



## Promoting the inclusion of infants and young children with disabilities in child care

Participant Module

Early Intervention  
Resources & Relationships



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# Session: Resources & Relationships

## OVERVIEW

The same federal law that governs special education for school age students also established programs for infants and toddlers and for preschoolers. These laws state that children with disabilities are entitled to participate in all settings in which all children would participate. Children with disabilities who are eligible for early intervention services may receive those services in their natural and inclusive environment. Some examples of natural environments are: child care settings, playgrounds, libraries, and YMCA/YWCA.

Due to the establishment of legislation regarding individuals with disabilities early intervention (EI) services are more frequently being provided in child care settings because of the emphasis on providing early intervention services in community environments. By including all children in child care, our learning grows about what every child needs. Additionally, child care providers can be an asset to an early intervention team. The child care provider is able to identify the child's interests and what strengths they bring to the program. Viewing a child in this light we can begin to understand how children with special needs can participate in child care programs and how children are identified and referred for early intervention services. Participants will explore the process for referring children for early intervention services and will also learn about the early intervention process. Participants will also be introduced to the history of legislation regarding individuals with special needs.

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**From this session, participants should gain understanding about:**

- i identify the history of legislation for individuals with disabilities
- i describe how to make referrals to better support infant's and toddler's participation in child care settings
- i describe what happens when children are referred for early intervention services
- i apply how the Americans with Disabilities Act impacts on child care settings

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## BACKGROUND

To address the needs of children who required different-than-typical instruction in order for them to be successful in school, legislation was passed that attended to their right to this special instruction. In 1975 Congress passed P.L. 94-142, the Education of All Handicapped Children's Act (EHA). This law entitled school-aged children to free and appropriate special education (termed FAPE) and the related services necessary to benefit from education.

Students are eligible for special education and related services after a team of professionals identifies their special learning needs. These children may not speak English as their first language or they may have difficulty learning, speaking, writing, or getting along with others. A plan called the Individualized Education Program (IEP) is developed outlining individual student goals and objectives and the ways in which those goals and objectives will be addressed. A student's needs may be met through specially trained teachers (e.g., special educators) and related services which include physical and occupational therapy, speech and language pathology, nursing, classroom para-educators, transportation, and other services that may assist a student to benefit from education.

Children three years of age and over receive early intervention services when a team of professionals decide that the child has a developmental delay or disability that has impacted on the child's development. Once the child is eligible for early intervention as documented on the Comprehensive Evaluation Report (CER), the IEP is developed and the child receives services **to the maximum extent possible with children who have typical development (a standard also used for school-aged children).**

The same federal law that governs special education for school age students also established programs for infants and toddlers and for preschoolers. In most states, the term early intervention refers to the state's program for infants and toddlers. In Pennsylvania, early intervention describes both the program for infants and toddlers and for children from

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three years old to the age of beginners (or kindergarten age as determined by the school district in which the child resides). In other words, there are two separate programs which join together under the term early intervention: infant/toddler program (administered by the Department of Public Welfare) and preschool program (administered by the Department of Education).

When children are under three years of age, a team decides whether or not the child is eligible for early intervention services through the Multidisciplinary Team Evaluation (MDT). Children are eligible when they have a developmental delay, a condition (diagnosis) with a high probability of delayed development, or are in need of services on the basis of the team's informed clinical opinion. An IEP is developed for eligible children three years of age and over; the plan for infants and toddlers is called the Individualized Family Service Plan (IFSP) and recognizes the critical importance of families in the growth and development of infants and toddlers. Parent(s) are members of the IFSP team and work together with early intervention professionals to develop the IFSP which is based on family-determined outcomes. Families may provide information about their priorities, resources, and concerns to the extent that they wish to share this information. Once the IFSP is developed, services are provided in environments that are natural to the child and family such as the child's home, child care settings, or community places where families and children spend time.

## Legislative History

The need for special education was apparent and compulsory school laws were enacted between 1850 and 1916 (Ysseldyke & Algozzine, 1995). Schools were arranged in two general tracks. One track was for students with typical development and students were expected to progress through the grading system. The other system developed to be a separate system for students who needed special instruction and who may otherwise be institutionalized.

Although there were special education classrooms and centers, until fairly

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recently public schools were not obligated to include students with disabilities in any education setting. By the 1960s it was not unusual to find parents organizing (a) to teach their own children with disabilities or (b) to obtain services for their children. Many parents of children with disabilities believed their children were receiving an inadequate education. Brown vs the Board of Education established that separate education was not equal. That is, educating children with disabilities in separate facilities was a form of discrimination.

Parents in many states worked together with legislators to enact state legislation to provide education and services for children with disabilities. For example, parents in Pennsylvania worked together to obtain the Pennsylvania Consent Decree. This consent decree enabled students with mental retardation to receive an education in the least restrictive environment. Additionally, due process rights were written into the decree. Parents had to provide informed consent before anything could change in the identification, evaluation, or placement of their child.

Specific legislation has enabled young children with disabilities to receive services in natural and inclusive settings, including child care programs. This is evident through four major features of the legislation. First, funds are provided for development of new models for early intervention as well as outreach activities for the models. Many of the new models developed through this legislation have been inclusive models. Second, children with disabilities are included in Head Start Programs. In fact, early intervention providers collaborate with Head Start. Third, early intervention is available for all infants, toddlers, and young children with delayed development or disabilities. Children from three to five years of age receive culturally fair, unbiased assessments, IEPs and special education and related services, and parents have due process rights. Birth to three services are an entitlement program in Pennsylvania with the same benefits as the preschool program but services are to be provided in natural environments and families receive IFSPs instead of IEPs. Finally, child care programs need to make reasonable accommodations for children with disabilities.

The results of the legislation as a whole have guaranteed civil rights to children and adults with disabilities including the right to access child care,

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schools, job settings, and community buildings and programs. Legislation has also established the right to a free and appropriate public education for all children with disabilities and recognized the importance of early intervention, intervention before kindergarten age, in lessening the effects of disabling conditions and in preventing the development of later-occurring disabilities.

Early intervention services are defined in IDEA, the federal law that outlines states responsibilities for educating children with disabilities. Part C of this law discusses state systems of early intervention for children aged birth through two years of age. Part B describes services for children aged three through 21 years of age. Each of these parts is a little different. Infants and toddlers may be provided with one or more services including education, therapies, or social work. Children who are school-aged (age three years and above) receive special education and related services necessary to benefit from education. Related services include things like transportation, speech and language, occupational and physical therapy, counseling, or other types of services.

Individualized planning is central to all legislation for children with disabilities -- whether an IEP, an IFSP, or some other type of individual plan. Parents of children with disabilities have a role in all plans, however, a very strong and central role for parents is described under Part C of IDEA, the part of the law that establishes the federal program for Infants and Toddlers and their Families.

## Finding Support from Outside Services

Early intervention services are more frequently being provided in child care because there is great emphasis on providing early intervention services in community environments. Additionally, more families are working and often they depend on the collaboration between child care and early intervention staff. Families, early intervention programs and early childhood program

can all benefit from their work with each other.

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Families are essential resources to child care staff and central to the whole early intervention process. Parents and other family members involved in early intervention can relay information about their child's services as well as things that work and do not work for their child. They can describe what has happened in the past and the child's current activities as well as strengths and needs.

In quality programs, families are considered to be equal members on early intervention teams. These teams are comprised of families and people who are providing specialized services to the child as well as child care providers. For example, a speech and language pathologist may be working with the child so that she can say words clearly. These early intervention teams are arranged individually according to children's strengths and needs.

Child care environments can benefit from these additional resources provided when a child is involved in early intervention. When child care providers work to be active team members, they may learn strategies to help the child through more difficult times during the day. Child care providers also can learn about particular skills that are important for the child to learn. The child care provider can assist the early intervention team by giving the team information about the child and helping the team to identify strategies and routines that do and do not work well.

The child care provider can be an asset to an early intervention team. The child care provider like the parent generally has the most broad based understanding of a particular child. The child care provider is able to identify the child's interests and what strengths they bring to the program. The provider also may have had extensive conversations with the family and have a good understanding of what the child is like outside of the child care setting. Child care providers bring their own unique expertise to the early intervention team and with effective collaboration the provider can learn skills that benefit the child and family.



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## How A Referral Is Made to the Single Point of Entry

A referral may come from many different sources. Some of these sources include: a doctor/nurse, parent, caregiver, or personnel from Department of Human Services (DHS). Once a developmental concern for a child is noticed, a call is placed to the early intervention program (in Philadelphia that organization is ChildLink). This is a **free and voluntary program**. The services from service providers also are **free**. The call goes through the Intake Department, which offers a phone screening to identify what the child can and can not presently do. This information is then passed on to the Clinical Supervisor who assigns a temporary diagnosis by looking at the information given and then researching and comparing this with the Diagnostic and Statistical Manual 4<sup>th</sup> Edition (DSM-IV). This manual lists all possible illnesses known to man. Some concerns already have diagnosis such as down's syndrome, cerebral palsy, etc. The information is then passed on to a team supervisor depending on the child's zip code.

The supervisor reviews the child's chart and then assigns a service coordinator to the family. At the same time, a family support coordinator is assigned and will be responsible for assisting the family in obtaining health appraisals (while this is not an issue for compliance, it is best practice, every child should have a health appraisal), and to inform them of community resources. Family support coordinators are parents of children who have disabilities who know how to maneuver through the "system". The service coordinator reviews the chart, and contacts the family within ten days to schedule an appointment to review the family's concerns. The family support coordinator also contacts the family to see how they can be of assistance to the family. The two coordinators may visit the family together. During this meeting, the family is given a brief outline of the next steps which include:

- \* Connect with Medical Assistance
- \* Complete a Health Appraisal
- \* Multi-Disciplinary Evaluation (MDE)

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- \* Eligibility
- \* Identify support services
- \* Prepare Individual Family Service Plan (IFSP)

The family is asked whether they wish to proceed and if they do, the next question is where would the family like to have the evaluation, at home, at a center, or neutral place such as a community church or center? Based on this information, the service coordinator has the task of selecting an evaluation team in the family's area to perform the evaluation after the family identifies possible dates for the evaluation. The evaluation team consists of two or three individuals from the following disciplines:

- \* Speech
- \* Physical Therapy
- \* Occupational Therapy
- \* Special Instruction
- \* Behavior
- \* Nurse
- \* Social Work
- \* Vision
- \* Hearing

On the day of the evaluation, the service coordinator, family support coordinator, and evaluation team will meet at the family's home or identified place of evaluation. The team informs the family the evaluation takes about one to two hours, before telling the family how the evaluation will take place: they will use parent's report via questions and answers along with a play based developmental scale to determine the child's present skill level. (The team will ask about the pregnancy, delivery, the child's first months of life if there were any difficulties, hospitalization both short and long term, surgeries, medications, etc to help them get a full, clear picture of the child.) The family will also be asked when the child performed major milestones such as rolling over, sitting up, crawling, etc. While someone is recording the family's responses, the other team member is engaging the child in play and checking off items a child can and can not do on the developmental scale. To qualify for Early Intervention services, a child must show at least a 25% delay in one or more of these developmental areas: cognitive, social, emotional, language, fine motor, gross motor or have a diagnosed condition

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that impacts development. If a child does not exhibit a 25% delay, they may be eligible to be enrolled in an At-Risk Program (in Philadelphia this program is also housed at ChildLink). The program monitors children every six months to determine if the child is still making progress or needs to be referred back to Early Intervention for evaluation and/or services. The At-Risk Coordinators conduct developmental screening via phone calls or home visits.

The team members review both sets of data, the parent's report and the child's scores from the developmental scale, followed by sharing with the family and service coordinator their findings. The family is asked if they have any questions about the findings, if not then all parties begin discussing possible ways to help the child. The team, including the parents, identify the child's strengths and needs, develop outcomes and then specific supports and services with frequencies and duration are determined. This document is the prescription for the services the child may need. There are sixteen services a child is entitled to receive. They include:

- \* Assistive Technology
- \* Audiology
- \* Family Training or Counseling
- \* Health Services
- \* Medical Service for Diagnostic or Evaluation Purposes Only
- \* Nursing Services
- \* Nutrition Services
- \* Occupational Therapy
- \* Physical Therapy
- \* Psychological Services
- \* Service Coordination
- \* Social Work
- \* Special Instruction
- \* Speech/Language Pathology
- \* Vision Services (or orientation and mobility instruction)
- \* Transportation (or related transportation costs)

This document is not set in stone, it will be reviewed every three to six months or at the family's request. The service coordinator works to locate a service provider and begin services in a timely manner. The services can

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occur at home, another relative's house, daycare, parent-child group or community center. If the services are provided with daycare personnel, usually the family will inform the child's teacher and review goals for the child to also be shared with the service provider. The service provider collaborates with the daycare teacher about techniques they can try during one to one sessions and large group activities such as circle time.

As the child approaches three years and still appears to require services, the family will be referred to the system that provides service for children between the ages of 3-5. The name of the referral agency in the Philadelphia area is Elwyn. Seven months prior to the child's third birthday, the service coordinator from the single point of entry program begins to make a referral to the 3-5 service coordinators. A meeting with the family, the 0-3 organization and the 3-5 organization will be set to identify the needs of the family. The 3-5 service coordinator will begin to complete a Comprehensive Evaluation Report (CER) at this time. In Philadelphia these organizations would be ChildLink (0-3) and Elwyn (3-5). After the meeting, the service coordinator will then try to locate services and finish the CER.

Once you have reviewed all of the above information with the family and they are interested in either getting more information or obtaining an evaluation, offer the early intervention organizations phone number ( ChildLink's phone number is 215 731-2100). Included in your packet are pages about Early Intervention legislation as a resource to share with other staff as well as families and caregivers.

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## SESSION OUTLINE

- I Welcome the group
- II Project Display
- III Overview of Legislation
- IV Application to Child Care Centers
- V Overview of Early Intervention Process
- VI Summary

## The ADA and Child Care Settings

Read the following statements and indicate by marking "T" for true if you believe the statement is true and "F" for false if you believe the statement to be false.

- \_\_\_\_\_ 1. Private child care centers that operate in a church setting are not required to comply with Title III of the ADA. (Question 2)
- \_\_\_\_\_ 2. Child care centers may exclude a child with a disability from their setting if the child poses a direct threat to the safety of other children. (Question 8)
- \_\_\_\_\_ 3. Child care directors may exclude a child from their setting if they believe the that they cannot meet the child's needs based on their disability. (Question 3 & 4)
- \_\_\_\_\_ 4. Child care centers who have a no diapering policy can exclude children with disabilities who are wearing diapers from their setting. (Questions 15 & 16)
- \_\_\_\_\_ 5. An older child with delayed speech can be placed in a room with younger children. (Question 12)
- \_\_\_\_\_ 6. A child with mental retardation must be included in all center activities. (Question 18)
- \_\_\_\_\_ 7. When child care settings make renovations to their building they must comply with the ADA guidelines. (Question 3)
- \_\_\_\_\_ 8. Child care centers that have a waiting list must accept children with disabilities ahead of non-disabled children. (Question 6)
- \_\_\_\_\_ 9. Child care centers that have a no medication policy must administer medication to children with disabilities if they require the medication in order to participate in the program. (Question 14)
- \_\_\_\_\_ 10. Child care centers must make reasonable accommodations for parents who have disabilities. (Question 10)

*(From U.S. Department of Justice Civil Rights Division Disability Rights Section [www.usdoj.gov/crt/ada/adahom1.htm](http://www.usdoj.gov/crt/ada/adahom1.htm))*

# Legislative History

The need for special education was apparent as compulsory school laws were enacted between 1850 and 1916. Schools were arranged in two general tracks. One track was for students with typical development and students were expected to progress through the grading system. The other system was special education and was developed to be a separate system for students who would be otherwise institutionalized.

Although there were special education classrooms and centers, until fairly recently schools were not obligated to include students with disabilities in any education setting. By the 1960s it was not unusual to find parents organizing (a) to teach their own children with disabilities or (b) to obtain services for their children. Parents of children with disabilities believed their children were receiving an inadequate education and as in *Brown vs the Board of Education* separate education was not equal. That is, educating children with disabilities in separate facilities was a form of discrimination. Parents in many states worked together with legislators to enact legislation.

For example, parents in Pennsylvania worked together to obtain the Pennsylvania Consent Decree. This consent decree enabled students with mental retardation to receive an education in the least restrictive environment. Additionally, due process rights were written into the decree. Parents had to provide informed consent before anything could change in the identification, evaluation, or placement of the child.

Taken together the specific legislation listed in the next section has enabled young children with disabilities to receive services and to be included in child care programs. This is evident through four major efforts of the legislation. First, funds are provided for development of new models for early intervention as well as outreach activities for the models. Many of the new models developed through this legislation have been inclusive models. Second, children with disabilities are included in Head Start Programs. In fact, early intervention providers collaborate with Head Start. Third, early intervention is an entitlement program. Preschool services are a federal entitlement program, children receive culturally fair, unbiased assessments, IEPs and appropriate services, and parents have due process rights. Birth to three services are an entitlement program in Pennsylvania, with the same benefits as for preschoolers, but services are to be provided in natural environments and families receive IFSPs instead of IEPs. Finally, child care programs need to make reasonable accommodations for children with disabilities.

# Legislation

**1968 - P.L. 90-358.** Authorized funds for the development, evaluation, and dissemination of model programs by establishing Early Education Program for Children with Disabilities (formerly called the Handicapped Children's Early Education Program). Programs funded have contributed to the knowledge base of specialized services for early childhood.

**1974 - P.L. 96-644.** Amended Head Start Legislation to mandate that 10% of all the children served by Head Start be children with disabilities. This established the first publicly funded provisions for preschool inclusion.

**1975 - P.L. 94-142.** Established the right to a free and appropriate public education (FAPE) for children with disabilities ages 6-21. Provided incentives for services for children ages 3-6. Insured that eligible children had due process rights (rights to prior notification and informed consent) and services are provided in the Least Restrictive Environment (LRE). LRE refers to the maximum extent possible children with disabilities are to be educated with children who have typical development.

**1983 - P.L. 98-199.** Made provisions for states to receive funding for planning and provision of services for children ages birth to six.

**1986 - P.L. 99-457.** Extended the same provisions for services for school-aged children with disabilities to preschoolers (children age 3 - 6). The legislation also provided incentives for states to provide services for children age birth to three. The birth to three program is optional for states. However, in order to receive federal funds for infants and toddlers states must agree to operate entitlement programs.

**1990 - P.L. 101- 576.** Reauthorized and renamed the Education for All Handicapped Children's Act (P.L. 94-142) to be the Individuals with Disabilities Education Act. This legislation also included early intervention services (P.L. 99-457).

**1990 - P.L. 101-336.** The Americans with Disabilities Act is civil rights legislation for people with disabilities. The legislation also mandates that reasonable accommodations be made so that people with disabilities have access to private and public services. Services include early childhood facilities.



## Results of Legislation

i  
Federal and state laws specify minimum requirements but serve as an impetus for developing new models for early intervention

i  
Children with disabilities are included in Head Start Programs, child care, and community preschools

i  
Children aged three through kindergarten age are entitled to special education and related services as outlined in IDEA, Part B

i  
Infants and toddlers aged birth through two years are entitled to early intervention services in Pennsylvania as outlined in PA Act 212

i  
Child care staff and preschool and Head Start teachers are important members of teams that, together with parents and specialists, provide the expertise to address an individual child's special needs so that each child can fully participate and be fully included in typical settings where children of the same age spend time

i  
Special education, specialty disciplines, child care teachers & staff, & parents meet the needs of all children through interdependent working relationships

# COMMONLY ASKED QUESTIONS ABOUT CHILD CARE CENTERS AND THE AMERICANS WITH DISABILITIES ACT

## Coverage

### 1. Q: Does the Americans with Disabilities Act -- or "ADA" -- apply to child care centers?

A: Yes. Privately-run child care centers -- like other public accommodations such as private schools, recreation centers, restaurants, hotels, movie theaters, and banks -- must comply with title III of the ADA. Child care services provided by government agencies, such as Head Start, summer programs, and extended school day programs, must comply with title II of the ADA. Both titles apply to a child care center's interactions with the children, parents, guardians, and potential customers that it serves.

A child care center's employment practices are covered by other parts of the ADA and are not addressed here. For more information about the ADA and employment practices, please call the Equal Employment Opportunity Commission (see question 30).

### 2. Q: Which child care centers are covered by title III?

A: Almost all child care providers, regardless of size or number of employees, must comply with title III of the ADA. Even small, home-based centers that may not have to follow some State laws are covered by title III.

The exception is child care centers that are actually run by religious entities such as churches, mosques, or synagogues. Activities controlled by religious organizations are not covered by title III.

Private child care centers that are operating on the premises of a religious organization, however, are generally not exempt from title III. Where such areas are leased by a child care program not controlled or operated by the religious organization, title III applies to the child care program but not the religious organization. For example, if a private child care program is operated out of a church, pays rent to the church, and has no other connection to the church, the program has to comply with title III but the church does not.

## General Information

### 3. Q: What are the basic requirements of title III?

A: The ADA requires that child care providers not discriminate against persons with disabilities on the basis of disability, that is, that they provide children and parents with disabilities with an equal opportunity

to participate in the child care center's programs and services. Specifically:

- Centers cannot exclude children with disabilities from their programs unless their presence would pose a *direct threat* to the health or safety of others or require a *fundamental alteration* of the program.
- Centers have to make *reasonable modifications* to their policies and practices to integrate children, parents, and guardians with disabilities into their programs unless doing so would constitute a *fundamental alteration*.
- Centers must provide appropriate auxiliary aids and services needed for *effective communication* with children or adults with disabilities, when doing so would not constitute an *undue burden*.
- Centers must generally make their facilities accessible to persons with disabilities. Existing facilities are subject to the *readily achievable* standard for barrier removal, while newly constructed facilities and any altered portions of existing facilities must be *fully accessible*.

#### **4. Q: How do I decide whether a child with a disability belongs in my program?**

A: Child care centers cannot just assume that a child's disabilities are too severe for the child to be integrated successfully into the center's child care program. The center must make an *individualized assessment* about whether it can meet the particular needs of the child without fundamentally altering its program. In making this assessment, the caregiver must not react to unfounded preconceptions or stereotypes about what children with disabilities can or cannot do, or how much assistance they may require. Instead, the caregiver should talk to the parents or guardians and any other professionals (such as educators or health care professionals) who work with the child in other contexts. Providers are often surprised at how simple it is to include children with disabilities in their mainstream programs.

Child care centers that are accepting new children are not required to accept children who would pose a *direct threat* (see question 8) or whose presence or necessary care would *fundamentally alter* the nature of the child care program.

#### **5. Q: My insurance company says it will raise our rates if we accept children with disabilities. Do I still have to admit them into my program?**

A: Yes. Higher insurance rates are not a valid reason for excluding children with disabilities from a child care program. The extra cost should be treated as overhead and divided equally among all paying customers.

#### **6. Q: Our center is full and we have a waiting list. Do we have to accept children with disabilities ahead of others?**

A: No. Title III does not require providers to take children with disabilities out of turn.

#### **7. Q: Our center specializes in "group child care." Can we reject a child just because she needs individualized attention?**

A: No. Most children will need individualized attention occasionally. If a child who needs one-to-one attention due to a disability can be integrated without fundamentally altering a child care program, the child cannot be excluded solely because the child needs one-to-one care.

For instance, if a child with Down Syndrome and significant mental retardation applies for admission and needs one-to-one care to benefit from a child care program, and a personal assistant will be provided at no cost to the child care center (usually by the parents or through a government program), the child cannot be excluded from the program solely because of the need for one-to-one care. Any modifications necessary to integrate such a child must be made if they are reasonable and would not fundamentally alter the program. This is not to suggest that all children with Down Syndrome need one-to-one care or must be accompanied by a personal assistant in order to be successfully integrated into a mainstream child care program. As in other cases, an *individualized assessment* is required. But the ADA generally does not require centers to hire additional staff or provide constant one-to-one supervision of a particular child with a disability.

**8. Q: What about children whose presence is dangerous to others? Do we have to take them, too?**

A: No. Children who pose a *direct threat* -- a substantial risk of serious harm to the health and safety of others -- do not have to be admitted into a program. The determination that a child poses a direct threat may not be based on generalizations or stereotypes about the effects of a particular disability; it must be based on an *individualized assessment* that considers the particular activity and the actual abilities and disabilities of the individual.

In order to find out whether a child has a medical condition that poses a significant health threat to others, child care providers may ask all applicants whether a child has any diseases that are communicable through the types of incidental contact expected to occur in child care settings. Providers may also inquire about specific conditions, such as active infectious tuberculosis, that in fact pose a direct threat.

**9. Q: One of the children in my center hits and bites other children. His parents are now saying that I can't expel him because his bad behavior is due to a disability. What can I do?**

A: The first thing the provider should do is try to work with the parents to see if there are reasonable ways of curbing the child's bad behavior. He may need extra naps, "time out," or changes in his diet or medication. If reasonable efforts have been made and the child continues to bite and hit children or staff, he may be expelled from the program even if he has a disability. The ADA does not require providers to take any action that would pose a *direct threat* -- a substantial risk of serious harm -- to the health or safety of others. Centers should not make assumptions, however, about how a child with a disability is likely to behave based on their past experiences with other children with disabilities. Each situation must be considered individually.

**10. Q: One of the children in my center has parents who are deaf. I need to have a long discussion with them about their child's behavior and development. Do I have to provide a sign language interpreter for the meeting?**

A: It depends. Child care centers must provide effective communication to the customers they serve, including parents and guardians with disabilities, unless doing so poses an undue burden. The person with a disability should be consulted about what types of auxiliary aids and services will be necessary in a particular context, given the complexity, duration, and nature of the communication, as well as the person's communication skills and history. Different types of *auxiliary aids and services* may be required for lengthy parent-teacher conferences than will normally be required for the types of incidental day-to-day communication that take place when children are dropped off or picked up from child care. As with other actions required by the ADA, providers cannot impose the cost of a qualified sign language

interpreter or other auxiliary aid or service on the parent or guardian.

A particular auxiliary aid or service is not required by title III if it would pose an *undue burden*, that is, a significant difficulty or expense, relative to the center or parent company's resources.

**11. Q: We have a "no pets" policy. Do I have to allow a child with a disability to bring a service animal, such as a seeing eye dog?**

A: Yes. A service animal is not a pet. The ADA requires you to modify your "no pets" policy to allow the use of a service animal by a person with a disability. This does not mean that you must abandon your "no pets" policy altogether, but simply that you must make an exception to your general rule for service animals.

**12. Q: If an older child has delayed speech or developmental disabilities, can we place that child in the infant or toddler room?**

A: Generally, no. Under most circumstances, children with disabilities must be placed in their age-appropriate classroom, unless the parents or guardians agree otherwise.

**13. Q: Can I charge the parents for special services provided to a child with a disability, provided that the charges are reasonable?**

A: It depends. If the service is required by the ADA, you cannot impose a surcharge for it. It is only if you go beyond what is required by law that you can charge for those services. For instance, if a child requires complicated medical procedures that can only be done by licensed medical personnel, and the center does not normally have such personnel on staff, the center would not be required to provide the medical services under the ADA. If the center chooses to go beyond its legal obligation and provide the services, it may charge the parents or guardians accordingly. On the other hand, if a center is asked to do simple procedures that are required by the ADA -- such as finger-prick blood glucose tests for children with diabetes (see question 20) -- it cannot charge the parents extra for those services. To help offset the costs of actions or services that are required by the ADA, including but not limited to architectural barrier removal, providing sign language interpreters, or purchasing adaptive equipment, some tax credits and deductions may be available (see question 24).

## Personal Services

**14. Q: Our center has a policy that we will not give medication to any child. Can I refuse to give medication to a child with a disability?**

A: No. In some circumstances, it may be necessary to give medication to a child with a disability in order to make a program accessible to that child. While some state laws may differ, generally speaking, as long as reasonable care is used in following the doctors' and parents' or guardians written instructions about administering medication, centers should not be held liable for any resulting problems. Providers, parents, and guardians are urged to consult professionals in their state whenever liability questions arise.

**15. Q: We diaper young children, but we have a policy that we will not accept children more than three years of age who need diapering. Can we reject children older than three who need diapering because of a disability?**

A: Generally, no. Centers that provide personal services such as diapering or toileting assistance for young children must reasonably modify their policies and provide diapering services for older children who need it due to a disability. Generally speaking, centers that diaper infants should diaper older children with disabilities when they would not have to leave other children unattended to do so.

Centers must also provide diapering services to young children with disabilities who may need it more often than others their age.

Some children will need assistance in transferring to and from the toilet because of mobility or coordination problems. Centers should not consider this type of assistance to be a "personal service."

**16. Q: We do not normally diaper children of any age who are not toilet trained. Do we still have to help older children who need diapering or toileting assistance due to a disability?**

A: It depends. To determine when it is a reasonable modification to provide diapering for an older child who needs diapering because of a disability and a center does not normally provide diapering, the center should consider factors including, but not limited to, (1) whether other non-disabled children are young enough to need intermittent toileting assistance when, for instance, they have accidents; (2) whether providing toileting assistance or diapering on a regular basis would require a child care provider to leave other children unattended; and (3) whether the center would have to purchase diapering tables or other equipment.

If the program never provides toileting assistance to any child, however, then such a personal service would not be required for a child with a disability. Please keep in mind that even in these circumstances, the child could not be excluded from the program because he or she was not toilet trained if the center can make other arrangements, such as having a parent or personal assistant come and do the diapering.

## Issues Regarding Specific Disabilities

**17. Q: Can we exclude children with HIV or AIDS from our program to protect other children and employees?**

A: No. Centers cannot exclude a child solely because he has HIV or AIDS. According to the vast weight of scientific authority, HIV/AIDS cannot be easily transmitted during the types of incidental contact that take place in child care centers. Children with HIV or AIDS generally can be safely integrated into all activities of a child care program. Universal precautions, such as wearing latex gloves, should be used whenever caregivers come into contact with children's blood or bodily fluids, such as when they are cleansing and bandaging playground wounds. This applies to the care of all children, whether or not they are known to have disabilities.



**18. Q: Must we admit children with mental retardation and include them in all center activities?**

A: Centers cannot generally exclude a child just because he or she has mental retardation. The center must take reasonable steps to integrate that child into every activity provided to others. If other children are included in group sings or on playground expeditions, children with disabilities should be included as well. Segregating children with disabilities is not acceptable under the ADA.

**19. Q: What about children who have severe, sometimes life-threatening allergies to bee stings or certain foods? Do we have to take them?**

A: Generally, yes. Children cannot be excluded on the sole basis that they have been identified as having severe allergies to bee stings or certain foods. A center needs to be prepared to take appropriate steps in the event of an allergic reaction, such as administering a medicine called "epinephrine" that will be provided in advance by the child's parents or guardians.

The Department of Justice's settlement agreement with La Petite Academy addresses this issue and others (see question 26).

**20. Q: What about children with diabetes? Do we have to admit them to our program? If we do, do we have to test their blood sugar levels?**

A: Generally, yes. Children with diabetes can usually be integrated into a child care program without fundamentally altering it, so they should not be excluded from the program on the basis of their diabetes. Providers should obtain written authorization from the child's parents or guardians and physician and follow their directions for simple diabetes-related care. In most instances, they will authorize the provider to monitor the child's blood sugar -- or "blood glucose" -- levels before lunch and whenever the child appears to be having certain easy-to-recognize symptoms of a low blood sugar incident. While the process may seem uncomfortable or even frightening to those unfamiliar with it, monitoring a child's blood sugar is easy to do with minimal training and takes only a minute or two. Once the caregiver has the blood sugar level, he or she must take whatever simple actions have been recommended by the child's parents or guardians and doctor, such as giving the child some fruit juice if the child's blood sugar level is low. The child's parents or guardians are responsible for providing all appropriate testing equipment, training, and special food necessary for the child.

The Department of Justice's settlement agreements with KinderCare and La Petite Academy address this issue and others (see question 26).

**21. Q: Do we have to help children take off and put on their leg braces and provide similar types of assistance to children with mobility impairments?**

A: Generally, yes. Some children with mobility impairments may need assistance in taking off and putting on leg or foot braces during the child care day. As long as doing so would not be so time consuming that other children would have to be left unattended, or so complicated that it can only be done by licensed health care professionals, it would be a *reasonable modification* to provide such assistance.

The Department of Justice's settlement agreement with the Sunshine Child Center of Gillett, Wisconsin, addresses this issue and others (see question 26).

## Making the Child Care Facility Accessible

### **22. Q: How do I make my child care center's building, playground, and parking lot accessible to people with disabilities?**

A: Even if you do not have any disabled people in your program now, you have an ongoing obligation to remove barriers to access for people with disabilities. Existing privately-run child care centers must remove those architectural barriers that limit the participation of children with disabilities (or parents, guardians, or prospective customers with disabilities) if removing the barriers is *readily achievable*, that is, if the barrier removal can be easily accomplished and can be carried out without much difficulty or expense. Installing offset hinges to widen a door opening, installing grab bars in toilet stalls, or rearranging tables, chairs, and other furniture are all examples of barrier removal that might be undertaken to allow a child in a wheelchair to participate in a child care program. Centers run by government agencies must insure that their programs are accessible unless making changes imposes an undue burden; these changes will sometimes include changes to the facilities.

### **23. Q: We are going to build a new facility. What architectural standards do we have to follow to make sure that our facility is accessible to people with disabilities?**

A: Newly constructed privately-run child care centers -- those designed and constructed for first occupancy after January 26, 1993 -- must be readily accessible to and usable by individuals with disabilities. This means that they must be built in strict compliance with the ADA Standards for Accessible Design. New centers run by government agencies must meet either the ADA Standards or the Uniform Federal Accessibility Standards.

## Tax Provisions

### **24. Q: Are there tax credits or deductions available to help offset the costs associated with complying with the ADA?**

A: To assist businesses in complying with the ADA, Section 44 of the IRS Code allows a tax credit for small businesses and Section 190 of the IRS Code allows a tax deduction for all businesses.

The tax credit is available to businesses that have total revenues of \$1,000,000 or less in the previous tax year or 30 or fewer full-time employees. This credit can cover 50% of the eligible access expenditures in a year up to \$10,250 (maximum credit of \$5,000). The tax credit can be used to offset the cost of complying with the ADA, including, but not limited to, undertaking barrier removal and alterations to improve accessibility; provide sign language interpreters; and for purchasing certain adaptive equipment.

The tax deduction is available to all businesses with a maximum deduction of \$15,000 per year. The tax deduction can be claimed for expenses incurred in barrier removal and alterations.

To order documents about the tax credit and tax deduction provisions, contact the Department of Justice's ADA Information Line (see question 30).



## The Department of Justice's Enforcement Efforts

### 25. Q: What is the Department of Justice's enforcement philosophy regarding title III of the ADA?

A: Whenever the Department receives a complaint or is asked to join an on-going lawsuit, it first investigates the allegations and tries to resolve them through informal or formal settlements. The vast majority of complaints are resolved voluntarily through these efforts. If voluntary compliance is not forthcoming, the Department may have to litigate and seek injunctive relief, damages for aggrieved individuals, and civil penalties.

### 26. Q: Has the United States entered into any settlement agreements involving child care centers?

A: The Department has resolved three matters through formal settlement agreements with the Sunshine Child Center, KinderCare Learning Centers, and La Petite Academy.

- In the first agreement, Sunshine Child Center in Gillett, Wisconsin, agreed to: (1) provide diapering services to children who, because of their disabilities, require diapering more often or at a later age than nondisabled children; (2) put on and remove the complainant's leg braces as necessary; (3) ensure that the complainant is not unnecessarily segregated from her age-appropriate classroom; (4) engage in readily achievable barrier removal to its existing facility; and (5) design and construct its new facility (planned independently of the Department's investigation) in a manner that is accessible to persons with disabilities.
- In 1996, the Department of Justice entered into a settlement agreement with KinderCare Learning Centers -- the largest chain of child care centers in the country -- under which KinderCare agreed to provide appropriate care for children with diabetes, including providing finger-prick blood glucose tests. In 1997, La Petite Academy -- the second-largest chain -- agreed to follow the same procedures.
- In its 1997 settlement agreement with the Department of Justice, La Petite Academy also agreed to keep epinephrine on hand to administer to children who have severe and possibly life-threatening allergy attacks due to exposure to certain foods or bee stings and to make changes to some of its programs so that children with cerebral palsy can participate.

The settlement agreements and their attachments, including a waiver of liability form and parent and physician authorization form, can be obtained by calling the Department's ADA Information Line or through the Internet (see question 30). Child care centers and parents or guardians should consult a lawyer in their home state to determine whether any changes need to be made before the documents are used.

### 27. Q: Has the Department of Justice ever sued a child care center for ADA violations?

A: Yes. On June 30, 1997, the United States filed lawsuits against three child care providers for refusing to enroll a four-year-old child because he has HIV. See *United States v. Happy Time Day Care Center*, (W.D. Wisc.); *United States v. Kiddie Ranch*, (W.D. Wisc.); and *United States v. ABC Nursery, Inc.* (W.D. Wisc.).

**28. Q: Does the United States ever participate in lawsuits brought by private citizens?**

A: Yes. The Department sometimes participates in private suits either by intervention or as *amicus curiae* -- "friend of the court." One suit in which the United States participated was brought by a disability rights group against KinderCare Learning Centers. The United States supported the plaintiff's position that KinderCare had to make its program accessible to a boy with multiple disabilities including mental retardation. The litigation resulted in KinderCare's agreement to develop a model policy to allow the child to attend one of its centers with a state-funded personal assistant.

**Additional Resources****29. Q: Are there any reference books or video tapes that might help me further understand the obligations of child care providers under title III?**

A: Through a grant from the Department of Justice, The Arc published *All Kids Count: Child Care and the ADA*, which addresses the ADA's obligations of child care providers. Copies are available for a nominal fee by calling The Arc's National Headquarters in Arlington, Texas:

800-433-5255 (voice)

800-855-1155 (TDD)

Under a grant provided by the Department of Justice, Eastern Washington University (EWU) produced eight 5-7 minute videotapes and eight accompanying booklets on the ADA and child care providers. The videos cover different ADA issues related to child care and can be purchased as a set or individually by contacting the EWU at:

509-623-4246 (voice) TDD: use relay service

**30. Q: I still have some general questions about the ADA. Where can I get more information?**

A: The Department of Justice operates an ADA Information Line. Information Specialists are available to answer general and technical questions during business hours on the weekdays. The Information Line also provides 24-hour automated service for ordering ADA materials and an automated fax back system that delivers technical assistance materials to fax machines or modems.

800-514-0301 (voice) 800-514-0383 (TDD)

The ADA Home Page, which is updated frequently, contains the Department of Justice's regulations and technical assistance materials, as well as press releases on ADA cases and other issues. Several settlement agreements with child care centers are also available on the Home Page.

[www.usdoj.gov/crt/ada/adahom1.htm](http://www.usdoj.gov/crt/ada/adahom1.htm)

The Department of Justice also operates an ADA Electronic Bulletin Board, on which a wide variety of information and documents are available.

202-514-6193 (by computer modem)

There are ten regional Disability and Business Technical Assistance Centers, or DBTAC's, that are

funded by the Department of Education to provide technical assistance under the ADA. One toll-free number connects to the center in your region.

800-949-4232 (voice & TDD)

The Access Board offers technical assistance on the ADA Accessibility Guidelines.

800-872-2253 (voice) 800-993-2822 (TDD)

The Equal Employment Opportunity Commission, or EEOC, offers technical assistance on the ADA provisions for employment which apply to businesses with 15 or more employees.

Employment questions

800-669-4000 (voice) 800-669-6820 (TDD)

Employment documents

800-669-3362 (voice) 800-800-3302 (TDD)

If you have further questions about child care centers or other requirements of the ADA, you may call the U.S. Department of Justice's toll-free ADA Information Line at: 800-514-0301 (voice) or 800-514-0383 (TDD).

# DEVELOPMENTAL DELAYS

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Physical Development	<p>Gross Motor large muscle groups including skills such as walking, running, jumping, and climbing stairs</p> <p>Fine Motor small muscle groups such as grasping, holding, and picking up things</p> <p>Sensory      hearing and seeing</p> <p>Health      health status (birth to three)</p>
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Social/Emotional	Relationships with others
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Cognitive	Problem solving or thinking
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Language	<p>Receptive - understanding language</p> <p>Expressive - expressing language</p>
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Adaptive	Self help or skills related to adapting to the environment
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## Some of the typically developing things we can observe through Play Based Assessment. (0-18 months)

### **At age 0 - 3 months**

#### **A child will typically:**

- Move her arms and her legs easily
- Follow your movements by turning his head side to side
- Easily take a bottle or breast and suck well
- Startle or cry at sudden loud noises
- Look at you, watch your face
- Make gurgling or cooing sounds
- Smile in response to your smile or talk
- Quiet easily when comforted
- Begins lifting head when lying on stomach

### **At Age 3 - 6 months**

#### **A child will typically:**

- Play with his feet when lying on his back
- Lift her head and chest with weight on hands when on her stomach
- Hold her head upright and steady without support
- Roll from stomach to back and back to stomach
- Play with his own hands by touching them together
- Reach for a toy
- Pick up a toy placed within reach
- Turn his head toward sounds
- Make lots of different sounds
- Laugh out loud
- Begin to show likes and dislikes

### **At age 6 - 12 months**

#### **A child will typically:**

- Pull himself to stand with some help
- Sit without help while playing with toys
- Transfer small objects from one hand to another
- Feed herself finger food
- Imitate waving bye-bye
- Let you know his needs with motions and sounds
- Copy speech sounds (ba-ba/ga-da)
- Take turns while playing with adult (actions, sounds, or facial expressions)
- Let you know he understands a simple question ("Do you want more?")
- Know parents from strangers

### **At age 12 - 18 months**

#### **A child will typically:**

- Walk alone
- Pick up small objects (raisin size)
- Put objects in and dump from containers
- Put one object on top of another
- Feed himself with a spoon
- Hold and drink from a cup with some spilling
- Point to several things or pictures when named
- Say two or three different words in addition to "Mama" or "Dada"
- Ask for things using words
- Know parents from strangers

**Some of the typically developing things we can observe through Play Based Assessment.  
(18 months - 5 years)**

**At age 18 mo - 2 yrs.**

**A child will typically:**

Walk up and down stairs with his hand held  
Scribble  
Move her body in time to music  
Put two words together ("more juice")  
Begin to ask questions, "Juice?"  
"bye-bye"  
Feed himself a sandwich taking bites  
Take off socks and shoes  
Look at storybook pictures with an adult  
Make simple choices among toys (puzzles or trucks)  
Mimic another child's play (pouring sand, throwing ball)

**At age 2 - 3 years**

**A child will typically:**

Walk well, run, stop, step up, and squat down  
Stack more than two objects  
Use the spoon and cup all by herself when eating  
Follow two-step directions ("Get the book and put it on the table")  
Name five to six body parts on himself  
Take part in simple conversation  
Answer simple "what" and "what do" questions  
Point to or name objects when told their use ("What do you drink with?")  
Help with simple tasks (picking up toys)  
Use 2 - 3 word sentences regularly

**At age 3 - 4 years**

**A child will typically:**

Jump, run, throw, climb, using good balance  
Draw up, down, around and sideways using a crayon  
Use materials and toys to make things  
Enjoy picture books and being read to  
Understand words that tell where things are (behind, under, in on)  
Use speech that is easily understood  
Ask a lot of "why" and "what" questions  
Enjoy playing with other children  
Wait his turn some of the time  
Answer simple "where" and "who" questions

**At age 4 - 5 years**

**A child will typically:**

Enjoy tumbling or other games that use large muscles (like the legs)  
Hop on one foot  
Draw a face that looks like a face  
Put on clothing with a little help  
Ask questions using "what, where, who and why"  
Say most speech sounds clearly except for "s, z, th, r"  
Enjoy playing with children of the same age

# Referral to Single Pointy of Entry



Initial Contact with Family to:  
provide and exchange information  
screen for program eligibility



MDE to determine:  
eligibility - 25% delay  
collect data on child's current performance status



Determine desired outcomes through:  
Initial IFSP Team meeting  
Family priorities, concerns, and resources

AND

Write the desired outcomes on an IFSP document



Establish child strengths / needs and family concerns / resources;  
Specify EI services that may be provided as selected by the family



Implementation of IFSP



Review or update of the IFSP



Annual Review of the IFSP



Transition at third birthday

## Goals of Early Intervention

1. To support families in achieving their own goals
2. To promote children's engagement, independence, and mastery
3. To promote children's development in key domains
4. To build and support children's social competence
5. To promote children's generalized use of skills
6. To provide and prepare children for normalized life experiences
7. To prevent the emergence of future problems or disabilities

**Source:** D.B. Bailey & M. Wolery (1992). *Teaching infants and preschoolers with disabilities* (2nd ed). Columbus, OH: Merrill.



## Resources

### Early Intervention/Special Education

Atwater, J.B., Carta J.J., Schwartz, I.S. & McConnell, S. R. (1994). Blending developmentally appropriate practice and early childhood special education: Redefining best practice to meet the needs of all children. In B.L. Mallory & R.S. New (Eds.), Diversity and developmentally appropriate practices: Challenges for early childhood education, (pp 185-201). New York: Teachers College Press.

Author. (undated). A family's introduction to early intervention in Pennsylvania. Harrisburg, PA: Department of Public Welfare (available through EITA, Tuscarora IU 11, RR1 Box 70A, McVeytown, PA 17051).

Bagnato, S.J., Neisworth, J.T., & Munson, S. (1997) Linking assessment and early intervention: An authentic curriculum-based approach. Baltimore: Paul H. Brookes.

Bailey, D.B. & Wolery, M. (1992). Teaching infants and preschoolers with disabilities, (2nd ed). Columbus, OH: Merrill.

Bergan, J. & Feld, J. (1994). Developmental assessment: New directions. Young Children, 48(5), 41-47.

Bredenkamp, S. (1993). The relationship between early childhood education and early childhood special education: Healthy marriage or family feud? Topics in early childhood special education, 13 (3): 258-73.

Early Intervention Technical Assistance. (1996). A child care provider's guide to early intervention services in Pennsylvania. McVeytown, PA: Author.

Campbell, P.H. (1995). Guide for Individual Family Service Planning (IFSP) in Pennsylvania: A resource for families and professionals. Harrisburg: Department of Public Welfare.

Philadelphia Inclusion Network a program of Child and Family Studies Research Programs at Thomas Jefferson University

Gelfer, J. & Perkins, P. (1992). Constructing student portfolios: A process and product that fosters communication with families. Day Care and Early Education, 20(2), 9-13.

Gullo, D. (1994). Understanding assessment and evaluation in early childhood education. New York: Teachers College Press.

Meisels, S. (1993). Remaking classroom assessment with the work sampling system. Young Children, 48(5), 34-40.

Meisels, S.J., & Fenichel, E. (Eds.). (1996). New visions for the developmental assessment of infants and young children. Washington: Zero to Three/National Center for Infants, Toddlers and Families.

Meisels, S.J., & S. Provence. (1989). Screening and assessment: Guidelines for identifying young disabled and developmentally vulnerable children and their families. Washington: National Center for Clinical Infant Programs.

NECTAS. (1995). Helping our nation's infants and toddlers with disabilities and their families. Chapel Hill: Author.

Rab, V. & Wood, K.I. (1995). Child care and the ADA: A handbook for inclusive programs. Baltimore: Paul Brookes.

Surr, J. (1992). Early childhood programs and the Americans with Disabilities Act (ADA). Young Children, 47 (5) 18-21.

Sweinhart, L. (1993). Observing children in action: The key to early childhood assessment. Young Children, 48(5), 29-33.

### Websites as a Resource

**Websites are a valuable resource for learning more about particular areas and for downloading information that can be used in training. Many websites are linked to other websites, providing easy access to related sites. However, website addresses may change. These lists are a place to begin exploring!!**

### Organizations

The Arc (formerly the Association for Retarded Citizens of the U.S.)  
500 East Border Street, Suite 300  
Arlington, TX 76010  
(800) 433-5255; (817) 261-6003 (Voice);  
(817) 277-0553 (TTY)  
<http://thearc.org>

Clearinghouse on Disability Information  
Office of Special Education and Rehabilitative Services (OSERS) Room 3132,  
Switzer Building  
330 C Street, SW  
Washington, DC 20202-2524  
(202) 205-8241 (Voice/TTY)  
<http://www.ed.gov/OFFICES/OSER>

Council for Exceptional Children – Division for Early Childhood  
(CEC – DEC)  
920 Association Drive  
Reston, VA 22091-1589  
(703) 620-3660  
(800) 8456-CEC  
<http://www.cec.org>

ERIC Clearinghouse on Elementary and Early Childhood Education  
University of Illinois Children's Research Center  
51 Gerty Drive  
Champaign, IL 61820-7469  
(800) 583-4135 or (217) 333-1386  
World Wide Web: <http://ericeece.org>

ERIC Clearinghouse on Disabilities and Gifted Education

Philadelphia Inclusion Network a program of  
Child and Family Studies Research Programs at  
Thomas Jefferson University

Council for Exceptional Children (CEC)  
1920 Association Drive  
Reston, VA 22091-1589  
(703) 620-3660  
(800) 328-0272; Email: [ericec@inet.ed.gov](mailto:ericec@inet.ed.gov)  
World Wide Web: <http://www.cec.sped.org>

Family Resource Center on Disabilities  
20 East Jackson Boulevard, Room 900  
Chicago, IL 60604  
(312) 939-3513 (Voice); (312) 939-3519 (TTY)

National Association for the Education of Young Children (NAEYC)  
1509 16<sup>th</sup> Street, NW  
Washington, DC 20036  
(800) 424-2460 (202) 232-8777  
World Wide Web: <http://www.naeyc.org/naeyc>

National Child Care Information Center  
243 Church Street North West  
Vienna, Va 22180  
Phone: (800) 616-2242  
TTY: (800) 516-2242  
<http://nccic.org>

National Early Childhood Technical Assistance System (NEC\*TAS)  
500 Nations Bank Plaza  
137 East Franklin Street  
Chapel Hill, NC 27514  
(919) 962-2001 (Voice); (919) 966-4041 (TTY)  
E-mail: [nectasta.nectas@mhs.unc.edu](mailto:nectasta.nectas@mhs.unc.edu)  
<http://www.nectas.unc.edu>

Parent Advocacy Coalition for Educational Rights (PACER)  
PACER Computer Resource Center  
4826 Chicago Avenue, South  
Minneapolis, MN 55417-1098  
(612) 827-2966  
<http://www.PACER.org>

Parent Educational Advocacy Training Center (PEATC)  
10340 Democracy Lane, Suite 206  
Fairfax, VA 22030  
(703) 691-7826 (800) 869-6782  
<http://www.PEATC.org>

## Session: Resources and Relationships

## Participant Guide

United Cerebral Palsy Associations  
1660 L Street, NW, Suite 700  
Washington, DC 20036  
(800) 872-5827  
<http://www.ucpa.org>

Zero To Three/National Center for Clinical Infant Programs  
734 15<sup>th</sup> Street, NW, 10<sup>th</sup> floor  
Washington, DC 20005-2101  
(202) 638-1144  
<http://www.zerotothree.org>

Early Childhood

Early Childhood.com  
<http://www.earlychildhood.com>

Highscope  
<http://www.highscope.org/default>

Housecall T. Berry Brazelton  
<http://www.babycenter.com>

National Association for the Education of Young Children  
<http://www.naeyc.org>

Early Intervention/Special Education

Americans with Disabilities Act (ADA): hotline 1-800-514-0301  
<http://www.adainfo.org>

The ARC Questions and Answers about Down Syndrome  
<http://thearc.org/fags/down.html>

Attention Deficit Disorder  
<http://add.org>

Attention Deficit/Hyperactivity Disorder (ADD): ADD Warehouse (publications)  
<http://www.addwarehouse.com>

Autism Society of America  
[http://www\\_autism-society.org/](http://www_autism-society.org/)

Philadelphia Inclusion Network a program of Child and Family Studies Research Programs at Thomas Jefferson University

Awesome Library  
[http://www.awesomeibrary.org/library/Special\\_Education/Special\\_Education.html](http://www.awesomeibrary.org/library/Special_Education/Special_Education.html)

Band-aids & Blackboards  
<http://funrsc.fairfield.edu/~jfleitas>

Children and Adults with Attention Deficit Disorders  
<http://chadd.org>

<http://cicrleofinclusion.org>

Coordinated Campaign for Learning Disabilities  
<http://www.idonline.org>

Disability International Links (major)  
<http://www.dpi.org>

Inclusion Press International  
[www.inclusion.com](http://www.inclusion.com)

Internet Resources for Special Children  
[www.irsc.org](http://www.irsc.org)

Inclusion...Yours, Mine, Ours  
<http://rushservices.com/inclusion>

Learning Disabilities: The National Center for Learning Disabilities  
Toll free information and referral  
<http://www.nclld.org>

National Early Childhood Technical Assistance System (NEC\*TAS):  
<http://www.nectas.unc.edu>

National Information Center for Children and Youth with Disabilities  
[www.nichcy.org](http://www.nichcy.org)

Parents American Academy of Pediatrics  
<http://www.aap.org>

## What Did You Learn Today?

1. Did you make any changes in your child space since the last session? Explain
2. List 2- 3 main points you learned from this session.
3. I am leaving this session with a better idea about how to:
4. How has your thinking been changed about inclusion and/or diversity of families, infants, and toddlers?