Determining Special Education Eligibility - Speech Language Impairment

Department of Education, Office of Special Education

Introduction

These eligibility guidelines were written to provide parents, teachers, special education personnel, administrators, and other professionals with information on the identification and determination of eligibility for special education services for children with speech language impairment.

This category of children has been defined by both federal and state regulations. A three-part eligibility requirement for a child to be eligible as a child with a speech-language impairment is as follows:

- Meet eligibility criteria (92 NAC 51.006);
- Documentation of adverse effect on development or educational performance;
- Determination that a need for special education is evident.

State Definition

Speech or Language Impairment – To qualify for special education services in the category of speech-language impairment, the child must have: a communication disorder, such as: stuttering; impaired articulation; language impairment; or voice impairment. This disorder must adversely affect the child's educational, or in the case of a child below age five, a child's developmental performance.

Section 1: MULTIDISCIPLINARY EVALUATION (MDT) CONSIDERATIONS

The Multidisciplinary Team (MDT) should include at least:

- The child's parent(s);
- For a school age child, the child's regular teacher(s) or a regular classroom teacher qualified to teach a child of that age;
    - For a child below age five, a teacher qualified to teach a child below age five;
- Special educator or a speech and language pathologist;
- A school district administrator or a designated representative; and
- At least one person qualified to conduct individual diagnostic examinations of children in their specific area of training (i.e., school psychologist, speech language pathologist, or other instructional specialist).

Section 2: GUIDELINES

In order for a child to be eligible as a child with a speech-language impairment the evaluation must demonstrate below average performance in language or articulation, or abnormal patterns in voice or fluency.

Documentation of a speech-language impairment must demonstrate a pattern of deficits that has an adverse effect on the child's developmental or educational performance in the areas of communication, social-emotional, or academics, based on the analysis of multiple data sources from among the following:

- Results of standardized and criterion-referenced assessments of speech or language
- Results of criterion-based speech-language sampling
- Results of criterion-based communication measures
- Direct observation of the child in the natural environment or classroom
- The child's response to short-term scientific, research-based intervention
- Measurement of the child's intellectual ability
- Results of criterion-referenced assessments related to the general curriculum
- Description of communication supports provided at home or at school
- Relevant medical data
- Information from child, parent and/or other caregivers, and teachers

Eligibility of a speech-language impairment shall be based on a pattern of communicative performance which is below the average range and documentation of significant adverse effect on the child's development or educational performance.

A child shall not be determined to have a speech-language impairment if the determining factor is a lack of instruction or limited English proficiency.

Communication Disorder

A **communication disorder** is an impairment in the ability to receive, send, process, and comprehend concepts or verbal, nonverbal, and graphic symbol systems. A communication disorder may be evident in the processes of hearing, language, and/or speech. Individuals may demonstrate one or any combination of communication disorders and may result in a primary disability or it may be secondary to other disabilities.

Language refers to the rule-based use and comprehension of spoken, written and/or other symbolic systems.

A language disorder is impaired comprehension and/or use of spoken, written, and/or other symbol systems which may involve content, form, and/or use. It may be developmental or acquired.

The basic elements of language are:

- Content: semantics, the meanings of words and word combinations
- Form:
  - Phonology, speech sounds, sound patterns and rules of sound organization
  - Morphology, units of meaning
  - Syntax, rules governing word order and word combinations to form sentences
- Use/Function: pragmatics, the social aspects of language

Speech refers to an impairment of the articulation of speech sounds, fluency, and/or voice.

The elements of speech are:

- **Articulation** (speech sound production) refers to the movements of the speech organs involved in the production of speech sounds/phonemes.

  An articulation disorder (speech sound production disorder) is the atypical production of speech sounds characterized by substitutions, omissions, additions, or distortions that may interfere with intelligibility.

- **Voice** refers to the production of pitch, loudness, resonance, and vocal quality appropriate for an individual's age and/or gender.

  A voice disorder is characterized by the abnormal production of vocal quality, pitch, loudness, resonance, and/or duration, which is inappropriate for an individual's age and/or gender.

- **Fluency** refers to the smooth, uninterrupted, effortless flow of speech; normal rate and rhythm of speech.

  A fluency disorder (stuttering) is an interruption in the flow of speaking, characterized by atypical rate, rhythm, and repetitions in sounds, syllables, words, and phrases. This may be accompanied by excessive tension, struggle behavior and secondary mannerisms, as well as by negative covert attitudes toward and perception of the communication process.

Definitions adapted from ASHA website: https://www.asha.org/policy/RP1993-00208/

Considerations Regarding Culturally and Linguistically Diverse Children

Interpreting the communicative behavior of culturally and linguistically diverse children during assessment is not substantially different from the process for native English speakers. However, it does require consideration of both the structure of their language/dialect and the cultural values that affect communication. Materials and procedures used to assess a child with limited English proficiency must be selected and administered to ensure that they measure the extent to which the child has a disability and needs special education, rather than measuring the child's English language skills.

- Some considerations
    - Stage of primary language development when English was introduced
    - Quality of English speech-language models
    - Child-rearing practices that may affect communication development (i.e. amount of parent-child vs. peer-peer talk)
    - Attitudes of family and child to English language culture

Considerations for Continued Eligibility

According to the Individuals with Disabilities Education Act (IDEA, 2004), a child is eligible for special education and related services when it is determined that:

1. A disability exists—the child's performance meets criteria under NAC 51; and
2. The disability has an adverse effect on the child's educational performance or development; and
3. The child needs special education and related services to address the adverse effect.

When determining continued eligibility, it is recommended that the MDT/IEP Team consider the following:

- Does the communication disorder continue to exist? (#1 above)
- Do the child's communication skills continue to constitute a disabling condition? (#1 OR #2 above)
- Do the child's communication skills interfere with his/her development or educational functioning? (#2 above)
- Does the child continue to need speech-language intervention in order to benefit from his-her educational program? (#3 above)
- Are the child's present communication skills within the expected range commensurate with his/her cognitive abilities/developmental levels (#1, #2, or #3 above)

SECTION 3: PROCEDURES TO DETERMINE ADVERSE EFFECT DEVELOPMENT/EDUCATIONAL PERFORMANCE

FACTORS TO CONSIDER

The following procedures and analysis of assessment information are recommended in the Multidisciplinary Evaluation Team's (MDT) determination of adverse effect on development or educational performance as it relates to language, articulation, voice, or fluency.

LANGUAGE	
Referral information	• Analysis of data collected by Student Assistance Team (or problem-solving team) (for children of school-age) • Parent/caregiver information (for children ages birth to five)
Educationally/ developmentally relevant medical information	• Medical history • Medication which may adversely affect language • Medical information relevant to language development • Hearing screening results

Formal and informal assessments	Standardized or criterion-referenced assessment of language in one or more of the following areas, as indicated by the referral for assessment: • Receptive language including auditory processing, where appropriate • Expressive language • Vocabulary • Syntax, morphology • Pragmatics • Phonology • Phonemic awareness • Narrative language • Word retrieval • Intellectual ability, when questioned • Parent/caregiver information on the child's developmental milestones and language skills through interviews and rating scales (for children ages birth to five)

Language Sample	• Consistency of language performance across structured and unstructured contexts
	• Information on nonverbal communication during spontaneous conversation
	• Ability to express a variety of communicative functions within the following areas:
	  • Behavioral Regulation—communication intended to manipulate the behavior of others
	  • Requesting object
	  • Requesting action
	  • Protesting/rejecting
	  • Social Interaction—communication intended to relate to/interact with others
	  • Requesting social routine
	  • Requesting comfort
	  • Greeting
	  • Calling
	  • Requesting permission
	  • Showing off
	• Joint Attention—communication intended to share focus with others
	  • Commenting
	  • Requesting information
	  • Providing information
	• Developmentally/age-appropriate interactions of language content/form/use

Observational data/ input from:	• Natural environment or classroom • Student Assistance Team (or problem solving team) • Classroom teacher • Parents/Caregiver • Child

Response to scientific, research-based intervention	

Children should not be found eligible for services based on low scores on a single test. Generally, all areas of language should be considered – structure, content, and use, including understanding and use of language, syntax, morphology, semantics, phonemic awareness, phonology, language formulation and retrieval, auditory processing, oral narratives, and pragmatics. When assessing a child with an intellectual disability, the child's "developmental age" should be a major consideration. The speech-language pathologist will need to apply professional judgment to the analysis of the child's pattern of phonological development.

The information in the following chart is designed to provide a descriptive continuum from typical development through disordered performance for selected linguistic elements.

Language Disorder Assessment Continuum				
STANDARD SCORE (formal measures of content, form & use)	**85 to 115 SS -1 to +1 SD 16 to 85%ile**	**78 to 84 SS >1 SD to -1.5 SD 7 to 15%ile**	70 to 77 SS >1.5 SD to –2 SD 2 to 6%ile	Below 70 SS >-2 SD Below 2%ile
EFFECT ON COMMUNICATION	No adverse impact	Language deficits may be obvious to familiar others; may impact academics	Language deficits impact ability to communicate orally, process oral language, read and write	Language deficits are linked to deficits in preliteracy/literacy skills and/or social relationships
PRAGMATICS (where no standard scores are available)	Able to maintain topic, take turns, and express all communicative functions age-appropriately	Does not adapt speaking style, give feedback, maintain topic appropriate to age	Difficulty initiating, requesting information, maintaining topic, making repairs, using eye contact, controlling prosody for meaning	Does not use language appropriately for behavioral regulation, social interaction, and joint attention
PHONOLOGY (where no standard scores are available)	Age appropriate phonological skills Phonological processes evident are within age range for typical development	One or two phonological processes evident that do not exceed the age-range for expected suppression Processes improve over time	Consistent phonological processes evident that exceed age-range for expected suppression by no more than 1 year Intelligibility may be adversely affected	Consistent phonological processes evident that exceed age-range for expected suppression by more than 1 year Intelligibility is adversely affected
PHONEMIC AWARENESS (where no standard scores are available)	Age-appropriate awareness of phonemic features: rhyming, isolating, blending, segmenting, etc.	Below average awareness of phonemic features: rhyming, etc. on criterion-referenced testing	Inability to manipulate phonemic features resulting in significantly below average literacy skills in classroom, on criterion-referenced and/or formal testing	Pervasive inability to manipulate phonemic features resulting in significantly below average literacy skills in the classroom

Phonological processes describe what children do in the normal developmental process of acquiring speech to simplify adult productions. (Shipley & McAfee, 2004) Typically, children outgrow or suppress such processes as they learn to produce the correct adult targets by around eight years of age. (Stoel-Gammon & Dunn, 1985).

Stoel-Gammon and Dunn (1985) reviewed a number of studies of phonological process occurrence and identified processes that are typically suppressed by age 3 years and those that typically persist after 3 years:

Processes Disappearing by 3 Years	Processes Persisting after 3 Years
* Unstressed syllable deletion	* Cluster reduction
* Final consonant deletion	* Epenthesis
* Consonant assimilation	* Gliding
* Reduplication	* Vocalization
* Velar fronting	* Stopping
* Prevocalic voicing	* Depalatalization
	* Final devoicing

Phonological process analysis compares a child's productions to standard adult productions. Different researchers describe a number of phonological processes.

It is important to note that there is limited research on when specific patterns of phonological processes are outgrown. The speech-language pathologist will need to apply professional judgment to the analysis of the child's pattern of phonological development.

Commonly used assessment batteries for evaluating phonological processes include:

- Assessment Link Between Phonology and Articulation (Lowe, 1986)
- Assessment of Phonological Patterns—Revised (Hodson, 2004)
- Bankson-Bernthal Test of Phonology (Bankson & Bernthal, 1999)
- Khan-Lewis Phonological Analysis (KLPA-2) (Khan & Lewis, 2015)
- Assessment of Articulation and Phonological Processes (Kenneth G. Shipley Julie G. McAfee, 1992)

Determination of Adverse Effect

The following questions are to guide documentation and determination of adverse effects of language deficits on a child's developmental/ educational performance and need for special education in the areas of communication, social-emotional, and academics:

Communication

- Does the child demonstrate:
  - Difficulty identifying and understanding important ideas and details in conversations
  - Limited understanding of word meanings; limited vocabulary compared to peers?
  - Difficulty defining and describing actions, objects, and events?
  - Difficulty in the production of complex utterances; simplified sentence structure that requires the individuals to produce multiple simple sentences rather than one complex utterance?
  - Difficulty conveying ideas; talking around a topic, using gestures in an attempt to get a point across, making irrelevant remarks
  - Difficulty with word retrieval?
  - Difficulty with topic maintenance in conversation?
  - A speech-sound system characterized by phonological processes beyond the normal age for suppression of such processes?
- Is the child unable to:
  - Make requests and ask questions to meet his/her needs?
  - Respond appropriately to age-appropriate requests and questions?

Social-Emotional

- Does the child demonstrate:
  - Difficulty establishing and maintaining interpersonal relationships with peers and adults due to language deficits?
  - Difficulty organizing, initiating, and sustaining social conversations?
  - Difficulty following conversational rules – turn taking, personal space, reciprocity?
  - Difficulty understanding jokes, puns, and riddles?
  - Difficulty recognizing, interpreting, and using nonverbal cues?

Academics

- Does the child demonstrate:
  - Difficulty understanding or using basic concepts, i.e. descriptors and colors?
  - Difficulty with comprehension of oral/written information and directions due to language deficits?
  - Difficulty remembering information that was previously learned?
  - Difficulty asking coherent questions to clarify information?

- Difficulty responding appropriately to questions?
- Difficulty identifying main ideas and relevant details in reading; distinguishing fact from opinion; predicting or inferring information; understanding multiple-meaning words?
- Difficulty analyzing and manipulating sounds in phonemic awareness activities – blending, segmentation, deletion, etc.?
- Difficulty organizing and editing written work, reflecting oral expression deficits in vocabulary and in written work?
- Difficulty understanding and using figurative language?
- Difficulty with space, time, and quantity concepts in math?
- Difficulty with sequencing tasks?
- Decreased participation in classroom discussions?

In no case should below average performance on a single measure be accepted as demonstrating a pattern of deficit.

ARTICULATION

Referral information

- Analysis of data collected by Student Assistance Team (or problem-solving team) (for children of school-age)
- Parent/caregiver information (for children ages birth to five)

Oral peripheral examination

- Assessment of the structures and functions of the oral-motor mechanism for speech

Educationally/developmentally relevant medical information

- Medical history
- Medication which may adversely affect articulation
- Examination of medical information relevant to the production of speech
- Hearing screening or results of previous hearing screening

Formal and informal measures

- Tests of articulation of both vowels and consonants at the single word, phrase, sentence, and conversational levels
- Stimulability at the isolation, nonsense syllable, word, phrase, and sentence levels
- Intelligibility of connected speech in known contexts

- Parent/caregiver information on the child's developmental milestones and language skills through interviews and rating scales (for children ages birth to 5)
- Results of articulation testing compared to the Iowa-Nebraska Articulation Norms or other scientific, research-based articulation norms

Speech sample

- Consistency of articulation across structured and unstructured contexts

Observational data/input from:

- Natural environment or classroom
- Student Assistance Team (or problem-solving team)
- Classroom teachers Parents/caregivers
- Child

The information in the following chart is designed to provide a descriptive continuum from typical development through disordered performance.

Articulation Disorder Assessment Continuum

SPEECH SOUND PRODUCTION	Child's articulation is developmentally appropriate	Child's chronological age (or developmental age) does not exceed acquisition age for the error phoneme(s). *(See IA-NE Articulation Norms)*	Child's chronological age (or developmental age) exceeds the acquisition age for the error phoneme(s) by no more than 1 ½ years (See IA-NE *Articulation Norms)*	chronological age (or developmental age) exceeds the acquisition age for the error phoneme(s) by 2 or more years. *(See IA-NE Articulation Norms)*
STIMULABILITY	Stimulability for phonemes indicates good prognosis for normal development	Sound errors are stimulable in at least one context	Sound errors may or may not be stimulable with effort	Sound errors are not generally stimulable
INTELLIGIBILITY	Intelligibility acceptable for age.	Connected speech at least 75% intelligible, although noticeably in error	Intelligibility of connected speech in unknown contexts may be adversely affected	Intelligibility of connected speech in both known and unknown contexts is generally severely affected
TYPES OF ERRORS	Developmental	Generally single phoneme errors, primarily distortions	Single or multiple phoneme errors, primarily substitutions or distortions	Generally multiple phoneme errors, often omissions.
CONSISTENCY OF ERRORS	N/A	Speech sound errors are generally inconsistent	Speech sound errors are generally consistent across all contexts	Speech sound errors are consistent across all contexts

EFFECT ON COMMUNICATION	Able to express all communicative functions in natural environment or classroom settings	Child is able to express all communicative functions Communication breakdowns are infrequent, confined to speech that is non-contextual	Frequent communication breakdowns which the child is able to repair Child is aware of speech difficulty and may occasionally withdraw and/or show frustration	Communication breakdowns without successful repair Child is aware of speech difficulty and withdraws and/or shows frustration often

Iowa Nebraska Articulation Norms

Listed below are the recommended ages of acquisition for phonemes and clusters, based generally on the age at which 90% of the children correctly produced that sound. These recommended ages are for phonetic acquisition only. These data may be used when evaluating children suspected of having a speech-language impairment.

Phoneme	Age of Acquisition Females	Males
/ m/	3;0	3;0
/ n/	3;6	3;0
/-ŋ /	7;0	7;0
/ h-/	3;0	3;0
/w-/	3;0	3;0
/ j-/	4;0	5;0
/ p/	3;0	3;0
/ b/	3;0	3;0
/ t/	4;0	3;6
/d/	3;0	3;6
/k/	3;6	3;6
/g/	3;6	4;0
/f-/	3;6	3;6
/-f/	5;6	5;6
/ v/	5;6	5;6
/θ/	6;0	8;0
/ð-/	4;6	7;0
/s/	7;0	7;0
/z/	7;0	7;0
/ʃ/	6;0	7;0
/tʃ/	6;0	7;0
/dʒ/	6;0	7;0
/l-/	5;0	6;0
/-l/	6;0	7;0
/r-/	8;0	8;0
/-ɚ/	8;0	8;0
Word-Initial Clusters		
/tw kw/	4;0	5;6
/sp st sk/	7;0	7;0
/sm sn/	7;0	7;0
/sw/	7;0	7;0
/sl/	7;0	7;0
/pl bl kl gl fl/	5;6	6;0
/pr br tr dr kr gr fr/	8;0	8;0
/θr/	9;0	9;0
/skw/	7;0	7;0
/spl/	7;0	7;0
/spr str skr/	9;0	9;0

Note regarding phoneme positions: e.g.

- / **m** / refers to prevocalic & postvocalic positions
- / **h-** / refers to prevocalic position
- / **-f** / refers to postvocalic position

Note: Lateralized variants are not considered to be developmentally appropriate and therefore are not to be considered within the parameters of these data. Decisions regarding intervention with children should take into consideration the dental development, motor maturation, and social / emotional welfare of the child. (Smit, et al. 1990)

Iowa Nebraska Articulation Norms
Predictive Assessment Considerations

The following variables should be taken into consideration when using predictive assessment of phonetic errors on /s/ and/z/:

A. Nature of the error:

Lateralization of /s, z/ does not undergo spontaneous improvement with age and therefore "should not be considered developmental."

B. Consistency of the error:

It is recommended that "a child exhibiting inconsistency (i.e.: if the /s, z/ could be produced correctly in any context) would not usually be considered for intervention unless the so-called inconsistency was governed by a phonological rule or was powerfully conditioned by phonetic context."

C. Dentition:

Dental conditions, such as the lack of eruption of the upper incisors, are important diagnostic considerations for the /s/ and /z/ phonemes.

Smit et al, in their findings from the Iowa Articulation Norms Project and its Nebraska Replication (JSHD, Nov. 1990) make the following recommendations:

1. Consider intervention for lateralized variants, other rare variants, and variants that appear to have damaging social consequences at or before age 7.0. In these cases early intervention is indicated, even for preschoolers, provided that (a) the child appears to respond favorably to treatment (a decision that might be based on the outcome of a brief period of diagnostic remediation); and (b) there are no indicators of spontaneous or impending improvement.

2. For any other kinds of phonetic errors, evaluate at age 7.0, but delay intervention if the deviation is considered slight or if any one of the following positive indicators is present: (a) acceptable /s/ or /z/ is used in any single or clustered context, even if the acceptable sound is used in only one or a few words; (b) the child is stimulable for acceptable /s/ or /z/; or (c) the permanent upper incisors have not erupted.

3. Recheck the child at 8.0. Provide intervention only if there has been no change in indicators or if there has been a negative change.

4. Recheck at age 9.0 and provide intervention for children who still have clinically significant errors on /s/, /z/.

5. Use the same kinds of criteria for each word-initial cluster with /s/ IF the primary error on the cluster involves the /s/. If the primary error on the cluster involves another element, for example, /r/ in /spr/, str/, /skr/, then use age 9.0 as the age of acquisition. (Smit et al,1990)

See additional information on phonological processes in **Section 8, References and Resources-** Additional Information on Articulation and Phonological Disorders; and **Web Sites- Net** Connections for Communication Disorders and Sciences, Judith Kuster (http://www.mnsu.edu/comdis/kuster2/welcome.html)

Determination of Adverse Effect

The following questions are to guide documentation and determination of adverse effects of articulation deficits on a child's developmental/ educational performance and need for special education in the areas of communication, social-emotional, and academics:

Communication

- Do the articulation errors call attention to the child's speech or distract from the message?
- Does the child experience:
  - Difficulty speaking effectively in classroom discussions, cooperative group activities, and presentations?
  - Difficulty talking on the telephone?
  - Frequent communication breakdowns without successful repair due to sound errors?
- Are the speech sound errors consistent across all contexts?
- Is the child stimulable for correct production of the speech sound errors?

Social-emotional

- Does the child demonstrate:
  - Difficulty establishing and maintaining interpersonal relationships due to multiple speech sound errors?
  - Reluctance to speak to peers and adults?
  - Avoidance of peers and social situations?
  - Difficulty making wants and needs known due to unintelligible speech?
  - Speech which results in making the child appear less mature, or less knowledgeable?

Academics

- Does the child demonstrate:
  - Limited and/or reluctant participation in classroom discussions?
  - Difficulty making oral presentations?
  - Difficulty reading aloud due to articulation problems?
  - Reluctance to participate in cooperative learning group activities due to problems communicating?
  - Reluctance to ask questions for clarification or help?
- Have the child's speech sound errors limited coursework attempted or career paths selected?

Voice

- Referral information
  - Analysis of data collected by Student Assistance Team (or problem-solving team) (for children of school-age)
  - Parent/caregiver information (for children ages birth to five)
- Oral peripheral examination
  - Assessment of the structures and functions of the oral-motor mechanism for speech
- Educationally/developmentally relevant medical information
  - Medical history
  - Medication which may adversely affect voice
  - Hearing screening results
  - Efficacy of medical intervention
  - Consider effects of allergies, chronic upper respiratory infection, insufficient respiratory function, etc.

- Formal and informal assessment measures
    - Sustained speech, phonation (with and without voicing) in both speaking and reading tasks
    - Interviews of the child, parent/caregiver, and teacher(s), including information on child's use of voice – sports, singing, performing, crying, shouting, cheering, talking over loud noise, exposure to noxious elements, etc.
    - Parent/caregiver information on the child's developmental milestones and language skills through interviews and rating scales (for children ages birth to five)
    - Analysis of times/settings in which the voice is best/worst
    - Evaluation of:
        - Intensity (loudness, ability to control loudness)
        - Frequency (pitch, pitch range, inflection, appropriateness for age and gender)
        - Resonation (hyper- or hypo-nasality, velopharyngeal functioning)
        - Phonatory quality (breathiness, hoarseness, glottal attack, intermittent aphonia, etc.)
- Speech sample
    - Consistency of voice performance across structured and unstructured settings
    - Information from at least two settings
- Observational data/input from:
        - Natural environment or classroom
        - Student Assistance Team (or problem-solving team)
        - Classroom teachers
        - Parents/caregivers
        - Child

<u>If vocal fold pathology is suspected, the child's physician shall be consulted prior to the initiation of voice therapy.</u>

Information in the following chart is designed to provide a descriptive continuum of disordered performance.

VOICE DISORDER ASSESSMENT CONTINUUM

The normal voice is unremarkable: its quality, pitch, resonance, and intensity are appropriate to the individual's age, gender, and cultural group. These vocal parameters do not call attention to themselves.

EVALUATION Quality	Normal glottal attack. Prolongation of /a/ for 10 seconds. Inconsistent voice breaks. S/z ratio: >1.0. May exhibit hypo-/hypernasality. Pitch may be too high or low. Loudness and pitch range may or may not be affected.	Evidence of deviant glottal attack. Prolongation of /a/ for 6-9 seconds with voice breaks or diplophonia. S/z ratio: >1.4. Reduced pitch range. Inappropriate pitch level, loudness, and/or nasality	Weak or absent voluntary phonation. Prolongation of /a/ less than 6 seconds with voice breaks or diplophonia. S/z ratio: >1.4. Probable adverse effect on pitch level, pitch range, loudness, and nasality
	(Evidence of hyponasality is usually organically based, a chronic disorder of resonance resulting from obstruction in posterior portion of nasal passages or nasopharyngeal area. Referral should be made for medical management.)		
Intensity	Evidence of problem in controlling loudness appropriate for message and setting	Evidence of insufficient neuromuscular support for appropriate loudness across settings	Weak or absent ability to produce adequate loudness for intelligible speech
Pitch	Habitual pitch inappropriate to children's age or gender; pitch calls attention to itself	Difficulty controlling pitch; restricted pitch range; habitual pitch and optimal pitch differ by 2 tones	Weak ability to control pitch; restricted pitch range; habitual pitch and optimal pitch differ by >2 tones
EFFECT ON COMMUNICATION	Voice is noticeably different; does not interfere with communication	Voice is noticeably deviant, may interfere with communication	Interferes with intelligibility of message; restricts communication
The child must exhibit chronic, persistent impairment(s) in connected speech in at least one of the following areas, with accompanying adverse effect on educational performance: *Phonation *Resonance *Prosody			

No child should receive voice therapy without prior medical examination. Neither a prescription for voice therapy nor the presence of a medical condition (e.g. vocal nodules) automatically means that the child is eligible for speech-language services.

Determination of Adverse Effect

The following questions are to guide documentation and determination of adverse effects of voice deficits on a child's developmental/educational performance and need for special education in the areas of communication, social-emotional, and academics:

Communication

- Does the child demonstrate:
  - Reduced intelligibility due to inadequate voice?
  - Atypical voice which calls attention to itself, distracting from the message?
  - Vocal dysfunction which limits the child's ability to express a variety of communicative functions through variations in loudness, stress, and pitch?
  - Evidence of deviant glottal attack?
  - Weak or absent voluntary phonation?
  - Pervasive hypernasality with articulation errors on high pressure consonants?
  - Does the child experience chronic discomfort and/or fatigue subsequent to use of voice for routine activities?

Social-emotional

- Are the acoustic properties of the child's voice aesthetically unpleasant to the listener?
- Do the acoustic properties fail to accurately reflect the child's gender or age?
- Does the child's vocal dysfunction limit participation in extracurricular activities – debate, theatre, choir, etc.?

Academics

- Does the vocal dysfunction prevent or limit the child's participation in public speaking, reporting, singing, class discussions, reading aloud, etc.
- Is the child reluctant or unable to ask questions for clarification or help due to the vocal dysfunction?
- Does the vocal dysfunction limit choices in terms of career paths?

FLUENCY

- Referral information
  - Analysis of data collected by Student Assistance Team (or problem-solving team) (for children of school-age)
  - Parent/caregiver information (for children ages birth to five)

- Oral peripheral examination
  - Assessment of the structures and functions of the oral-motor mechanism for speech

- Educationally/developmentally relevant medical information
  - Parent/caregiver information on the child's development and language skills through interviews and rating scales (children ages birth to five)
  - Medical history
  - Medication which may adversely affect fluency Hearing screening results
  - Analysis of previous intervention for dysfluency, where appropriate

- Formal and informal measures
  - Standardized test of fluency
  - Standardized test of language skills
  - Structured interviews with the child, parent/caregiver, and teacher(s) Types and frequency of dysfluencies
  - Adaptation effect and consistency effect Social-emotional impact rating scales
  - Parent/caregiver information on the child's developmental milestones and language skills through interviews and rating scales (for children ages birth to five)

- Speech sample
    - Consistency of fluency performance across structured and unstructured contexts
    - Information on secondary behaviors and avoidance behaviors Information from at least two settings

- Observational data/input from:
    - Natural environment or classroom
    - Student Assistance Team (or problem-solving team)
    - Classroom teachers Parent/caregiver
    - Child
    - Parent/child interaction (for children birth to five)

Information in the following chart is designed to provide a descriptive continuum of disordered performance.

Fluency Disorder Assessment Continuum

Normal fluency is characterized by the smooth, uninterrupted, effortless flow of speech. The individual's rate and rhythm do not call attention to themselves.

FREQUENCY OF DYSFLUENCIES	**Less than 5%**	**5% to 10%**	**Greater than 10%**
TYPES OF DYSFLUENCIES	Primarily whole word and phrase repetitions; may be easy sound prolongations and/or occasional interjections	Primarily phrase, whole word or sound/ syllable repetitions. Little tension and struggle behavior	Predominantly "fixed articulatory" type of dysfluencies (i.e. audible and inaudible prolongation). Generally visible tension and struggle behavior. May use sounds or words as "starters"

DESCRIPTION OF TYPES OF DYSFLUENCIES	REPETITIONS: Rhythmic, effortless whole word repetition: "I-I-I have a new puppy." Rhythmic, effortless phrase repetitions: "She went – she went to the store." PROLONGATIONS: Brief, easy prolongations: "I>>want one." INTERJECTIONS: "Uh, um"	REPETITIONS: Phrase repetitions: "I like – I like – I like ice cream." Whole word repetitions: "I heard what she – she – she said." Sound/syllable repetitions: "He ga—ga—ga—gave mea puppy." REVISIONS: "She ate – I mean he ate the cookies." INTERJECTIONS: "Uh, um, er," etc. CIRCUMLOCUTIONS (i.e. using an excess of words in order to avoid the more direct, but difficult word)	PROLONGATIONS: Audible prolongations: "I want some m>>>>>ore cake." Silent blocks: (Silence) "Throw me the ball."
CONSISTENCY OF DYSFLUENT BEHAVIOR	Episodic; more dysfluent in times of stress, excitement	Dysfluency fluctuates – may be related to situational demands	Dysfluency is present in most speaking situations and is consistent and non-fluctuating
NUMBER AND VARIETY OF ASSOCIATED BEHAVIORS	Not present	If present, not considered significant	Severely detracts from the content of communication. Some or all of the following behaviors present: tension, struggle, frustration, and/or avoidance

EFFECT ON COMMUNICATION	Repetitions are noticeable, but do not interfere with communication	Reluctance to speak; dysfluency calls attention to itself; embarrassment and self-consciousness; anxious and fearful in some speaking settings; may interfere with participation in school or family activities	Difficulties in most speaking situations; avoids speaking; may have difficulty establishing and maintaining peer relationships; fearful about certain sounds, words, settings; interferes with school/family/community participation – academic, social, and emotional areas

MULTIPLE SAMPLE METHOD (preferred):
Obtain a representative 100-300 word sample from at least two environments/settings – home, school, with peers, etc. Determine the number of dysfluencies in each 100 word sample. Compute the "average" from the samples obtained. (This method yields both a "mean" and a "range.") Example: three 100-word samples with 4, 9, and 8 dysfluencies. The average would be 7 (7%) and the range would be 4-9 dysfluencies. Samples could be obtained from a variety of settings.

SINGLE SAMPLE METHOD:
Divide the number of dysfluencies by the total number of words in sample; multiply result by 100 (this yields a percentage). Sample results should be confirmed with parents and/or teachers as representative of typical performance.

Adaptation Effect—the tendency for overall stuttering to decrease with repeated reading or speaking of the same material. Adaptation is measured by having the child repeat a short passage or series of sentences five times (readers can read the material orally). Adaptation is calculated by subtracting the number of dysfluencies in the fifth recitation from the number of dysfluencies in the first, and then dividing this difference by the number of dysfluencies in the first. Multiplying this quotient by 100 creates a percentage. Adaptation measurements of 50% or higher indicate greater adaptation; scores lower than 50% indicate the individual has not significantly reduced the frequency of dysfluencies with repeated recitations.

Consistency Effect—the tendency for stuttering to occur on the same sounds or words during repeated reading or speaking of the same material. Consistency is measured by comparing the dysfluencies produced in the first three recitations only. Three indices are computed: Comparison of Recitations 1 and 2, 1 and 3, and 2 and 3. The indices for each comparison are computed by dividing the proportion of dysfluent words in one recitation that also are produced in the second recitation by the number of dysfluent words in the second reading. The consistency effect is present if the individual exhibits an index of 1.0 or higher. Indices higher than 1.0 reflect greater consistency. Indices less than 1.0 reflect that the individual did not reveal consistency in the location of dysfluencies within the recitation.

Determination of Adverse Effect

The following questions are to guide documentation and determination of adverse effects of fluency deficits on a child's development/ educational performance and need for special education in the areas of communication, social-emotional, and academics:

Communication

- Does the dysfluency call attention to itself, distracting from the message?
- Does the child experience difficulty speaking to peers and adults?
- Does the child demonstrate problems expressing opinions and ideas in classroom discussions due to dysfluencies?
- Does the child experience difficulty speaking on the telephone? Does the child avoid speech sounds, words, or situations?
- Are the dysfluencies primarily part-word repetitions, blocks, or prolongations
- Is there evidence of tension or struggle behavior?
- Are the dysfluencies present in most speaking situations?

Social-emotional

- Does the child demonstrate:
  - Difficulty introducing self and others?
  - Difficulty establishing and maintaining interpersonal relationships due to the child's perceptions about communication?
  - Avoidance of social situations?
- Does the child perceive him/herself as having difficulty speaking?

Academics

- Does the child demonstrate:
  - Difficulty communicating in family or community events?
  - Difficulty reading aloud and speaking in class due to dysfluent speech?
  - Reluctance to ask questions for clarification or help due to dysfluent speech?
  - Reluctance to participate in class discussions?
  - Avoidance of coursework or career paths based on the verbal communication required?
  - Reluctance to participate in cooperative learning group activities?

Section 4: RELATED DEFINITIONS

Academic Achievement – A student's level of performance in basic school subjects, measured either formally or informally. (Norlin, 2003, p. 1)

Achievement Test – A test that objectively measures educationally relevant skills or knowledge; a test that measures mastery of content in a subject matter area. (Norlin, 2003, p. 3)

Aphasia – A language disorder resulting from damage to the brain in which the person loses some ability to understand speech, formulate speech, read, write, calculate, or some combination of these abilities. (Silverman, 2006, p. 89)

- **Developmental Aphasia** – (1) A congenital receptive language disorder or, more commonly, expressive language disorder in children with normal intelligence and adequate sensory and motor skills that prevents acquisition of language. (2) Identified in IDEA regulations…as a "specific learning disability." (Norlin, 2003, p. 57)

Behavioral Regulation – Communication intended to manipulate the behavior of others - requesting an object, requesting action, or protesting/rejecting.

Communication Disorder – Impairment in the ability to receive, send, process, or comprehend concepts or verbal, non-verbal, and graphic symbols systems. A communication disorder may be evident in the processes of hearing, language and/or speech. A communication disorder may range in severity from mild to profound. It may be developmental or acquired. Individuals may demonstrate one or any combination of communication disorders. A communication disorder may result in a primary disability or it may be secondary to other disabilities. (ASHA 1993)

Dysarthria – A speech disorder caused by neuromuscular impairment in respiration, phonation, resonation, and/or articulation. (Heward, 2003, p. 613)

Dysfluency – Includes hesitations, repetitions, mispronunciations, and interjections in one's speech. (Silverman, 2006, p.153)

Dysphonia – A voice disorder characterized by faulty resonance, phonation, or pitch. (Norlin, 2003, p. 67)

Echolalia – Repetition of what other people say as if echoing them; characteristic of some children with delayed development, autism, and communication disorders. (Heward, 2003, p. 613)

Expressive Language – An individual's written, oral, or symbolic communication. (Norlin, 2003, p. 81)

Inflection – The change in pitch or loudness of the voice to indicate mood or emphasis. (Heward, 2003, p. 614)

Joint Attention – Communication intended to share focus with others -- commenting, requesting information, or providing information.

Language Delay – A child's language is developing in the right sequence, but at a slower rate. http://www.med.umich.edu/1Libr/yourchild/speech.

Limited English Proficiency – Refers to language differences that are found in some individuals who are learning English as a second language. Differences do not in themselves constitute language impairments. (Owens, Metz and Haas, 2007, p. 94)

Morpheme – Refers to the smallest unit of meaningful language. (Norlin, 2003, p. 1148)

Phoneme – Refers to the smallest unit of an individual's speech that distinguishes one utterance from another like a syllable; the English language has 24 consonant and 12 vowel phonemes. (Norlin, 2003, p. 174)

Phonemic Awareness – Is the ability to manipulate sounds, such as blending sounds to create new words or segmenting words into sounds. (Owens, Metz and Haas, 2007 p.145)

196**Phonological Awareness** – The awareness of how words sound and how they are represented in written language or print; ability to identify and manipulate the sounds of language. Many children with learning disabilities cannot readily learn how to relate letters of the alphabet to the sounds of language. (Norlin, 2003, p. 174)

Receptive Language – The language understood; listening is receptive. (Hegde, (2001)

Receptive Language Disorder – Presents as an inability to understand spoken or written language that may affect reading, writing, and problem-solving in arithmetic. (Norlin, 2003, p. 196)

Social Interaction – Communication intended to relate to/interact with others - requesting social routine, requesting comfort, greeting, calling, requesting permission, or showing off.

Section 5: FREQUENTLY ASKED QUESTIONS

1. Does a child have to be eligible as having a speech-language impairment in order to receive speech-language services?

No. If the child needs speech-language intervention in order to benefit from his/her educational program, that intervention can be provided as a related service. The child must, however, be eligible under at least one other disability category.

2. Is a child's communication problem a disability?

Whether the problem is considered a deficit or disability depends on the individual child. In determination of a disability, it is critical to document whether or not the problem is having an adverse effect on the child's social, emotional, or academic performance. If the MDT is unable to document adverse effects on the child's development or educational performance, the eligibility criteria have not been met, and the child does not have a disability.

3. If the child's articulation is not within the normal range, but there is no adverse effect on communication, academics, or social-emotional development, does the child meet eligibility criteria of a speech-language impairment?

No. The disability category of Speech-Language Impairment requires documentation of both the articulation errors relative to the Iowa-Nebraska Articulation Norms or other scientific research-based articulation norms and adverse effect on development or educational performance.

4. Can a child with chronic hoarseness, whose performance meets criteria for Speech-Language Impairment in the area of voice, be eligible for speech and language services without examination by a physician?

Yes, the child may be eligible. Although the criteria for a speech-language impairment does not require an evaluation by a physician, that examination is strongly recommended prior to the delivery of services if vocal fold pathology is suspected. There are a number of laryngeal pathologies that pose significant health risks, although they are rare in children. In order to rule out the presence of

a more serious disorder, the child's family should seek an examination by a physician prior to the initiation of voice therapy to rule out the existence of a more serious medical condition.

5. For a child who demonstrates dysfluent speech, is it necessary to obtain a speech sample from the home environment?

Yes, it is important to obtain a representative sample of the child's speech fluency from at least two settings, one of which may be the home environment. The MDT can ask the parents to audiotape or videotape a sample of the child's speaking behavior within the home environment.

6. Once the child with Limited English Proficiency has acquired basic conversational skills, can s/he be expected to perform at grade level academically?

It is the contention of many authorities in the field of second language acquisition that conversational fluency is often acquired to a functional level within about two years of initial exposure to the second language. At least five years is typically required to master the academic aspects of the second language. The acronyms BICS and CALP refer to these distinctions between basic interpersonal communicative skills and cognitive academic language proficiency. Search the internet: Limited English Proficiency.

7. Can a child with Limited English Proficiency have a speech-language impairment?

If the child has acquired average skills in his/her primary language, the limited proficiency in English is considered a language difference, not a disability. However, if the child has deficits in his/her primary language, the individual may have a language impairment. Since second language acquisition is similar, though not identical, to first language acquisition, a language disorder in the primary language may predict difficulty in learning English as a second language and a potential for a language impairment. The child may exhibit a speech language impairment in the areas of voice or fluency.

8. Can a child with Limited English Proficiency qualify for special education and related services?

Yes, if it can be established that the child's deficits are not primarily the result of his/her primary language, culture, or lack of opportunities to learn.

9. How can the English-speaking speech-language pathologist evaluate the articulation (speech-sound system) of a child with Limited English Proficiency?

The speech-language pathologist can utilize a process of comparative phonology to assess the speech-sound system of the child with Limited English Proficiency. For more references on Limited English Proficiency, refer to http://ww.asha.org (https://pubs.asha.org/doi/pdf/10.1044/2017_AJSLP-15-0161)

SECTION 6: RESOURCES AND REFERENCES

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Owens, R., Farinella, K., & Metz, D. (2019*). Introduction to Communication Disorders: A Lifespan Perspective. (6th edition):* Pearson Education, Inc. https://www.pearson.com/us/higher-education/program/Owens-Introduction-to-Communication-Disorders-A-Lifespan-Evidence-Based-Perspective-with-Enhanced-Pearson-e-Text-Access-Card-Package-6th-Edition/PGM1794305.html

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RESOURCES

Commonly Used Assessment Batteries for Evaluating Phonological Processes

Assessment Link Between Phonology and Articulation (Lowe, 1986)

HAPP-3: Hodson Assessment of Phonological Patterns–Third Edition (Hodson, B.W.) *Pro-Ed Inc, 2004.*

Bankson-Bernthal Test of Phonology (BBTOP). (Bankson, N.W., and J.E. Bernthal.) Pearson Education, Inc. 1999.

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WEB SITES

American Academy of Pediatrics www.aap.org

American Speech Language Hearing Foundation (ASHA Foundation) www.asha.org

IDEA Practices www.ideapractices.org

National Aphasia Association (NAA) www.aphasia.org

National Institute on Deafness and Other Communication Disorders (NIDCD) https://www.nichd.nih.gov/

National Stuttering Association (NSA) http://westutter.org

Net Connections for Communication Disorders and Sciences (Judith Kuster):

http://www.communicationdisorders.com

Resources and Information for Speech-Language Pathologists (Caroline Bowen):

http://www.slpsite.com

Stuttering Foundation of America (SFA) www.stutteringhelp.org

The Voice Foundation www.voicefoundation.org

SECTION 7: Recommended Forms

Speech/Language Impairment – LANGUAGE Verification Guidelines for School-Age Students

Documentation of a Speech/Language Impairment in the area of language must demonstrate a pattern communicative performance, which is below the average range and has an adverse effect on the student's educational performance in the areas of communication, social-emotional, or academics, based on the analysis of multiple data sources.

A three-part eligibility requirement for a student to be identified as a student with a Speech/Language Impairment in the area of language is as follows:

1. MEETS VERIFICATION CRITERIA (92 NAC 51.006)

❖ **Results of standardized and criterion-referenced assessments of language**

- ❒ Assessment yields standard score points of 84 or below
  - ✓ Receptive language standard score:
  - ✓ Expressive language standard score:
  - ✓ TOTAL language standard score:

❖ **Results of criterion-based speech-language sampling based on formal testing responses, language samples, and/or story retells**
Student demonstrates difficulty with:

- ❒ Sentence Length and Complexity (e.g., MLU, transitions, conjunctions, etc.)
- ❒ Semantics/Vocabulary
- ❒ Syntax/Grammatical Structures (e.g., verb tense, pronouns, word order, word endings, articles, auxiliary verbs, etc.)
- ❒ Word Finding/Word Retrieval
- ❒ Linguistic Non-fluencies (e.g., revisions, false-starts, repetitions, fillers)
- ❒ Pragmatics
- ❒ Retells less than 70% of a grade-level story retell
- ❒ Answers less than 70% of comprehension questions

❖ **Consideration of the student's intellectual ability**

- ❒ _____

❖ **Educationally relevant medical information**

- ❒ _____

2. DOCUMENTATION OF ADVERSE EFFECT ON EDUCATIONAL PERFORMANCE

- **Information from the parent/teacher survey and/or direct observation of the student in the natural environment or classroom**

  - ❒ Rating Scale or Checklist, EXAMPLES:
    - o CELF-5 Observational Rating Scale identifies 3 or more descriptors within 2-4 skill areas (listening, speaking, reading, writing) across multiple environments
    - o Teacher Input – LANGUAGE Survey identifies 3 or more descriptors with 2-3 areas (communication, social-emotional, academics) in the general education classroom
      NOTE: "Often" and "Always" constitute as areas of concern
  - ❒ SLP observational data from the natural environment or general education classroom

- **Results of criterion-referenced assessments related to the general curriculum**

  - ❒ Reading – Below Average ability as compared to same-age peers (e.g., DIBELS, MAP Growth, Lexile Level, Guided Reading Level, etc.), Below Standards on NSCAS
  - ❒ Writing – Beginning or Developing rating on writing prompts, Below Standards on NSCAS
  - ❒ Math – Beginning or Developing rating on formative assessment measures (e.g., Math District Interim Benchmarks), Below Standards on NSCAS

3. DETERMINATION THAT A NEED FOR SPEECH/LANGUAGE SERVICES IS EVIDENT

- **The student's response to short-term scientific, research-based intervention (Reference to NeMTSS processes/procedures)**

  - ❒ Intervention strategies implemented and outcome

  - ❒ Student has not made sufficient progress to meet age or state-approved grade-level standards and it would not be likely that without special education intervention the rate of progress would meet that of same-age peers.

- **Description of communication supports provided at home or at school**

  - ❒ Student requires significant supports (e.g., low- or high-tech communication devices, visual schedules, etc.)

ELIGIBILITY DETERMINATION

Does this student demonstrate a pattern of communicative performance that consistently falls below the average range on multiple data sources (i.e., standardized language assessments, oral narrative retell, state/district assessments, classroom observation, parent/teacher survey), and has a significant adverse effect on the student's educational performance?

- ❒ YES, this student meets qualifying criteria as a student with a Speech/Language Impairment in the area of language and demonstrates a need for specialized services.

- ❒ NO, this student's performance on both formal and informal language assessments measures was consistently in the average range. The student also exhibited adequate communication skills in functional settings.

NSLHA acknowledges the contributions of Grand Island Public Schools in the development of this information.

Speech/Language Impairment – LANGUAGE Verification Matrix

(school age)

Documentation of a Speech/Language Impairment in the area of language must demonstrate a pattern communicative performance, which is consistently below the average range and has an adverse effect on the student's educational performance in the areas of communication, social-emotional, or academics, based on the analysis of multiple data sources.

A three-part eligibility requirement for a student to be identified with a Speech/Language Impairment in the area of language is as follows:

MEETS VERIFICATION CRITERIA (92 NAC 51.006)		BELOW AVERAGE RANGE		AVERAGE RANGE	
	❖ **Results of standardized assessments of language** ✓ Receptive Language: _____ ✓ Expressive Language: _____ ✓ TOTAL Core Language: _____	Standard Score 69 or below Below 2nd percentile	Standard Score 70-84 2nd-14th percentile	Standard Score 85-89 16th-23rd percentile	Standard Score 90-110 25th-75th percentile
	❖ **Results of criterion-based speech/language sampling based on formal testing responses, informal language samples, and/or oral narrative retells** ✓ Story Elements Retold ✓ Comprehension Questions ✓ Character Names ✓ Sentence Length/Complexity ✓ Syntax/Grammatical Structures (verb tense, pronouns, word order, word endings, articles, auxiliary verbs, etc.)	0-49% story elements retold	50-69% story elements retold	70-85% story elements retold	86-100% story elements retold
		Answers Wh- questions with 0-49% accuracy	Answers Wh- questions with 50-69% accuracy	Answers Wh- questions with 70-85% accuracy	Answers Wh- questions with 86-100% accuracy
		Unable to identify any characters by name; uses only labels (e.g., the kid, the lady)	Uses she or he; or one character name	Consistently remembers 2 or more characters by name.	Recalls all character names accurately.
		Uses words & phrases only.	Simple sentences with limited use of prepositional phrases, adjectives, adverbs; numerous run-on sentences.	Complete sentences with prepositional phrases, adjectives, adverbs; consistently uses concise & coherent ideas.	Use of complex sentence structures & connected ideas (e.g., because, so, then, since, but, etc.).
		Numerous errors in grammar & usage, which significantly interfere or confuse the meaning/message.	Frequent errors in grammar & usage, which interfere or distort the meaning/message.	Minor errors in grammar & usage, which are noticeable, but do not interfere with the meaning/message.	Demonstrates control of grammar & usage – uses syntactical skills effectively to enhance communication.
	❖ **Consideration of student's intellectual ability**	Best Estimate of Ability Below 70	Best Estimate of Ability 70-84	Best Estimate of Ability 85-100	Best Estimate of Ability 100-115
	❖ **Educationally relevant medical data**	Documented medical disability directly affects language development.	Documented medical disability directly affects language development; medication adversely affects language.	Documented medical disability &/or medication may affect language development &/or usage.	No medically relevant information or concerns.

		BELOW AVERAGE RANGE		AVERAGE RANGE	
DOCUMENTATION OF ADVERSE EFFECT ON EDUCATIONAL PERFORMANCE	❖ **Information from parent or teacher survey, for example:** ✓ CELF-5 Observational Rating Scale (listening, speaking, reading, writing) ✓ Teacher Input – LANGUAGE Survey (communication, social-emotional, academic)	3 or more concerns in all categories	3 or more concerns in 2-3 categories *"Often" and "Always" constitute as areas of concern.*	At least 3 concerns in 1-2 categories	No language concerns indicated by parent or teacher.
	❖ **Direct observation of the student in the natural environment or general education classroom**	Language deficits significantly impede ability to understand oral/written information, participate in classroom discussions, & use interpersonal skills to interact effectively.	Language deficits result in difficulties with ability to understand oral & written information, participate in classroom discussions, & use interpersonal skills to interact effectively.	Language skills may affect ability to understand & use language to communicate effectively for both academic & social purposes.	Demonstrates adequate ability to understand & use language to perform effectively in the classroom &/or interact socially.
	❖ **Results of criterion-referenced assessments related to the general curriculum** ✓ DIBELS, MAP Growth, Lexile Level, Guided Reading Level, NSCAS, etc.	Below Expectations	Approaching or Below Expectations	Meeting or Approaching Expectations	Exceeding or Meeting Expectations
DETERMINATION A NEED FOR SPEECH/LANGUAGE SERVICES IS EVIDENT	❖ **Response to scientific, research-based intervention** ✓ SAT, RtI/MTSS data ✓ Current special education data	Requires sustained, intensive intervention, which is beyond what is considered reasonable in the general education curriculum.	Exhibiting limited response to intensive evidence-based intervention; ongoing and/or supplemental intervention is required.	Responding positively to direct evidence-based intervention(s) & progressing toward proficient performance.	No concerns related to language indicated by SAT team; responding well to classroom instruction.
	❖ **Description of communication supports provided at home or at school** ✓ AAC = Augmentative – Alternative Communication (both high & low tech.)	Requires 1:1 staff in close proximity to facilitate functional communication; relies on AAC supports.	Requires staff to implement appropriate modifications &/or accommodations; benefits from AAC supports.	Participates effectively with modifications &/or accommodations requiring occasional reminders, assistance, & cueing; AAC supports are not necessary.	Participates in core curriculum within general education classroom requiring few if any modifications &/or accommodations; AAC supports are not necessary.

In no case should below average performance on a single measure be accepted as demonstrating a pattern of deficit.

ELIGIBILITY DETERMINATION

Does this student demonstrate a pattern of communicative performance that consistently falls below the average range on multiple data sources (i.e., standardized language assessments, oral narrative retell, state/district assessments, classroom observation, parent/teacher survey), and has a significant adverse effect on the student's educational performance?

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	❖ **Results of standardized assessments of language** ✓ Receptive Language: _____ ✓ Expressive Language: _____ ✓ TOTAL Core Language: _____	Standard Score 69 or below Below 2nd percentile	Standard Score 70-84 2nd-14th percentile	Standard Score 85-89 16th-23rd percentile	Standard Score 90-110 25th-75th percentile
	❖ **Results of criterion-based speech/language sampling based on formal testing responses, informal language samples, and/or oral narrative retells** ✓ Story Elements Retold ✓ Comprehension Questions ✓ Character Names ✓ Sentence Length/Complexity ✓ Syntax/Grammatical Structures (verb tense, pronouns, word order, word endings, articles, auxiliary verbs, etc.)	0-49% story elements retold	50-69% story elements retold	70-85% story elements retold	86-100% story elements retold
		Answers Wh- questions with 0-49% accuracy	Answers Wh- questions with 50-69% accuracy	Answers Wh- questions with 70-85% accuracy	Answers Wh- questions with 86-100% accuracy
		Unable to identify any characters by name; uses only labels (e.g., the kid, the lady)	Uses she or he; or one character name	Consistently remembers 2 or more characters by name.	Recalls all character names accurately.
		Uses words & phrases only.	Simple sentences with limited use of prepositional phrases, adjectives, adverbs; numerous run-on sentences.	Complete sentences with prepositional phrases, adjectives, adverbs; consistently uses concise & coherent ideas.	Use of complex sentence structures & connected ideas (e.g., because, so, then, since, but, etc.).
		Numerous errors in grammar & usage, which significantly interfere or confuse the meaning/message.	Frequent errors in grammar & usage, which interfere or distort the meaning/message.	Minor errors in grammar & usage, which are noticeable, but do not interfere with the meaning/message.	Demonstrates control of grammar & usage – uses syntactical skills effectively to enhance communication.
	❖ **Consideration of student's intellectual ability**	Best Estimate of Ability Below 70	Best Estimate of Ability 70-84	Best Estimate of Ability 85-100	Best Estimate of Ability 100-115
	❖ **Educationally relevant medical data**	Documented medical disability directly affects language development.	Documented medical disability directly affects language development; medication adversely affects language.	Documented medical disability &/or medication may affect language development &/or usage.	No medically relevant information or concerns.

		BELOW AVERAGE RANGE		AVERAGE RANGE	
DOCUMENTATION OF ADVERSE EFFECT ON EDUCATIONAL PERFORMANCE	❖ **Information from parent or teacher survey, for example:** ✓ CELF-5 Observational Rating Scale (listening, speaking, reading, writing) ✓ Teacher Input – LANGUAGE Survey (communication, social-emotional, academic)	3 or more concerns in all categories	3 or more concerns in 2-3 categories *"Often" and "Always" constitute as areas of concern.*	At least 3 concerns in 1-2 categories	No language concerns indicated by parent or teacher.
	❖ **Direct observation of the student in the natural environment or general education classroom**	Language deficits significantly impede ability to understand oral/written information, participate in classroom discussions, & use interpersonal skills to interact effectively.	Language deficits result in difficulties with ability to understand oral & written information, participate in classroom discussions, & use interpersonal skills to interact effectively.	Language skills may affect ability to understand & use language to communicate effectively for both academic & social purposes.	Demonstrates adequate ability to understand & use language to perform effectively in the classroom &/or interact socially.
	❖ **Results of criterion-referenced assessments related to the general curriculum** ✓ DIBELS, MAP Growth, Lexile Level, Guided Reading Level, NSCAS, etc.	Below Expectations	Approaching or Below Expectations	Meeting or Approaching Expectations	Exceeding or Meeting Expectations

DETERMINATION A NEED FOR SPEECH/LANGUAGE SERVICES IS EVIDENT	❖ **Response to scientific, research-based intervention** ✓ SAT, RtI/MTSS data ✓ Current special education data	Requires sustained, intensive intervention, which is beyond what is considered reasonable in the general education curriculum.	Exhibiting limited response to intensive evidence-based intervention; ongoing and/or supplemental intervention is required.	Responding positively to direct evidence-based intervention(s) & progressing toward proficient performance.	No concerns related to language indicated by SAT team; responding well to classroom instruction.
	❖ **Description of communication supports provided at home or at school** ✓ AAC = Augmentative – Alternative Communication (both high & low tech.)	Requires 1:1 staff in close proximity to facilitate functional communication; relies on AAC supports.	Requires staff to implement appropriate modifications &/or accommodations; benefits from AAC supports.	Participates effectively with modifications &/or accommodations requiring occasional reminders, assistance, & cueing; AAC supports are not necessary.	Participates in core curriculum within general education classroom requiring few if any modifications &/or accommodations; AAC supports are not necessary.

In no case should below average performance on a single measure be accepted as demonstrating a pattern of deficit.

ELIGIBILITY DETERMINATION

Does this student demonstrate a pattern of communicative performance that consistently falls below the average range on multiple data sources (i.e., standardized language assessments, oral narrative retell, state/district assessments, classroom observation, parent/teacher survey), and has a significant adverse effect on the student's educational performance?

- ❒ YES, this student meets qualifying criteria as a student with a Speech/Language Impairment in the area of language and demonstrates a need for specialized services.
- ❒ NO, this student's performance on both formal and informal language assessments measures was consistently in the average range. The student also exhibited adequate communication skills in functional settings.

Speech/Language as a Related Service

for students (school-age) with a primary verification of Autism, Developmental Delay & Intellectual Disability

Individuals with Disabilities Education Act (IDEA) 2004: Related Services

IDEA views speech/language services as both special education and a related service.

A student may be eligible for additional services (related services) if the services "are required to assist a student with a disability to benefit from special education…" (34 C.F.R. Section 300.34).

Although a student may benefit from a related service, the student will not be eligible to receive that service if the student can perform academically without it. For example, a student can benefit from instruction from an occupational therapist in holding a pencil, but if that instruction is not necessary to progress his/her elementary classroom, the student is not eligible.

Conversely, it is reasonable that a student whose primary disability is SLD receive speech/language services as a related service. Because of the close relationship between oral and written language, it is likely that the student will need a related service (speech/language services) to benefit from the learning disability services.

Similarly, a student with an emotional disturbance who has difficulty with social communication also may need speech-language services to benefit from his or her primary special education service.

These students are often referred to as receiving "speech/language as a related service."

Example Statement on the MDT/IEP: *Based on the primary verification of Intellectual Disability and the Adaptive Behavior standard score of 72 (6%ile), the MDT/IEP team determined STUDENT requires Speech/Language as a related service in order to progress toward special education goals.*

Students may be eligible to receive speech/language as a related service in the following verification categories due to delayed language/communication skills being key components in identifying those verifications in an educational setting.

AUTISM	DEVELOPMENTAL DELAY	INTELLECTUAL DISABILITY
006.04B Autism 006.04B1 To qualify for special education services in the category of Autism (AUT), the student must have a developmental disability which: ***006.04B1a Significantly affects verbal and nonverbal communication and social interaction;*** 006.04B1b Is generally evident before age three; and 006.04B1c That adversely affects the student's educational performance. 006.04B1d Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routine, and unusual responses to sensory experiences. 006.04B2 Autism does not apply if a student's educational performance is adversely affected primarily because the student has an emotional disturbance as defined in 92 NAC 51-006.04E. 006.04B3 A student who manifests the characteristics of autism after age 3 could be verified as having autism if the other criteria in 92 NAC 51-006.04B1 are met.	006.04D Developmental Delay 006.04D1 To qualify for special education services in the category of Developmental Delay (DD), the student shall have a significant delay as measured by appropriate diagnostic instruments and procedures in one or more of the following areas and, by reason thereof needs special education and related services: 006.04D1a Cognitive development, 006.04D1b Physical development, ***006.04D1c Communication development,*** 006.04D1d Social or emotional development, 006.04D1e Adaptive behavior or skills development, or 006.04D1f A diagnosed physical or mental condition that has a high probability of resulting in a substantial delay in function in one or more of such areas. 006.04D2 Developmental delay may be considered as one possible eligibility category for studentren age three through the school year in which the student reaches age eight.	006.04G Intellectual Disability 006.04G1 To qualify for special education services in the category of Intellectual Disability (ID), the student must demonstrate: 006.04G1a Significantly subaverage general intellectual functioning existing concurrently with deficits in **adaptive behavior* and manifested during the developmental period, that adversely affects a student's educational performance. ***Adaptive behavior*** ♦ **Communication** ♦ Self-care ♦ Independent living skills ♦ Safety ♦ Participation and use of community resources ♦ Work-related performance skills ♦ Travel skills ♦ Recreation/leisure ♦ **Social-interpersonal skills** ♦ Self-direction ♦ Motor skills

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