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I.
Introduction to Occupational and Physical Therapy Services
Perryton Special Education, SSA

Perryton Special Education SSA occupational and physical therapy services are provided primarily in an integrative programming model. Integrative programming means that activities recommended by the therapist(s) can be provided regularly by the teacher in the educational setting. Students receiving integrative services demonstrate significant benefits because their programs are functionally designed to be implemented daily in natural environments, such as school and home. The occupational and physical therapist, along with the classroom teacher and other professional staff, work together to help develop and maintain the students' maximum independence and participation in the educational activities.

Occupational and physical therapists have many similarities in their professional roles. Both are concerned with the development of physical skills and activities of daily living as well as adaptation of the environment. The occupational therapist has additional expertise in the area of fine motor and sensorimotor skills, certain areas of activities of daily living and academic/vocational skills. The physical therapist has additional expertise in the areas of walking patterns, postural deviations, cardiorespiratory problems, joint mobility and improvement of individual muscle strength.

An occupational and/or physical therapy referral form may be completed by the classroom teacher, if your child has difficulty in one or more of the previously mentioned areas that interferes with his ability to benefit from his educational program. The therapist(s) will begin the assessment process by gathering information from parents and teachers, and by reviewing school and medical records. Standardized test, informal measures and classroom observations may be included in the assessment. Once the written report is completed, the assessment information will be shared with parents and school personnel, and with parent permission, with physician and other community sources, as needed. Eligibility for therapy services is based on assessment. Frequency of service is determined by your child's educational need, recommendations made by the therapist(s), and the members of the ARD committee. When occupational and/or physical therapy services are no longer needed, the ARD committee will discontinue those services.

When occupational and physical therapy services are provided in an integrative programming model, your child's program may include one or more of the following service models by the therapist(s): direct, monitor, consult (student centered, classroom program and individual centered)

1. Assisting the classroom teachers with the development of the IEP to address the fine motor, gross motor, sensorimotor and self-help skills.

2. Suggesting and demonstrating activities that can be used in the implementation of the IEP.

3. Teaching the instructional staff techniques for appropriate handling and positioning.

4. Providing adaptive/assistive devices for the classroom and providing instruction for their proper use.

5. Recommending classroom/task modifications.

6. Developing home programs to enhance the school program.

7. Assisting families with information regarding the type of equipment for home that may be appropriate for your child and may be helpful with home management.

8. Providing information to physicians and other community sources regarding your child's school program.

9. Contributing general consultative, management and teaching skills to help modify the educational environment to enable your child to benefit form his educational program.
10. Providing direct hands-on intervention then instructing staff in the technique so technique can be implemented on a day to day basis.

The Perryton Special Education SSA occupational and physical therapy services are provided by licensed occupational and physical therapists and therapy assistants. Parental involvement in the educational program is recommended and parents are encouraged to be in contact with their child's therapist(s).

II.
Are There Differences in ECI Services and School Service Delivery???

***Early Intervention*:**

1. There must be interagency cooperation in the provision of early intervention services.
2. Part H of P.L. 99-457 focuses on the family's needs, the program is documented on the Individualized Family Service Plan (IFSP) as an outgrowth of multidisciplinary assessment of both the child's status and the family's strengths and needs.
3. Occupational therapy is considered a primary early intervention service for the child from birth through age two and can be provided along with or separate from any other health or educational services the child and family might need. It is not dependent on the child's need for special education.
4. The fact that occupational therapy is a primary service DOES NOT mean that all children and families eligible for early intervention services will receive occupational therapy; it does mean that occupational therapy may be the only service identified.
5. Family-focused intervention is provided to empower families to facilitate their children's growth and development, to develop and implement interactional strategies with their children, and to use effective coping strategies that meet the challenge of care giving and family life.
6. Therapists plan and deliver services in collaboration with parents and within the context of families' needs.
7. Therapist encourage the development of functional skills by utilizing prevention-intervention and remediation and support compensatory strategies to increase independence.
8. Service provision may be done in center-based programming or in home-based programs, but the focus is the family and providing means to promote development of the child.

9. There is strong emphasis on transitions within the service delivery system because the child and family must make transitions from one program to another, from one funding agency to another, and from one set of service providers to another.

School Systems:

1. P.L. 94-142 focuses on the student's educational needs
2. P.L. 94-142 mandates that occupational therapy and physical therapy are related services, services to be provided as an adjunct or addition to identified special education needs.
3. As an education-related service, occupational therapy and physical therapy can only be provided to students who have been identified as handicapped under the definitions within P.L.94-142 and who need special education.
4. Occupational therapy and physical therapy services as part of public school education are governed by Part B of EHA.
5. Therapy programs are designed to assist the development of underlying skills that are prerequisites for academic learning and vocational training, which may include improving gross and fine motor skills, organizing and using materials appropriately, interacting with peers appropriately, improving coordination skills, and learning to dress oneself, feed oneself or toilet independently.
6. The unique needs of the child with disabilities are determined by the Individualized Education Program (IEP). The IEP is based on the needs of the child as identified through assessment and developed by an interdisciplinary team, specifying the goals and objectives for that child and the services needed to implement the program.

III.
Models of Service Delivery in Educational Settings

1. **Direct Service Delivery :** Therapist or assistant carry out occupational and/or physical therapy interventions with children. Children may receive occupational therapy either individually or in small groups. Some problems may require 1: I intervention, and this is built into the child's schedule. Other therapy interventions may be scheduled in small groups to work on common objectives. This method has the advantage of saving time for the PT or OT and is comparable to groupings used for classroom instruction. The therapist helps develop the IEP.

2. **Monitoring Therapy Programs:** The OT/PT may monitor therapy programs being carried out by others. In this type of service delivery, the OT/PT directly supervises non-occupational therapy personnel who implement all or part of the therapy program. The therapist is responsible for teaching correct procedures to the classroom personnel, maintaining regular contact with them to ensure proper implementation of the program, and reassessing to determine whether adequate progress is being made or whether adjustments are needed in the program.

3. **Consultative Education Services:** (Student, Teacher, Parent)

A. ***Student Centered:*** The therapist helps develop the IEP which the teacher implements. A physician's prescription may be required for either therapy under certain circumstances if direct therapy is part of the student-centered consultation. No specific occupational therapy and/or physical therapy goals or objectives are written other than the educational goals already in IEP. The frequency of consultation and the implementer responsible should be noted on the IEP. The IEP should reflect consultation/direct is provided by the therapist.

B. ***Classroom-Centered.-*** These services may address individuals or groups of students and educational program needs (e.g. pre-vocational and vocational activities, feeding and positioning programs, and motor labs). This may be a onetime consult with no specific assessments performed. No occupational therapy or physical therapy goals or objectives are written. A physician prescription/referral is not required.

C. **Program-Centered.-** This service may address staff and/or system needs (e.g. environmental adaptations, inservice). No occupational therapy or physical therapy goals or objectives are written. A physician prescription is not required.

IV.
Eligibility Requirements for Special Education Service

To qualify for occupational therapy and/or physical therapy services within the educational system, the student must qualify for special education services.

To be eligible for special education services, a student must have one or more of the following conditions listed in the federal regulations or in state law or both.

ELIGIBILITY CRITERIA [19 TAC S89.211]:

A. ***Physically Handicapped*** shall include the following:

1. ***Orthopedically Handicapped (OH):*** a student is determined by a licensed physician to have a severe orthopedic impairment.

2. ***Other Health Impaired (OHI):*** a student is determined by a licensed physician to have limited strength, vitality, or alertness due to chronic or acute health problems.

B. ***Auditorially Handicapped (AH):****a* student is determined by an otologist or a licensed medical doctor to have a serious hearing loss even after correction medical treatment or use of amplification. With documentation that an otologist is not reasonably available, an audiological evaluation by a certified audiologist shall also be conducted.

C. ***Visually Handicapped (VH):*** a student is determined by a licensed ophthalmologist or optometrist to have no vision or to have a serious loss after correction. For students having residual vision, a functional vision test must be administered by a certified professional in the education of the visually impaired or a certified orientation and mobility instructor.

D. ***Deaf-Blind (DB):*** a student is determined to be both visually and auditorially handicapped according to the specific eligibility criteria for each of these handicapping conditions.

E. ***Mentally Retarded (MR):***a student is determined by a licensed or certified psychologist, a psychological associate, or an educational diagnostician to be functioning two or more standard deviations below the mean on individually administered scales of verbal ability and either performance or nonverbal ability, existing concurrently with deficits in adaptive behavior.

F. ***Emotionally Disturbed (ED):*** a student is determined by a licensed or certified psychologist, psychiatrist, or a psychological associate under the direct supervision of a licensed or certified psychologist to meet the criteria defined in 34 CFR §300.5 (b)(8).

G. ***Learning Disabled (LD):*** a student is determined to be eligible by meeting the criteria defined in the 1 9 TAC §89.234.

H. ***Speech Handicapped (SH):*** a student is determined by a certified speech and hearing therapist, certified speech and language therapist, or a licensed speech/language pathologist to have a communication disorder such as stuttering, impaired articulation, a language impairment, or a voice impairment.

1. ***Autistic (AU):*** a student is determined by a multi-disciplinary team to meet the criteria for autism or other pervasive developmental disorders, using the definition stated in the third edition-revised of the DSM-111-R.

J. ***Multiply Handicapped (MH):*** a student has a combination of handicaps and meets all the following:
   1. the handicapping condition is expected to continue indefinitely.
   2. performance is severely **impaired** in **two** or more of the following areas: psychomotor skills. self-care skills, communication, social and emotional development, or cognition.

K. ***Traumatic Brain Injury (TBI):*** a student is determined by a licensed physician to have a traumatic brain injury.

V.
Educational Relevance Of Therapy

Special education is specifically designed instruction to meet a students unique needs. Related services are defined as those supportive services that may be required to assist a student from special education

The role of the occupational and/or physical therapist is to facilitate a student s functioning in the school setfing. The goal of educationally relevant therapy is to minimize the effects of the student's dis&ing condition on his/her ability to participate in the educational process.

The following are functional areas of occupational therapy and physical therapy intervention in a school-based setting:

FUNCTIONAL AREA	RELATIONSHIP TO EDUCATION	MEANS OF OT/PT INTERVENTION
SELF-HELP	To permit the child to manage in classroom and school with minimal assistance for personal needs	Provide mobility and transfer skills, feeding, adaptive equipment, wheelchairs, splints, braces, artificial limbs, adaptive equipment for grooming, toileting, feeding, adaptive clothing
FUNCTIONAL MOEUUTY	To permit child greatest freedom of movement within the educational environment	Assist child to develop equilibrium and balance reactions, transfer skills, wheelchair management pregait and gait training with or without ambulatory aids
ENVIRONMENTAL ADAFRTATIONS	To permit child ft access to and mobility within educational environment	Provide recommendations for modification of school's or child's adaptive/assistive devices, removal of architectural barriers, provide consultation on use of technology to access computer, environment
POSITIONING	To maintain child in the best position for learning and functional use of the body	Provide instruction in positioning with adaptive devices, handling methods, skin care, splints, braces

FINE MOTOR GROSS MOTOR	To provide child with stable postural base to allow attention to be focused on educational tasks, to enable child to complete written class work in appropriate time frames	Evaluate, recommend, and construct positioning devices. modify existing devices, provide adaptive/assistive devices to facilitate fine motor tasks
COMMUNICATION	To enable child to communicate ideas and answers to classroom teacher and interact with peers and family	Evaluate and recommend appropriate positioning of child, adaptive equipment and/or communication devices necessary for functional communication
LIFE SKILLS TRAINING/ VOCATIONAL SKILLS	To prepare student for vocational placement and general life skills	Evaluate vocational needs and recommend strategies, perform task4ob analysis, develop work behaviors, use of adapted equipment
SENSORY-MOTOR PROCESSING	To facilitate child's ability to effectively process and respond to **basic** sensory and motor information as a foundation for acquiring and developing gross and fine motor skills needed for learning to occur	Provide instruction in the integration of the multisensory approach in the classroom
PSYCHC)/SOCIAL	To enable ft child to interact with peers and educational staff in **ways** necessary to function in the educational setting	Evaluate behaviors, recommend strategies and programs for appropriate integration into the educational setting

NOTE: If a problem ***is not*** interfering with the student's ability to participate in the educational program, then the problem ***is not*** educational relevant and ***would not*** constitute a need for occupational therapy and/or physical therapy intervention.

VI.
Occupational and Physical Therapy - Where Can I Get It?

A Guide for Families and Professionals about Types of Therapy and Service Delivery Models

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Occupational and Physical Therapy - Where Can I Get It?

If occupational or physical therapy has been recommended for your child by your physician or therapist, and if you agree with this recommendation, you now have several decisions to make and questions to answer about getting that therapy.

Where is therapy available? How far do I have to drive? How many times a week? What time during the day? How much will it cost? Will my insurance pay? What if insurance will not pay, or if I do not have insurance?

As parents begin to find answers to these questions, they discover that occupational and physical therapists work in a variety of different settings including hospitals, clinics, rehabilitation centers, private practice offices, and public schools. At first, it may seem that the pediatric occupational and physical therapists in each of these setting are essentially the same. Therefore, the therapy services provided in each of these settings should be the same. Therapy is therapy, right?

Actually, no. The therapists may, indeed, be equally trained, licensed, and registered no matter where they work. But the purposes of the agency or clinic are often very different. Therefore, the type of therapy and the goals of that therapy may be very different from one setting to another. It is important to understand the different types of therapy and different goals of therapy before you choose a therapist for your child.

There are two main types of occupational and physical therapy: clinical and educational The basic purpose behind each of these is different, although sometimes they overlap.

1. **<u>Clinical Therapy</u>**

Clinical occupational and physical therapy are based on a medical model. They
are based on the underlying medical cause of a child's disability and try to treat that medical cause or the symptoms. For example, if a child has spastic cerebral palsy, the therapist tries to relax the child's muscle tone. 'Me goals of clinical therapy are usually to improve a child's function or quality of movement For example, goals may be to walk independently, or with better posture, or to increase range of motion of joints.
Sometimes clinical therapists help a child prepare for or recover from surgery. There are three types of clinical therapy: Active therapy, which can be either acute or long-term, and maintenance therapy.

A. **<u>Acute Clinical Therapy</u>**, Acute clinical therapy is often done in a hospital or an in-patient rehabilitation center. It is usually very intense, i.e., many sessions per week, and it usually lasts only a short time, i.e., perhaps a few weeks or months. Acute therapy is often done in preparation for surgery, or right after surgery or an injury to get the most improvement in function as fast as possible. A short course of acute therapy may also be done when a child gets a new piece of equipment to teach him or her how to use it.

B. **<u>Long-Term Clinical Therapy</u>**. Long-term clinical therapy usually is done in an out-patient clinic or in your home. It may occur as often as two or three times per week, or as little as once a month. It may continue for several months or for several years. Goals include improving quantity and quality of sells; for example, learning how to walk first with a walker, then with a cane, then all alone. Therapy may be stopped when a child reaches a plateau in development and may resume later to work on new skills. Some children go on and off therapy repeatedly during childhood years and even during teenage and young adult years if needed.

C. **<u>Maintenance Clinical Therapy</u>**. Maintenance therapy is done during the time a child is not receiving active therapy. This is usually done by the family or other regular care-takers rather than by the therapist directly. The therapist teaches the family what to do and how to do it. The therapist may see the child once every month or so if needed to provide new instructions

and check for problems. The goals of maintenance therapy are to maintain (or keep) the skills that the child developed while on active therapy, and to prevent the child from getting worse. It is not designed to improve function or help the child learn new skills.

A child may switch from active therapy to maintenance therapy when he or she reaches therapy goals and has no new goals to work on, or when his or her progress has stopped in active therapy and no further progress is expected in the near future.

All of the above are clinical therapy, that is, they follow a medical model and try to help the child by treating his or her underlying medical problem or symptoms. 'Me goal is to improve function so the child can achieve the best motor function possible.

2. **Educational Therapy**

There is another way children may receive therapy. It is done in the public school system and is sometimes referred to as Educational Occupational Therapy and Physical Therapy. Occupational and Physical Therapy are considered "related services" in school. They are provided only if needed to help a child learn from his educational program. Therapy in school does not necessarily focus on the child's underlying medical problem in order to maximize the child's motor function. The purpose of Occupational and physical therapy in school is to help the child function in the school setting so that he or she can benefit from the educational program. If the child has a problem that would normally be treated with clinical Occupational or physical therapy to improve his or her motor function,

but the problem does not interfere %kith his ability to learn in the classroom or school, then the student might not receive occupational or physical therapy at school. ('Me child might still get clinical therapy somewhere else.)

For example, if a child can walk well with a walker and can get to and from classrooms, etc., then the child may not receive educational therapy at school because he is able to learn, unrelated to his walking. That is, using the walker does not interfere with his learning. He is considered a functional walker. (He might get clinical therapy after school to help develop better balance so he or she can eventually walk alone, but that is not related to his education.)

Another example is a child whose sitting balance is so poor that he cannot sit in the classroom chairs properly. Educational, occupational or physical therapy in school might help find an appropriate seating arrangement for the child so he could sit up with classmates as well as work on activities to improve his trunk balance and make it easier for the child to use his hands for things such as writing or cutting. In this case, therapy is necessary to allow the child to benefit from his educational program. Once a good seating solution is found, the child may no longer receive occupational or physical therapy at school because the child is now able to benefit from the educational program.(The child may still be going to clinical therapy after school somewhere else to work on other things.)

3. **Differences**

A. **How Therapy is Provided**. Educational therapy and clinical therapy are provided differently. Clinical therapy is usually done directly by the therapist with the child. It is usually done one-on-one or in small groups, and parents may be taught some activities to do at home. Educational therapy begins with an assessment which is done directly by the school occupational or physical therapist If the school therapist recommends educational therapy, it may be done directly by the OT or PT, or the therapist may consult with the child's teacher or classroom aide. Since the goal of educational therapy is to help the child benefit from his or her educational program, a big part of the school therapist's job is to show teachers and aides ways to reach these goals in the classroom. Then the teacher or aide uses the therapist's instructions in the classroom to reach the goals set. Educational therapy is often transdisciplinary, involving role release.

This means that one therapist, either an occupational or physical therapist, might address both gross motor and fine motor skills With your child, and that a teacher or aide might carry out the therapist's recommendations.

B. **Qualifying for Therapy**. Another difference between clinical and educational therapy is how a child qualifies to receive occupational and physical therapy. For clinical therapy, if a physician writes a prescription, the therapist can begin treatment. For therapy, you may still need a doctor's prescription, but you also need to qualify" as a special education student because OT & PT are special education related services in school. The therapy must also be needed to help the child function and learn in the classroom and to achieve the goals set for him in his ARD meeting (see below). it is important to realize that just because the doctor prescribes therapy, this does not automatically mean that the child can get it at school. He must first "qualify" and the therapy must be necessary for him to benefit from his educational program.

There are many disabilities which will qualify a student for special education services. The school can give you information and test your child to see if he or she has a disability that makes your child eligible for special education services. The disability must be accompanied by an educational need. This means that the disability must interfere with the child's ability to learn.

Once your child qualities for special education services, you will have an ARD meeting with the school. (ARD means "Admissions, Review, and Dismissal" and it is a meeting between you and the school staff.) You will develop an Individual Education Program with the school. It will list what the goals will be for your child in school, and what related services will be needed to help achieve those goals. If the goals on your child's EF-P might require occupational and/or physical therapy to help achieve them, then your child will have an occupational and/or physical therapy assessment at school. the school therapist will make recommendations which might include direct therapy, consultation, monitoring, or perhaps no therapy at this time. If therapy goals are set, they may be carried out by a therapist (either occupational or physical), an aide, or the teacher, as discussed above.

C. **Paying for Therapy.** Finally, there is a difference in how therapy fees are paid. Clinical therapy is a medical service and may be paid for by health insurance, Medicaid or by you directly. Therapy in school is an educational-related service and is paid for by your school tax dollars and sometimes by Medicaid in a special program for school health related services. It does not cost you extra money out of your packet Some families who do not have health insurance (or the therapy recommended is not covered by insurance) hope to get *WI* of their child's therapy at school, both clinical and educational occupational and physical therapy. But the school can provide only educational therapy, not medical or clinical therapy. This can cause misunderstandings and hard feelings when the child would benefit from clinical therapy but does not qualify for educational OT or PT, and the school cannot provide you the therapy that you and your doctor think the child needs. It is important to understand that educational therapy and clinical therapy have different purposes, and are provided in different ways.

D. **Fuzzv Boundaries.** From these definitions and descriptions, it sounds like the differences between clinical and educational therapy are clear and that deciding which therapy a child "needs" is simple and clear-cut. Sometimes it is; usually it is not.

What a child needs to "function" at school is sometimes unclear and sometimes a matter of perspective or opinion. For example, a child may walk with a walker and get around the classroom adequately, but if he walked independently and could move around the school more easily, could he benefit from the school program even more? If so, should he get therapy at school? Questions like these have no single night or wrong answer and each child's case must be examined individually. It is the job of the ARD Committee to work with you to make these tough decisions.

4. **Summary**

There are many factors to consider when therapy is prescribed for your child. There are Different kinds of occupational and physical therapy with different purposes and goals. Families will have many questions, and they deserve clear and honest answers. Open communication among family, doctor, therapist and school Will help you understand your child's needs and match them to the resources available. It can also help avoid misunderstandings and begin to solve any problems.

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One author wishes to thank the many parents and professionals who provided critical review and comments of this article.

VII.
General Notes

General Notes:

School Calendars and Maps will be available at the SSA office in July before school begins.

ARDs - Admission, Review and Dismissal Committee:
All personnel (administrators, instructional services, personnel and related services) as well as the parents of the special education student and sometimes the student are members of the ARD committee. All members contribute to the development of IEPs and special education programming for the student. The occupational and physical therapists' role in ARDs is to provide information on assessments, progress and recommendations for OT/PT services. OTs/PTs should attend Annual ARDs and ARDs to review assessments when its possible.

Confidentiality:
All therapists in contact with the special education student must adhere to the SSA's confidentiality policies included in the Special Education Procedures manual. In the community, students shall not be identified by name or school with other district personnel or

other students or parents. Other students in special education should not be referred to in ARD meetings. All documents relating to inactive special education students should be shredded at the Special Education office.

Ethical and Professional Behavior:
All therapists are expected to display professional behavior and appropriate dress while on duty. Conflict of interest occurrences may include but is not limited to referrals of the student to one's self in either private pay or outpatient facilities services. Referrals may be made to local facilities but the therapist cannot serve the same student for medically related services unless that therapist is the sole provider of such services in the community. Therapists are cautioned to delineate between medical/clinical services and educational services as defined by IDEA 97.

Working/Active Special Education Folders:
Original OT/PT documentation that should be included in these folders include Initial Assessment reports, 3 year Re-Assessment reports, and Eligibility forms filed under "Related Service" tab. Past Annual reports, updated OT/PT IEPs, and EYS documentation should be found in the inactive folder. Orginal Protocals should be filed behind the "Protocals" tab.

Occupational and Physical Therapy Notebook:
The OT/PT working notebook may contain: Daily notes/Attendance, copies of current IEPs, Updated IEPs, past Annual reports, a current copy of the Physician's referral, and any previous reports including the OT/PT Evaluation report and assessments. Samples of the student's work and copy of test protocols may be included as well. The OT/PT will record notes on the teachers working IEP at each visit. The working IEP is kept in the classroom. OT/PT should make an effort to sign all progress/grade reports along with the teacher.

Other Occupational and Physical Therapy Documentation:

Physician's Referrals/Prescriptions:
Students who are receiving occupational and physical therapy services in the schools and for whom these services are billed to Medicaid, must have a doctor's referral on file each year. The SSA is responsible for getting this form to the physician and having it signed.

Daily Notes:
Each OTR/PT has the choice of the types of visitation/service documentation she/he chooses to use. But each time a student is seen for OT/PT services, consult or direct, a daily note must be completed on the working IEP that states the date, the performance area/IEP goal addressed, the student's performance and any other pertinent information (ie: special equipment that is ordered or provided, additional problem areas, etc). Equipment needs must be brought to attention of the director of the SSA if that equipment is not available on that campus. Use the SSA's "Equipment Tracking and Planning Form" found in Section XII of this notebook.

Annual Reports:
This report should include summary progress on IEP goals, document the need for EYS services if necessary and recommendations for services the following year. Please use the SSA's "Annual End of the Year Summary Form" found in Section XII of this notebook. If for some unusual reason OT/PT is serving child with direct service only, then a separate IEP is required. It must be written in collaboration with teacher and support the educational IEP.

Equipment Tracking and Planning Forms:
A tracking form with the student's name, school, grade, special equipment needs is kept and turned in at the end of the year to the Director of Special Education. This enables the SSA office to purchase needed equipment/materials or arrange to have equipment moved to campus/district to follow the child. Any equipment or matierials needed throughout the year should be listed on this form. You must include the catalog name, page number, item number, quanity, current price, address and fax.

OTR/PT Task List

1. **Evaluation of students referred to OT/PT**
    a. Review folder to determine possible testing areas and significant information
    b. Gather testing materials
    c. Consult with teacher to determine specific difficulties in classroom/cafeteria, playground environment
    d. Determine available and appropriate test setting
    e. Perform evaluation
    f. Write evaluation report with recommendations
    g. Evaluation report must be turned in to SSA office with completed eligibility report, any goal/equipment suggestions should be result of collaboration with the teacher

2. **Annual Reports End of the Year Summary of students receiving OT/PT services**
    a. Report includes review of progress in student's IEP, this information can be gathered by analysis of work samples, observations, teacher report, collaboration with COTA/PTA.
    b. New IEP recommendations determined and documented as a result of collaboration with the teacher. All recommendations will be educational. ie. continued work on self-feeding skills.
    c. Information for EYS if necessary

3. **Goal Planning of students receiving OT/PT**
    a. Determine appropriate areas to be addressed by OT/PT
    b. Develop, in collaboration with teacher, appropriate goals to address these areas in a clear, concise, and measurable manner.

4. **Services Planning**
    a. In collaboration with other professionals (COTA's, PTA's, teachers) plan appropriate services to meet the determined IEP of each student.

5. **6 weeks progress notes or 9 weeks depending on campus and district**
    a. The OT/PT must sign off on the teacher's progress report support of the educational IEP.

6. **Medicaid Forms**
    a. Blank forms available from the SSA secretary
    b. List of students receiving Medicaid is available from SSA
    c. Complete form
    d. Students billed for Medicaid must have a physician's referral on record which is provided by SSA
    e. COTA's/PTA's able to fill in headings, codes service times, social security #'s, school district, and physician's name.
    f. Sign/co-sign and date all forms

7. **Medicaid Administrative Claim (MAC)**
    a. Fill out and sign time log study sheets when name is drawn.

8. **ARD Committee/Meetings**
    a. Evaluation ARD meeting: participates to present evaluation recommendations
    b. Annual ARD meeting: participates to discuss student progress on IEP goals, and make further recommendations/IEP plan for the next 12 months.
    c. Placement ARD meeting: participates in discussing placement issues *OTR/PT cannot make a placement recommendation.
    d. OTR/PT may collaborate with ARD committee regarding student's services, contribute to ARD meetings.

9. **Consultation with teachers, other professionals on the ARD committee**
    a. Classroom modifications, recommendations, progress, etc.

10. **Daily Notes**
    a. Documentation after daily services on the student's working IEP

11. **SSA's Equipment Tracking and Planning Form (At the end of the year and/or when there's a need)**
    a. i.e.. adaptive feeding equipment, positioners, and information on where to order or access
    b. Equipment/material to be moved with child to the next campus/district

VIII.
PT/PTA and OTR/COTA: Role Delineations

Occupational Therapist and Physical Therapist:
Must be certified in accordance to guidelines established by the National Board for Certification in Occupational Therapy (NBCOT) and hold a valid, regular or provisional license to practice occupational therapy in the state of Texas. The Physical therapist must be certified by the National Board for Certification in Physical Therapy (NBCPT) and hold a license to practice Physical therapy in the state of Texas.

The duties of an OTR/PT will be to screen and evaluate children referred for occupational and/or physical therapy assessment; serve as a member of the admission, dismissal and review (ARD) committee, help write interdisciplinary individualized education plans (IEPs) and develop service plans. Service delivery models include direct, direct/consult, consultative and monitor services in the area of:
1. Improving motor skills necessary for interaction with the environment ranging from mobility to manipulation of objects to handwriting.
2. Improving the student's ability to receive, process, and use sensory information (including visual perceptual skills) allowing for more environmental interaction.
3. Promote development of motor skills, reduce efforts of dysfunction and prevent deformity which limits function.
4. Improve self-care skills (feeding, dressing, grooming, and toileting) through use of adapted equipment and strategies to compensate for disability.
5. Increase movement available at all joints to allow for better positioning during activities and rest as well as allow for more functional use of arms, legs and head.
6. Increase a student's ability to function within the classroom and make adaptations necessary within the classroom to allow the child to function more efficiently and effectively.

OTRs/PTs supervising COTAs/PTAs responsibilities include:
1. The OTR/PT shall delegate responsibilities to the COTA/PTA that are within the scope of his/her training.

2. Provide a minimum of eight hours of supervision per month for full time COTAs/PTAs as documented on the COTA/OTR or PTA/PT Supervision Log. The number of hours beyond the minimum of eight hours per month for supervision shall be dependent upon the OTR's/PT's determination of the COTA's/PTA's competency level, setting and caseload.
3. A COTA/PTA may initiate the screening process and collect information for the OTR's/PT's review in preparation for assessment/evaluation. The OTR/PT is responsible for determining if a physician's referral is required for occupational therapy assessment or intervention.
4. The OTR/PT is responsible for completing the student evaluation/assessment. The supervising OTR/PT may delegate any evaluative task to a COTA/PTA that the OTR/PT and COTA/PTA agree is within the competency level of that COTA/PTA.
5. The OTR/PT is responsible for developing and modifying the student's IEP and services plan in collaboration with the teacher. The services plan must include the following components: goals, interventions/modalities, frequency and duration. The COTA/PTA must follow the IEP and services plan and cannot make any modifications without approval (either verbal or written) by the supervising OTR/PT.
6. The supervising OTR/PT has overall responsibility for providing the supervision necessary to protect the health and welfare of the student receiving services by a COTA/PTA. However, this does not absolve the COTA/PTA from his/her professional responsibilities.
7. The supervising OTR/PT is responsible for writing the student's annual reports and 3 year re-assessments.
8. The OTR/PT is responsible for updating IEPs using same schedule as teacher. The COTA/PTA may complete/sign progress reports with co-signature of the supervising OTR/PT.
9. The supervising OT/PT along with the COTA/PTA is responsible for co-signing all documentation by the COTA/PTA that becomes part of the student's permanent record.

Certified Occupational Therapy Assistant (COTA) and Physical Therapy Assistant (PTA):
Must be certified in accordance to guidelines established by the National Board for Certification in Occupation Therapy (NBCOT) / National Board of Physical Therapist and hold a valid, regular or provisional license to practice occupational/physical therapy in the state of Texas, and who is required to be under general supervision of an OTR and/or PT.

The duties of a COTA/PTA will be to represent the supervising OTR/PT in the ARD committee by reading the assessment or annual report and suggesting IEP goals; also with the teacher however no changes can be made without verbal or written approval by the supervising OTR/PT. The COTA/PTA will also provide services in the areas of:
1. Improving motor skills necessary for interaction with the environment ranging from mobility to manipulation of objects to handwriting.
2. Improving the student's ability to receive, process, and use sensory information (including visual perceptual skills) allowing for more environmental interaction.
3. Promote development of motor skills, reduce effects of motor dysfunction and prevent deformity which limits function.
4. Improve self care skills (feeding, dressing, grooming and toileting) through use of adapted equipment and strategies to compensate for disability.
5. Increase movement available at all joints to allow for better positioning during activities and rest as well as allow for more functional use of arms, legs and head.
6. Increase a student's ability to function within the classroom and make adaptations necessary within the classroom to allow the child to function more efficiently and effectively.

Supervision of COTAs/PTAs:

A COTA/PTA shall provide occupational therapy services only under the general supervision of a licensed OTR/PT. The COTA's PTA's responsibilities will include:

1. Maintaining a COTA/OTR or PT/PTA Supervision Log - providing a copy to both the supervising OTR(s)/PT(s).
2. Ensure that all documentation prepared by the COTA/PTA that becomes part of the student's permanent record is co-signed by the supervising OTR(s)/PT(s).
3. Maintain consistent, regular contact with the supervising OTR(s)/PT(s), either by face to face meetings at the school/worksite, by telephone, written report or conference.
4. Completion of regular progress notes (as determined by each district) and other documentation as assigned by the supervising OTR/PT.

Responses to Parent Concerns About Integrated Therapy and/or Request for Direct (Isolated/Episodic) Therapy

1. **Learn what parent/parents are concerned about.**
   a. What goal do they want their child to achieve through isolated therapy?
   b. What concerns do they have about integrated therapy?

2. **Explain why integrated therapy is appropriate and least restrictive.**
   a. It allows continued social integration;
   b. It allows ongoing instruction in a range of skills and activities (i.e., related services complement and support, rather than compete for time with special education); and
   c. It promotes aquisisiton, use, synthesis, and generalization of motor and communication skills.

3. **Develop clear procedures to address parent concerns, such as:**
   a. Document implementation of the IEP and provision of therapy (time);
   b. Listen and respond to concerns about students progress; and
   c. Formally evaluate program effectiveness.

4. **Explain the research on integrated therapy and isolated/episodic therapy.**
   Currently there are individual demonstrations of the effectiveness of integrated therapy (instruction on motor/communication skills in natural contexts). In many studies, the baseline phase presents a comparison with separate therapy and systematic instruction procedures. There is no comparable body of literature that demonstrates the effectiveness of isolated therapy; it is recommended because it is the traditional (familiar) service delivery model. There is some research on direct/isolated therapy for children that questions the effectiveness of therapy services (at all!) Other research on adults without disabilities questions the effectiveness of isolated therapy and practice of skills without clear functional outcomes.

5. **When the team determines that isolated/episodic therapy is needed:**
   a. Base the decision on some clear decision-making process and criteria;
   b. Establish clear objectives and criteria for the desired outcomes of the isolated therapy services;
   c. Identify the functional application of the desired skills in current and future least restrictive environments:
   d. Identify the current strategies for skill acquisition through integrated therapy, and review the performance data to date;
   e. Establish a specific procedure for generalization from isolated direct therapy to integrated therapy, with criteria to initiate this procedure;
   f. Establish criteria to discontinue isolated therapy,
      a. When outcomes are achieved, and
      b. When out comes are not achieved.

If your team cannot do **c** and **d** at the outset, the justification must be compelling to initiate isolated therapy services, which will cause the student to miss other instruction that is comprehensive and relevant.

5. When the team disagrees about educational relevance or appropriateness of isolated/episodic services, choose a course of action, establish a plan for evaluation, implement your plan, and make a data-based decision.

6. When families request isolated direct therapy that is not educationally relevant, assist them to find another source for those services. (Caution: Educational relevance is not defined only in terms of academic performance.)

IX.
OT/PT Referral Process for Perryton SSA

Referral Process:

A request for occupational or physical therapy assessment may be initiated by the ARD committee, parents, student or any other school personnel (including another OT/PT). Prior to a request for occupational therapy or physical therapy assessment, the student should have met eligibility for special education services. Occasionally the OT or PT may be asked to complete an assessment as part of the initial assessment process. This is commonly done when it is reasonably assumed that the child will meet Special Education eligibility or when a child is transitioning from the ECI program and he/she has previously received OT/PT services. In these two situations, the OT/PT will typically not receive a referral form but may be informed by the diagnostician or director.

Timelines:
Re-Authorization of IDEA states that related services assessments must be completed within a reasonable time. We've interpreted this to mean within 30 school days. The minutes from the ARD will state a concern for the referral and the minutes from the ARD committee meeting requesting the assessment should be attached to the completed screener/assessment report. Be sure to read the minutes as special requests or considerations may be stated (ie: parents want to be present when testing or the teacher is particularly concerned with the student's handwriting problems).

NOTE: Physician referrals/prescriptions are not required to do an assessment.

OT/PT Referral Process Outline

1. Special Education teacher, parent, or student suspects need for OT/PT services.

2. Teacher obtains OT/PT Screening Referral Checklist from SSA Office (SSA PT/OT1)

3. Teacher completes Referral and sends to Special Education SSA Office.

4. Therapist(s) review referral and pertinent information. Appropriate follow-up is provided following communication with the teacher.

5. If a comprehensive evaluation is recommended by the OT or PT then teacher must secure a signature on the "Consent to Evaluate" form and give parent a copy of the Procedural Safeguards and a copy of "A Parent Handbook/Guide for Occupational and Physical Therapy Services in the Public School". Consent must be dated prior to evaluation not prior to screening. Consent is valid for one year from date of signature on initial or re-evaluation packets.

6. OT/PT Assessment Report with recommendations for service (if student qualifies) is completed. ARD is convened.

7. Teacher will give Parent a form for Physician's prescription. The form (SSA PT/OT 2) must be returned before direct/consultative services can begin.

X.
Assessment Information

Assessment:
Related service assessments should answer these questions:

1. What education objective will be furthered by this service?
2. Why is the provision of this services necessary for the student to benefit from education?
3. Are all problems identified by the assessment impacting school performance?

** Note: A physician's prescription/referral is not required for a screening or evaluation

Occupational and Physical Therapy Assessment Form:
The assessment report should include data sources, history, present levels of competency, eligibility functional implications and recommendations. Please use the SSA's PT/OT Assessment Form. A sample has been included. Annual End of the Year Summary - This report reviews progress and is an informal assessment unless otherwise specified. It should include information on student's progress toward having met the goals and objectives. It should also address need for EYS services. OT/PT may make suggestions for the next years goals, objectives and services after collaborating with the teacher.

Screening:
This is a preliminary and often informal process to identify those students who need further evaluation. Sometimes a teacher or diagnostician will ask you to "take a look" at a student to determine if he/she requires an OT/PT evaluation. The screening may include but is not limited to a review of the child's educational folder, direct observations, review of work samples, a screening tool (SSA's or HCDE) and a conference with the classroom teacher. Generally a screening should only take about 10-20 minutes to complete.

Assessments:
OTRs/PTs and field work students use standardized tests whenever possible to determine eligibility. A COTA/PTA and field work students are permitted to administer a standardized test once his/her competencies have been established by the supervising OTR/PT. The OTR/PT is responsible for scoring and interpreting the evaluation tool if a COTA/PTA administered a portion of the test; the student is responsible during field rotation. The therapist should use professional judgment in determining the appropriate assessment tools and criteria to determine OT/PT services and additional assistance will be provided by the Lead OT/PT.

504 Evaluation requests:
Not all students qualify for special education under Re-Authorization of IDEA but may qualify for services under Public Law 504. OT/PT services may be called into assessing a student receiving 504 services. The 504 request for assessment is very similar to Special Education and similar procedures are followed. Recommendations for OT/PT services under this program may require some additional considerations.

Protocols:
All test protocols should be kept and placed in the students' eligibility file along with a copy of the assessment report.

Assistive Tech Assessment:
AT Assessment is more thorough and functional when completed by a team. Every student receiving OT/PT services will be screened then assessed by the AT team if necessary. (See Section XVI for
process). Team members will decide which discipline will write the report. Tthat individual will vary depending on the needs of child.

Three Year Re-Evaluations:
Every 3 years the student must be re-evaluated to determine the student's eligibility for OT/PT services. As with initial assessments standardized test should be used whenever possible and a Re-Evaluation report must be written and presented to the ARD committee. Sample 3 year Re-Evaluation reports are included in section XII for your consideration and to guide you.

Recommendations in Assessment Reports:
Recommendations must clearly state the following:

1. The student's eligibility for OT/PT services,

2. Functional areas to be addressed (fine motor, visual perception, locomotion, oral motor, and/or self-care skills).
3. Service delivery model (direct and/or consult etc.) (SSA perfers you state frequency in terms of total minutes per year/semester. See sample in Forms Section XII.)
4. Frequency (1 time per week, 2 times per month, etc.)
5. Duration (20 minutes or 30 minutes)

Eligibility Report:
For each Assessment, and Re-Evaluation report an eligibility report **must** be completed. Complete ALL portions of the form as demonstrated in the example included in Section XII.

*** Special NOTE: If a problem is NOT interfering with the student's ability to participate in his/her educational program, then the problem is NOT educationally relevant and does NOT constitute a need for occupational therapy or physical therapy intervention.*

XI.
Assessment Protocols

Please call Special Education Office for copies or check class plus OT/PT manual.

XII.
Forms/Sample Reports

OT/PT ARD or End of Year Summary

Student Name: ____ Date: ___________

I. Summary of progress toward mastery of IEP Goals within student's capability range.
(Please address goals with specificity).____

____

____

____

____

____

____

____

____

____

II. Present Services:

☐ **OT: _______ Time ______ Frequency _______ Duration *Type*: Direct or Consult**
☐ **PT: _______ Time ______ Frequency _______ Duration *Type*: Direct or Consult**

III. Eligibility for Related Services:

☐ **It is the professional opinion of the therapist based on observation, assessment, and interview that the student *does not* need ☐PT ☐OT services to benefit from his/her education.**

☐ **It is the professional opinion of the therapist based on observation, assessment, and interview that the student *does* need ☐PT ☐OT services to benefit from his/her education.**

IV. Recommendations after collaboration with instructional staff.

**** All final determinations will be made by ARD committee with regard to LRE and educational need.**

☐ **OT: _______ Time ______ Frequency _______ Duration *Type*: Direct or Consult**
☐ **PT: _______ Time ______ Frequency _______ Duration *Type*: Direct or Consult**

V. EYS ☐ is ☐ is not recommended. If EYS is recommended please use the back to document the necessity of this service based on Federal and State Guidelines.

A home program ☐ *will* ☐ *will not* be provided.

_______________________________________ _____________________ __________
Signature Position Date

Perryton Special Education SSA
Equipment Tracking and Planning

Student/Program name(s): ____

School: __________________________________ Room: _________________

Purpose: ____

Date needed: ________________________

Do we currently have the equipment/program? ____ Yes _____ No

If no, we need the following information to order it:

Vendor name: ________________________________

Address: ____________________________________

Phone #: ____________________________________

Fax #: ______________________________________

P	Item #	Description	Qu	

* The more complete information you provide, the faster the PO can be processed!

* If ordering from more than one company, please fill out separate tracking forms.

____ _____________

Signature Date

Teacher Screener/Referral

Student: ____ DOB: __________________ Grade: ____________

School: __________________________ District: ____________________ Teacher: ____________________

Parent's names: ____ Phone #: _______________________

Date of Referral :_________ Date of last Annual ARD: _________ Date of Comprehensive Assessment: _________

Requested by: ARD ___________ Teacher: ____________________ Other: ____________________

What are the primary concerns in regard to this student's educational program that need to be addressed by the Occupational and/or Phy
Therapist(s)? ____

____

1. Physical / motor problems that interfere with learning: ____
   ____
2. Intellectual function: ____
   ____
3. Behavior that interferes with classroom performance: ____
   ____

An Occupational Therapy Referral may be appropriate if on
he following is checked:

1. The student exhibits difficulty with motor or perceptual skills which interferes with classroom performance:
   - ____ Delayed motor development
   - ____ Appears uncoordinated or clumsy
   - ____ Has difficulty with writing, copying, tracing or cutting.
   - ____ Is easily distracted; has short attention span
   - ____ Has abnormal movement pattern
   - ____ Other: ______________________________
2. The student exhibits difficulty with self-help skills.

   Feeding:
   - ____ Has difficulty chewing, swallowing, eating solid foods or drinking.
   - ____ Has difficulty using eating utensils

   Dressing:
   - ____ Does not have age appropriate skills
   - ____ Needs suggestions for alternative techniques

   Toileting:
   - ____ Is not toilet trained/ scheduled.
   - ____ Requires adaptive toileting equipment
3. ____ May need adaptive / assistive device in order to participate in classroom activities

A Physical Therapy Referral may be appropriate if one or mo
ollowing is checked:

1. The student exhibits difficulty with mobility skills.
   - ____ Has a wheelchair
   - ____ Requires assistive devices of physical assistance for walking
   - ____ Walks independently, but with difficulty
   - ____ Cannot walk, but able to move by rolling, crawling, scooting, etc.
   - ____ Does not have independent mobility
2. The student needs positioning assistance
   - ____ Needs adaptive positioning equipment
   - ____ Has significant posture problem
3. Physical / motor problems are present
   - ____ Active movements are absent, weak, and/or stiff
   - ____ Joint contractures are present

*** Other information that might be helpful to the Occupational / Physi**

____
____
____
____
____

<u>Please have the Occupational or Physical Therapist contact:</u>

Name: ____ Title: __________________________

XIII.
IEPs: Individualized Education Plans

IEPs: Individualized Education Plans

Once a student has been determined to require OT/PT services to benefit from his/her special education, the ARD committee must determine how the related services will support the current IEP. The ARD committee may decide to modify or add new educational goals and objectives to the existing IEP. Drafts of IEPs may be completed prior to ARD meetings but all final IEPs are developed and approved by the ARD committee. The IEP represents the plan that the school district is obligated by law to implement. However the therapist should be aware of the student's educational program and assessment results when determining areas and goals for intervention. Frequently services will be direct/consult enabling staff and other members to support the child's goals on a daily basis. In this case the OT/PT, teacher and other educational personnel collaborate on goals and objectives which are functional in nature and support the educational IEP. You would not expect to see a goal or objective which did not directly support the educational IEP.

A new IEP must also be drafted and approved each year by the ARD committee. The original or working IEP will be kept in the folder at the school but the therapist may keep a copy in her/his possession (see Updating IEPs section for additional information).

Writing IEPs:

IEPs consist of measurable long-term goals and short term objectives. For students receiving consultative services, the therapist may assist the classroom teacher or other special education personnel in formulating IEP goals/objectives, which the special education personnel will implement with assistance from time to time from the therapist. The therapist may only need to modify the classroom and/or minimize classroom activity demands to maintain the present curriculum rather than provide direct services. If the therapist is providing direct/consult services then the therapist must assist the teacher in determining goals and objectives and how OT/PT will support the educational goals and objectives. Further information on direct, monitor and consult services are discussed in Section III.

All IEPs must state the following:

1. Projected dates (for not more than one year's period),
2. The position responsible for implementation of IEP goals (may include the parent or the student as well as the classroom staff),
3. Frequency, duration, and location,
4. Current competencies (what the student can do at this time- refer to assessment or updated IEPs for this information)
5. A measurable long term goal
6. Level of mastery (stated as "X out of X times" not by percentages), and evaluation procedures.

Long-term Goals:

Re-authorization of IDEA mandates that all long-term goals must be measurable. Measures can include standardized assessments, objective measures, criterion-referenced tests, curriculum measures, etc. Below is an example of a measurable, educational long-term goal.

Child will master 3.0 - 3.6 year fine motor skills as measured by the Class Plus Developmental Checklist

Updating IEPs:

Each grading period (6 -9 weeks depending on campus, program, and age of student), all IEPs are updated for students receiving OT/PT services on the original IEP form, which the teacher will keep in her/his possession until the following Annual ARD. IEPs are updated and a progress report is sent to the parent by the teacher; the therapist updates and makes notes on working IEPs after each classroom visit through out the year. It is preferable that the OT/PT also sign off on the progress report.

IEP:
Select one set of goals - one IEP - one implementor - the teacher (several co-implementors).
Agree on priority of goals. Does the IEP answer:

Is the task functional?
Is it age appropriate
Will services increase the child's functioning?
Will it be important to the child's development?
What does child need to function in school setting? (tie shoes, ride bus)
Does it make a difference in the quality of life?
Does it reflect important health and safety concerns?

Do IEP Goals require:

1. Skills training
2. Compensatory training
3. Change in environmental exceptions
4. Adaptive equipment

XIV.
EYS: Extended Year Services

EYS - Extended Year Services
For students who experience regression when not participating in special education or related services (such as during school breaks), EYS services may be provided beyond the regular school year. Specific criteria for determining the student's need for EYS services from Special Education Procedures and Operating Guidelines Manual are included on the following pages of this section.

Documentation for the need for EYS must be provided in either daily notes, formal/informal testing and in the updated IEPs. These EYS services must be approved by the ARD Committee. EYS objectives should be similar to those IEP objectives that address the areas of regression and should be focused on **maintenance** of skills.

EYS sample form and report are included in this section.

XV

Current Special Education Programs in Perryton Special Education SSA

Special Education Programs:

Special Education Programs in the Perryton SSA as defined in the Perryton SSA Special Education Procedures manual are included in the following pages in this section.

Occupational/Physical Therapy's Role in Special Education Programs:
As noted in the pages following, students are placed in the least restrictive environment whenever possible. Possible performance components that the therapist may address for the student in various programs are listed below.

Content Mastery/Resource:

Students in this program are often in regular education classes and are often learning disabled. Focus is on academic skills particularly fine motor, handwriting/visual motor skills and visual perception skills as well as access issues.

Resource (Mild/Moderate and Severe LD)

Focus is on academic skills but at a slower pace in elementary and junior high with emphasis on vocational preparation at the high school level. Focus for Occupation Therapy services in this setting may include but is not limited to visual motor, fine motor, visual perception skills and self-help skills. Focus for PT may include self-help, setting, positioning, accessing environment.

Lifeskills Program (Moderate and Severe)

Focus in this program is toward functional skills used in the home, community and in the classroom. Elementary Lifeskills address skills for self-help; junior high address skills for community and high school towards vocational skills acquisition. Often therapists address a student's self-help skills, pre-writing/writing skills in preparation for writing the student's name if appropriate, appropriate recreational skills and fine motor skills for pre-vocational programs. as well as accessing the environment and materials to enhance vocational opportunities

PPCD (Preschool Program for Children with Disabilities)
Students in this program are aged 3 to 5 years and are often identified as Developmentally Delayed or Non-categorical Early Childhood. Occupational therapy emphasis in this program is toward motor development, self-help skills acquisition and play/social development. Physical therapy emphasis is toward motor development, self-help and positioning to access the environment.

Homebound/Hospital Program:

OT services for students in homebound/hospital programs must be educationally relevant and not medically focused. OT services address needs as identified by the special education programming and OT assessment.

Behavior Adjustment Program

Primary goals of BA programs are to assist students towards appropriate social behavior and progress in academics. Some students in this program are learning disabled. PT/OT services may address motor, visual perception and self-help skills.