Mobility Defined

The definition of homelessness (including conditions some define as high mobility) is provided by the U.S. Congress in the May 2009 reauthorization of the Hearth Act (Appendix I). As a general definition, a homeless person is anyone who:

1. lacks a fixed, regular, and adequate nighttime residence; and
2. has a primary nighttime residence that is a supervised, publicly or privately operated temporary living accommodation, including emergency shelters, transitional housing, and battered women's shelters; or
3. has a nighttime residence in any place not meant for human habitation, such as under bridges or in cars.

A parent not meeting any of these criteria may be included if they have a child with them, and have a significant history of residential instability, and have a barrier (or have a child with a barrier) that interferes with housing or employment (Wilder, September 2013).

Homelessness, Instability and Developmental Delay

There is clear evidence that young children who are homeless are at increased risk of developmental delay – and, indeed, there is evidence that supports the stance that H/HM children 0-3 are at substantial risk. “While homelessness has lasting consequences for children at any age, the effects are especially harmful in the earliest years of life” (Wilder Research, May 2014, p.5). Indeed, "The impact of homelessness on the children, especially young children, is devastating and may lead to changes in brain architecture that can interfere with learning, emotional self-regulation, cognitive skills, and social relationships” (Bassuk, DeCandia & Beach, November 2014; Masten, et al, 1993).

Instability and homelessness are conditions tied to developmental delay in one or more areas by school age (Sandstrom & Huerta, September 2013).

Masten and colleagues (1993) described children as falling on a “continuum of risk” in which children who experience homelessness are worse off than other poor children, and both are worse off than middle class groups. That is, children who are homeless share all of the adversities of poverty and also experience additional risks associated with episodes of homelessness, which for most are temporary (Samuels, Shinn & Buckner, May 2010).

Low family income negatively affects children’s social-emotional, cognitive, and academic outcomes, even after controlling for parental characteristics; family instability is linked to problem behaviors and some academic outcomes, even at early ages. Children’s problem behaviors further increase with multiple changes in family structure; family transitions that occur early in children’s development, prior to age 6, and in adolescence appear to have the strongest effects. ...; and residential instability is related to poor social development across age groups (Sandstrom & Huerta, September 2013).
Children who are homeless and highly mobile:
- Are four times more likely to show delayed development as non-homeless children,
- Have twice the rate of learning disabilities as non-homeless children (The National Center on Family Homelessness, 2011).
- Have three times the rate of emotional and behavioral problems compared to non-homeless children,
- Are sick four times more often than other children, and have:
  - Four times as many respiratory infections
  - Twice as many ear infections
  - Five times more gastrointestinal problems
  - Four times more likely to have asthma,
- Go hungry at twice the rate of other children, and
- Have high rates of obesity due to nutritional deficiencies (Bassuk, DeCandia & Beach, 2014).

Homelessness is associated with a myriad of issues, the crushing cumulative effects of which raise the risk of developmental delay in children to a high level. “Psychosocial responses to multiple stressors quadruple the risk of homeless mothers and their children for adverse outcomes, including low birth weight, infant mortality, injuries and hospitalizations, malnutrition, and behavioral health problems” (Froehlish, Montauk & Tucker, June 2009).

Infants who are homeless start life needing special care four times more often than other babies, and homeless toddlers show significantly slower development than other children. They suffer higher rates of chronic and acute health problems (The National Center on Family Homelessness, 1999).

Overcrowded and unsafe conditions limit their ability to crawl, walk and play. These young children are experiencing the trauma of homelessness just as their brains are forming the connections that will guide their learning and growth for the rest of their lives (National Center for Children in Poverty, June 1999).

Further, many studies have shown that homeless children present a unique risk group that is distinct from the larger group of children living in poverty. When compared to economically disadvantaged children living at home, homeless children show lower levels of literacy and arithmetic skills, are more likely to report having no close friends, and are at higher risk for clinical levels of psychopathology. These differences often remain after controlling for important confounds, such as race, social class, and family composition (Obradovic, 2010).

Research establishes a link between the complex, convoluted and often additive or multiplicative inter-relationships (Appendix J) between income (poverty), environment (mobility, hygiene, safety, toxicity), access (gender, class, race, quality care, supports, education), and health (low birth weight, physical, mental, nutrition, alcohol or drug dependency), environmental hazards, family separation, parental emotional or behavioral problems, chronic or severe health problems, hunger (American Psychological Association, May 2014; Sandstrom & Huerta, September 2013;

**Homelessness, Parenting and Child Effects:** “Uncertain and chaotic homeless environments place children at increased risk for developmental delay across the range of domains: cognitive, speech, motor, and personal-social” (Froehlish, Montauk & Tucker, June 2009). Children 0-3 are especially sensitive to their environments – scarcity, instability, dis-attachment – as 85% of the child’s brain is developed by age 3 (Ounce of Prevention Fund, undated). Additionally, the experience of homelessness puts families in situations where they are “at greater risk of additional traumatic experiences such as assault, witnessing violence, or abrupt separation” (Bassuk & Freedman, 2005, p. 2; Institute for Children, Poverty & Homelessness, November 2011).

The well-being of young children is inextricably linked to the well-being of their primary caregivers. The experience of homelessness itself, as well as the experiences of mothers who are homeless, places children at significant risk for insecure or disrupted attachment relationships. Most families (84%) experiencing homelessness are headed by single women;... Maternal depression, particularly when children are very young, has been linked to behavioral and cognitive problems for children in early childhood, including lack of school readiness and delayed language skills (Knitzer, Theberge & Johnson, 2008). Many mothers who are homeless also struggle with substance use (41%) and poor physical health (The National Center on Family Homelessness, Undated; Turya, et. al, December 2010). These parents must parent their children in public, while facing the stress, shame, and fear of living without a home (Friedman, 2000; Gerson, 2006) (Volk, K.T., September 2013).

<table>
<thead>
<tr>
<th>%</th>
<th>Homeless Parents</th>
</tr>
</thead>
<tbody>
<tr>
<td>52</td>
<td>reported being recently told by a medical professional that they had a serious or persistent mental health disorder (major depression 37%; post-traumatic stress disorder 23%; bipolar disorder 16%; severe depression is a condition in which the mother is unable to respond to the child’s need adequately, reducing the child’s ability to develop language, self – regulation, and skills to explore the environment)</td>
</tr>
<tr>
<td>48</td>
<td>had a chronic health condition</td>
</tr>
<tr>
<td>52</td>
<td>had a serious mental illness</td>
</tr>
<tr>
<td>12</td>
<td>considered themselves to be alcoholic or chemically dependent</td>
</tr>
<tr>
<td>31</td>
<td>mothers reported that they were homeless because of domestic abuse</td>
</tr>
<tr>
<td>29</td>
<td>had a history of incarceration at some point in their lives</td>
</tr>
<tr>
<td>67</td>
<td>were unemployed</td>
</tr>
<tr>
<td>48</td>
<td>report having children who are coping with a learning or school problem</td>
</tr>
</tbody>
</table>

*(all numbers from Wilder Research, May 2014, though wording may be paraphrased)*
“Parents experiencing homelessness often are managing multiple, major stressors that can absorb their attention, making it difficult to recognize and respond to the needs of very young children” (The National Center on Family Homelessness, 2012). A great deal of research shows the connection between parents in stress and effect on children.

Family stressors like poverty are interrelated in complex ways to child maltreatment and child disability. Maltreatment is theorized to be both a cause and an effect of developmental disability and delay. It makes intuitive sense that maltreatment and neglect, related to family functioning and parent well-being, can influence the developing human brain. Infant brain development is largely experiential and throughout the early childhood years, lack of affection, stimulation, or nutrition can be associated with poor neurological outcomes (Larson & Stewart, 2009).

While most studies try to measure individual stressors such as nutrition, parental drug use, living in a dangerous neighborhood, and witnessing or being a victim of violence, cumulative risk counts of significant negative life events a child has dealt with are more predictive of children’s outcomes (Masten, et al, 1993; Shonkoff, Boyce & McEwan, June 3, 2009; The National Center on Family Homelessness, 2011) (National Center for Children in Poverty, June 1999). It might generally be considered that multiple adverse life conditions such as those mentioned, extreme poverty, disruption, poor diet, distracted parents, and unsafe housing could be described as chaos (Wachs & Evans, 2010; Orr, 2012). “Just as lack of stimulation can impede development, unpredictable and uncontrollable settings may have adverse physiological consequences, interfere with children’s self-regulation and sense of efficacy, impair the quality of parenting they receive, and impede their ability to regulate external demands and acquire a sense of order and continuity” (Samuels, Shinn & Buckner, 2010).

<table>
<thead>
<tr>
<th>%</th>
<th>Homeless Parents Whose Children Were With Them</th>
</tr>
</thead>
<tbody>
<tr>
<td>26</td>
<td>said that at least one of their children had an emotional or behavioral problem (up from 21% in 2009); the closest general population comparison for this figure is 7% (among children age 4–17)</td>
</tr>
<tr>
<td>10</td>
<td>could not get needed dental care for at least one child in the past year</td>
</tr>
<tr>
<td>15</td>
<td>had at least one child with a chronic or severe physical health problem</td>
</tr>
<tr>
<td>11</td>
<td>said their children skipped meals in the previous month because there was not enough money to buy food</td>
</tr>
<tr>
<td>6</td>
<td>had been unable to obtain needed health care for a least one child in the past year</td>
</tr>
<tr>
<td>5</td>
<td>had been unable to get needed mental health care for at least one child in the past year</td>
</tr>
<tr>
<td>11</td>
<td>has a child who has repeated a grade</td>
</tr>
<tr>
<td>47</td>
<td>have at least one school-age child with learning problems that resulted in the need for additional services, and about one in five report a child with a drop in grades (19%), excessive absences (17%) or tardies (14%), or dismissals or suspension (14%); homeless parents who are not staying in shelter are most likely to report a child who has experienced a drop in grades (27%), excessive tardies (24%), or skipping school entirely (9%)</td>
</tr>
<tr>
<td>44</td>
<td>reported bullying (Masten, et al, 1993)</td>
</tr>
</tbody>
</table>
Homelessness and Toxic Stress: “Chronic stress causes damage to the body and brain, reduces overall physical health, and contributes to reduced short-term working memory, which is critical to learning and judgment” (Wilder Research, 2014; Evans and Schamberg, 2009; Center on the Developing Child, 2014). “If chronic poverty is combined with other risk factors, such as neglect or abuse, or exposure to parental mental illness or substance abuse, or exposure to violence, the odds of long-term damage to the child’s learning capacity are multiplied” (Wilder Research, 2014).

We find increasing evidence of the catastrophic effects of toxic stress and other traumas associated with instability, homelessness and high mobility.

Extensive research on the biology of stress now shows that healthy development can be derailed by excessive or prolonged activation of stress response systems in the body (especially the brain), with damaging effects on learning, behavior, and health across the lifespan. ... The implications of this framework for the practice of medicine, in general, and pediatrics, specifically, are potentially transformational. They suggest that many adult diseases should be viewed as developmental disorders that begin early in life and that persistent health disparities associated with poverty, discrimination, or maltreatment could be reduced by the alleviation of toxic stress in childhood (Center on the Developing Child, 2014).

Further, as the number of Adverse Childhood Experiences (ACES) (abuse, neglect, household dysfunction) increases, the risk for health problems increases in a strong and graded fashion in areas such as alcohol and substance abuse, depression, anxiety, and smoking (Centers for Disease Control and Prevention, May 13, 2013).

“Thanks to decades of neuroscience research on brain development, adversity and toxic stress, we now understand how a child who is exposed to violence, or neglect, or homelessness at an early age may develop behavioral and physical health problems later in life. We can now use this rapidly evolving knowledge to create real-world solutions” (Lowe, undated; Centers for Disease Control and Prevention, May 13, 2014; Center on the Developing Child, 2014; Garner & Shonkoff, January 2012; Sandstrom & Huerta, 2013; Shonkoff and Garner, December 26, 2011).

Conclusion: A Recommendation

“Although debates about early childhood policy focus almost entirely on educational objectives, science indicates that sound investments in interventions that reduce adversity are also likely to strengthen the foundations of physical and mental health, which would generate even larger returns to all of society” (Shonkoff & Garner, December 26, 2011). “Neuroscience, child development, and the economics of human capital formation all point to the same conclusion: creating the right conditions for early childhood development is far more effective than trying to fix problems later” (Shonkoff, 2010; Center on the Developing Child, 2014; Grunewald & Rolnick, 2003).
“...these effects can be minimized through effective services to children and their families” (Wilder Research, May 2014), and expansion of Minnesota’s statutory eligibility criteria for Part C services is a way to improve outcomes for H/HM children who are 0-3 years of age.

“Early childhood is a once-in-a-lifetime window of opportunity for every child. Much of a child’s brain development occurs during the earliest years of life, setting the stage for future physical, cognitive, social and emotional development” (Children’s Defense Fund, 2014, p. 32). Children experiencing homelessness, even brief episodes, exhibit developmental delay in one or more areas by school age; we find substantial evidence that homeless and highly mobile fits Minnesota’s threshold to be a determinant criterion for receiving Part C interventions.

Minnesota must include Homeless and Highly Mobile (or H/HM)... as “eligibility criteria for Part C services, or early intervention for infants and toddlers with disabilities and their families, as provided under requirements of the Federal Individuals with Disabilities Education Act” (McConnell, memo, 12/6/14).

It is not only the right thing to do, it fits within the legal mandate.
Bibliography


Appendix A
What is Part C?

Federal Program, U.S. Department of Education
Early Intervention Program for Infants and Toddlers with Disabilities
Program Office: Office of Special Education Programs (OSEP)
CFDA Number: 84.181
Program Type: Formula Grants
Also Known As: Grants for Infants and Families, Part C of IDEA, Grants for Infants and Toddlers

PROGRAM DESCRIPTION
The Grants for Infants and Families program (Part C) awards formula grants to the 50 States, District of Columbia, Puerto Rico, Secretary of the Interior, and Outlying Areas to assist them in implementing statewide systems of coordinated, comprehensive, multidisciplinary, interagency programs and making early intervention services available to children with disabilities, aged birth through 2, and their families. Under the program, states are responsible for ensuring that appropriate early intervention services are made available to all eligible birth-through-2-year-olds with disabilities and their families, including Indian children and families who reside on reservations geographically located in the state. Infants and toddlers with disabilities are defined as children who:

1. are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures, in one or more of the following five areas: cognitive development, physical development, communication development, social or emotional development, or adaptive development; or
2. have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay.

Within statutory limits, "developmental delay" has the meaning given the term by each state. In addition, states have the discretion to provide services to infants and toddlers who are at risk of having substantial developmental delays if they do not receive appropriate early intervention services.

The Individuals with Disabilities Education Act (IDEA)\(^1\) gives states the discretion to extend eligibility for Part C services to children with disabilities who are eligible for services under section 619 and who previously received services under Part C, until such children enter or are eligible under state law to enter kindergarten or elementary school, as appropriate. The IDEA further stipulates that any Part C programs serving children aged 3 or older must provide an educational component that promotes school readiness and incorporates preliteracy, language, and numeracy skills and provide a written notification to parents of their rights regarding the continuation of services under Part C and eligibility for services under section 619. In fiscal year 2009, two states (New Mexico and Maryland) elected to make Part C services available to children with disabilities beyond their third birthday and continued to do so in 2010, 2011, and 2012. No additional states elected to implement this option in fiscal years 2010 through 2012.

In any fiscal year in which the appropriation for Part C exceeds $460 million, the statute also includes authority for the Secretary to reserve 15 percent of the amount above $460 million for a State
Incentive Grants program. The purpose of this program is to provide funding to assist states that have elected to extend eligibility for Part C services to children with disabilities aged 3 years until entrance into kindergarten or elementary school, or for a portion of this period. No state can receive more than 20 percent of the amount available for State Incentive Grants in a fiscal year. In fiscal year 2009, due to the addition of funds from the American Recovery and Reinvestment Act, the total of funds appropriated for Part C exceeded the $460 million level. The states that opted to extend their provision of Part C services beyond age 3 received additional funds through this program, and had until September 30, 2011, to expend these funds. The appropriation for fiscal years 2010 through 2014 did not exceed $460 million, so the Department did not have authority to award State Incentive Grants in any of these fiscal years.

The statewide system also must comply with 17 statutory requirements, including having a lead agency designated with the responsibility for the coordination and administration of funds and a State Interagency Coordinating Council to advise and assist the lead agency. One of the purposes of the Part C program is to assist states to coordinate payment for early intervention services from federal, state, local, and private sources, including public and private insurance coverage. These include Medicaid, the State Children’s Health Insurance Program (SCHIP), Social Security Disability Insurance and Supplemental Security Income, and Early Head Start.

TYPES OF PROJECTS
Funds allocated under this program can be used to:

1. maintain and implement the statewide system described above;
2. fund direct early intervention services for infants and toddlers with disabilities and their families that are not otherwise provided by other public or private sources;
3. expand and improve services that are otherwise available;
4. provide a free appropriate public education, in accordance with Part B of the IDEA, to children with disabilities from their third birthday to the beginning of the following school year;
5. continue to provide early intervention services to children with disabilities from their third birthday until such children enter or are eligible to enter kindergarten or elementary school; and
6. initiate, expand, or improve collaborative efforts related to identifying, evaluating, referring, and following up on at-risk infants and toddlers in States that do not provide direct services for these children.

The IDEA requires that early intervention services be provided, to the maximum extent appropriate, in natural environments. These services can be provided in another setting only when early intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment. The natural environment includes the home and community settings where children would be participating if they did not have a disability. Each child’s individualized family service plan (IFSP) must contain a statement of the natural environments in which early intervention services will be provided, including a justification of the extent, if any, to which the services will not be provided in a natural environment.

Allocations are based on the number of children in the general population aged birth through 2 years in each state. The Department of Education uses data provided by the United States Census Bureau in making this calculation. No state can receive less than 0.5 percent of the funds available to all states,
or $500,000, whichever is greater. The Outlying Areas may receive not more than 1 percent of the funds appropriated. The Secretary of the Interior, Bureau of Indian Education, receives 1.25 percent of the aggregate of the amount available to all states. Interior must pass through all the funds it receives to Indian tribes, tribal organizations, or consortia for the coordination of early intervention services on reservations with Interior schools. Tribes and tribal organizations can use the funds they receive to provide:

1. help to States in identifying Indian infants and toddlers with disabilities,
2. parent training, and
3. early intervention services.


STATUTE

An Act

To reauthorize the Individuals with Disabilities Education Act, and for other purposes. <<NOTE: Dec. 3, 2004 - [H.R. 1350]>>

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, <<NOTE: Individuals with Disabilities Education Improvement Act of 2004. 20 USC 1400 note.>>

SECTION 1. SHORT TITLE.

This Act may be cited as the ``Individuals with Disabilities Education Improvement Act of 2004``.

SEC. 2. ORGANIZATION OF THE ACT.

This Act is organized into the following titles:
Title I--Amendments to the Individuals With Disabilities Education Act. 2
Title II--National Center for Special Education Research.
Title III--Miscellaneous Provisions.


§ 303.21 Infant or toddler with a disability.
(a) Infant or toddler with a disability means an individual under three years of age who needs early intervention services because the individual—
   (1) Is experiencing a developmental delay, as measured by appropriate diagnostic instruments and procedures, in one or more of the following areas:
      (i) Cognitive development.
      (ii) Physical development, including vision and hearing.
(iii) Communication development.
(iv) Social or emotional development.
(v) Adaptive development; or
(2) Has a diagnosed physical or mental condition that—
   (i) Has a high probability of resulting in developmental delay; and
   (ii) Includes conditions such as chromosomal abnormalities; genetic or congenital disorders;
       sensory impairments; inborn errors of metabolism; disorders reflecting disturbance of the
development of the nervous system; congenital infections; severe attachment disorders; and
disorders secondary to exposure to toxic substances, including fetal alcohol syndrome.
(b) Infant or toddler with a disability may include, at a State’s discretion, an at-risk infant or toddler
   (as defined in § 303.5).
(c) Infant or toddler with a disability may include, at a State’s discretion, a child with a disability who is
   eligible for services under section 619 of the Act and who previously received services under this part
   until the child enters, or is eligible under State law to enter, kindergarten or elementary school, as
   appropriate, provided that any programs under this part must include—
   (1) An educational component that promotes school readiness and incorporates pre-literacy,
       language, and numeracy skills for children ages three and older who receive part C services
       pursuant to § 303.211; and
   (2) A written notification to parents of a child with a disability who is eligible for services under
       section 619 of the Act and who previously received services under this part of their rights and
       responsibilities in determining whether their child will continue to receive services under this
       part or participate in preschool programs under section 619 of the Act.
   (Authority: 20 U.S.C. 1401(16), 1432(5))
§ 303.5 At-risk infant or toddler.
At-risk infant or toddler means an individual under three years of age who would be at risk of
experiencing a substantial developmental delay if early intervention services were not provided
to the individual. At the State’s discretion, at-risk infant or toddler may include an infant or
toddler who is at risk of experiencing developmental delays because of biological or
environmental factors that can be identified (including low birth weight, respiratory distress as
a newborn, lack of oxygen, brain hemorrhage, infection, nutritional deprivation, a history of
abuse or neglect, and being directly affected by illegal substance abuse or withdrawal
symptoms resulting from prenatal drug exposure).
   (Authority: 20 U.S.C. 1432(1), 1432(5)(B)(i) and 1437(a)(6))
TITLE I -- AMENDMENTS TO THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT

SEC. 101. AMENDMENTS TO THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT.

Parts A through D of the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.) are amended to read as follows:

Part C--Infants and Toddlers With Disabilities
Sec. 631. Findings and policy.
Sec. 632. Definitions.
Sec. 633. General authority.
Sec. 634. Eligibility.
Sec. 635. Requirements for statewide system.
Sec. 636. Individualized family service plan.
Sec. 637. State application and assurances.
Sec. 638. Uses of funds.
Sec. 639. Procedural safeguards.
Sec. 640. Payor of last resort.
Sec. 641. State interagency coordinating council.
Sec. 642. Federal administration.
Sec. 643. Allocation of funds.
Sec. 644. Authorization of appropriations.

Appendix B

How does Minnesota define eligibility?

In brief, this federal law allows states some flexibility to define eligibility standards, and consequently provide family-focused interdisciplinary early intervention services, to infants and toddlers and their families (McConnell, S., memo, 12/6/14). As described by the Early Childhood Technical Assistance Center (http://ectacenter.org/topics/earlyid/partcelig.asp, retrieved October 6, 2014):

> Part C eligibility is determined by each state’s definition of developmental delay and includes children with established physical or mental conditions with a high probability of resulting in developmental delay and includes conditions such as chromosomal abnormalities; genetic or congenital disorders; sensory impairments; inborn errors of metabolism; disorders reflecting disturbance of the development of the nervous system; congenital infections; severe attachment disorders; and disorders secondary to exposure to toxic substances, including fetal alcohol syndrome. States may choose to include children at risk for disabilities in the eligible group (§303.21). An important part of the evaluation process for infants and toddlers includes informed clinical opinion of professionals experienced with development in the very young.

The State of Minnesota has determined a “list of diagnosed conditions that result in automatic eligibility for Minnesota’s Infant and Toddler Intervention services...the list...should be considered...examples” (Minnesota Department of Health, High Probability Conditions, Undated).

However:

“The absence of a specific diagnosis or condition listed on this web page does not automatically rule out a child’s eligibility status” (Minnesota Department of Health, High Probability Conditions, Undated).

And:

“It is important to remember that children with conditions with a high probability of resulting in a delay are eligible for services even if the child is not currently demonstrating a need or delay” (Minnesota Department of Health, High Probability Conditions, Undated).

Keep in mind that:

“High probability” means that current research findings indicate that at least 50% of children with a given condition will experience a developmental delay in one or more areas of development at school age (Minnesota Department of Health, High Probability Conditions, Undated).

How is this monitored in Minnesota?

Interagency Early Intervention Committees (IEICs) coordinate these education, public health and social services. Minnesota has 95 operating IEICs in 87 counties, with metro-area counties hosting multiple IEICs. The entire state system is overseen by the Interagency Coordinating Council (https://www.revisor.mn.gov/statutes/?id=125A.28), a body appointed by the Governor with majority family membership (Minnesota Department of Human Services, Part C, February 2014).
In Minnesota this program is called HELP ME GROW. The IDEA requires that early intervention services be provided, to the maximum extent appropriate, in natural environments. These services can be provided in another setting only when early intervention cannot be achieved satisfactorily for the infant or toddler in a natural environment. The natural environment includes the home and community settings where children would be participating if they did not have a disability.

In Minnesota this program is called HELP ME GROW, through Parents Know, a site sponsored by the Minnesota Department of Education (Parents Know, 2013).

Part C services of I.D.E.A are designed to:
- Enhance the development of infants and toddlers with disabilities.
- Reduce future educational costs by minimizing special education through early intervention.
- Minimize institutionalization and maximize independent living.
- Enhance the capacity of families to meet their child’s needs (Minnesota Department of Health, Infant and Toddler Intervention, Undated).

What types of services are available to eligible children?
The Help Me Grow initiative is an interagency effort of the Minnesota Departments of Education, Health, and Human Services.

Services are based on the child and family’s needs and priorities. Parents are essential team members in the decision-making process of identifying services for their family. Core services at no cost to the family include service coordination and Early Childhood Special Education and related services (i.e. occupational therapy, physical therapy, speech services). Additional services, which depend on the child and family’s specific needs, may include:
- Assistive technology devices and services
- Audiology services
- Family training, counseling, and home visits
- Health services
- Medical services, diagnostic only
- Nursing services
- Nutrition services
- Psychological services
- Transportation and related costs
- Vision services
- Other – this list is not exhaustive

(Minnesota Department of Health, Infant and Toddler Interventions, Undated)

These services are designed to meet the unique developmental needs of each child and their family and are offered at no cost to families.

Help Me Grow Infant and Toddler Intervention services provide developmental support and instruction for young children with disabilities or delays in their development. Minnesota children from birth to three years old who are eligible for Help Me Grow can receive services in their home,
child care setting or in their local school early childhood programs. These services are free regardless of income or immigration status.

Once eligibility has been determined through a comprehensive evaluation process, early childhood specialists work with families to plan the services and supports they and their child need. These may include:
- Special developmental instruction, speech, physical and occupational therapy;
- Ways that a family can support their child’s development at home; and
- Coordination and assistance to access other needed community resources and programs.

(Minnesota Departments of Education, Health, and Human Services, Help Me Grow, Undated).
Minnesota Department of Education

Part C of the Individuals with Disabilities Education Act (IDEA)

IDEA Part C is a federal program that helps states provide early intervention services for children, birth to 3 years having developmental delays. This includes children diagnosed with a mental health condition that could cause such delays. Interagency Early Intervention Committees (IEICs) coordinate these education, public health and social services. Minnesota has 95 operating IEICs in 87 counties, with metro-area counties hosting multiple IEICs. The entire state system is overseen by the Interagency Coordinating Council, a body appointed by the Governor with majority family membership.

In 2006, the Minnesota Department of Education changed eligibility for Part C of IDEA to include 13 early childhood mental health diagnoses listed in the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood: Revised Edition (DC:0-3R). This list of social or emotional conditions for determining eligibility includes:

- Adjustment Disorders
- Anxiety Disorders of Infancy and Childhood
- Depression of Infancy and Early Childhood
- Deprivation/Maltreatment Disorder
- Disorders of Affect
- Disorders of Relating and Communicating
- Feeding Behavior Disorders
- Mixed Disorder of Emotional Expressiveness
- Multisystem Developmental Disorder (MSDD)
- Post-Traumatic Stress Disorder (PTSD)
- Prolonged Bereavement/Grief Disorder
- Regulation Disorders of Sensory Processing
- Sleep Behavior Disorder

These new criteria allow children from birth to two years with mental health conditions to receive the full early intervention services offered through Part C. New websites, Help Me Grow and Minnesota Parents Know, help parents, doctors and others find referrals and resources. The Parents Know site contains research-based information for families on child development, health and parenting related to children birth through grade 12. While research surrounding effective treatments for very young children is still minimal, it is rapidly growing.

(Minnesota Department of Human Services, Part C, February 2014)

Minnesota Programs that Distribute / Oversee Part C Funding and Eligibility

Interagency Coordinating Council
http://education.state.mn.us/MDE/Welcome/AdvBCT/ICC/

The Governor’s Interagency Coordinating Council (ICC) advises and assists the Minnesota Department of Education in the planning, coordination and delivery of a coordinated statewide, interagency system of services to children birth to five with special needs and their families.
Minnesota Administrative Rules
Chapter 3525

Part 3525.1350

3525.1350 INFANT AND TODDLER INTERVENTION SERVICES.

Subpart 1.

Services required.
Infant and toddler intervention services under United States Code, title 20, chapter 33, sections 1431, et seq., and Code of Federal Regulations, title 34, part 303, must be available to children from birth through two years of age who meet the criteria described in subpart 2.

Subp. 2.

Criteria for birth through two years of age.
The team shall determine that a child from birth through the age of two years is eligible for infant and toddler intervention services if:

A. the child meets the criteria of one of the disability categories in United States Code, title 20, chapter 33, sections 1400, et seq., as defined in Minnesota Rules; or

B. the child meets the criteria for developmental delay in subitem (1), (2), or (3):

   (1) the child has a diagnosed physical or mental condition or disorder that has a high probability of resulting in developmental delay regardless of whether the child has a demonstrated need or delay;

   (2) the child is experiencing a developmental delay that is demonstrated by a score of 1.5 standard deviations or more below the mean, as measured by the appropriate diagnostic measures and procedures, in one or more of the following areas:

       (a) cognitive development;

       (b) physical development, including vision and hearing;

       (c) communication development;

       (d) social or emotional development; and

       (e) adaptive development; or

   (3) the child's eligibility is established through the application of informed clinical opinion. Informed clinical opinion may be used as an independent basis to establish a child's eligibility under this part even when other instruments do not establish eligibility; however, in no event may informed clinical opinion be used to negate the results of evaluation instruments to establish eligibility.

Subp. 3.
[Renumbered 3525.1351]

Subp. 4.

Evaluation.
Evaluation of the child and assessment of the child and family will be conducted in a manner consistent with Code of Federal Regulations, title 34, section 303.321.
Subp. 5.

Transition.

The service coordinator provided for in Minnesota Statutes, section 125A.33, must facilitate transition from infant and toddler intervention services before the child's third birthday. The IFSP must include steps to determine and document eligibility for special education, and steps to support the transition of the child to special education under United States Code, title 20, chapter 33, sections 1411 et seq., and Code of Federal Regulations, title 34, part 300, or to other appropriate community-based services that may be available.

A. For a child who may be eligible for special education services under United States Code, title 20, chapter 33, sections 1411 et seq., and Code of Federal Regulations, title 34, part 300, the service coordinator must, with the approval of the family of the child, convene a conference between the family, the local educational agency, and community-based service providers to discuss services that the child may receive under United States Code, title 20, chapter 33, sections 1411 et seq., and Code of Federal Regulations, title 34, part 300. The conference must be held not less than 90 days, and, at the discretion of all the parties, not more than nine months, before the child is eligible for the preschool services.

B. For a child who may not be eligible for special education services under United States Code, title 20, chapter 33, sections 1411 et seq., and Code of Federal Regulations, title 34, part 300, the service coordinator must, with the approval of the family, take reasonable steps, to convene a conference between the family, the lead agency, and community-based service providers to discuss appropriate services that the child may receive after exiting infant and toddler intervention services.

Statutory Authority:
MS s 14.389; 121.11; 125A.07; L 1994 c 647 art 3 s 23; L 1999 c 123 s 19,20; L 2013 c 116 art 5 s 29

History:
19 SR 2432; L 1998 c 397 art 11 s 3; 24 SR 1799; 26 SR 657; 32 SR 653; 38 SR 1145

Published Electronically:
March 3, 2014

014 Minnesota Statutes  
*Chapter 125A*  
*Section 125A.02*  

**Topics**  
- Autism and Autism Spectrum Disorders  
- Brain  
- Children  
- Communication Disabilities, Persons with  
- Deaf Persons  
- Developmentally Disabled Persons  
- Disabled Children  
- Emotionally Disturbed Children  
- Illness  
- Schools (k-12)  
- Special Education

**125A.02 CHILD WITH A DISABILITY, from DEFINED.**  

**Subdivision 1. Child with a disability.**  
“Child with a disability” means a child identified under federal and state special education law as deaf or hard of hearing, blind or visually impaired, deafblind, or having a speech or language impairment, a physical impairment, other health disability, developmental cognitive disability, an emotional or behavioral disorder, specific learning disability, autism spectrum disorder, traumatic brain injury, or severe multiple impairments, and who needs special education and related services, as determined by the rules of the commissioner. A licensed physician, an advanced practice nurse, or a licensed psychologist is qualified to make a diagnosis and determination of attention deficit disorder or attention deficit hyperactivity disorder for purposes of identifying a child with a disability.

**Subd. 1a. Children ages three through seven experiencing developmental delays.**  
In addition, every child under age three, and at local district discretion from age three to age seven, who needs special instruction and services, as determined by the rules of the commissioner, because the child has a substantial delay or has an identifiable physical or mental condition known to hinder normal development is a child with a disability.

**Subd. 2. Not a child with a disability.**  
A child with a short-term or temporary physical or emotional illness or disability, as determined by the rules of the commissioner, is not a child with a disability.

**History:**  
Ex1959 c 71 art 1 s 3; 1969 c 981 s 1; 1975 c 432 s 7; 1981 c 358 art 3 s 1; 1Sp1985 c 12 art 3 s 1; 1987 c 398 art 3 s 1; 1991 c 265 art 3 s 38; 1998 c 397 art 2 s 164; 1998 c 398 art 2 s 1; art 5 s 55; 2005 c 56 s 1; 2006 c 263 art 2 s 18; 2008 c 326 art 1 s 1; 2009 c 96 art 3 s 5; 1Sp2011 c 11 art 3 s 1

Copyright © 2014 by the Revisor of Statutes, State of Minnesota.  
Retrieved December 14, 2014https://www.revisor.mn.gov/statutes/?id=125A.02
Minnesota Eligibility Decision Guidelines
(Birth to 3 Years)

The information below is meant as a guide to assist those working to determine the eligibility status of an infant or toddler under the age of three for Infant and Toddler Intervention (Part C) services.

The absence of a specific diagnosis or condition listed on this web site does not automatically rule out a child’s eligibility status. In order to adequately determine eligibility, it might be necessary to obtain additional information from the child’s health care provider, as well as compile available developmental outcome information related to the condition. Eligibility technical assistance is available by emailing us at mde.ecse@state.mn.us.

An infant or toddler residing in MN under the age of three is eligible for early intervention services when:

- The child meets the criteria for any one of the thirteen special education disability categories – as defined in MN Administrative Rules Chapter 3525, Children with a Disability:
  - Autism Spectrum Disorders (ASD)
  - Deaf-Blind
  - Deaf and Hard of Hearing
  - Developmental Cognitive Disability
  - Emotional or Behavioral Disorders
  - Other Health Disabilities
  - Physically Impaired
  - Severely Multiply Impaired
  - Specific Learning Disability
  - Speech or Language Impairments
  - Traumatic Brain Injury
  - Visually Impaired

OR

- The child meets one of the following criteria for developmental delay:
  1. the child is experiencing a developmental delay that is demonstrated by a score of 1.5 standard deviations or more below the mean, as measured by the appropriate assessment and evaluation procedures, in one or more of the following areas:
     - Cognitive development
     - Physical development, including vision and hearing
     - Communication development
     - Social or emotional development
     - Adaptive development

OR
2. the child has a diagnosed physical or mental health condition or disorder with a high probability of resulting in a delay, regardless of whether the child is currently demonstrating a need or delay. Here are some examples of these conditions.

OR

An Informed Clinical Opinion (ICO) is used to independently establish eligibility through the use of professional knowledge and skills of the early intervention staff, as well as other professionals involved with the child and family. When establishing eligibility using ICO independently, clearly describe the rationale behind the decision and incorporate information from a variety of sources. ICO for eligibility under developmental delay is established through a review of medical or other records. For more information, see Informed Clinical Opinion paper from the National Early Childhood TA Center (PDF: 49KB/4 pages)

High Probability Conditions

What does “conditions or disorders with a high probability of resulting in a delay” mean?
“High probability” means that current research findings indicate that at least 50% of children with a given condition will experience a developmental delay in one or more areas of development at school age (Minnesota Department of Health, High Probability Conditions, Undated).

The following list of diagnosed conditions that result in automatic eligibility for Minnesota’s Infant and Toddler Intervention services has been developed through a review of current literature and other state’s lists of eligible conditions. Developing an exhaustive list of conditions is not practical. Therefore, the list below should be considered as examples of conditions with a high probability of resulting in a delay. If you are unsure, please view the list of actions you should take in determining eligibility if a specific condition is not listed.

The absence of a specific diagnosis or condition listed on this web page does not automatically rule out a child’s eligibility status. In order to provide a definite “yes” or “no” answer, you may need to obtain additional information from the child’s health care provider, as well as compile available developmental outcome information from various reputable sources. Eligibility technical assistance is available by emailing mde.ecse@state.mn.us.

It is important to remember that children with conditions with a high probability of resulting in a delay are eligible for services even if the child is not currently demonstrating a need or delay.

Conditions or disorders with a high probability of resulting in a delay

1) Chromosomal / genetic
2) Neurodevelopmental
3) Prenatal / perinatal conditions
4) Physical conditions
5) Sensory conditions
6) Social or emotional conditions

1. Chromosomal / genetic
A. Conditions or syndromes that are likely to result in intellectual disabilities such as:
- Angelman Syndrome
- Coffin–Lowry Syndrome
- Cornelia de Lange Syndrome
- Down syndrome
- Fragile X Syndrome
- Hunter Syndrome (Mucopolysaccharidosis II, MPS II)
- Hurler Syndrome (Mucopolysaccharidosis I, MPS I)
- I–Cell Disease (Mucolipidosis II alpha/beta)
- Prader–Willi Syndrome
- Williams Syndrome
- Wolf–Hirschhorn Syndrome / 4p Deletion Syndrome
B. Conditions where life expectancy may be limited such as:
- Tay–Sachs Disease
- Trisomy 13 (Patau Syndrome)
- Trisomy 18 (Edward Syndrome/Trisomy E)
C. Certain metabolic, endocrine and hemoglobinopathies generally identified by the newborn screening program

- Galactosemia (GALT)
- Homocystinuria (HCY)
- Long Chain Fatty Acid Oxidation Disorders (LCHAD)
- Maple Syrup Urine Disease (MSUD)
- Methylmalonic Acidemia Cobalamin Disorders (MMA Cbl A, B)
- Methylmalonic Acidemia with Homocystinuria (MMA Cbl C, D, F)
- Phenylketonuria (PKU)
- Sickle Cell Disease

2. Neuro–developmental disorders such as:
   A. Autism Spectrum Disorders
      (may include Autistic Disorder, Childhood Autism, Atypical Autism, Pervasive Developmental Disorder Not Otherwise Specified, Asperger’s Disorder, or other related pervasive developmental disorders)
   B. Cerebral palsy
   C. Neural Tube Defects
      (NTDs – birth defects of the spine and brain) such as:
      - Encephalocele
      - Spina Bifida
   D. Epilepsy

3. Certain prenatal / perinatal conditions
   A. Disorders secondary to exposure to toxic substances, such as:
      - Fetal alcohol syndrome
      - Fetal Hydantoin Syndrome
   B. Prenatal infections such as: Cytomegalovirus (CMV)
   C. Very Low Birth Weight: Infants born at <1500 grams
   D. Grades III and IV intracranial hemorrhage (PVH–IVH, stroke)
   E. Hypoxic–Ischemic Encephalopathy (HIE)
   F. Congenital Diaphragmatic Hernia (CDH)

4. Physical conditions
   A. Neuro–muscular disorders such as:
      - Muscular Dystrophies
      - Neonatal Adrenoleukodystrophy (NALD)
      - Spinal Muscular Atrophy (SMA)
   B. Respiratory
      - Bronchopulmonary Dysplasia (BPD)
   C. Toxic Exposures such as:
      Elevated blood lead level of ≥ 45 µg/dL (based on MN Childhood Blood Lead Screening Guidelines
      A child with ≥ 15 µg/dL should be automatically referred to: Minnesota Help Me Grow for a developmental evaluation.
   D. Complex Health Conditions which are conditions impacting multiple organs or systems
      - CHARGE Syndrome
      - DiGeorge, Opitz, Velocardiofacial and Related Syndromes (22q 11.2 deletion syndrome)
      - Noonan Syndrome
      - Sacral Agenesis (Caudal Regression Syndrome)
   E. Musculoskeletal
      - Arthrogryposis Multiplex Congenital, TNNT3
5. Osteogenesis Imperfecta

5. Sensory

A. Hearing loss as recommended by the Minnesota Early Hearing Detection and Intervention team
B. Vision impairment: A diagnosed vision impairment that is not correctable with treatment, surgery, glasses or contact lenses. CDC Vision Loss Fact Sheet, English and Spanish (PDF 118KB/2 pages)

6. Social or Emotional Conditions

A. Axis I conditions from the Diagnostic Classifications 0–3 including:
   - Adjustment Disorders
   - Anxiety Disorders of Infancy and Childhood
   - Depression of Infancy and Early Childhood
   - Deprivation/Maltreatment Disorder
   - Disorders of Affect
   - Feeding Behavior Disorders
   - Mixed Disorder of Emotional Expressiveness
   - Post–Traumatic Stress Disorder (PTSD)
   - Prolonged Bereavement / Grief Disorder
   - Regulation Disorders of Sensory Processing
   - Sleep Behavior Disorder
   - Disorders of Relating and Communicating
   - Multisystem Developmental Disorder (MSDD)

Retrieved December 15, 2014, from
http://www.health.state.mn.us/divs/cfh/program/cyshn/delay.cfm
Appendix C
The Medical Case for Early Intervention

The recent discovery of the catastrophic consequences of environmental stress in a child’s development has led leaders in the medical field to express their concern on the phenomenon of toxic stress. Toxic stress is a medical condition that arises when children are raised in an at-risk environment in which their developmental need for strong social relationships is not met. The result of this absence is that their bodies’ stress response is set into overdrive leading to extensive biological and neurological ramifications. Toxic stress is thought to be a lead indicator of why individuals from low-income environments are significantly more likely to suffer early deaths. Mounting research indicates that targeting toxic stress is of grave importance.

The Lifelong Effects of Early Childhood Adversity and Toxic Stress
The American Academy of Pediatrics

“Longitudinal Studies document the long-term consequences of childhood adversity indicate that alterations in a child’s ecology can have measurable effects on his or her developmental trajectory, with lifelong consequences for educational achievement, economic productivity, health status, and longevity.” – The American Academy of Pediatrics

What is Toxic Stress?
Toxic stress is defined by the American Academy of Pediatrics as “the excessive or prolonged activation of the physiologic stress response systems in the absence of the buffering protection afforded by stable, responsive relationships.” In other words, when a child is not properly cared for early in his or her lifetime lacks the protective relationships critical to healthy development. Here, it is argued, one’s nature is largely dependent on nurture.

When this social reinforcement is absent, a highly disruptive physiologic response takes place, producing “biological memories” that interrupt a child’s development. Such interruption has the ability to disrupt brain circuitry and other critical regulatory systems to such a severe extent that it can continue to influence physiology, behavior, and health. In short, placing a child in an unstable environment can lead to high levels of stress that deter adaptive capacities, coping skills, and social relationships for the rest of his or her life.

Biology Behind the Issue
Bodily functioning is regulated through a multitude of systems critical to keeping the body in a state of homeostasis, or balance. Consistent elevation in stress-related hormones can lead to a wearing of the organ and brain systems when coping with this excess, also known as an “allostatic load.” Heightened stress leads to over activation of stress related symptoms resulting in impaired levels of cortisol, deters one’s inflammatory response and interrupts normal functioning. Although the body is designed to handle brief periods of increased stress due to sudden tragic acts or threats to life, it is not capable of managing the constant elevation brought on by toxic stress. Thus, adversity at an early age can forever alter the architecture of the brain by causing permanent damage to one’s amygdala, orbitofrontal cortex, hippocampus, and medial pre-frontal cortex.

Why it Matters
Impairments to these parts of the brain lead to grave implications in physical and mental health. There is a high correlation between toxic stress and engaging in health-threatening behaviors,
including substance abuse, gambling, obesity, and promiscuity. Furthermore, the consequences of toxic stress predispose individuals to higher rates of risk-taking, such as joining a gang, school failure, violent crime, and single parenthood. Toxic stress additionally impairs one’s ability to maintain supportive social networks. With up to 40% of early deaths being attributed to behavioral and lifestyle patterns, these consequences of toxic stress matter a great deal. Toxic stress serves as a significant deterrent to one’s overall health, with victims suffering increased incidences of cardiovascular disease, viral hepatitis, liver cancer, asthma, pulmonary disease, autoimmune disease, and depression. The impact of these effects is exacerbated by the fact that roughly 30% of early deaths are attributable to lack of adequate medical care and socioeconomic discrepancies.

“How to Prevent the Onset of Toxic Stress
By lessening the adverse environments that many children are forced to endure, the harmful effects of toxic stress could be significantly mitigated. Toxic stress manifests when a child’s physiologic stress response system is in overdrive. To ensure that this system’s functioning is brought back to baseline there is no better solution than to target parents directly. Because toxic stress is highly correlated with depression, substance abuse, domestic and community violence, and food scarcity within a child’s home, it is critical to focus resources in areas where these factors are most prevalent. Successful deterrents to the onset of toxic stress include educational efforts targeting caregivers and educators, stability of home and school environments, community based mentor initiatives, family based therapies, and finally more aggressive identification and intervention when toxic stress is present. Other succinct measures to aid in the eradication of toxic stress include addressing maternal depression, providing counseling on the importance of the mother-child bond, and more broadly, expanding the concerns of child welfare to also pertain to the social, emotional, and cognitive components of maltreatment.

“Protecting young children from adversity is a promising, science-based strategy to address many of the most persistent and costly problems facing contemporary society, including limited educational achievement, diminished economic productivity, criminality, and disparities in health.” – American Academy of Pediatrics

Why it is overlooked
The reason toxic stress, though scientifically proven, has yet to be widely recognized within the medical community is the emphasis on sick care. The connection between toxic stress and later implications of developmental disorders has been cemented, yet early intervention is commonly overlooked because the implications of toxic stress do not fully manifest until later in one’s lifetime. Toxic stress is one of the newly recognized “millennial morbidities” that has surfaced in modern times due to a deeper exploration of the socioeconomic disparities in care. According to the American Academy of Pediatrics, over the last 58 years ethnic and racial inequalities in health care have been worsening, meaning the implications of toxic stress are getting increasingly severe.

“This is the biology of social class disparities. Early Experiences are literally built into our bodies.” – Dr. Jack Shonkoff, Harvard Pediatrician and leader of American Academy of Pediatrics

Sources Cited:


**Adverse Childhood Experiences – in the general adult population:**

- 11% experienced emotional abuse.
- •28% experienced physical abuse.
- •21% experienced sexual abuse.
- •15% experienced emotional neglect.
- •10% experienced physical neglect.
- •13% witnessed their mothers being treated violently.
- •27% grew up with someone in the household using alcohol and/or drugs.
- •19% grew up with a mentally-ill person in the household.
- •23% lost a parent due to separation or divorce.
- •5% grew up with a household member in jail or prison


Appendix D

The numbers
One in 45 children experience homelessness in America each year. That’s over 1.6 million children. While homeless, they experience high rates of acute and chronic health problems. The constant barrage of stressful and traumatic experience also has profound effects on their development and ability to learn (The National Center on Family Homelessness, 2011).

Table 1:
In Minnesota in 2011, the number of children 0-3 (Birth through 2) participating in Part C by age, race, and gender:

<table>
<thead>
<tr>
<th>Age</th>
<th>Birth to 1</th>
<th>Age 1 to 2</th>
<th>Age 2 to 3</th>
<th>Birth 2 Hispanic/Latino</th>
<th>Birth 2 American Indian/Alaska Native</th>
<th>Birth 2 Black or African American</th>
<th>Birth 2 Native Hawaiian or Other Pacific Islander</th>
<th>Birth 2 White</th>
<th>Birth 2 Two or More Races</th>
<th>Male Ages Birth through 2</th>
<th>Female Ages Birth through 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages</td>
<td>597</td>
<td>1,562</td>
<td>2,918</td>
<td>5,077</td>
<td>399</td>
<td>105</td>
<td>172</td>
<td>466</td>
<td>7</td>
<td>3,704</td>
<td>224</td>
</tr>
<tr>
<td>Birth to 1</td>
<td>Birth through 2</td>
<td>Birth through 2</td>
<td>Birth through 2</td>
<td>Birth through 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

These data are from Technical Assistance & Dissemination Network, 2011.

Table 2:
In 2012, the number of homeless children in Minnesota:

<table>
<thead>
<tr>
<th>Age Birth to 1</th>
<th>Ages 1 and 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>315</td>
<td>676</td>
</tr>
</tbody>
</table>

These data are from Wilder Research, September 2013. The number for “Ages 1 and 2” is extrapolated; Wilder reports “…there are 3,931 minor children homeless with their parents on any given night. This number excludes a far larger number of children who are with parents who are doubled-up with friends or families and eligible for school services to homeless students under the McKinney-Vento Act (McKinney-Vento (1) and (2), 2004). One-half (51%) of homeless children with their parents are age 5 or younger” (Wilder Research, September 2013). “8% of homeless children are under the age of 1” (Wilder Research, May 2014). Additionally, the data is from a one-night count – a point in time; this is not a cumulative number.
### Table 3:
Race and ethnicity of homeless parents, by percent:

<table>
<thead>
<tr>
<th></th>
<th>Hispanic/Latino</th>
<th>American Indian</th>
<th>Asian</th>
<th>Black or African American</th>
<th>Other, Including Multi-racial</th>
<th>White</th>
<th>Children in care of mother or other single female</th>
<th>Children in care of father or other single male</th>
<th>Children in the care of two parents or caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless</td>
<td>8</td>
<td>8</td>
<td>2</td>
<td>49</td>
<td>6</td>
<td>27</td>
<td>72*</td>
<td>4*</td>
<td>24*</td>
</tr>
<tr>
<td>All Parents</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>64</td>
<td>6</td>
<td>27</td>
<td>16.9**</td>
<td>5.7**</td>
<td>77.4**</td>
</tr>
</tbody>
</table>

These data are from Wilder Research, May 2014, except for those marked * which are from Wilder Research, September 2013, and ** which are from Office on the Economic Status of Women, August 2005.

### Table 4:
Children evaluated for Part C services.

<table>
<thead>
<tr>
<th></th>
<th>In U.S.</th>
<th>In Minnesota</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Children 0-3 Total</td>
<td>12,028,122</td>
<td>205,991</td>
</tr>
<tr>
<td>Number of Children 0-3 Receiving Part C Services</td>
<td>333,542</td>
<td>5,027</td>
</tr>
<tr>
<td>Percent of Children 0-3 Receiving Part C Services</td>
<td>5.12</td>
<td>2.44</td>
</tr>
<tr>
<td>Age Eligible Children are Identified</td>
<td>0-1</td>
<td>1-2</td>
</tr>
<tr>
<td></td>
<td>42,225</td>
<td>102,970</td>
</tr>
</tbody>
</table>


Federal Child Count Data, using Developmental Delay and Emotional Disturbance when counting Race, Disability, and Age. http://w20.education.state.mn.us/MDEanalytics/Data.jsp
Appendix E

Additional Resources


Frank Porter Graham Child Development Institute
http://fpg.unc.edu/

Institute for Children, Poverty & Homelessness
http://www.icphusa.org/The-Institute/Overview/

The National Center on Family Homelessness
http://www.familyhomelessness.org

Start Early Funders Coalition for Children and Minnesota’s Future
http://startearlyfundersmn.org/index.html

Wilder Research
Quick look at key findings and links to all homeless information on our website
http://www.wilder.org/Wilder-Research/Research-Areas/Homelessness/Pages/Statewide-Homeless-Study-Most-Recent-Results.aspx

Detailed data tables from the 2012 and 2009 studies
http://www.wilder.org/Wilder-Research/Research-Areas/Homelessness/Pages/Statewide-Homeless-Study-Detailed-Data.aspx

All homeless publications from Wilder Research
http://www.wilder.org/Wilder-Research/Publications/Pages/results-Homelessness-Housing.aspx

Websites:
http://aspe.hhs.gov/hsp/10/homelesschildrenroundtable/index.shtml
http://aspe.hhs.gov/hsp/10/homelesschildrenroundtable/index.shtml#sec2
http://aspe.hhs.gov/hsp/homelessness/improving-data08/apd.htm
http://center.serve.org/nche/ibt/sc_preschool.php
http://centerforeducation.rice.edu/slcs/LS/Medical.html
http://ectacenter.org/partc/partc.asp
http://fpg.unc.edu/
http://gradworks.umi.com/36/19/3619165.html
http://media.proquest.com/media/pq/classic/doc/3319974691/fmt/ai/rep/NPDF?_s=v1xXrMvry8acjyuCL4FQR1up0yc%3D
http://parentawareratings.org/tools-provider-early-educators
http://pediatrics.aappublications.org/content/129/1/e224.full.pdf+html
http://psycnet.apa.org/books/12057/001.pdf
http://startearlyfundersmn.org/index.html
http://tadnet.public.tadnet.org/pages/712p
http://www.acf.hhs.gov/sites/default/files/opre/early_intervention_0.pdf
http://www.education.state.mn.us/MDE/SchSup/EarlyLearnProg/EarlyChildSpecEd/index.html
http://www.familyhomelessness.org
http://www.familyhomelessness.org/media/306.pdf
http://www.familyhomelessness.org/media/306.pdf
http://www.familyhomelessness.org/media/327.pdf
http://www.health.state.mn.us/divs/cfh/program/cyshn/delay.cfm
http://www.health.state.mn.us/divs/cfh/program/cyshn/delay.cfm#social
http://www.health.state.mn.us/divs/cfh/program/cyshn/earlyintro.cfm
http://www.health.state.mn.us/divs/cfh/program/cyshn/guidelines.cfm
http://www.icphusa.org/Publications/Reports/
http://www.icphusa.org/The-Institute/Overview/
http://www.lcesw.leg.mn/
http://www.mn.gov/governor/budget/middle-class/education/
http://www.naehcy.org/
http://www.naehcy.org/educational-resources/early-childhood
http://www.ncbi.nlm.nih.gov/pubmed?LinkName=pubmed_pubmed&from_uid=2304777
http://www.nctsnet.org/resources/topics/special-populations-and-trauma
http://www.nctsnet.org/sites/default/files/assets/pdfs/Facts_on_Trauma_and_Homeless_Children.pdf
http://www.wilder.org/Wilder-Research/Publications/Pages/results-Homelessness-Housing.aspx
http://www.wilder.org/Wilder-Research/Research-Areas/Homelessness/Pages/
Statewide-Homeless-Study-Detailed-Data.aspx
http://www.wilder.org/Wilder-Research/Research-Areas/Homelessness/Pages/Statewide-Homeless-Study-
Most-Recent-Results.aspx
http://www.zerotothree.org/
http://www2.ed.gov/programs/homeless/index.html
https://www.acf.hhs.gov/sites/default/files/ecd/building_partnerships.pdf
https://www.bcbsmnfoundation.org/system/asset/resource/pdf_file/69/Homeless_in_MN_2012-
Children_Families_5-14.pdf?utm_source=Blue+Cross+and+Blue+Shield+of+Minnesota+Foundation-
Newsletter&utm_campaign=c2b0e71ff7-Foundation_News_June_26_2014_6_25_2014&utm_medium=
email&utm_term=0_e76d2394fb-c2b0e71ff7-20453457
Appendix F

The State of America’s Children, 2014

Endnotes (Extensive additional resources, by topic)

Preventable Costs
Child poverty
Child maltreatment
Gun deaths and injuries
Health disparities
Dropouts
Achievement gap

We Can Afford to Do Better
Revenue lost to corporate tax breaks in 2011 ($181.3 billion
Child care worker mean salary 2012 ($21,210)
Children on child care assistance state waiting lists in 2013 (223,995)
Child care assistance boosts poor mothers’ work participation
Average cost of Supplemental Nutrition Assistance Program per participant
in 2012 ($1,683)
Children who don’t have enough food (737,000)
Tax breaks for corporate jets ($370 million)
Average secondary school teacher salary in 2012 ($57,770)
U.S. military budget in FY2012 ($681.4 billion)
Cost of Early Head Start per child participant ($1,267,875,016 FY2012
budget / 110,884 FY12 funded enrollment = $11,343)
Percent of eligible children able to be served by Early Head Start (110,884
FY2012 funded child enrollment / 2,938,000 children ages
0-2 in poverty in 2012 = 3.8%)
Return on investment of high quality early education programs
F-35 fighter jet cost ($137 million per plane)
Cost of Head Start per participant ($6,415,222,712 FY2012 budget/
821,852 FY12 funded enrollment = $7,806)

Child Well-Being: A 50-year Snapshot
Child poverty
Child poverty taking into account government benefits
Income share
Unemployment
Minimum wage
Family structure
Teen births
School enrollment
High school graduates
College graduates
School segregation
Infant mortality
Gun deaths

Moments in America and Each Day in America
Suspensions
High School Drop Outs
Juvenile Arrests
Unmarried Mothers
Corporal Punishment
Abuse and Neglect
Babies Born in Poverty
Babied Born Without Health Insurance
Teen Mothers
Infant Low Birthweight
Juvenile Arrests for Drug Crimes
Juvenile Arrests for Violent Crimes
Infant Mortality
Accident Deaths
Suicide Deaths
Gun Deaths
Child Maltreatment Fatalities
Maternal Death
### How America Ranks Among Industrialized Countries
- Gross Domestic Product
- Number of Billionaires
- Child Poverty Gaps
- Gap between Rich and Poor
- Defense Expenditures
- Military Weapons Exports
- Persons Incarcerated
- Gun Violence
- Preschool Enrollment Rates
- Reading, Math and Science Scores of 15-year-olds
- Health Expenditures
- Low Birthweight
- Immunization Rates
- Infant Mortality Rates
- Teenage Births
- Infant Mortality Rates for Black Children
- Low Birthweight for Black Children

### Child Population

### Child Poverty

### Family Structure and Income

### Housing and Homelessness

### Child Hunger and Nutrition

### Child Health

### Early Childhood

### Education

### Child Welfare

### Juvenile Justice

### Gun Violence
Appendix G

Post-Referral Actions
(Accessible format on page below)

Day 0

Referral made through statewide phone or online system. Minnesota Department of Education will conduct designated local intake as soon as possible and in no case more than one business day after receiving referral.

Day 1

Local education agency will gather and review information available, determine status of referral and appropriate next steps.

Screen

No diagnostic, prior screening or other data indicating a suspected disability is available evidence.

No

Diagnosis determined. Screening is administrated.

Yes

Evaluation

A disability is suspected due to professional observation or prior screening or evaluation is requested by parent.

1) Appoint a Service Coordinator

2) Prepare a comprehensive, multidisciplinary evaluation assessment through a PWN

3) Obtain informed consent

4) Implement evaluations as planned

- Review medical records
- Interview parents
- Test in all the domain areas
- Observe in setting routines to the child
- Gather information from
other sources

5) Consider all information using informed clinical opinion.

6) Determine child's needs (30, 60, 90 days)

Adopt

Evidence of a diagnosed condition or documentation of previous evaluation results.

1) Appoint a Service Coordinator

2) Provide Part C Procedural Safeguards Notice to family

3) Obtain medical or other records document a condition with a high probability or a delay of 1.5 standard deviations below the mean in one or more areas?

No

Provide Notice of Screening Results

- Include all required components of PWN
- Describe parent's right to request an evaluation

Screening Results: Child suspected of having a disability OR parent with no evidence of a suspected disability parent has requested an evaluation.

No

Yes

Provide Notice of Screening Results

- Include all required components of PWN
- Describe parent's right to request an evaluation

Evaluate

Determination that a child is NOT eligible

- Provide parent(s) with PWN

- Notice must include a description of parents right to dispute eligibility determination through dispute resolution mechanisms, e.g. mediation, hearing or due process

Is there a developmental concern that warrants intervention based solely on Informed Clinical Opinion?

No

Yes

Initial Individual Family Service Plan (IFSP) team meeting must be held: 1) within 45 days of referral, 2) at a time and place convenient to the family, 3) in their native language or other mode of communication of the family unless not feasible. Provide written notice of a meeting early enough to allow parents to attend.
Post Referral Actions

Receiving a referral

1) A primary referral source has identified and referred an infant or toddler who is NOT within 45 days of their third birthday and has a diagnosed condition, a suspected developmental delay or atypical development, or as the subject of a substantiated case of child abuse or neglect.

2) Referral made through statewide phone or online system. Minnesota Department of Education will contact designated local intake ASAP and in no case more than one business day after receiving referral or local education agency will receive referral and determine the appropriate next step.

Acting on a referral: Screen

1) No diagnosis, prior screening or other data indicating a suspected disability is available so the team determines screening is appropriate.

2) Provide prior written notice or intent to screen and make sure to include all required components of prior written notice and describe parent’s right to request an evaluation at any point during screening.

3) Obtain written consent.

4) Screen the child using appropriate instruments and trained staff.

5) If the screening results indicate that the child is suspected of having a disability OR even with no evidence of a suspected disability the parent has requested an evaluation, begin the evaluation and assessment process described below.

6) If the screening results indicate that the child is NOT suspected of having a disability and parents have not requested an evaluation, provide prior written notice containing screening results. Include all required components of the prior written notice and make sure to describe parent’s rights to request an evaluation.

Acting on a referral: Evaluation and Assessment

1) A disability is suspected due to professional observation or prior screening OR evaluation is requested by parent. The team determines evaluation is appropriate.
2) Team will appoint a Service Coordinator for the family. The Service Coordinator will propose a comprehensive, multidisciplinary evaluation/assessment through a prior written notice.

3) Obtain informed consent from the parents.

4) Implement evaluations as planned. Make sure to review medical records that are available and interview parents regarding their concerns and observations. Make sure the evaluation includes evaluations of all five domain areas, observations in settings routine to the child and contains information from other sources as appropriate.

5) Consider all information using informed clinical opinion.

6) Determine if child meets criteria.

7) If child does meet eligibility criteria parents must have also given written consent on a prior written notice for the child assessment in ALL developmental areas. (This consent could have been obtained on the original prior written notice for evaluation.)

8) Conduct the child focused assessment in all areas thorough review of evaluation results, personal observations of the child and identification of the child need in each domain. A criterion referenced tool may be used.

9) If the family gives verbal permission (prior written notice consent is not required) conduct a Family-directed Assessment. This must be voluntary for the family and requires the use of an assessment TOOL and INTERVIEW. It will highlight the individual family description of concerns, priorities and resources.

10) Conduct an initial Individual Family Service Plan meeting within 45 days of the referral date. Make sure that the meeting is at a time and place convenient to the family. Provide information in the native language or other mode of communication of the family unless not feasible. Provide written notice of a meeting date and location early enough to allow parents and other required team members to attend.

Acting on a referral: Informed Clinical Opinion

1) AFTER formal evaluation procedures have been conducted as described above the team determines that the child does not meet eligibility criteria based upon standardized evaluation measures. The team may choose to use informed clinical opinion to establish eligibility for Developmental Delay under Part C.

2) If the team believes the child does meet eligibility standards under this decision the parents must also give written consent on a prior written notice for the child assessment in ALL developmental areas.

3) Conduct the child focused assessment in all areas thorough review of evaluation results, personal observations of the child and identification of the child need in each domain. A criterion referenced tool may be used.

4) If the family gives verbal permission (prior written notice consent is not required) conduct a Family-directed Assessment. This must be voluntary for the family and requires the use of an assessment TOOL and INTERVIEW. It will highlight the individual family description of concerns, priorities and resources.

education.state.mn.us
5) Conduct an initial Individual Family Service Plan meeting within 45 days of the referral date. Make sure that the meeting is at a time and place convenient to the family. Provide information in the native language or other mode of communication of the family unless not feasible. Provide written notice of a meeting date and location early enough to allow parents and other required team members to attend.

Acting on a referral: Independent Evaluation will be adopted

1) Evidence of a diagnosed condition OR documentation of previous evaluation results have been given to the educational team. Review of this data indicates that child has met the eligibility criteria for an infant or toddler with a disability under Part C criteria.

2) The team will appoint a Service Coordinator. The Service Coordinator will provide Part C procedural safeguards notice to family.

3) The parents must give written consent on a prior written notice for the child assessment in ALL developmental areas.

4) Conduct the child focused assessment in all areas thorough review of evaluation results, personal observations of the child and identification of the child need in each domain. A criterion referenced tool may be used.

5) If the family gives verbal permission (prior written notice consent is not required) conduct a Family-directed Assessment. This must be voluntary for the family and requires the use of an assessment TOOL and INTERVIEW. It will highlight the individual family description of concerns, priorities and resources.

6) Conduct an initial Individual Family Service Plan meeting within 45 days of the referral date. Make sure that the meeting is at a time and place convenient to the family. Provide information in the native language or other mode of communication of the family unless not feasible. Provide written notice of a meeting date and location early enough to allow parents and other required team members to attend.

Acting on a referral: Evaluation and application of Informed Clinical Opinion results in NO eligibility

1) Formal evaluation and applied use of informed clinical opinion has determined that the child is NOT eligible; does not have a disability.

2) Provide parents with prior written notice describing outcome of the evaluation process. This notice must include a description of parent’s right to dispute eligibility determination through dispute resolution mechanisms, e.g. mediation, hearing or complaint.

3) If available, provide information about community programs, resources and services.
Appendix H
Part C Services and Homeless/Highly Mobile Children and Families
In response to a request from Sharon Henry Blythe
Organizing Questions
Prepared by Scott McConnell, Updated 2/6/2015 12:03:00 PM

Sharon is leading an effort to expand Minnesota’s statutory eligibility criteria for Part C services, or early intervention for infants and toddlers with disabilities and their families, as provided under requirements of the Federal Individuals with Disabilities Education Act. In brief, this federal law allows states some flexibility to define eligibility standards, and consequently provide family-focused interdisciplinary early intervention services, to infants and toddlers and their families. As described by the Early Childhood Technical Assistance Center (http://ectacenter.org/topics/earlyid/partcelig.asp, retrieved October 6, 2014):

*Part C eligibility is determined by each state’s definition of developmental delay and includes children with established physical or mental conditions with a high probability of resulting in developmental delay and includes conditions such as chromosomal abnormalities; genetic or congenital disorders; sensory impairments; inborn errors of metabolism; disorders reflecting disturbance of the development of the nervous system; congenital infections; severe attachment disorders; and disorders secondary to exposure to toxic substances, including fetal alcohol syndrome. States may choose to include children at risk for disabilities in the eligible group (§303.21). An important part of the evaluation process for infants and toddlers includes informed clinical opinion of professionals experienced with development in the very young.*

Sharon and her colleagues are interested in gathering information that will help determine whether Minnesota should include Homeless and Highly Mobile (or H/HM) children in this classification.

Sharon and Scott met in late July 2014 and identified a set of questions, and potential informants, to provide context and support for this effort. This document describes some possible questions to be addressed, with the assumption that any information gathered here will be used to determine additional information (and experts) to consider.

1. What are the characteristics of children and families receiving early intervention services under Part C?
   a. How many children, and what percentage of the population, have been evaluated and found eligible for Part C services...
      i. In Minnesota?
      ii. In the US?
   b. For children evaluated and found eligible for Part C services in Minnesota and in the US...
      i. At what age were they identified?
      ii. What are the demographic characteristics (sex, race, family income, family language, H/HM status)?
      iii. What conditions are identified as basis for eligibility, if reported?
c. Descriptively, how are children and families screened, referred, evaluated, and found eligible for early intervention services?

2. What are the characteristics of H/HM infants and toddlers and their families in Minnesota?
   a. How many children birth to age 3, and what percentage of the population, are H/HM?
   b. What are the demographic characteristics of these children and families (sex, race, family income, family language, early intervention status)?

3. Descriptively, what evidence exists for known effects of H/HM status in early months on short- and long-term development?
   a. What evidence exists for H/HM status preceding special education eligibility?
Appendix I
The McKinney-Vento Homeless Assistance Act
As amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009

1 SEC. 103. [42 USC 11302]. GENERAL DEFINITION OF HOMELESS INDIVIDUAL.
(a) IN GENERAL.—For purposes of this Act, the term “homeless”, “homeless individual”, and “homeless person” means—

(1) an individual or family who lacks a fixed, regular, and adequate nighttime residence;
(2) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
(3) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);
(4) an individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided;
(5) an individual or family who—
   (A) will imminently lose their housing, including housing they own, rent, or live in without paying rent, are sharing with others, and rooms in hotels or motels not paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, as evidenced by—
      (i) a court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days;
      (ii) the individual or family having a primary nighttime residence that is a room in a hotel or motel and where they lack the resources necessary to reside there for more than 14 days; or
      (iii) credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days, and any oral statement from an individual or family seeking homeless assistance that is found to be credible shall be considered credible evidence for purposes of this clause;
   (B) has no subsequent residence identified; and
   (C) lacks the resources or support networks needed to obtain other permanent housing; and
(6) unaccompanied youth and homeless families with children and youth defined as homeless under other Federal statutes who--
   (A) have experienced a long term period without living independently in permanent housing,
   (B) have experienced persistent instability as measured by frequent moves over such period, and
   (C) can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment.

(b) DOMESTIC VIOLENCE AND OTHER DANGEROUS OR LIFE-THREATENING CONDITIONS.—Notwithstanding any other provision of this section, the Secretary shall consider to be homeless any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual’s or family’s current housing situation, including where the health and safety of children are jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing.
Appendix J
Example of Linked Effects

Economic Instability

- Low family income negatively affects children’s social-emotional, cognitive, and academic outcomes, even after controlling for parental characteristics.
- Children’s cognitive development during early childhood is most sensitive to the experience of low family income.
- Employment Instability.
- Parental employment instability is linked to negative academic outcomes, such as grade retention, lower educational attainment, and internalizing and externalizing behaviors.
- Family Instability.
- Family instability is linked to problem behaviors and some academic outcomes, even at early ages.
- Children’s problem behaviors further increase with multiple changes in family structure.
- Family transitions that occur early in children’s development, prior to age 6, and in adolescence appear to have the strongest effects. While young children need constant caregivers with whom they can form secure attachments, adolescents need parental support, role models, and continuity of residence and schools to succeed.
- Children demonstrate more negative behaviors when they lack the emotional and material support at home that they need to smoothly handle a family transition.
- Residential Instability.
- Children experiencing residential instability demonstrate worse academic and social outcomes than their residentially-stable peers, such as lower vocabulary skills, problem behaviors, grade retention, increased high school drop-out rates, and lower adult educational attainment.
- Academically, elementary school children appear to be the most sensitive to residential change as compared with younger, non-school-age children and older children, but residential instability is related to poor social development across age groups.
- Home and neighborhood quality may mediate the effect of residential instability on children as housing moves lead to changes in children’s environments.

(Sandstrom, H. & Huerta, September 2013)