Determination of Eligibility for Michigan Mandatory Special Education for Infants and Toddlers, Birth to Age Three
Speech and Language Impairment Guidance

Table of Contents

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Purpose

The purpose of this document is to provide guidance for the determination of Michigan Mandatory Special Education (MMSE) eligibility for infants and toddlers, birth to age three, exhibiting a Speech-Language Impairment (SLI) as defined by the Michigan Administrative Rules for Special Education (MARSE). For children 3–7 years of age, please see the Determination of Eligibility for SLI found on the Michigan Department of Education website.

Personnel who will be able to utilize this guidance include:

- Part C personnel (including special education personnel) considering a referral of an infant or toddler.
- Multidisciplinary evaluation team members, including parent or guardian.
- Individualized Family Service Plan (IFSP) team members, including parent or guardian.
- Administrators.

This document serves to clarify eligibility issues in order to ensure:

- Consistency among school districts within and across counties.
- Compliance with current Michigan special education laws.
- Appropriate determination of eligibility within this category.

Acronyms

ASHA – American Speech-Language-Hearing Association
IDEA – Individuals with Disabilities Education Act
IFSP - Individualized Family Service Plan
ISD – Intermediate School District
MARSE – Michigan Administrative Rules for Special Education
MLU – Mean Length of Utterance
MMSE – Michigan Mandatory Special Education
SLI – Speech and Language Impairment
SLP – Speech and Language Pathologist

Applicable Regulations

Individuals with Disabilities Education Act (IDEA), Part C, 34 CFR §303 (2011)

§ 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

(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.

§ 303.321 Evaluation of the child and assessment of the child and family.

(a) *General.*

(1) The lead agency must ensure that, subject to obtaining parental consent in accordance with § 303.420(a)(2), each child under the age of three who is referred for evaluation or early intervention services under this part and suspected of having a disability, receives –
  (i) A timely, comprehensive, multidisciplinary evaluation of the child in accordance with paragraph (b) of this section unless eligibility is established under paragraph (a)(3)(i) of this section; and
  (ii) If the child is determined eligible as an infant or toddler with a disability as defined in § 303.21—
    (A) A multidisciplinary assessment of the unique strengths and needs of that infant or toddler and the identification of services appropriate to meet those needs;
    (B) A family-directed assessment of the resources, priorities, and concerns of the family and the identification of the supports and

services necessary to enhance the family's capacity to meet the developmental needs of that infant or toddler. The assessments of the child and family are described in paragraph (c) of this section and these assessments may occur simultaneously with the evaluation, provided that the requirements of paragraph (b) of this section are met.

Michigan Administrative Rules for Special Education (MARSE) (October 2015)

R 340.1710 "Speech and language impairment" defined

(1) A "speech and language impairment" means a communication disorder that adversely affects educational performance, such as a language impairment, articulation impairment, fluency impairment, or voice impairment.

(2) A communication disorder shall be determined through the manifestation of one or more of the following speech and language impairments that adversely affects educational performance:

(a) A language impairment which interferes with the student's ability to understand and use language effectively and which includes one or more of the following: (i) Phonology. (ii) Morphology. (iii) Syntax. (iv) Semantics. (v) Pragmatics.

(b) Articulation impairment, including omissions, substitutions, or distortions of sound, persisting beyond the age at which maturation alone might be expected to correct the deviation.

(c) Fluency impairment, including an abnormal rate of speaking, speech interruptions, and repetition of sounds, words, phrases, or sentences, that interferes with effective communication.

(d) Voice impairment, including inappropriate pitch, loudness, or voice quality.

(3) Any impairment under subrule (2)(a) of this rule shall be evidenced by both of the following:

(a) A spontaneous language sample demonstrating inadequate language functioning.

(b) Test results on not less than two standardized assessment instruments or two subtests designed to determine language functioning which indicate inappropriate language functioning for the student's age.

(4) A student who has a communication disorder, but whose primary disability is other than speech and language may be eligible for speech and language services under R 340.1745(a).

(5) A determination of impairment shall be based upon a full and individual evaluation by a multidisciplinary evaluation team, which shall include a teacher of students with speech and language impairment under R 340.1796 or a speech and language pathologist qualified under R 340.1792.

R 340.1862 Individualized family service plan; timelines; eligibility. Rule 162.

(1) Eligibility for Michigan special education services for all children with a disability birth to age three shall be determined by and documented in an individualized family service plan.
(2) Evaluations conducted to determine eligibility for Michigan special education services shall meet the requirements of 34 CFR part 303 and R 340.1705 to R 340.1717.
(3) Determination of eligibility for Michigan special education services, for a child birth to three with a disability shall follow all timelines and requirements pursuant to 34 CFR part 303.
(4) Special education services for children birth to three with disabilities shall be all of the following:
  (a) Determined by the child's individual needs and specified in an individualized family service plan.
  (b) Provided by an approved or endorsed early childhood special education teacher or approved related services staff.
  (c) Provided for not less than 72 clock hours over one year. The time line begins upon receipt of signed parental consent to provide services.
  (d) Provided in an appropriate early childhood setting, school setting, community setting, or family setting.
  (e) Have a parent participation and education component.
(5) Approved related services staff shall work under the educational direction of an approved or endorsed early childhood special education teacher.

Considerations

A speech and language impairment means a communication disorder that adversely affects educational performance. Because infants and toddlers are not in an educational school-based setting, examining how a child functions within their daily routines, taking into consideration their family's culture, is necessary. Therefore, "functional performance" for an infant or toddler, birth to age three, is the equivalent of "educational performance" for school-aged children.

Determining if the child's speech/language impairment(s) affects his/her ability to fully participate within his/her daily activities is factored into determining how the speech/language impairment adversely affects functional performance. The adverse

effect should be referenced in relationship to same-age peers. For example, consider a 13-month old leading his caregiver to the kitchen versus a 2-year old doing the same thing—both may be communicating, but the ways in which they communicate are very different.

Children who are diagnosed within the first few months of life with a medical condition that is known to result in a communication and/or feeding/swallowing concern (e.g., Down syndrome, hearing loss, cleft palate, low birth weight) are considered to have established risk for communication delays. These children typically receive MMSE under other disability categories as a result of their medical diagnosis. When children are found eligible for MMSE under another disability category and demonstrate a need for communication supports, they may still receive services and supports by the speech-language pathologist. A child with an Individualized Family Service Plan (IFSP) is entitled to services and supports that meet their identified needs.

Signs of communication risk attributable to language delay, including delayed development or loss of babbling, failure to use eye contact/proximity to interact with others, and limited communication functions and means in children without known medical conditions are often not consistently noted until at least the latter half of the first year of life (ASHA, 2008). For communication risks attributable to articulation, fluency, or voice concerns, possible delays can be even more difficult to identify early on because of the individual and more protracted nature of these specific milestones prior to age three. For example, it is not until mid-way through the second year of life when articulation risks (delayed appearance of consonant sounds or a lack of multi-syllabic babbling) may begin to be uncovered. For these reasons, it would be rare for a child to be eligible for MMSE under SLI solely as a result of articulation, fluency or voice impairment before the age of three when an established medical condition is not present.

Regardless of the child's MMSE eligibility, the category does NOT dictate the program or service. Rather, the child's IFSP team must make a data-based decision to determine appropriate services.

Determining Eligibility for SLI

The information-gathering process to determine eligibility includes the following three steps:

- Evaluation
- Data collection
- Data analysis

Evaluation

Evaluation is the procedure used by qualified personnel to determine a child's initial and continuing eligibility (IDEA §303.321). A multidisciplinary evaluation team, consisting of a minimum of two persons, is responsible for completing a full and individual evaluation when a child is suspected of having a disability. The team shall include a teacher of students with speech and language impairment under R 340.1796 or a speech-language pathologist qualified under R 340.1792.

According to the Michigan Part C State Plan, adjusting for prematurity is needed for every child born earlier than 37 weeks gestation. This adjustment should continue until the child reaches the chronological age of 24 months. After the child is two years old (chronologically), adjustments for prematurity will be discontinued.

Data Collection

Infants and toddlers under age three can be found eligible for MMSE under SLI based on:

(i) Communication and language samples
(ii) Assessment data
(iii) Adverse impact on functional performance
(iv) Guidance from peer-reviewed research

There are specific communication skills that develop or appear within typical, predictable age ranges which have been documented repeatedly in the research. The absence or delay of these functional communication skills is documented as the Speech and Language Pathologist (SLP) applies informed clinical opinion to interpret results from commonly available assessment tools, observation protocols, and sampling procedures based on the context and experiences of the child. Due to the wide variability in individual development, clinicians evaluating children younger than 15 months must place even greater emphasis on informed clinical opinion and peer-reviewed research when interpreting assessment results along with the quality of a child's interaction and communication within daily routines in the natural environment.

American Speech-Language-Hearing Association (ASHA) guidance (www.asha.org/policy/GL2008-00293) for the roles and responsibilities of SLPs in early intervention summarizes the peer-reviewed research that is useful for informing clinical opinion and identifying communication disabilities in this age range.

The MARSE 340.1710(3(a)) requires a spontaneous language sample in cases where language impairment is suspected. Language samples should be collected using direct observation of the child, in addition to parent report. Analysis of the child's communication and language in the sample is critical to understanding the extent and

variety of the child's communication repertoire during daily activities. Analysis of any samples should include attention to:

- □ Communication means and functions
- □ Joint attention
- □ Communication initiation in any modality (eye contact, body movements, proximity, signs, vocalizations, etc.)
- □ Behavior regulation
- □ Vocalizations
- □ Babbling
- □ Mean Length of Utterance (MLU)
- □ Number and type of words used (nouns, verbs, modifiers)
- □ Tense marking
- □ Speech intelligibility
- □ Proportion of consonants to vowels
- □ Phonological inventory development

A language sample of 25-50 utterances is suggested for analysis of MLU. In the event that a language sample cannot be obtained and MLU is not established, a complete inventory of vocabulary should be gathered from observation and parent report. For example, the *McArthur-Bates Communicative Development Inventory* is a standardized tool that can be used to obtain a percentile rank regarding how the child's vocabulary is developing compared to monolingual English-speaking peers.

The MARSE 340.1710(3)(b)) requires that when identifying language impairment, the results of two standardized assessment instruments or two subtests designed to determine language functioning are documented. The Rule does **not** require two standard scores, but rather two standardized assessments or subtests. A standardized assessment is a tool that has been developed empirically, has adequate norms, definite instructions for administration, and evidence of reliability and validity. This requirement does **not** specify that the standardized assessment instruments must be norm-referenced; it allows for the use of assessments that are norm-referenced, criterion-referenced, or based on developmental data that allows for intra-individual comparisons across time. This understanding is important for teams serving the birth to three populations because available norm-referenced standardized assessment tools that offer valid and reliable scores for this age range are limited.

A combination of assessment methods and tools are required to yield the most culturally-sensitive and linguistically-valid results. Assessment tools may include use of:

(i) Norm-referenced standard scores.
(ii) Criterion-referenced scores.
(iii) Developmental benchmarks.
(iv) Dynamic assessment results (e.g., response to test-teach-retest protocols).
(v) Percentile ranks.
(vi) Age equivalents when determining eligibility for MMSE.

Standardized assessment tools should be used along with information-gathering through parent interview, observation of interactive play, and collection of communication samples in the natural environment to determine the child's functional performance.

Data Analysis

The data analysis process is an important step in completing the evaluation for eligibility under SLI. Standardized assessment data is only one source of data required by the MARSE to document eligibility, and this source does not carry more weight than any other data. For birth to three especially, it is crucial to use multiple sources of data (assessment tools, a spontaneous language sample; parent report and child observation) to triangulate the information, apply clinical opinion, and make a judgment about the presence or absence of a disability.

Considerations for Culturally and Linguistically Diverse Children

Children birth to three who are English learners often have limited language in every language. Therefore, it can be difficult to determine a true language impairment. For that reason, the following skills/behaviors become particularly important to observe:

- Gaze
- Gesture
- Vocalizations
- Communication means
- Communication frequency
- Communication function
- Play
- Speech sound inventory in spontaneous speech
- Syllable complexity

In order for a child to be eligible for services under SLI, a child's communication difficulties must not be due to cultural or linguistic differences. In addition, "a regional, social, or cultural/ethnic variation of a symbol system should not be considered a disorder of speech or language" (ASHA, 1993). Understanding the typical development of the child's native language or dialect, exploring the child's language-learning or exposure history, and considering the values of culturally and linguistically diverse children, are all required when attempting to determine if language characteristics represent a difference or a true impairment.

All evaluations and assessments of the child must be conducted in the native language of the child unless clearly not feasible to do so. If a child is learning more than one language, the assessment should include the child's skills in all languages available to the child. Using an interpreter during assessments of a child who is learning more than one language is important because the team must describe the child's comprehension, expression, and social communication skills in all languages available to the child. An interpreter can also help the team understand and interpret the child's behaviors, play, use of gesture, nonverbal communication, purposes of communication, joint attention, initiation skills and feeding skills within the cultural lenses that make up the child's natural environment. The interpreter should be fluent in both oral and written modalities of the language spoken by the child and parent. The sole use of translator apps or technology would not be best practice unless despite best efforts, it is clearly not possible to locate an interpreter for a particular language.

Parents are a vital source of information in the evaluation process. The parent interview is critical as part of the review of existing data to understand the cultural and language-learning history of the child and to uncover any possible delays of language development in the native language(s). Use of norm-referenced parent report forms given in the parent's language can be helpful.

The way in which data are used for a child with limited English proficiency must be carefully considered to ensure an accurate measure of the child's speech and language skills in all languages available to the child, not only English language skills. Any adaptations of standardized test administrations should be described in the team report. Reporting norm-referenced standard scores for standardized assessments in which the normative sample is different from the child being assessed, even in cases where the speech-language pathologist interprets or translates items from English into the child's native language, is not a valid assessment practice. Instead, use descriptive practices and accuracy ratings to describe the child's communicative functioning in all languages of exposure.

Eligibility Recommendations

The *Michigan Speech-Language Guidelines: Suggestions for Eligibility, Service Delivery, and Exit Criteria Revised* note that the rule in the MARSE defining language impairment under 340.1710 states that standardized assessment instruments or subtests must "indicate inappropriate language functioning for the student's age." It does not specify that the student's scores be a minimum number of standard deviations from the mean (cut-off score e.g., -1.3 standard deviations). There are no cut-off scores in federal law,

the MARSE, the Michigan guidelines, nor in guidelines from the American Speech-Language Hearing Association (MI Guidelines, 2006).

When teams do use norm-referenced standardized assessment instruments, it is important they know the scoring interpretation and normative sample characteristics for each assessment tool used. Norm-referenced standard scores between 84 and 78 can indicate functioning between -1 and -1.5 standard deviations from the mean, or the 7th – 14th percentile, which is not within a typically-developing range. Although test scores and standard deviations should not be the sole criterion for determining eligibility, here are some general guidelines:

- Children demonstrating a 20% delay (-1 standard deviation) are clearly eligible for *Early On*.
- Children demonstrating a 20 to 30% (-1 to -1.5 standard deviations) delay should be considered for MMSE and may qualify if clinical opinion and/or data support eligibility.

Since standardized assessment results are only one source of data required by the MARSE to document eligibility for language impairment, a child may be determined eligible for MMSE despite higher norm-referenced scores, or not eligible despite lower norm-referenced scores, depending on the analysis of data from all sources. It is the comprehensive collection and analysis of the data that leads to an eligibility determination.

Further information regarding developmental and criterion-referenced benchmarks for this age range is summarized in ASHA's Early Intervention Guidance document (http://www.asha.org/policy/GL2008-00293).

Termination of Eligibility

Eligibility as a child with SLI may be terminated when:

- The child no longer meets SLI criteria.
- Analysis of data demonstrates the child meets criteria in a different eligibility category.

Appendix/Resources

American Speech-Language-Hearing Association. (1993). *Definitions of Communication Disorders and Variations* [Relevant Paper]. Available at the ASHA Practice Policy (http://www.asha.org/policy/RP1993-00208).

American Speech-Language Hearing Association. (2008). *Roles and Responsibilities of Speech-Language Pathologists in Early Intervention: Guidelines*.

American Speech-Language Hearing Association. Typical Speech and Language Development (http://www.asha.org/public/speech/development/%20). Accessed November 10, 2015.

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Oakland Schools. (2010). *Linking ASHA's Early Intervention Guidance with the Michigan Speech-Language Guidelines' Infant/Toddler Eligibility Guide (Birth to 3 years).* Waterford, MI.

Oakland Schools. (2015). *Oakland Schools Guidance: Big Ideas When Considering a Special Education Evaluation of a Student Learning English as a Second Language.* Waterford, MI.

Warning Signs for Communication Delays in the First Three Years of Life chart.

Warning Signs for Communication Delays in the First Three Years of Life.
The Warning Signs for Communication Delays in the First Three Years of Life chart was developed to provide guidance as to when to refer for a MMSE speech and language evaluation. The chart is intended to reflect skills at specific developmental stages that would be highly correlated with a speech and language delay if they were not present by the age range noted. The chart is intended to be shared with all providers working with children birth to three to help them make decisions about when to seek additional support.

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Workgroup participants included the following:

- Lynn Bonynge, Calhoun ISD
- Jessica Brady; Michigan Department of Education, Office of Special Education
- Christy Callahan; Clinton County RESA, Office of Innovative Projects
- Beth Cook; Michigan Department of Education, Office of Special Education
- Christin Dowd, Lenawee ISD
- Michelle Driscoll, The Arc Northwest
- Paul Dymowski, Allegan ISD
- Ann Gendron, Marquette-Alger RESA
- Laura Goldthwait; Michigan Department of Education, Office of Great Start
- Cheryl Granzo, Ionia ISD
- Cathy Gyurich, Clinton County RESA
- Kelly Hurshe; Michigan Department of Education, Office of Great Start
- Diane Katakowski, Oakland Schools
- Dawn Koger, Oakland Schools
- Sandee Koski, Michigan Alliance for Families
- Chris Lerchen, The Arc Northwest
- Denise Ludwig, Grand Valley State University
- Lena Montgomery, Wayne RESA
- Jorri Novak, Bay Arenac ISD
- Melissa Pelkey- Epstein, Parent/SICC
- Lisa Perugi, Woodhaven Brownstown School District
- Tierney Popp, Central Michigan University
- Susan Powell, Oakland Schools
- Nancy Surbrook; Clinton County RESA, Office of Innovative Projects
- Charles Thomas; Michigan Department of Education, Office of Special Education

Facilitators:

- Stefanie Rathburn; Clinton County RESA, Office of Innovative Projects; *Early On* Training & Technical Assistance Specialist
- Carol Spaman; Clinton County RESA, Office of Innovative Projects; *Early On* Training & Technical Assistance Specialist

Resources:

- Sherri Boyd, Michigan Alliance for Families
- Jessica Brady; Michigan Department of Education, Office of Special Education
- Christy Callahan; Clinton County RESA, Office of Innovative Projects
- Karen Fales, Blue Heron Consulting
- Emily Houk, Research To Practice Consulting
- Nancy Surbrook; Clinton County RESA, Office of Innovative Projects

– Vanessa Winborne; Michigan Department of Education, Office of Great Start