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Bernard P. Conway

Pacific University
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Degree Type
Thesis

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ACUITY ASSESSMENT IN MENTALLY IMPAIRED CHILDREN

AGES 18 MONTHS TO 8 YEARS

BY

BERNARD P. CONWAY

A thesis submitted to the faculty of the
College of Optometry
Pacific University
Forest Grove, Oregon
for the degree of
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Advisors:

Paul Kohl, O.D.

Norman S. Stern, O.D., PhD.
BIOGRAPHY

Bernard P. Conway attended the College of St. Thomas in St. Paul, Minnesota where he received his B.A. degree in Psychology. He will begin a residency in vision training at the State University of New York College of Optometry located in New York City after graduation.
ABSTRACT

There has been an abundance of data collected on the high prevalence of visual anomalies in mentally impaired children. Sensitive periods in visual binocular development mandate the need for early visual assessment and intervention. This study assessed three visual acuity tests used with this population: the Broken Wheel acuity test, the Lighthouse acuity test and the Acuity Card Procedure (ACP). Twenty-four children aged 18 months to 8 years old were tested. For 100% of the children the ACP was successfully administered. Measuring acuities is an important step in establishing visual performance records and evaluating visual remediation strategies in children with visual dysfunction. It appears that the ACP is a useful test in evaluating children often thought untestable.
ACKNOWLEDGEMENTS

I would like to thank Dr. Norm Stern for providing me with the opportunity to work with this unique population. I feel fortunate to have seen the enthusiasm with which his functional information is received by many different professionals. I would also like to thank Dr. Paul Kohl for his guidance into the organization and format of this thesis. These two educators have been inspirational and instrumental throughout my Optometry education.
INTRODUCTION

Providing vision care to mentally impaired, multihandicapped children provides optometrists with a unique opportunity to work with a population often neglected by mainstream health care. At the same time the optometrist becomes part of a multidisciplinary team including occupational therapists, physical therapists, speech and language therapists, special educators, parents, and a host of other committed individuals. An abundance of data exists on the high prevalence of visual anomalies in the mentally impaired population. Some studies have shown that up to 50% require spherical correction.¹⁻³ A large incidence of strabismus and anisometropia has also been reported.⁴⁻⁵ Interestingly, a large amount of the strabismus can be attributed to refractive error alone.¹ In one study of children with cerebral palsy, 92% were found to have ocular motor dysfunction and 100% were found to have accommodative insufficiency.⁶ Of particular importance to the optometrist is the frequent use of medications with this population. These medications influence the accommodative system and often effect ocular motility and retinal function. Such drugs often necessitate the use of a near distance prescription. The need for early vision care exists in this population. Whether or not equalizing acuities and establishing clear
single binocularity is a realistic goal, these individuals deserve the best care optometry can provide. Fortunately, with the exception of acuity assessment, the vision care these individuals require can be provided without special instrumentation.

In a non-verbal mentally impaired population, measuring visual acuity presents a significant challenge. In this paper a case for early intervention will be made. In addition, various types of visual acuity tests will be addressed and a study which evaluates three popular methods of measuring visual acuity in mentally impaired children will be presented.

As eluded to earlier, the cause of strabismus can often be attributed to uncorrected refractive error. Unfortunately the visual system has a time frame during which disruption of normal vision can cause embedded deficits in acuity. Although vision training in later childhood can remediate such deficits, a more efficient strategy would stress early measurement and remediation.

It appears that these time frames known as critical periods are thought to be present at increasingly younger ages. Ingram suggests that the sensitive period secondary to refractive amblyopia may be over by one year of age.\(^7\) Occlusion amblyopia resulting from ptosis congenital cataracts and lid abnormalities is thought to be greatest if occlusion appears during the first six months of age.\(^8\) Other investigators report that children deprived of binocular experience during the first three years
of life will have permanent deficits in binocular function. A unique type of amblyopia currently being investigated by Gwiazda et al is meridional amblyopia.10,11

Meridional amblyopia is an uncorrectable loss of grating visual acuity along the habitually blurred meridian of adult astigmats. This loss in grating acuity is found to persist even after optical correction has been initiated. Research has suggested that meridional amblyopia does result from astigmatism in early childhood.11 The critical periods in meridional amblyopia are found to begin late in the first half of the first year of life and continue to the end of the second year. This research was the first of its kind on human subjects. When looking at these early critical periods for the various types of amblyopia one hopes to prevent the occurrence by early detection and optical correction. To date no such guidelines have been developed. A first unsuccessful attempt to use spectacle correction on one year olds was reported by Ingram et al in 1985.12 Obviously the work in this area is in an infancy stage. The first step in prevention and remediation of strabismus and amblyopia secondary to uncorrected refractive error is the early indentification of the problem.

A skilled optometrist has in his/her armamentarium a number of methods of determining refractive error ranging from retinoscopy and keretoscopy to more elaborate procedures such as sweep visual evoked responses and photorefraction.
Measuring acuity in infants and children can be a humbling experience yet alone measuring acuity in a special needs population. What acuity test works best with this young population? McDonald (1986) reviewed acuity assessment techniques in toddlers age 15-35 months and breaks down the tests into three types: detection, resolution and recognition.13 In detection acuity tests the child is required to detect or distinguish a stimulus from the background. Common detection tests include the Bock Candy Bead and the Dot Visual acuity test. In these tests the recorded acuity threshold is the smallest sized edible cake decoration or black dot a child can retrieve or identify correctly at least twice in succession. Recognition acuity tests unlike detection tests require the child to recognize a stimulus from other competing stimuli. Typical recognition tests are the Illiterate E's, Landolt C's and the Lighthouse picture card acuity test. In the Illiterate E's the letters point in one of the four principle directions (up, down, left, right) and the child must simply point in the direction that the E's legs point. In a typical Landolt C test for children the child can point to the direction of the opening in the C or when paired with an O of identical size the child can be asked to point to the broken one. This paradigm is used in the Broken Wheel test.16 The Broken Wheel acuity test consists of a set of paired cards with a black and white car printed on each card. The wheels on one card in each set contain broken wheels (Landolt C's) and the other card
contains wheels with complete circles (O's). The child preferentially looks at or points to the car with the broken wheels. McDonald felt that using the Landolt C's in a preferential looking mode offered the best available method for measuring acuity in young children. "Using the same optotypes in both adults and children would guarantee continuity of visual acuity assessment." Interestingly, the Lighthouse picture charts are a familiar recognition test used extensively with young children. In this test optotypes of various objects easily identified by children are used (i.e. umbrella, apple, houses) and the child simply identifies smaller optotypes of increasing acuity demands until threshold is reached.

The final type of acuity is resolution acuity. Resolution acuity tests were developed after the observation was made that infants will preferentially fixate a pattern rather than a blank field. The Acuity Card Procedure (ACP) is an in-office method of measuring resolution acuity. The test involves presentation of a single card with a high contrast grating pattern on one half of the card and a luminance matched blank surface on the other half. Different cards containing gratings with higher spatial frequencies are used until the child's detection threshold is reached. Spatial frequencies are converted to Snellen equivalents and the cards are photographically produced with equal luminance to eliminate cues relating to contrast. Investigators have used the Acuity Card
Procedure successfully with children labeled developmentally delayed, mentally retarded and neurologically impaired. In this study three methods of measuring visual acuity were evaluated on 24 children with a variety of mental and physical impairments. Two recognition tests and one resolution test were chosen. The recognition tests were the Broken Wheel acuity test and the Lighthouse cards. The resolution test selected was the Acuity Card Procedure.

METHOD

SUBJECTS

Twenty-four children aged 18 months to 8 years old were tested at two different day care facilities for mentally impaired children. The specific disabilities present in this population are listed in Tables 1 and 2. Testing was performed using standard room illumination in a quiet setting adjacent to the child's regular classroom. A teacher, aid or parent usually accompanied the child. Each test was performed on every child and the order of presentation was random. Testing distance was at 10 feet for the distance tests and 13 inches for the near testing. The testing distance for the ACP was 38 cm.
The Broken Wheel distance acuity test uses a series of 5" x 7" posterboard cards with black and white photographically produced cars on each card. Cards are paired with one card in each pair containing a car with broken wheels (Landolt C’s) and the other complete circles (O’s). The broken wheels correspond to the following Snellen equivalents at a 10 foot test distance: 20/20, 20/25, 20/40, 20/60, 20/80, 20/100. A trial begins by presenting the child with two demonstration cards and explaining to him/her how one has broken wheels and the other has wheels that are not broken. The child is then asked to point at or look at the car with the broken wheels. The examiner then randomly switches the cards and presents them again. Once the concept is grasped the examiner begins testing the child at 10 feet with the large (20/100) cards and proceeds sequentially to smaller cards until threshold is reached. Four trials correct in succession is the criteria used to ensure that the choices are less than 6% by chance. The test is performed first binocularly and then monocularly with the aid of a patch.

The Lighthouse vision test consists of a distance (10 feet) flash card test and a near Lighthouse chart at 35 cm. Both tests use photographically produced pictures of apples, umbrellas, and houses. The various pictures represent acuity demands ranging from 20/400 to 20/20. For the distance test the child can name the picture or match it to one on the near card. A forced choice procedure can also be used by having the child point at or look at one picture, i.e. apple, when it is paired with
another picture (house) of equal size. A distance Lighthouse chart is available but for this study the flash cards were chosen because of the forced choice option. The near Lighthouse card consisted of a single card with closely grouped optotypes. Pictures within a row all have the same acuity demand. Descending rows contain increasingly more difficult acuity demands. The test was administered at a 13 inch distance. The child is instructed to call out pictures of decreasing size until threshold is reached. Variants on this procedure include isolating single pictures to decrease confusion with the surrounding pictures or having the child point at a specific picture within a row.

With the Acuity Card Procedure a set of eight 28x51 cm cards are used. Each card contains 15.5 x 15.5 cm square wave gratings ranging in approximately one half octave steps from 38.0 to 1.6 cycles/cm (20/20 to 20/400 Snellen equivalents). The gratings are positioned on one half of the cards. The remaining half of the card is blank. In the center of the card is a small opening through which the observer can observe the child's response. A trial typically began with a card containing a low frequency grating (large stripes) and proceeds sequentially to gratings of higher frequencies (fine stripes) until threshold is reached. A testing distance of 38 cm was used for each card. Binocular testing was accomplished first then each eye was tested individually. If an immediate correct response was elicited, as assessed subjectively by the examiner, then a second card
of greater acuity demand was presented. This was repeated with additional cards until threshold was reached.

RESULTS

Of the 24 children tested all 24 could perform the ACP, 8 could perform the Broken Wheel, 10 could perform the Lighthouse at near and 7 performed the Lighthouse at distance. For 52% the only successful test was the ACP.

In order to assess the utility of the various tests in the different age groups, the data was organized into two groups. The first age group consisted of children 18 months to 3 1/2 years old (Table 1). The second group consists of children from 4 to 8 years old (Table 2). The tables indicate how many children could competently perform each of the visual acuity tests. Among the 12 children in the younger group all 12 (100%) responded to the ACP. Only 3 children (25%) were successfully tested by the Lighthouse test and none (0%) were successfully tested by the Broken Wheel test.

In the older age group 13 children (100%) responded to the ACP. Seven children (54%) were successfully tested with the Lighthouse and 8 children (67%) could perform the Broken Wheel test.
DISCUSSION

In the clinical measurement of acuity there must be reliability and validity of the tests used. Many tests are reported to lack data to support their usefulness and have much variability in their reported norms.\textsuperscript{13,21} Evidence exists that detection acuity is two to three octaves better than recognition acuity and resolution acuity is reported as being one octave better than recognition acuity.\textsuperscript{13,22} In an article by Mosely et al resolution acuities were found to overestimate recognition acuities, particularly in young amblyopes.\textsuperscript{23} The important point is that the professional interpreting these different acuities must be aware of these critical differences and make interpretations accordingly. Although resolution acuities overestimate standard Snellen acuity, the resolution test the ACP was the only test which was successful in 52% of our population. In light of this study it is very exciting that the ACP is available for testing very young, impaired children. In conjunction with the results of other testing it enables optometrists to better serve patients who were once thought to be untestable. An instance which expounded the merits of the Acuity Card Procedure involved a three year old girl who had suffered severe brain damage after running in front of a moving bus. The mother of this child was certain that her daughter responded to her facial expressions. However, on past testing she was told that her child was completely blind, without even light perception.
During the ACP testing this child repeatedly responded to a 20/2000 grating acuity card. This test result brought tears to the mother's eyes. It was reaffirmed that her daughter was in fact responding to her mother's face. An example from one assessment was a child who was examined and found to have a right esotropia with increased nystagmus in the right visual field. Subsequent testing showed decreased visual acuity in the right eye with a strong preference for pursuing objects to the left. It was explained to the teacher that the nystagmus causes the child to have an oscillatory view of the world when his eyes twitch and that the turned-in eye does not receive information as well as the right. It was suggested that Johnny be positioned on the teacher's left side in group training and that materials be presented from his left side to maximize visual and cognitive gain. This information was applauded and appreciated by the teacher.

The development of this valid and reliable acuity test is an important step in establishing visual performance records and evaluating the effect of remediation strategies. Scientific evidence supports the fact that the earlier the intervention the greater likelihood of optimizing visual function.7,12

While conducting this study it was apparent that visual function was not being addressed in this special needs population. Medical records often contained limited information such as "no vision" or "the child can
fixate and follow”. Optometry has a unique functional knowledge. Working with mentally impaired children is an excellent opportunity for optometrists to join with other committed professionals in serving this challenging population. In this way optometrists can experience the dynamics of team participation and most importantly help these patients function at their highest and most productive level.

For information about programs for mentally/physically impaired children in your area contact the special education department within your local public school. In Appendix I of this paper is a section of the special education manual for the Portland Public Schools. The manual lists eligibility requirements for classification of children with various mental and physical impairments. Included in Appendix II is an example of the Progress Center’s program designed for impaired children under four years of age.
## TABLE 1

ACUITY TESTING OF MENTALLY IMPAIRED CHILDREN BETWEEN THE AGES OF 18 MONTHS AND 3 1/2 YEARS

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>AGE/SEX</th>
<th>SYSTEMIC/OPTHALMIC DIAGNOSIS</th>
<th>SCREENING REFRACTION</th>
<th>BROKEN WHEEL</th>
<th>LIGHTHOUSE FAR / NEAR</th>
<th>ACP</th>
</tr>
</thead>
<tbody>
<tr>
<td>L.S.</td>
<td>3/f</td>
<td>Developmentally Delayed, Seizure Disorder</td>
<td>+3.00-1.00x180 NR</td>
<td>NR</td>
<td>NR</td>
<td>20/150 20/100 OU</td>
</tr>
<tr>
<td>J.D.</td>
<td>3/m</td>
<td>Brain Injury, Seizure Disorder, Nystagmus</td>
<td>+1.25 NR</td>
<td>NR</td>
<td>NR</td>
<td>20/200 OU</td>
</tr>
<tr>
<td>B.D.</td>
<td>3.5/m</td>
<td>Downs Syndrome</td>
<td>+0.50 20/400 20/400 OU 20/100 OU</td>
<td>NR</td>
<td>NR</td>
<td>20/100</td>
</tr>
<tr>
<td>K.M.</td>
<td>1.5/m</td>
<td>Premature</td>
<td>pl-0.50x180 NR</td>
<td>NR</td>
<td>NR</td>
<td>20/100 20/100 OU</td>
</tr>
<tr>
<td>K.M.</td>
<td>1.5/m</td>
<td>Premature</td>
<td>pl-0.50x180 NR</td>
<td>NR</td>
<td>NR</td>
<td>20/80 OU 20/100</td>
</tr>
<tr>
<td>O.J.</td>
<td>3/m</td>
<td>Developmentally Delayed</td>
<td>-0.50-0.50x180 NR</td>
<td>NR</td>
<td>NR</td>
<td>20/50 20/50 OU</td>
</tr>
<tr>
<td>V.A.</td>
<td>2.5/f</td>
<td>Downs Syndrome, Left Esotropia, Nystagmus</td>
<td>+1.25 20/100 OU 20/100</td>
<td>NR</td>
<td>NR</td>
<td>20/100 OU</td>
</tr>
<tr>
<td>D.K.</td>
<td>3.5/m</td>
<td>Downs Syndrome</td>
<td>-1.00 20/200 OU 20/200 OU 20/100</td>
<td>NR</td>
<td>NR</td>
<td>20/100 20/80 OU</td>
</tr>
<tr>
<td>J.A.</td>
<td>2/m</td>
<td>Developmentally Delayed</td>
<td>+0.50-0.25x180 NR</td>
<td>NR</td>
<td>NR</td>
<td>20/80 OU 20/100</td>
</tr>
<tr>
<td>D.H.</td>
<td>2/m</td>
<td>Developmentally Delayed, Low Muscle Tone</td>
<td>pl NR</td>
<td>NR</td>
<td>NR</td>
<td>20/100 20/100 OU</td>
</tr>
<tr>
<td>J.R.</td>
<td>2/f</td>
<td>Hydrocephalia Ptosis OS</td>
<td>pl-0.50x180 NR</td>
<td>NR</td>
<td>NR</td>
<td>20/100 20/80</td>
</tr>
<tr>
<td>C.V.</td>
<td>1.7/f</td>
<td>Downs Syndrome</td>
<td>+0.25-0.25x100 NR</td>
<td>NR</td>
<td>NR</td>
<td>20/80 OU</td>
</tr>
</tbody>
</table>
### Table 2

**ACUITY TESTING OF MENTALLY IMPAIRED CHILDREN BETWEEN THE AGES OF FOUR AND EIGHT YEARS OLD**

<table>
<thead>
<tr>
<th>PATIENT</th>
<th>AGE/SEX</th>
<th>SYSTEMIC/OPHTHALMIC DIAGNOSIS</th>
<th>SCREENING REFRACTION</th>
<th>BROKEN WHEEL</th>
<th>LIGHTHOUSE FAR / NEAR</th>
<th>ACP</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.H.</td>
<td>6/m</td>
<td>Educationally Mentally Retarded</td>
<td>+1.25-0.50x180</td>
<td>NR</td>
<td>NR</td>
<td>20/100 20/100 OU</td>
</tr>
<tr>
<td>S.M.</td>
<td>4/m</td>
<td>Microcephalia Nystagmus</td>
<td>+0.75</td>
<td>NR</td>
<td>NR</td>
<td>20/60 20/80 OU</td>
</tr>
<tr>
<td>Z.T.</td>
<td>6/m</td>
<td>Developmentally Delayed</td>
<td>+1.25-1.00x180</td>
<td>NR</td>
<td>NR</td>
<td>20/80 OU 20/100</td>
</tr>
<tr>
<td>T.F.</td>
<td>6/f</td>
<td>Educationally Mentally Retarded (EMR)</td>
<td>+1.00</td>
<td>NR</td>
<td>NR</td>
<td>20/80 OU 20/100</td>
</tr>
<tr>
<td>S.S.</td>
<td>5/m</td>
<td>EMR</td>
<td>-0.75</td>
<td>20/60 OU</td>
<td>NR</td>
<td>20/80 OU 20/50</td>
</tr>
<tr>
<td>A.P.</td>
<td>4/f</td>
<td>EMR</td>
<td>Not Available</td>
<td>20/60 OU</td>
<td>NR</td>
<td>20/50 20/50 OU</td>
</tr>
<tr>
<td>K.V.</td>
<td>7/m</td>
<td>EMR</td>
<td>+0.50</td>
<td>20/25</td>
<td>20/60 20/100</td>
<td>20/50</td>
</tr>
<tr>
<td>V.N.</td>
<td>7/m</td>
<td>EMR</td>
<td>+0.50-1.00x.090</td>
<td>20/60 OU</td>
<td>20/60 20/50</td>
<td>20/50</td>
</tr>
<tr>
<td>R.C.</td>
<td>6/m</td>
<td>EMR</td>
<td>+1.00-1.00x180</td>
<td>20/40</td>
<td>20/60 20/80</td>
<td>20/50</td>
</tr>
<tr>
<td>A.N.</td>
<td>7/f</td>
<td>EMR</td>
<td>pl</td>
<td>20/25</td>
<td>20/80 20/40</td>
<td>20/50</td>
</tr>
<tr>
<td>A.D.</td>
<td>6/m</td>
<td>EMR</td>
<td>NA +1.50</td>
<td>20/60 OU</td>
<td>20/60 20/50</td>
<td>20/50</td>
</tr>
<tr>
<td>M.R.</td>
<td>8/m</td>
<td>Microphthalmia, Xotropia</td>
<td>NA +1.00</td>
<td>20/40 OU</td>
<td>20/60 20/50</td>
<td>20/50</td>
</tr>
</tbody>
</table>
REFERENCES


SPECIAL EDUCATION PROCEDURES MANUAL

TEACHER'S EDITION

Portland Public Schools

Special Education Department
531 S.E. 14th Avenue
Portland, Oregon 97214
SPECIAL EDUCATION HANDICAPPING CONDITIONS
DEFINITIONS ACCORDING TO OREGON ADMINISTRATIVE RULE

Following are definitions of handicapping conditions which have been established under Oregon Administrative Rules which comply with the requirements of P.L. 94-142. In order for a student to receive special education and related services, a student's eligibility must be determined according to specific procedures and criteria under Oregon Administrative Rule 581-15-051. Once a student is referred for evaluation, these procedures and criteria are used to establish a student's eligibility. Student's suspected of a handicap should be referred for evaluation only after a pre-referral process which includes written documentation of attempted interventions/options utilizing building level resources. Parents are kept informed throughout this step and should have the opportunity for input at all times. The specific problem must be well defined and in writing.

Handicapped Children includes children who require special education in order to obtain the education of which they are capable, because of mental, physical, emotional or learning problems. These groups include, but are not limited to those categories that traditionally have been designated: mentally retarded, hard of hearing, deaf, speech impaired, visually handicapped, seriously emotionally disturbed, orthopedically impaired, other health impaired, children with specific learning disabilities, and individuals who are pregnant.

VISUALLY IMPAIRED

(a.) Eligibility as a student who is visually impaired shall be determined by a multidisciplinary team. The team shall include two or more individuals, at least one of whom shall be a specialist knowledgeable and experienced in the education of students with the suspected disability.

(b.) The following are required:

(A.) A statement by an ophthalmologist or optometrist licensed by a state board supporting one or more of the eligibility criteria listed under subsections (1)(d)(A),(B) and (C) of this rule; and

(B.) A functional vision assessment or an informal observation by a certificated educator of the visually impaired.

(c) Other information related to the student's suspected disability shall be obtained when the minimum requirements do not adequately assess the problem.

(d) The multidisciplinary team may determine that a student is visually impaired when one or more of the following apply:

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(A) The student's residual acuity is 20/70 or less in the better eye with correction;

(B) The student's visual field is restricted to twenty degrees or less in the better eye; or

(C) The student has an eye condition, either an eye pathology or a progressive eye disease, which in the opinion of the ophthalmologist or optometrist is expected to reduce either acuity of field to the criteria stated in paragraph (A) or (B) of this subsection.

(e) A student who is unable to be adequately tested may meet eligibility criteria as specified in paragraph (1)(d)(C) of this rule and/or when the student demonstrates inadequate functional vision. Continuation of eligibility for more than one year will require a written statement by the multidisciplinary team concerning the status of the suspected eligibility. The statement will confirm/deny/continue the student's eligibility based upon behavioral and observational data compiled over the period of the review.

(f) The multidisciplinary team shall prepare a statement of eligibility, and each member of the team shall sign the statement signifying his/her concurrence or dissent.

(2) HEARING IMPAIRED

(a) Eligibility as a student who is hearing impaired shall be determined by a multidisciplinary team. The team shall include two or more individuals, at least one of whom shall be a specialist knowledgeable and experienced in the education of students with the suspected disability.

(b) The following are required:

(A) An audiological assessment by an audiologist licensed by a State Board using standard audiological procedures to confirm hearing levels and determine amplification needs; and

(B) A physician's statement relative to the suspected disability by a physician licensed by a State Board of Medical Examiners indicating whether or not the hearing loss, if conductive, is treatable, and whether or not there is contra indication for use of amplification.

(c) Other information related to the student's suspected disability shall be obtained when the minimum requirements do not adequately assess the problem.
(d) The multidisciplinary team may determine that a student is hearing impaired when the student exhibits one or more of the following:

(A) The student has a pure tone average loss of 25dbHL or greater in the better ear for frequencies of 500Hz, 1000Hz, and 2000Hz or a pure tone average loss of 35 dbHL or greater in the better ear for frequencies of 3000Hz, 400Hz and 6000Hz. The loss can be sensorineural or conductive, if the conductive loss has been determined to be currently not treatable by a physician; or

(B) A student with unilateral hearing impairment will be considered for eligibility on an individual basis if the student has a significant educational deficit that can be attributed to the hearing loss.

(e) The multidisciplinary team shall prepare a statement of eligibility, and each member of the team shall sign the statement signifying his/her concurrence of dissent.

SPEECH/LANGUAGE IMPAIRED

(a) Eligibility as a student with a communicative disorder shall be determined by a multidisciplinary team. The team shall include two or more individuals, at least one of whom shall be a specialist knowledgeable and experienced in the education of students with the suspected disability.

(b) The following are required:

(A) A speech and language assessment administered by a certificated or licensed speech and language pathologist;

(B) A physician's statement by an otolaryngologist or other physician licensed by a State Board of Medical Examiners when the student has a suspected voice disorder or when a medical diagnosis is needed; and

(C) A hearing screening.

(c) Other information related to the student's suspected disability shall be obtained when the minimum requirements do not adequately assess the problem.
(d) The multidisciplinary team may determine that a student has an ARTICULATION disorder when:

(A) The student, given a test of articulation competence following developmental norms, exhibits disordered misarticulations of one or more phonemes; and

(B) The articulation disorder interferes with communication, and calls attention to itself.

(e) The multidisciplinary team may determine that a student has a VOICE disorder when the student demonstrates chronic vocal characteristics that deviate in at least one of the areas of pitch, quality, intensity and/or resonance.

(f) The multidisciplinary team may determine that a student has a FLUENCY problem when:

(A) The student demonstrates an interruption in the rhythm and/or rate of speech, which is characterized by hesitations, repetitions, and/or prolongations of sounds, syllables, words or phrases; and

(B) The disorder interferes with communication and calls attention to itself.

(g) The multidisciplinary team may determine that student has a LANGUAGE disorder when the student demonstrates a significant delay in one or more of the following areas: phonology, morphology, syntax, semantics or pragmatics as indicated by standard tests and/or language samples such as to interfere with the student's educational progress.

(h) The multidisciplinary team shall prepare a statement of eligibility and each member of the team shall sign the statement signifying his/her concurrence or dissent.

ORTHOPEDICALLY IMPAIRED

(a) Eligibility as a student who is orthopedically impaired shall be determined by a multidisciplinary team. The team shall include two or more individuals, at least one of whom shall be a specialist knowledgeable and experienced in the education of students with the suspected disability.
(b) The following are required:

(A) A physician's statement by a pediatrician or other physician licensed by the Board of Medical Examiners for the State of Oregon indicating a diagnosis of the orthopedic impairment, if known, or a description of the motor limitations; and

(B) A motor assessment by a specialist knowledgeable about the student's suspected disability if the condition is chronic.

c) Other information related to the student's suspected disability shall be obtained when the minimum requirements do not adequately assess the problem.

d) The multidisciplinary team may determine that a student is orthopedically impaired when:

(A) The student has a motor disability and requires special education; and

(B) The condition is permanent or is expected to last for more than 60 calendar days.

e) The multidisciplinary team shall prepare a written statement of eligibility and each member of the team shall sign the statement signifying his/her concurrence or dissent.

SPECIFIC LEARNING DISABILITIES

(a) Eligibility for a child with a specific learning disability shall be determined by a multidisciplinary team. The team shall include:

(A) A specialist knowledgeable in the child's suspected disability;

(B) The child's regular teacher or if the child does not have a regular teacher, a regular classroom teacher qualified to teach a child at his/her age, or for a child of less than school age, an individual qualified by appropriate teacher certification requirements to teach a child of his/her age;

(C) At least one other individual qualified to conduct individual diagnostic examinations of children, if the individual in paragraph (5) (a) (A) of this rule is not qualified to conduct individual diagnostic examinations.
(b) The following are required:

(A) An assessment of the child in all areas related to the suspected disability, including, where appropriate, health, vision, hearing, social and emotional status, general intelligence, academic performance, communicative status and motor abilities.

(B) An observation by a team member other than the child's regular teacher of the child's academic performance in the regular classroom setting, or in the case of a child less than school age or out of school, the team member shall observe the child in an environment appropriate for a child of that age.

(C) A medical examination by a physician licensed by a State Board of Medical Examiners is recommended when the learning problem(s) may be associated with neurological, vision, or hearing problem(s) or when after a period of special education, the child has failed to make reasonable progress.

(c) The multidisciplinary team may determine that a child has a specific learning disability when:

(A) The child does not achieve commensurate with his/her age and ability levels in one or more of the areas listed in paragraph (5)(c)(B) of this rule, when provided with learning experience appropriate for the child's age and ability levels; and

(B) The child has a severe discrepancy between achievement and intellectual ability in one or more of the following areas:

(i) Oral expression
(ii) Listening comprehension;
(iii) Written expression
(iv) Basic reading skills;
(v) Reading comprehension;
(vi) Mathematics calculation; or
(vii) Mathematics reasoning.

(d) The multidisciplinary team may also determine that a child has a specific learning disability if evidence is obtained of a deficit in perception, conceptualization, language, memory, motor skills, or control of attention such as to prevent the child from profiting adequately from regular classroom methods and materials without special education.
(e) The team may not identify a child as having a specific learning disability if the severe discrepancy between ability and achievement is primarily the result of:

(A) A visual, hearing, or motor handicap;
(B) Mental retardation;
(C) Emotional disturbance; or
(D) Environmental, cultural, or economic disadvantage.

(f) The multidisciplinary team shall prepare a written report based upon the results of the evaluation. The report shall include statements regarding the following:

(A) Whether the child has a specific learning disability;
(B) The basis for making the determination;
(C) The relevant behavior noted during the observation of the child;
(D) The relationship of that behavior to the child's academic functioning;
(E) The educationally relevant medical findings, if any;
(F) Whether there is a severe discrepancy between achievement and ability which is not correctible without special education and related services; and

(G) The determination of the team concerning the effects of environmental, cultural, or economic disadvantage.

(g) Each member shall certify in writing whether the report reflects his/her conclusion. If it does not, the team member must submit a separate statement presenting his/her conclusions.

SERIOUSLY EMOTIONALLY DISTURBED:

(a) Eligibility as a student who is seriously emotionally disturbed shall be determined by a multidisciplinary team. The team shall include two or more individuals, at least one of whom shall be a specialist knowledgeable and experienced in the education of students with the suspected disability.
(b) The following are required:

(A) An evaluation of the student conducted by qualified educational authorities with psychological evaluation, when appropriate:

(B) A physician's statement by a physician licensed by a State Board of Medical Examiners indicating whether or not there are any physical factors contributing to the student's educational problems; and

(C) An observation in the classroom, and in at least one other setting by someone other than the student's regular teacher.

(c) Other information related to the student's suspected disability shall be obtained when the minimum requirements do not adequately assess the problem.

(d) The multidisciplinary team may determine that a student is seriously emotionally disturbed when the student's emotional problems shall have existed over an extended period and to such a degree as to significantly interfere with the student's educational progress, and the student exhibits one or more of the following:

(A) An inability to learn at a rate commensurate with the student's intellectual, sensory-motor, and physical development:

(B) An inability to establish or maintain satisfactory interpersonal relationships with peers, parents, or teachers;

(C) A variety of excessive behavior ranging from hyperactive, impulsive responses to depression and withdrawal;

(D) Inappropriate types of behavior or feelings under normal circumstances; or

(E) A tendency to develop physical symptoms, pains, or fears associated with personal, social, or school problems.

(e) Students who are socially maladjusted may not be identified as seriously emotionally disturbed unless the student also meets the eligibility criteria under subsection (6)(d) of this rule.

(f) The multidisciplinary team shall prepare a statement of eligibility, and each member of the team shall sign the statement signifying his/her concurrence or dissent.
MENTALLY RETARDED

(a) Eligibility as a student who is mentally retarded shall be
determined by a multidisciplinary team. The team shall
include two or more individuals, at least one of whom shall be
a specialist knowledgeable and experienced in the education of
students with the suspected disability.

(b) The following are required:

(A) A standardized individual intelligence test meeting the
standards reliability and validity of the American
Psychological Association and administered by a
certificated school psychologist, a psychologist licensed
by a state board of psychological examiners, or other
individual assigned by the district who has the training
and experience to administer and interpret individual
intelligence tests;

(B) An individual standardized test that measures educational
performance or developmental abilities administered by a
certificated teacher or other qualified examiner
authorized by the school district to administer such
tests;

(C) An assessment of the student's adaptive behavior
administered by an individual trained to assess adaptive
behavior using a valid adaptive behavior scale;

(D) A physician's statement by a pediatrician or other
physician licensed by a State Board of Medical Examiners
indicating whether or not there are any sensory or
physical factors contributing to the student's
educational problems; and

(E) A developmental history of the student.

(c) Other information related to the student's suspected
disability shall be obtained when the minimum requirements do
not adequately assess the problem.

(d) The multidisciplinary team may determine that a student is
educable mentally regarded when:

(A) The student's intelligence test score is between two and
three standard deviations below the mean on a standardized
intelligence test administered in accordance with OAR 581-
15-072(1);
(B) The student has deficits in adaptive behavior coexistent

(C) The student's developmental level or educational achievement is significantly below age or grade norms; and

(D) It has been determined that the student's educational problems are not primarily the result of sensory disabilities and/or other physical factors.

(e) The multidisciplinary team may determine that a student is trainable mentally regarded when:

(A) The student's intelligence test score is three standard deviations or more below the mean on a standardized intelligence test administered in accordance with OAR-581-15-072(1); and

(B) The student meets the requirements under paragraphs (7)(d)(B)(C), (D) and (E) of this rule.

(f) The multidisciplinary team shall prepare a statement of eligibility, and each member of the team shall sign the statement signifying his/her concurrence or dissent.

AUTISM

(a) Eligibility is a student with autism shall be determined by a multidisciplinary team. The team shall include two or more individuals, at least one of whom shall be a specialist knowledgeable and experienced in the education of students with the suspected disability.

(b) The following are required:

(A) A developmental history of the student;

(B) At least three, twenty minute direct behavioral observations of the student in multiple environments on at least two different days by a specialist knowledgeable about the student's suspected disability;

(C) A speech and language assessment of functional communication administered by a certificated or licensed speech and language pathologist; and

(D) A physician's statement by a physician licensed by a State Board of Medical Examiners indicating whether or not there are any physical factors contributing to the student's educational problems.
(c) Other information related to the student's suspected disability shall be obtained when the minimum requirements do not adequately assess the problem.

(d) The multidisciplinary team may determine that a student has autism when the student exhibits four of the following five indicators:

(A) The student exhibits impaired or deviant comprehension and/or use of language;
(B) The student exhibits impaired abilities to relate to people or the environment;
(C) The student exhibits or previously exhibited disturbances in responses to sensory stimuli;
(D) The student exhibits or previously exhibited disturbances in developmental rates and/or sequences;
(E) The student exhibits a significant rating on a standardized autism rating scale; and
(F) It has been determined that the student's educational problems are not primarily the result of sensory disabilities and/or other physical problems.

(e) The multidisciplinary team shall prepare a statement of eligibility, and each member of the team shall sign the statement signifying his/her concurrence or dissent.

DEAF/BLIND

(a) Eligibility for a student who is deaf/blind shall be determined by a multidisciplinary team. The team shall include two or more individuals, at least one of whom shall be a specialist, knowledgeable and experienced in the education of students with the suspected disability.

(b) The multidisciplinary team may determine that a student is deaf/blind when the student meets eligibility criteria for visual and hearing impairment in accordance with this rule.

(C) The multidisciplinary team may determine that a student is SUSPECTED DEAF/BLIND when there are:

(A) Inconsistent or inclusive responses during hearing and/or vision evaluations;
(B) Inconsistent responses to auditory and/or visual stimuli in the environment; or
(C) When the student has a degenerative pathology or disease that will affect vision and/or hearing acuity.

(d) Continuation of eligibility status for more than one year for a student suspected DEAF/BLIND will require a written statement by the multidisciplinary team concerning the status of the suspected visual or auditory impairment. The statement will confirm/deny/continue the student's eligibility status based upon behavioral and observational data compiled over the period of the review.

(e) The multidisciplinary team shall prepare a statement of eligibility, and each member of the team shall sign the statement signifying his/her concurrence or dissent.

OTHER HEALTH IMPAIRED

(a) Eligibility as a student who is other health impaired shall be determined by a multidisciplinary team. The team shall include two or more individuals, at least one of whom shall be a specialist knowledgeable and experienced in the education of students with the suspected disability.

(b) The following are required:

(A) A physician's statement by the student's physician(s) licensed by the Board of Medical Examiners for the State of Oregon indicating a diagnosis of the health impairment, if known, or a description of the impairment; and

(B) An assessment of the impact of the student's health impairment on his/her educational performance by a specialist knowledgeable in the area of the student's suspected disability.

(c) Other information related to the student's suspected disability shall be obtained when the minimum requirements do not adequately assess the problem.

(d) The multidisciplinary team may determine that a student is other health impaired when:

(A) The student's health condition requires special education; and

(B) The student's condition is permanent or is expected to last for more than 60 calendar days.
(e) The multidisciplinary team shall prepare a written statement of eligibility, and each member of the team shall sign the statement signifying his/her concurrence or dissent.

**INDIVIDUALS WHO ARE PREGNANT**

(a) The individual shall be examined by a physician licensed by a State Board of Medical Examiners verifying the condition of pregnancy.

(b) When home instruction is provided, individualized goals and objectives shall be compatible with those developed in the regular classroom.

(c) Teachers of individuals receiving home instruction shall hold appropriate certification.

(d) Nothing contained herein shall be construed to prevent individuals who are pregnant from electing to continue to attend classes in the regular school program.
PROGRESS CENTER
NEUROMUSCULAR
CLINIC
HANDBOOK
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Dear Parents and Guardians:

I would like to take a moment to extend, on behalf of the staff, a warm welcome to you and your child.

The Progress Center Neuromuscular Clinic has been operating since 1961 as a center for developmentally delayed children and infants. We currently serve young children with some form of developmental disability from birth to 3 years old.

We are here to assist you and your child, and with your help, plan and implement the best possible program to meet the needs of your child.

This handbook was developed to give you a general idea of the programs Progress Center provides and other helpful information.

Sincerely,

Linda Cooper,
Director
MISSION STATEMENT

It is the mission of the Progress Center to conduct early intervention programs of education and therapy for children birth to three years old who are developmentally delayed, mentally retarded and/or physically handicapped with emphasis on the family unit and parent education.
PROGRESS CENTER HISTORY

The forerunner of the present Progress Center, Inc., was begun in the spring of 1961. It all started when a retarded child was turned away from public school special education classes because there was no place in the local schools where she would fit into a classroom situation. The local ARC chapter was approached, and with the help and encouragement from that source, the Progress Center was born.

During the early years, donated space was provided in various churches, private homes, and the Elks Memorial Building. All work was volunteer, all equipment and supplies were donated, and classes were held several days a week.

In the fall of 1969, Progress Center moved to the second floor of old St. John’s Hospital. This proved to be the most important year in the progress of the Center.

Between that year and 1984, enrollment climbed from 32 to more than 100 children when we served children from birth through 7 years old. Currently we are serving young children birth through 3 years old. Programs were added including physical therapy, communication therapy and occupational therapy. In addition, the Center is now a Level I Neuromuscular Clinic under the guidelines of the State of Washington’s Crippled Children’s Services program. This program, coordinated by our medical coordinator, provides for a multi-disciplinary team evaluation and services to infants and young children known to have or suspected of having neuromuscular/neurodevelopmental disorders, or significant delays in motor development.

In the summer of 1987 Progress Center moved from the Harding facility to an interim facility on Vandercook Way to prepare for our home-based services. In April 1988 Progress Center moved to its present home on 16th Avenue.

The Progress Center currently has 9 staff members including a director, office manager, teachers, communication therapist, physical therapist, and parent educator. We currently contract with St. John's Hospital for occupational therapy services.
Who is served at Progress Center?

Children from birth to 3 years old who are developmentally delayed, mentally retarded, physically handicapped and/or have other handicapping conditions.

How are children referred?

A family member, nurse, doctor, therapist or an individual from another community resource can refer a child. Our medical coordinator evaluates all referrals to determine whether our program is appropriate for the child. If not, the child can be referred to another agency/resource in the community.

After the initial home visit by the medical coordinator, the child is seen for an evaluation by members of our staff, which may include a teacher, physical therapist, occupational therapist, communication therapist and medical coordinator. After the assessment session, the medical coordinator contacts the family, reviews test results and plans the child's program with the parents.
THERAPY

The therapy department provides physical therapy, occupational therapy, communication therapy and nursing services. The aim or goal of therapy is to help the child develop better movement and communication patterns. The therapy program for the child is based on the child's needs and is provided on a one-to-one basis. Therapists also provide group therapy in a classroom setting. Individualized therapy programs are written for each child to help parents carryover the programs at home. Parents' participation in the therapy sessions is strongly encouraged.

NURSING

A pediatric nurse is responsible for coordinating the child's therapy program and schedule. She/he will arrange the appointment times for the child to see the various therapists. The nurse is also the first person whom the parent meets when the child is referred to Progress Center. She/he will do a nursing assessment and developmental screening before the child is scheduled to be evaluated by the therapists and teachers. After the child's evaluation, the nurse arranges a conference for parents and staff to discuss the results and appropriate therapist needed. The nurse also acts as a child/parent advocate and liaison between the local medical community and other medical referral centers when needed.

PHYSICAL THERAPY

A pediatric physical therapist, who has also received special training in providing neurodevelopmental therapy, is responsible for helping the child develop better movement patterns, balancing skills and head and trunk control. The physical therapist focuses on the child's big muscle groups and muscle tone to improve the child's movements and coordination. She/he will also make adaptive equipment to improve the child's body stability.

OCCUPATIONAL THERAPY

An occupational therapist works to help the child use more normal movements in appropriate play and self-help skills (e.g., dressing, eating, etc.). The therapist's area of focus is the child's small muscle groups and eye-hand coordination. He/she will also help the child to understand and use sensory information from his/her environment to improve body awareness and control.

COMMUNICATION THERAPY

A communication therapist works with children who have problems in the area of communication development. These children may have difficulty
with sound production (speech), understanding and using words (language), or with skills considered prerequisite to speech and language such as good feeding skills. The communication therapist will develop programs that may include verbal communication, early feeding skills, manual communication and/or verbal gestural communication.

All the therapists will work closely with the child's teacher and parent to make sure that there is appropriate carryover of the child's individualized therapy programs.
MEDICALLY FRAGILE INFANT/TODDLER PROGRAM

The Progress Center now offers a medically fragile program. The program, taught and administered by the Progress Center medical coordinator, is a comprehensive home stimulation program focusing on all areas of the child's development. Children are enrolled in the medically fragile program based on their disability, their state of health and their physician's wishes. The nurse/medical coordinator is also available to listen to parents concerns about their child's health or programming and to provide suggestions to address these concerns. When a child's medical condition stabilizes, he/she can then be transferred to another teacher's caseload. Children in the medically fragile program, as in all education programs, are programmed based on the Individual Education Plan/Family Service Plan.
HOMEBOUND EDUCATION SERVICES

Our Progress Center program revolves around a homebased educational model. Children are visited in their homes, one hour per week, by a teacher from our staff. During this home visit, the teacher, student and parent(s) will work on areas of development of the children, striving toward positive progress in skills.

When a child is ready, the Progress Center teacher can assist the parent in obtaining integration experiences with his/her peers in local daycares and preschools in the area. The teacher will also visit the integration site to make sure that the transition is a smooth one for parent and child. Please ask your child's teacher for more information on integrating your child.

CLASSROOM EXPERIENCE

For those children ready, the Progress Center has begun a classroom experience on Wednesdays from 10:00 to 12:00 noon. Enrollment in this class is by reservation only so please sign your child up for this class prior to Wednesdays. As always, if your child will unexpectedly miss the class, please call so another child can attend.

Parents assist in the class on a rotating basis. Children utilize their fine/gross motor skills, cognitive/problem solving skills and generally have a great time with all their buddies! Ask your child's teacher for more details.
The following is a listing of public school district contact persons in the special education department:

<table>
<thead>
<tr>
<th>School District</th>
<th>Phone</th>
<th>Contact Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Longview Schools</td>
<td>577-2715</td>
<td>Jean Custer, special education director; or, Cathy Evans, assistant</td>
</tr>
<tr>
<td>Kelso Schools</td>
<td>577-2410</td>
<td>Dave Bagby, special programs director</td>
</tr>
<tr>
<td>Kalama Schools</td>
<td>673-5225</td>
<td>Mal Swanson, superintendent</td>
</tr>
<tr>
<td>Castle Rock Schools</td>
<td>274-8311</td>
<td>Dr. Richard Galt, superintendent</td>
</tr>
</tbody>
</table>
PROGRAM POLICIES

The following pages are derived from our Personnel Policy Manual for employees. These policies outline our program, no-show policy, medical coupon usage, evaluations/NDT, services not provided by Progress Center, children turning 3 years old, therapy/education services, enrollment, illness, private insurance clients and reimbursement for therapy services.

1. Children birth to 3 will be served and criteria for enrollment at Progress Center is as follows:
   
   A. 25% delay in one developmental area if under 2 years old; delay in two developmental areas if under 3 years old.

   B. Eligibility for funding from the Division of Developmental Disabilities (DDD) and Crippled Children's Services (CCS).

2. A waiting list may be started if enrollment is at its maximum. Children will be enrolled in the program on need based on the following:

   A. Children ages birth through 2 with no alternative for services to be given priority.

   B. Children with severe delay and medically involved given priority over less delayed children.

   C. Some children may be monitored monthly if caseload is full and family does not have alternative for service.

NO-SHOW POLICY:

Progress Center will allow 3 no-shows for home visits or therapy before the slot is reassigned to another child and the following steps occur:

1. Family will receive a letter from the medical coordinator followed by a phone call to notify parents of absences.

2. If no response is received in one month, the family will receive another follow up call.

3. If no notice is given, the child is then dropped from Progress Center enrollment.

Families are required to do the follow up of instructions and activities with their child as given by teacher or therapist. Failure to do so will indicate lack of interest in the program. The director or medical coordinator will meet with the family to discuss their interest in Progress Center.

MEDICAL COUPONS:

Medical coupons will be accepted with the following stipulations:
1. The family has medical coupons and no other funding sources.

2. Pre-authorization to provide the service.

3. Medical coupons will be used for therapy and nursing services when CCS funds are not attainable and then CCS can be utilized for other services needed. We will collect medical coupons or CCS funds for therapy or nursing services.

4. Medical coupons will be given priority and CCS funds then could be used for alternative services for psychologist, social work or occupational therapy.

EVALUATIONS/NDT (neurdevelopmental testing):

1. At least one NDT will be done per month.

2. A child who has recently (within 6 months) been evaluated at a level 2-4 neuromuscular center can be enrolled at Progress Center without formal evaluation.

3. The medical coordinator will work with referral agencies to obtain evaluation services when Progress Center evaluations are at the maximum to facilitate early enrollment at Progress Center.

SERVICES NOT PROVIDED AT PROGRESS CENTER:

1. Progress Center is not responsible for obtaining medical services for children. We will provide assistance in obtaining medical services, if needed.

2. Tympanogram services will not be provided. A referral elsewhere can be made, if needed.

3. Direct medical care is not provided at Progress Center.

CHILDREN WHO TURN 3 YEARS OLD:

When children in the Progress Center program turn 3 years old, the following will happen:

1. The child may continue enrollment at Progress Center, pending space available and no younger children on the waiting list.

2. If younger children are on the waiting list, and since no alternative for services exists for the younger developmentally delayed child, the child who turned 3 will be instructed by the teacher as to his/her alternatives, which may include:

   A. Special education through public schools.

   B. Continuation with integration at daycare/preschools.

   C. Limited monthly visits if needed and if other options are not met
and the child does not qualify for the school district.

D. Continuing at Progress Center and paying privately for services.

The teacher will assist the parent as needed to make transition from Progress Center smooth for the parent and child.

NEW THERAPY/EDUCATION SERVICES:

No new therapy or education services or additional services will be allowed without previous approval from the director or medical coordinator.

TEACHER/ThERAPIST NO-SHOW INSTRUCTIONS:

Teacher/therapist will implement the following for no-shows:

1. Inform the medical coordinator of all no-shows.
2. Medical coordinator will implement no-show policy.
3. Employees will attempt to reschedule with other children in their caseload. The teacher/therapist may see a child more than 1 time a week to attempt to fill a slot in another child's absence.

ENROLLMENT:

The maximum number of children served shall be 37.

ILLNESS:

If a child is ill the parent should call and cancel services, giving as much time as possible for the teacher/therapist to reschedule. If parent questions if a child is ready to receive a home visit or therapy after an illness, they can call our medical coordinator or their family doctor. Therapy/home visits can be ended early if teacher/therapist assess the child is too ill to continue.

PRIVATE INSURANCE POLICY:

To assist Progress Center in defraying the costs of therapy services, the following guidelines will be used for families who have private medical insurance:

1. In the event that the insurance company does not pay 100% of the billable amount for therapy services, the family will be requested to reimburse the difference.
2. All families will be informed in writing of this change in policy.
3. If a family does not have the financial resources to reimburse Progress Center for the difference in the billable amount that the private insurance company did not pay, no services will be denied. A need assessment will be made with the family by the director or medical coordinator to determine exception from payment.
REIMBURSEMENT FOR THERAPY SERVICES:

Families of children who qualify for therapy services but are not eligible for CCS or medical coupons will be requested to reimburse Progress Center for services from private funds. This will only apply to families whose medical insurance company does not recognize Progress Center as a provider. Families who do not have the financial resources to reimburse Progress Center can be eligible to apply for a scholarship fund to obtain the therapy services.
PARENT EDUCATION

Within the Progress Center program we offer continuing parent education. Pam Helgeson is our parent educator and she offers monthly parent meetings with topics of interest to parents and staff. We have offered short term group counseling services with Dr. Dave Hawkins, who is with Northwest Counseling Services. We anticipate offering this again in the fall of 1988. Pam is also available to offer her assistance to families in transition from Progress Center to public school or other programs.

PROGRESS CENTER AUXILIARY

The Auxiliary is a parent support and fundraising group on behalf of Progress Center. There are approximately 40 members made up of parents, relatives, friends or anyone interested in helping handicapped children.

The Auxiliary projects include:

1. Providing food, supplies or other assistance to Progress Center school parties.
2. Christmas bazaar.
3. Quilt raffle.
4. Garage sales.
5. Other fundraisers.

The Auxiliary meets once a month, usually the 4th Tuesday. We welcome new members - please call the Center at 425-9810 if you are interested.
TIPS FOR PARENTS

--- Each teacher/therapist has a time just for your child. Please keep that appointment time.

--- It is important that there be a space in your home for the teacher to work with your child. If that is a problem the teacher may be able to loan a chair or other equipment to you.

--- Children work better when they are fed and rested. We will try to accommodate your child's eating or resting schedule. Please try to be sure your child is "ready to learn" when the teacher visits.
FUNDING RESOURCES FOR PROGRESS CENTER STUDENTS

The services of Progress Center are funded by many sources. Various funding sources have detailed regulations as to who is eligible for their services and for what they will pay. The following is a basic list and description of our major funding sources. Please note that this in no way covers all the details of eligibility and services provided.

MEDICAL INSURANCE:

Many families have medical insurance which may pay for physical therapy, occupational therapy or speech therapy and consultations. The amount paid will depend on the terms of the insurance policy.

TITLE I:

The Federal government supplements the education program through Title I programs.

DIVISION OF DEVELOPMENTAL DISABILITIES:

In Cowlitz county the Division of Developmental Disabilities pays a set amount toward the education services given at Progress Center. Children must reside in Cowlitz or Wahkiakum county to qualify for services.

CRIPPLED CHILDREN’S SERVICES:

The Progress Center has a contract with CCS as a level I neuro muscular center. Children must meet CCS guidelines to obtain services through our CCS contract. CCS primarily funds therapy, nursing and other related services.

UNITED WAY OF COWLITZ COUNTY:

Through the generosity of this community donating to United Way, they allocate monies to Progress Center. Through the United Way sponsorship program we are able to fund additional education and therapy sessions.

PROGRESS CENTER AUXILIARY:

The Progress Center Auxiliary has assisted Progress Center and its young students for many years. They plan and implement several fundraisers during the year and support the programs for our young children.
FEE SCHEDULE FOR PRIVATE INSURANCE
1988-89

The fee schedule below does not, in most cases, represent the cost, if any, to parents. Most families have resources available to them in the form of medical insurance, Crippled Children's Services, etc.

<table>
<thead>
<tr>
<th>Service</th>
<th>30 min.</th>
<th>15 min.</th>
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<tbody>
<tr>
<td>Occupational therapy</td>
<td>$26.28</td>
<td>$13.14</td>
</tr>
<tr>
<td>Physical therapy</td>
<td>26.28</td>
<td>13.14</td>
</tr>
<tr>
<td>Communication therapy</td>
<td>26.28</td>
<td>13.14</td>
</tr>
<tr>
<td>Nursing services</td>
<td>19.50</td>
<td>9.75</td>
</tr>
</tbody>
</table>
EMERGENCY PROCEDURES

Up to date family emergency numbers are kept in the front office. If your emergency number changes, please notify the office manager immediately.

1. Accident: In case of an accident the staff will use their best judgment on the procedure used and the family will be notified. If the child needs to be taken to the hospital, the child will be taken to the hospital listed by the family on the emergency form.

2. Snow/severe weather: Progress Center follows the Longview School District guidelines for school closure. Local radio stations broadcast whether or not school will be held in the Longview District that day. Additionally, Progress Center may choose to close school when the Longview District remains open. In this case you will be notified individually by Progress Center staff.

3. Disaster: In the event of a disaster which would threaten the safe operation of Progress, children will be moved to the nearest place of shelter.

4. Fire: In case of fire all children will be moved from the building to the civic center across 16th Avenue.