# TABLE OF CONTENTS

VALUES AND PROGRAM APPROACH ............................................................... 4  
REFLECTIVE PRACTICE AND OUR CLINICAL TEACHING PRINCIPLES ....... 6  
CURRICULUM OVERVIEW ................................................................. 8  
THE TODDLER PLAYGROUPS ............................................................... 10  
THE PRESCHOOL CLASSROOM ........................................................... 13  
COMPONENTS OF THE TODDLER AND PRESCHOOL PROGRAMS ......... 17  
HOME VISITS .................................................................................. 17  
PARENT CONFERENCES .................................................................... 17  
BEHAVIOR MANAGEMENT ................................................................. 17  
  PREVENTING DISRUPTIVE BEHAVIOR ........................................ 17  
  MODIFYING DISRUPTIVE BEHAVIOR ......................................... 18  
HOLIDAYS AND SPECIAL OCCASIONS ............................................ 18  
  SPECIAL OCCASIONS .................................................................. 18  
  BIRTHDAYS .................................................................................. 19  
FACILITATING STRATEGIES FOR INDIVIDUAL AND GROUP NEEDS ... 19  
  ENVIRONMENTAL ARRANGEMENTS ............................................. 19  
  INDIVIDUALIZED GROUP INSTRUCTION .................................... 20  
ROUTINES ....................................................................................... 20  
TRANSITIONS .................................................................................. 20  
HIGH STRUCTURE ACTIVITIES ......................................................... 21  
LOW STRUCTURE ACTIVITIES .......................................................... 21  
SPECIFIC LANGUAGE INTERVENTION STRATEGIES ..................... 22  
ICRP PROCEDURES AND REQUIREMENTS ...................................... 25  
  ARRIVAL AND DEPARTURE ........................................................ 25  
  CLEAN UP .................................................................................... 25  
  FIELD TRIPS ............................................................................... 26  
  VOLUNTEERS AND OBSERVERS .............................................. 26  
  CLASS ALLOWANCE ................................................................. 26  
  TEAM MEETINGS ....................................................................... 26  
  DIAGNOSTIC ASSESSMENTS ...................................................... 27  
SUPERVISION PAPERWORK AND REPORTING REQUIREMENTS ........ 27  
  CONFIDENTIALITY/ HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA) .......................................................... 27  
  INDIVIDUALIZED FAMILY SERVICES PLAN (IFSP) ....................... 27  
  TODDLER INTERVENTION PLANS (TIP) ...................................... 28  
  PRESCHOOL INTERVENTION PLANS (PIP) .................................... 28  
  LESSON PLANS .......................................................................... 29  
  DATA COLLECTION ...................................................................... 29  
  WEEKLY SUMMARIES .............................................................. 29  
  FORMAL STANDARDIZED ASSESSMENT ................................... 29  
  LANGUAGE SAMPLE ANALYSIS AND SUMMARY ......................... 30  
  LANGUAGE COMMUNICATION SAMPLE SCHEDULE ..................... 30
END OF THE SEMESTER PROGRESS REPORTS ............................................................. 31
GENERAL GUIDELINES ............................................................................................ 31
FORMAT FOR THE PROGRESS REPORT ............................................................... 31
GOALS, OBJECTIVES AND PROGRESS .............................................................. 32
SUMMARY AND RECOMMENDATIONS .................................................................. 32
FILES ....................................................................................................................... 33
COMPUTER FILES .................................................................................................. 33

APPENDIX A: JOURNALING .................................................................................... 35
JOURNALING ............................................................................................................. 35
THE PRACTICA JOURNAL FORMAT ....................................................................... 35

APPENDIX B: GRADING .......................................................................................... 36
CRITERIA FOR “PASSING” .................................................................................... 36
OBSERVATION FORM: PRACTICA ......................................................................... 38
INTERPERSONAL RATING SCALE .......................................................................... 39
PROFESSIONAL MANAGEMENT SCALE ............................................................ 40
OBSERVATION FORM: OPERATIONAL DEFINITIONS ............................................ 41
OPERATIONAL DEFINITIONS .................................................................................. 41
INTERPERSONAL SKILLS ...................................................................................... 43
PROFESSIONAL AND MANAGEMENT SCALE ..................................................... 46
PROFESSIONALISM ............................................................................................... 46
MANAGEMENT ...................................................................................................... 47
PRACTICA MISSION STATEMENT AND GOAL PLANNING ................................... 49
REQUIRED GOALS AND OBJECTIVES ................................................................ 50

APPENDIX C: SNACKS ............................................................................................ 51

APPENDIX D: HOME VISIT FORMS ...................................................................... 53
INITIAL HOME VISIT/FAMILY PLANNING FORM .................................................. 54
INFANT CHILD RESEARCH PROGRAMS: HOME VISIT SUMMARY ....................... 55

APPENDIX E: INTERVENTION STRATEGIES ......................................................... 56

APPENDIX F: HIPAA PRIVACY PRACTICES ......................................................... 60
USE AND DISCLOSURE .......................................................................................... 60
MANDATORY DISCLOSURES .................................................................................. 60
CONSENT ................................................................................................................ 60
AUTHORIZATION ..................................................................................................... 60
OPPORTUNITY TO AGREE OR OBJECT ................................................................ 60
EMPLOYEE/STUDENT AGREEMENT GUIDELINES ................................................. 60
RIGHT TO COMPLAINT .......................................................................................... 61
CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FORM .................................................................................................................. 62
ICRP DE-IDENTIFICATION CHECKLIST .................................................................. 63
AUTHORIZED FOR RELEASE OF INFORMATION .................................................... 64
THE FAMILY’S RIGHTS AND RESPONSIBILITIES .................................................. 65
LETTER TO PARENTS CONCERNING HIPAA ......................................................... 66

APPENDIX G: IFSP, TIP, AND PIP FORMS ............................................................ 67
AzeEIP INITIAL PLANNING PROCESS ................................................................... 1
VALUES AND PROGRAM APPROACH

"Through experience we learn. Experience needs language to give it form. Language needs experience to give it content."

(Loban, 1926, p.73)

ICRP educational and play group programs are open to all young children, including those who are developing typically, those who are at developmental risk, and those who demonstrate some developmental delays. We provide all children with contextually-rich experiences in order to promote acquisition of developmental competencies. Children with developmental delays are provided with focused experiences and enhanced supports to facilitate positive developmental outcomes, with a special focus on communication, language, and social interaction.

We focus on building effective relationships with each other, participating children, and their families. We promote partnerships and actively seek collaborations with parents/guardians and other interested family members. We value cultural diversity and respect the unique characteristics of each other, and the families who participate in our programs. We strive to offer informal and formal support to each other and families. We view learning as a reciprocal, dynamic process in which we learn from each other, the children we serve, and their families. The following sections will provide you with information about our beliefs that underlie our early childhood programs as well as specifics regarding the design and implementation of our classroom programs.

The Centrality of Relationships

Human learning takes place in the context of relationships and is diminished or enhanced by the quality of those relationships. As noted by Norman-Murch (1996), "For young children, the quality of their earliest relationships (attachments) with parents and caregivers will affect their intellectual, social/emotional, and physical development. Children who experience the world as responsive to their needs and efforts, predictable, and supportive will have the emotional foundations that make them ready to learn" (p. 18). This is as true for children with disabilities as for any children, but is far too often overlooked in designing intervention programs, and in personnel training. In similar fashion, attention must be paid to the quality of the relationships between parents and professionals and among the professionals themselves.

At the ICRP we are actively attempting to implement the concept of the "centrality of relationships", (Weston, Ivins, Heffron, & Sweet, 1997), which means that we try to focus on all levels of relationships within the organization. Thus, we are concerned with relationships that we have with the children, our relationships with the children's families, and our relationships with each other as peers and supervisors. The quality of your relationship at each of these levels (children, family, peers, supervisors) influences your effectiveness as an interventionist. The dynamics of each of these relationships must include mutual respect, safety, and a willingness to engage in a meaningful collaborative effort. At the ICRP you will join a partnership effort that includes you and your
student peers, the children, their families, and the professional staff. Within this team context we focus on supporting and facilitating (a) the children's acquisition of key developmental skills and competencies, (b) the families abilities to promote their children's development, and (c) the development and use of professional self by students and supervisors alike.

The concept of "professional use of self" is relatively new in its application to early childhood services and refers to a conscious examination and reflection upon how one reacts and behaves as a professional. Included within the concept is an understanding and acceptance of the fact that “who you are” influences “how you are" in your professional interactions, with families and children as well as your peers and supervisors. Regular reflection, in which you strive to understand your personnel and professional responses to others, is the primary means by which you will monitor and develop your professional use of self. Therefore, many training activities at the ICRP have been designed to provide you with sufficient time and structure to engage in meaningful reflection upon your experiences and professional practices.

A Family Centered Program

We are committed to a family-centered approach, recognizing that families are the experts regarding their children’s abilities and serve as their children’s first teachers. While child rearing is a challenge for all, families of children with developmental disabilities are faced with particularly difficult roles. They must be both parents and advocates for their children. Professionals working with families must maintain an objective role, yet be caring and sensitive to families needs in order to provide effective intervention services. Young children, including those with disabilities, spend a majority of time within their family setting and it is important for professionals to understand and acknowledge the central role a child's family plays in his/her development. Further, parents serve as their children's first teachers and primary models. Accordingly, family members must be considered integral and essential members of the programming team. From a legal standpoint, PL 105-17 Individuals with Disabilities Education Act Reauthorization and Amendments of 1997, mandate the participation of family members to the fullest extent possible when planning and implementing services for young children with disabilities. Hence, family-centered services have come to be increasingly regarded as a key quality indicator for early childhood services. Although professionals are aware of the legal and theoretical implications of providing family-centered services, most would agree that day-to-day implementation of this component presents it share of challenges and obstacles. It may often appear easiest to be child-focused and relegate family interactions to those brief post-treatment conversations in the hall. However, it is well documented that primarily child-focused services are not in the best interests of children or their families. Thus, the goal of family-centered services in early intervention and preschool programs must be to provide meaningful and relevant opportunities for family participation.

An Inclusive Toddler/Preschool Experience

Program plans and classroom activities are designed to benefit all children, including those demonstrating typical development. In settings in which children with disabilities are included it
is important that their needs do not override or displace the needs of the typical peers. While a key aspect of programming is to provide the children developing atypically with typical peer models, the typical peers also learn important social and language skills, increase self-esteem, and develop leadership skills.

Children with developmental disabilities who are enrolled in the ICRP programs have a primary problem with the acquisition of communication, speech, and/or language skills. Accordingly, the curriculum has been designed to provide these children with maximal opportunities for learning appropriate skills in these areas. However, communication skills (including appropriate speech & language) are central to any activity in which children may be engaged and may therefore be facilitated while also emphasizing other important skills areas (e.g., cognitive, gross motor, fine motor, social, self-help). In this way, the children with and without disabilities are provided with a quality toddler/preschool experience that while communication-based, provides them with important learning opportunities in all developmental skill areas.

The Importance of Social Interaction

The ability to relate and interact appropriately is crucial to the formation and maintenance of relationships with other people. Maximum opportunities for learning appropriate social behaviors should be an integral part of programming for young children with and without disabilities. In many respects, the opportunity to learn socially appropriate behavior and interactive strategies is a primary benefit that children with disabilities derive from inclusive toddler and preschool programs. Through interactions with peers and adults, children are able to learn appropriate social and language skills. However, simply placing children with and without disabilities in physical proximity does not ensure that the children will engage in meaningful interactions with each other. Professionals working with young children with disabilities must create opportunities that help to facilitate interactions among children. Within the classroom setting clinicians can promote social interactions (and acquisition of communication and language skills) by (a) arranging the environment in such a manner that children will have physical contact with each other, (b) providing materials and activities which promote interactions (i.e., group projects), (c) prompting children to seek assistance from or involve each other, and (d) training typical peers.

A Play-Based Curriculum

Play is the most effective context for facilitation of skills in early childhood. A play-based curriculum provides the most effective and enjoyable way for children to learn. Children learn best when they are actively engaged, when they are involved in "hands-on" experiences, and when activities are pleasurable to them. From the very earliest age, children explore and learn about their world through play. Through play nearly all aspects of development may be addressed including, language and communication skills, perceptual-fine motor skills, cognitive and problem-solving skills, social and self-help skills, and gross motor development.

REFLECTIVE PRACTICE AND OUR CLINICAL TEACHING PRINCIPLES
We define our model for clinical teaching (i.e., supervision) as Reflective Mentorship. We believe that every student needs and deserves the support that is provided through reflective mentorship. The following principles characterize the process of reflective mentorship:

1. Clinical teaching/supervision must be provided on a regular, scheduled basis. When it is not scheduled regularly, there is a tendency for it to only take place when crises arise, thereby losing opportunities for reflection and preventative actions.

2. Clinical teaching must be reflective in nature. There should be a time to describe a situation (focus on the facts), talk about personal reactions (focus on the feelings), and discuss possible solutions (focus on problem-solving). All of these steps are essential to a reflective process.

3. Clinical teaching must be a collaborative effort, reflected as a relationship between clinical mentor and student clinicians that is mutually respectful, collegial, and perceived as safe.

4. The reflective model of clinical mentorship is based on an understanding of life span developmental theory. This focuses on the various stages of social and emotional development that all individuals experience and which have a lasting impact throughout adult life. Understanding of one’s own past experiences and the ways in which they may influence current relationships is important in this model.

5. There is an acknowledgment of parallel processes at work in relationships between clinical mentor and student clinicians, student clinicians and children’s parents, student clinicians and children, and parent and child. The quality of support provided in clinical teaching activities will lay the groundwork for supporting relationships between parents and their children. Basically, the concept of parallel processes can be stated as do unto others, as you would have others do unto others!

6. Peer mentorship is a valuable resource. Anytime student clinicians come together an opportunity is afforded for this type of support and should be used as such. Business or procedural concerns should not consistently take precedence over facilitating a mentorship-based supervisory relationship. The practice of keeping a group discussion of issues related to our work with families and their young children.

7. Student journaling is a tool that has been adopted by many as a method for exploring one’s own identity beliefs and feelings. These factors have a powerful influence on the decision-making process both in personal and professional arenas. Journaling may aid the supervisory process by creating a shared vision between the supervisor and the supervisee-partners in the decision-making process (Brown, Hebert-Remson, Budrzysky, & Wilcox, 1997).

Therefore you may be required to keep a journal for this practica. You may use the format given to you (see Appendix A) or use your own format. However, the information should be substantive.
That is, a chronology of therapy is not acceptable. Instead, reflect on what happened and attempt to discern the meaning behind what you are feeling. Attempt to relate these insights to other segments of life experiences.

Your clinical mentor is a certified speech-language pathologist. S/he will collaborate with you to assist in your development of (a) an expertise in programming for families and their infants and young children, (b) a professional identity that includes an ongoing process of reflection, and (c) strategies for continuing your professional growth and development beyond this particular practica experience. Your clinical mentor will collaborate with you in the design and carrying out of classroom activities, providing you with opportunities to assume more responsibilities as you feel confident. Several vehicles will be used to engage in performance review including direct observation, discussion, and review of your journaling activities. You will be provided with written feedback on four (4) sessions, including two before midterm and two after mid-term (see Appendix B). For the shorter summer session, written feedback is provided on two occasions. In addition, you will be provided with ongoing opportunities to review your performance (and that of your peers and clinical mentor) before, during and after each classroom session. At the end of the semester, please fill out the clinical hours form and submit to your supervisor for a signature. It is your responsibility to become familiar with this form and keep track of the hours you are accruing.

CURRICULUM OVERVIEW

The curriculum at ICRP is based on developmentally appropriate practices while addressing the interests and needs of individual children. This means that the environment, activities, and interactions must be based upon the clinician's knowledge of children's individual developmental levels and interests. Because children "learn by doing", clinician-directed activities should be limited with the major emphasis placed on opportunities for child-initiated play, active exploration, and making choices. Opportunities to practice "old skills" and acquire "new skills" should be provided within the context of children's interactions with materials, activities, peers, and adults. Guiding curricular principles are detailed below.

1. Children with developmental disabilities who are enrolled in the ICRP have a primary problem with the acquisition of communication, speech, and/or language skills. Accordingly, the curriculum has been designed to provide these children with maximal opportunities for learning appropriate skills in these areas. However, because communication skills (including appropriate speech & language) are central to any activity in which children may be engaged, they may be facilitated while also emphasizing other important skill areas (e.g., cognitive, gross motor, fine motor, social, self-help). In this way, the children with and without disabilities are provided with a quality toddler/preschool experience that while communication-based, provides them with important learning opportunities in all developmental skill areas.

2. Children develop differently. These differences are identified, and incorporated in the Individual Family Service Plan (IFSP - for children birth to 3 years of age receiving services
through the Arizona Early Intervention Program-AzEIP), the Toddler Intervention Plan (TIP - for all other children enrolled in the toddler playgroups) or the Preschool Intervention Plan (PIP - for all preschool-aged children). Individual lesson plans are developed for all children. Details on how to develop these documents are discussed under the heading of Paper Work and Report Writing.

3. Themes are used to help children learn about the world around them. Through the use of themes, children can acquire vocabulary concepts and information through meaningful activities. Pre-determined units/themes are integrated across developmental domains and classroom activities. During ICRP staff meetings, unit and weekly themes are developed into weekly and daily lesson plans. The goal of this planning is to ensure that the theme is reflected throughout the daily activities and across developmental domains.

4. The development of self-esteem and trust are essential components of the curriculum. Many of the children have difficulty with self-esteem and trust that is due to their poor communication skills. Our goal is to emphasize their strengths and decrease the attention that is focused on their needs. At the ICRP we attempt to create a nurturing environment in which children can develop confidence and trust, but at the same time learn to discriminate between healthy and harmful interactions.

5. Individual learning needs can be addressed in the classroom environment through the selection and use of specific intervention strategies. Discussion of specific facilitating strategies is included in a following section entitled Facilitating Strategies for Individual and Group Needs. Rarely is there need to remove a child from the classroom setting for an individual treatment setting. When necessary, individual or small group sessions can supplement the classroom program by providing a brief focused intervention to teach a new skill or practice a newly acquired skill.

6. We are interested in “process” rather than “means to an end”. Children are encouraged to participate in all activities; however, many of them are hesitant because they realize that they are not capable of completing some tasks. Activities are selected and presented in a manner that encourages attempts, not necessarily the completion of the task. All attempts are reinforced.

7. Activities are designed to promote emergent literacy and numeracy skills. We attempt to create a "print rich" and "number rich" environment that provides children with multiple opportunities to develop important early literacy (e.g. proto-reading and proto-writing) and numerical (e.g., counting) skills. These emphases are incorporated throughout the day in all activities from book sharing in the Toddler Play Groups to practicing pre-academic skills at the computer center in the Preschool Class.

8. Families are encouraged to participate in classroom activities. Initially parents may choose to stay in the classroom if it makes their child more comfortable with their new surroundings. At no time do we require parents to leave their children in the classroom if they are not
comfortable doing such. Also, the ICRP is equipped with an observation room and families are welcome to observe whenever they wish. In addition, home visits are scheduled during the semester. Families are the "major players" in the development of their children's IFSP, TIP or PIP. It is important to remember that families are the experts with regard to their children's abilities and their input and guidance in the development of individual children's goals and objectives is critical.

9. Children are born with unique temperaments. It is a challenge for teachers to acknowledge those differences and channel them into appropriate social and interactional skills. At ICRP children have the opportunity to learn impulse control through decentering, negotiating, and bargaining.

THE TODDLER PLAYGROUPS

CLASSROOM SETUP AND PRIMARY OBJECTIVES

The Toddler Playgroups provide a safe environment for children 18 months to 3 years old to develop motor, language, cognitive, adaptive, and social-emotional skills. Individualized group instruction is provided to meet overall developmental objectives and specific individual objectives that are identified for each child. Opportunities are presented to the toddlers to explore their environment, and make choices and decisions on their own in order to develop independence, self esteem and trust.

The toddler playgroups meet twice a week for two hours (9:00 – 11:00). A typical playgroup schedule includes the following activities:

1. Arrival/free play time
2. Theme-based activities - children are encouraged to explore the activities at their own pace while classroom staff facilitate communication, language, personal-social and cognitive skills within these activities
3. Opening songs
4. Outdoors play time
5. Snack
6. Closing activity/ songs

The toddler classrooms are arranged to provide areas of exploration in the following areas:

The sensory area allows children to explore a variety of sensations. The sensory table is filled on different weeks with water, sand, cornmeal or another substance. A variety of objects are available (funnels, shovels, nesting cups, etc.) to encourage children to experience these different sensations in order to promote development of cognitive and fine motor skills.

The art area provides children with an opportunity to use paints, crayons, glue, markers and other materials. Children at this age are just beginning to mark on paper and scribble spontaneously. Art
activities at this young age are sensory experiences and the "process" rather than the "product" is the focus.

The **dramatic play area** (kitchen/baby doll area) allows children to develop important play skills. Children at this age are beginning to engage in imitative play, including imitation of adult tasks, especially caretaking and housekeeping tasks. Young children are developing an understanding of simple functional relationships (e.g., spoon in bowl or mouth, blanket on doll) and symbolic representations (e.g., using blocks as food for the baby). Exposure to these play sequences helps children develop important cognitive skills so necessary for language acquisition.

The **literacy area** provides children with an opportunity to explore a variety of books as a solitary or as a shared activity. Books are changed based on the theme for that week. Book sharing allows an opportunity to introduce nursery rhymes and encourages children to identify pictures in books. Adults read books to children whenever a child shows an interest in a book.

The **constructive play and curiosity areas** provide opportunities for children to explore and learn about their world in order to develop important cognitive and fine motor skills. Toddlers are beginning to show interest in causing effects, combining objects with other objects, and grouping and sorting objects. Activities include play dough, blocks, simple puzzles, nesting toys, pegboards and other toys that develop these skills in young children.

The **movement area** provides children with a place to practice newly acquired physical skills. Toddlers love to climb and tumble. At this age, toddlers enjoy pushing and pulling toys or carrying objects from place to place. An area of the classroom is set up with mats, bolsters, large therapy balls etc. to encourage gross motor development. **Our outdoor playground** offers a variety of equipment for expanding movement skills.

When appropriate, **individual treatment sessions** may supplement the group program by providing a brief focused intervention to teach new skills or practice an emerging skill in a one-to-one situation. There is no additional charge for these sessions and they are usually scheduled either before or immediately after the classroom session. Families are included in these therapy sessions in order to provide opportunities for family members to learn how to provide opportunities for children to use newly emerging behavior at home.

**Facilitating Adjustment and Attachment**

Children’s development of attachment to their caregivers follows a predictable pattern but is dependent on each child’s temperament and individual pace of development. Toddlers often demonstrate separation and stranger anxiety as they are developing strong secure attachments to their caregivers. During this time, toddlers are fearful of strange adults and unfamiliar situations and often demonstrate clinging, crying and screaming in response to unfamiliar adults. Clinicians in the playgroup can facilitate adjustment by following the family’s lead and inviting the parents to stay in the playgroup until the child becomes more comfortable and familiar with the staff and the routines. Help the family develop consistent, predictable good-bye routines. Supporting toddlers through this
stage of attachment is an important part of healthy emotional development for young children.

**GUIDANCE TECHNIQUES FOR TODDLERS**

Toddlers are learning how to be safe, how to get what they need without taking from others, how to use peers and adults as resources, how to use words to express feelings and how to act appropriately in different situations. Toddler’s exploration of the social world often involves conflict. The most basic conflict concerns what is mine and what is yours. Toddlers react impulsively, but their feelings of empathy blossom as they negotiate these conflicts and see that other people have feelings too. They can easily fall into despair at not getting what they want or feeling the displeasure of a beloved adult; just as easily, they can react with amazing generosity and warmth. Through such negotiations, toddlers build a sense of themselves as social beings—competent, cooperative, and emotionally connected.

The Toddler Play Groups offer toddlers experiences that foster cooperation and facilitate the toddler’s development of a strong sense of self. The clinician must be prepared to prevent injuries and handle conflicts as toddlers learn to defend themselves, share, and cooperate with others. **Distraction** and **redirection** are two techniques that are often used by parents and teachers to modify the situation for very young children. These techniques should be used before a situation turns into a problem and are not appropriate techniques when there is a danger to a child. **Distraction** involves changing the child’s focus from an activity that is unacceptable to one that is acceptable without directly confronting the inappropriate behavior. For example: draw a child’s attention to the pretty blue cup at the chair you want the child to sit in when two children are fighting to sit in the same chair for snack; or give the child the pompom for song time as he begins to protest joining the group for songs. In this way the child is distracted from the undesirable behavior and given an acceptable activity. **Redirection** also prevents undesirable behavior by directing the child to engage in more appropriate behavior. For example: help the child scribble with the marker rather than put the marker in his mouth; or give a different truck to a child that is getting ready to grab a toy truck from a friend; or encourage a child to whisper rather than yelling a favorite rhyme. Distraction and redirection work best when sensitive adults respond to situations before there is a problem. Once there is a problem requiring intervention, it will be necessary to use some of the techniques described later in Behavior Management.
THE PRESCHOOL CLASSROOM

CLASSROOM SETUP AND PRIMARY OBJECTIVES

The physical environment of the preschool classroom has been designed around five centers to stimulate learning. These include (a) a literacy center, (b) blocks and manipulative center, (c) dramatic play center, (d) art center, and (e) a sensory area which includes water/sand play. As part of the initial circle, children are asked to select one of these areas for play. The purpose of these centers are explained in detail below:

1. **Literacy Center.** The literacy area is designed to foster a love for numbers, reading, and writing, which opens the world for young children. The specific areas include a computer with various number-based and print-based software that is designed for young children as well as a selection of books. The skills learned in this area will form the foundation for successful numeracy, reading, and writing in the early school years. To guide you in planning activities for this Center, it may be helpful to consider the five developmental stages in using books which include: book exploration, sequencing events, relating stories to the pictures, and focusing on the text. Likewise, there are predictable stages in writing and development of numeracy concepts. During the first stages the child's written attempts are indistinguishable but they are meaningful to him/her and differ from drawings. In the second stage scribbles are intermingled with identifiable marks. Finally, the child's writing becomes more purposeful and organized (Dodge, 1988). The computer is used to enhance many developmental tasks. These include cognitive (e.g., causality, memory, classification, number, space, seriation, and time), and perceptual-fine motor skills. All of these developmental tasks facilitate language, reading and writing.

2. **Blocks and Manipulatives.** Blocks and manipulative (e.g., puzzles, peg-boards, shape-sorters) play important roles in the emergence of developmental skills associated with fine-motor (e.g., eye-hand coordination, visual perception, use of a more mature grasp pattern), cognitive/problem-solving (e.g., concepts of size, shapes, numbers, order, area length), and language and social interaction. The stages of block usage include carrying blocks; piling blocks and laying blocks on the floor; connecting blocks to create structures; and making elaborate constructions.

3. **Dramatic Play.** The dramatic play area is essential in creating a language enriched environment. Children are given the opportunity to act out scripts by role-playing and interacting with their peers. During dramatic play children develop their imaginations and act out fearful situations. There are three stages of dramatic play. Stage one consists of imitative play with concrete objects (e.g., talking on the telephone to mommy). Stage two incorporates make-believe play and is characterized by events beyond real-life happenings. The child is no longer dependent upon concrete objects. When the child becomes three or four years old, he enters the final stage of dramatic play and socio-dramatic play. Children will seek interactions with their peers, which require verbal or non-verbal initiations and appropriate responses to initiations.
Clinicians set up the housekeeping area with props that are an integrative part of the unit/theme and give the children different roles to play in designated scripts. Favorite scripts at ICRP include barbershop/hairdresser, fix-it-person, supermarket, restaurant, doctor, and post office. Clinicians should be aware of the children's role-playing behavior; that is, their use of props, use of make-believe, time spent in dramatic play, interactions with other children and verbal communications.

4. **Art.** The art created by children helps them to develop creativity, eye-hand coordination, control over small muscle movements, and an appreciation for beauty. In addition, they develop a sense of pride in their accomplishments. It also gives them the opportunity to discuss their projects with family members. The developmental sequence for drawing and painting is basically the same. Children go through the stages of disordered scribbling, controlled scribbling, naming pictures that were not planned, and creating pictures that are representational. At least one art activity that is theme related is included in the daily classroom routine.

5. **Sensory.** Different textures are used in the sensory/water table so that children will have the opportunity to explore the world in a safe environment. Some children are not comfortable with their bodies and the stimuli they receive from the environment. They have difficulty organizing information and appropriately acting on it. At the sensory table children learn, through the medium of sand, water, beans, Easter grass, bird seed etc., that interactions with the environment can be safe and enjoyable. One sensory item is selected for each weekly theme.

**Organization of the Preschool Class**

The learning environment includes organization of the daily schedule, planning themes and units, selection of daily activities, and planning for group activities and free play.

**Organization of the Daily Schedule**

The daily schedule includes natural events that occur in the classroom. The daily schedule provides specific times for events to occur in order to help children and adults organize the day. Consistency and predictability are important characteristics of the daily routine. Consistency helps children maintain order in their lives and make predictions concerning their actions. It also allows children to build trust in the environment. An example of the preschool classroom schedule follows:

- **8:30 - 9:00** Phonology Group
- **9:00 - 9:15** Arrival/Play Ground
- **9:15 - 9:30** Opening Circle/Story
- **9:30 - 10:30** Free Play (Structured and Unstructured)
- **10:30 - 11:00** Snack
By providing a predictable sequence of events such as "first we have group then we have free play", children develop a sense of time, as well as independence and control over their environment. When developing a daily class schedule, teachers should offer a balance between activity and quiet time; indoor and outdoor play; and structured free play and group activities. Adequate time should also be allotted for arrival and departure, toileting, transitions, and snack. Free play period(s) should be long enough for children to select materials and activities, carry out their plan, and clean up. Large group activities should allow children to learn through song, movement, dance, and brief discussion. Children's participation and independence can also be increased by establishing routines within large group activities such as the opening and closing circle. Please note that opening circle should not be longer than twenty minutes. The following is an example of a routine that could be followed during the opening circle:

1. Greet children and sing the opening song.
2. Review of Job Chart
3. Calendar Song and Calendar Helper
4. Star of the Week as appropriate
5. Story
6. Clinician presents Options for Free Play (use the choice board for non-verbal children)
7. Children take turns making a choice and then transition to the activity.

**OPENING CIRCLE: SURVIVAL SUGGESTIONS**

The initial circle gives the children the opportunity to learn routines and practice language comprehension and expression skills. Before the formal circle begins the children are allowed to play with pre-selected toys. The transition song "It is circle time" is used to signal a change in activates. In time, all of the children will respond to this cue. Clinicians should provide children with options for songs that help the children learn greetings and each other’s names. Nursery rhymes and other songs that are related to the theme for the day may be chosen. Helpers are reviewed using the helper chart. Every child should get the opportunity to function as a helper several times during the semester. The specific task is dependent upon each child’s ability. The calendar helper assists the clinician by placing the appropriate numeral(s) on the chart and leading their peers in counting the days. The theme for the day is discussed and finally the children are allowed to "Pick a place to play." It's okay if a child changes his/her mind after indicating an initial selection. However, clinicians should encourage the children to follow through on their initial selection to facilitate language comprehension. The child may give a verbal or non-verbal response to indicate his/her choice. If the child has difficulty accomplishing this task, the clinician can use the choice board to help the child select a center.
To facilitate the introduction and understanding of the week's theme and targeted concepts, the lead clinician will need to have a selected group of props with her during opening circle. A special drawstring bag is to be used consistently during opening circle for storing the props. This keeps possible distractions "out-of-sight"; the children's curiosity heightened, and strengthens the daily routine. Warning: The management of props once they have been introduced to the group is a real art. It is important to let the children inspect the props but don't let them keep them or have so many props available that you are unable to manage the circle.

**Middle Circle**

This circle can be used to teach songs, poems related to the theme or to conduct special group activities such as cooking or science. Recipes are written using Board Maker so that the children can follow along as they participate in the cooking activity. In addition, they are encouraged, but not required, to participate in science activities in the Monday, Wednesday, Friday class.

**Closing Circle**

This circle should be short in duration because the children will learn to associate closing routines with departing. However, it can be used to reiterate what happened during the day, sing songs, or to retell a story. Make sure that the children have their belongings before the good-bye song is sung. This should insure an orderly dismissal.

**Snack**

Snack is not only an opportunity to feed the children, but it also allows the children to interact with each other on another social level. They learn turn-taking, sharing, and social rules of etiquette. Generally, children expect clinicians to met their needs. This practice is discouraged. Utilize the snack helpers in setting up for snack and meeting the needs of their peers. Use smaller pitchers so that the children can learn self-help skills by serving themselves. Moreover, all children, assisted or unassisted, are asked to throw away used paper products and to put their place mats and utensils in the sink before transitioning to another activity.

The clinicians should be seated at the table with the children during snack. Select a snack that corresponds to the theme. Try to select foods that vary in taste, color, and texture. A list of nutritious snacks and drinks are included in Appendix C.
COMPONENTS OF THE TODDLER AND PRESCHOOL PROGRAMS

HOME VISITS
An initial home visit is scheduled with the family prior to the first day of class. This initial visit provides an opportunity to meet the family, and listen and learn about their child and the family’s hopes for that child. Home visits may also be used to complete assessments and language samples since young children tend to function better in the familiar environment of their own home. A summary of the visit is written to describe the purpose, participants and outcomes of the home visit. Forms for home visits are located in Appendix D.

Home visits are also conducted monthly through the semester as requested by the families participating in the Toddler Playgroups. The purpose of these visits is to support the families’ efforts to facilitate their young children’s development and to address any concerns or questions that the families may have regarding their child's development. Home visits are optional and all families should be asked if they would like an opportunity to address concerns in their home or if they would prefer to meet with you in the ICRP. Forms for home visits are located in Appendix D.

PARENT CONFERENCES
Conferences are scheduled with parents at the end of the semester to discuss their child's progress and to address any concerns the family has regarding their child’s development. This is an excellent time to begin transition planning, if it is appropriate. Written progress reports are also provided at the end of each semester. The parent conferences can be conducted at the ICRP.

BEHAVIOR MANAGEMENT
Young children and children with disabilities in particular, often challenge adults in terms of the type and frequency of inappropriate behaviors. Clinicians must carefully examine the dynamics of the situation before assuming the problem is arising solely from the child. This is true in preventing as well as reducing inappropriate behaviors in children with disabilities. Through assessment of the physical environment, including adult behavior, necessary modifications can be made to encourage appropriate and acceptable behavior in children. However, for some children direct intervention in the form of individual behavior modification plans may be necessary to limit disruptive behaviors. Clinicians can assist children in modifying their behaviors through careful planning and ongoing assessment of the plan.

PREVENTING DISRUPTIVE BEHAVIOR
It is important for clinicians to plan and organize the learning environment to encourage positive behavior in children. Considerations in planning should include the length and content of structured groups, the number and structure of transitions, developmental levels of individual children, teacher expectations, and the rules and limits placed on children. Staff flexibility is crucial in preventing and eliminating behavior problems as they arise. For example, children who have difficulty sitting and
attending during group activities may be communicating to adults that the activity is too long or inappropriate to their developmental level. Clinicians who are sensitive to these warning signs can make the necessary changes and modifications either by ending the activity or increasing opportunities for participation of the children. Clinicians may sometimes expect children to wait for extended periods of time before activities begin or opportunities for turn-taking are provided. Clinicians can decrease the likelihood of behavioral problems by having materials and activities ready in advance and avoidance of lengthy demonstrations and discussions.

Transitions between activities can also increase the occurrence of disruptive behavior in children. Clinicians should be careful to limit the number of transitions when planning the daily schedule. Allowing children to move naturally to the next activity when they are ready may accomplish this. For example, children can immediately sit down at the snack table after washing their hands versus returning to the group situation and waiting for others to finish. Clinicians can also promote positive behavior in children by establishing and applying rules and limits appropriate to children's individual levels. These rules should be stated in a manner, which is positive and tells children what behavior is expected. For example, by saying "Please walk" as opposed to "No running", children are provided with a positive alternative behavior. Clinicians can also promote positive behavior in children by encouraging expected behaviors through prompts and cues such as "When you put your cup on the table, I can pour you some juice." During play activities, clinicians can model appropriate behaviors such as waiting for a turn and asking children "Can I use the black truck after you're finished playing with it?" or "When you're done it will be my turn."

MODIFYING DISRUPTIVE BEHAVIOR

For some children it may be necessary to develop individual behavior modification plans. However, prior to an attempt to modify disruptive behaviors in individual children, it is important for staff members to meet and develop a behavior modification plan. This will ensure that parents and all staff members manage inappropriate behaviors systematically and consistently. Strategies for modifying disruptive behavior should NEVER be aversive or punishing. Examples of aversive strategies include calling children names, grabbing children by the arm, or putting a hand over children's mouths. Appropriate strategies would include ignoring or redirecting negative behaviors, or removing children from situations for brief periods of time. Behavioral plans should be reviewed and evaluated by parents and staff members on a regular basis to determine if modifications are necessary. Data in the form of baseline measures, anecdotal notes, etc., should be maintained and reviewed by all team members on a regular basis to determine if modifications are necessary.

HOLIDAYS AND SPECIAL OCCASIONS

SPECIAL OCCASIONS

Clinicians need to always remember that the best language learning opportunities are those that are naturally occurring events that seem to capture a child's attention and imagination. Although birthdays and holidays may not be the predominant theme of the week, curriculum modifications need to be made and these special events should be incorporated in the planned classroom activities.
Clinicians need to recognize how important these events are to the child and the important role they play in everyday family life. These present excellent and unique language learning opportunities.

**BIRTHDAYS**

Children should be greeted with a happy birthday and made to feel special from the moment they walk in the door. There are few events in a child’s life that are as significant and anticipated as a magical birthday. Children can be given a birthday crown to be worn all day, choose the job of their choice, and/or sit in a special spot during circles. The parent or care giver can provide a favorite birthday snack and the class can make a group card for the child to treasure as they sign-in for the class that day.

Summer or holiday birthdays can be celebrated on a preselected day closest to the child’s actual birthday. It is the responsibility of the child’s clinician to make sure that this day has been scheduled and accommodated for.

**FACILITATING STRATEGIES FOR INDIVIDUAL AND GROUP NEEDS**

The context for learning must be structured to increase children's opportunities to participate as successfully and independently as possible. The classroom experience provides a context for learning through routines, transitions, high structure activities, and low structure activities. Prior to implementing instruction, it is important for the clinician to assess the environment to determine what activities would be appropriate for learning and what objectives will be targeted for individual children within the chosen activities. Next, the clinician must decide how to structure the activity by arranging the environment and providing the necessary levels of cues and prompts (i.e., specific intervention strategies) to ensure children will participate to the fullest extent possible.

**ENVIRONMENTAL ARRANGEMENTS**

Before implementing activities, clinicians must examine what skills individual children need to acquire to increase participation and what changes will be needed in the environment for learning to occur. For example, if the clinician wants children to learn to make requests for food during snack time, providing limited portions will create the need as well as increase opportunities to make requests. For children with disabilities, it is important that they are given multiple opportunities to practice a skill however; these opportunities should be as natural as possible. For example, it is not appropriate to ask a child the same question "What do you want?" 5 times after they have already answered the question when first asked. Nor is it natural for the adult to prompt the child to respond by saying, "Tell me, I want a cookie". Instead, it would be more appropriate to employ the sabotage strategy of limiting portions of food and then modeling "Cookie, you want a cookie?" when the child reaches out his hand. By employing this teaching sequence numerous times, opportunities are increased for the adult to model the target phrase as well as for children to make attempts at communicating.
INDIVIDUALIZED GROUP INSTRUCTION

The use of individualized group instruction is necessary in order to address the varying range of individual needs, levels, and interests of children during group activities in the inclusive setting. Although clinicians are able to facilitate learning in typical children during group activities with less preparation, specific modifications based on individual children's levels will be necessary to facilitate participation in children with disabilities. When planning group activities the clinician must first structure the activity by establishing a regular routine for the children to follow such as first singing a greeting song and then allowing a child to choose a song for the group to sing. Next, the clinician must decide children's individual goals within the components of the routine. It will also be necessary to determine the level of prompts and cues necessary to facilitate participation and learning of individual objectives. For example, some children's goals will be to imitate a sequence of motor movements when given partial physical assistance during a music and movement activity. Other children's goals may be to take a turn telling others what to do when provided with a choice modeled by the clinician such as "Do you want us to clap hands or turn around?" During group activities, clinicians must make sure the necessary modifications are made to ensure that all children are either active or partial participants with very little "down" time. All children with communication impairments should have a designated form of communication (i.e., sign language, picture board, or augmentative communication device), which is used to interact with others. For children with sensory impairments such as a visual or hearing impairment, it may be necessary to modify how directions or instructions are given and make adaptations in materials and task requirements.

ROUTINES

The use of routines such as arriving and departing class, clean-up, etc. occur in the classroom quite frequently and allow opportunities for teaching independence and many other skills (i.e., communication, social, motor, etc.). When children arrive at school for example, the clinician can either take their jackets off, put them away, and hang up their backpacks or allow children to participate at whatever level they are able. For some children, the principle of partial participation will need to be applied. For example, children with physical disabilities may be able to independently request assistance in taking off their jacket however, it may be necessary for the teacher to assist in the motor portion of the routine.

TRANSITIONS

Transitions involve completing an activity, moving to the next activity, and starting the new one. Transitions occur between structured and unstructured activities such as circle time and walking to the bathroom, between unstructured times and structured times such as washing hands and snack time, or between unstructured activities such as moving from one interest area to another during freepay. It is important for children to learn to transition as independently and quickly as possible. Transitions are difficult for some children because they do not readily adapt to changes. By providing natural cues and prompts, clinicians can guide children in moving between activities in increasingly independent ways. For example, the clinician might cue children by saying, "First we're going to sing a song, and then we will go outside". Providing children with a warning allows them
to prepare for change. Using songs to focus children's attention also helps to ease transitions. For example, the teacher can tell the children that in five minutes it will be time to clean up. Then she can ask the light helper to flick the lights as the clean up helper carries around a pictorial cue for his peers. When it is actually time to change activities, the teacher should lead the children in a transition song such as "It is clean-up time."

HIGH STRUCTURE ACTIVITIES

High structure activities are usually times when clinicians take the lead and direct the activity such as circle time, story time, or small group experiences. Highly structured activities should be designed for learning to occur through activities, which allow children to participate, as much as possible. Clinician reliance on a multitude of directives (e.g. "put it here") and questions (e.g. "What's this?") may have detrimental effects on learning. Learning will be maximized through clinicians' use of more naturalistic conversational techniques. For example, by commenting, "You're stirring the Kool-aid, You're pouring the water, etc." Children learn to make the connection between words and actions, as opposed to when constantly asked, "What are you doing?" During activities, clinicians should encourage creative thinking in children by allowing them to express their ideas. Active participation of children at their individual levels can be accomplished by modifying the activity requirements or using adapted material or devices when necessary. Children with communication impairments for example, may use a communication device in the activity for turn-taking and initiating requests and commands. Children can provide partial physical assistance in manipulating materials such as stirring with a spoon.

LOW STRUCTURE ACTIVITIES

Low structure activities are usually child directed in that children choose what they will do, how they will do it, and how long they will participate. Examples of low structure activities include freeplay in interest areas, outdoor play, and snack. During freeplay it is necessary for staff to make activities available that encourage choice-making, independent interactions with materials, and social interactions among peers. Children should be encouraged to regularly make choices and decisions regarding their play. By having children make a plan prior to freeplay, teachers provide an opportunity for children to verbally express themselves and see themselves as able to act on their own decisions. For children who are unable to communicate effectively, a picture symbol communication board offering choices representing areas of the room, objects, and peers may be utilized to help children make choices either through pointing or using single words or phrases. By arranging and equipping the physical environment within an organized framework, children are able to develop independence in choosing, obtaining and returning materials. Once they are engaged in an activity, the teacher can follow their lead and take advantage of opportunities to facilitate learning through the use of naturalistic teaching strategies such as modeling.

Child-initiated play activities do not always provide multiple opportunities for practicing skills and it may be necessary for the clinician to structure the environment to allow for practice. For example, if children are putting on clothes in the housekeeping area, the clinician may encourage the idea of going to the store and trying on different clothes. This will allow the clinician to provide multiple
opportunities for children to practice dressing skills. The clinician by participating in the activity, can model appropriate language, social, and self-help skills. Social interaction skills among children can also be encouraged during freeplay activities through the use of group activities such as art projects or playing house in the dramatic play area. For example, during an art project the clinician can limit materials to encourage children to take turns, make requests for sharing, and respond to others requests for obtaining materials. While playing house, clinicians can use prompts and cues to encourage interactions with peers. Upon observing a child cooking food on the pretend stove, the clinician might prompt the child by saying, "Mm that looks good. Who is going to eat it or Let's have Joseph taste it." Through the use of frequent cues and prompts, the clinicians can help expand and maintain the interaction.

**SPECIFIC LANGUAGE INTERVENTION STRATEGIES**

The natural, nurturing environment at ICRP, with the application of specific strategies, will enhance language and communication skills. These strategies are based on the functional need of the child to communicate. This need to communicate gives him/her control over the environment. Such naturalistic needs can be created through arranging the environment to create a need to communicate and then applying an appropriate language facilitation strategy. Appropriateness of the strategy is determined by the context and individual child skills. At all times care should be taken to provide exciting and fun opportunities for using communication skills while avoiding extensive drill and unnatural conversational requests. Specific intervention strategies that may be selected for facilitation of communication and language skills are detailed below. It is important to note, that often the best intervention includes a combination of strategies and many of the following strategies may naturally occur or co-occur with each other. The important naturalistic teaching strategies are described below. Specific examples of these strategies used within the classroom activities can be found in [Appendix E](#).

1. **Creating Opportunities for Communication (through environmental arrangements)**: The goal is to engineer the environment so as to create a need for the child to communicate or to attempt a new skill. These procedures must appear natural to the child, with no suggestion that the adult is being negative or withholding. Specific strategies may include:

   A. **Violation of Routine Events**: A familiar and/or necessary step is omitted or performed incorrectly.

   B. **Withholding Objects and Turns**: Most activities require the use of several materials, and many require turn taking. Withholding an object or turn (in an apparent oversight) is effective in stimulating children to initiate language to gain attention, request an object, or code intention or state.

   C. **Violation of Object Function or Object Manipulation**: When children are familiar with action schemes for specific objects or object roles that compose routine events, the clinician may intentionally violate these routines to stimulate children to initiate directives and make protests.

   D. **Hiding Objects**: This is useful in facilitating use of question forms and coding negation.
2. **Providing Choices:** This strategy provides the child with options of objects or activities from which to select. By giving a child choices during play activities the adult provides natural opportunities for communication. Very young children can make choices between toys or snack items by simply reaching and looking at the object that they want. Older children can be given choices of materials, activities, or even playmates.

3. **Interactive Modeling:** With this strategy, the adult demonstrates the word or words necessary for the child to communicate within the context of typical ongoing activities. For example, if a child attempts to take a toy that another child has, the adult might say "Ask Susan if you can play too." As a further example, if a child is looking at and reaching for a ball that is out of reach, the adult would say "Ball. You want the ball" and then hand the child the ball. It is important to note that with modeling strategies the adult DOES NOT REQUIRE THE CHILD TO IMITATE THE MODELED UTTERANCE. Modeling is one of the simplest and most effective intervention strategies when the model is provided at the exact moment a child is focusing his/her attention on the object or event.

Techniques closely related to modeling are focused stimulation, modeling with expansion, and modeling with recast. **Focused Stimulation** occurs when the adult talks about what the child is doing, while she/he is doing it. **Modeling with expansion** occurs when the adult adds more information to the words the child is already using (for example, when the child says "car" the adult might expand by saying "yeah, a red car."). **Modeling with recast** includes repeating the child's utterances but changing some semantic, syntactic or morphological element of that utterance.

4. **Vertical Structuring:** With this strategy the clinician attempts to provide the structure necessary for the child to produce a specific language form. There are several components involved in vertical structuring including expanding the child's utterance, asking questions to elicit more information from the child, and modeling more complex language structures for the child to produce. Through adult responses to the child's utterances, a “structure” is built for the child to use a particular language form. Vertical structuring is typically used when you are trying to teach a child a specific language form.

5. **Scaffolding:** This is a strategy in which the teacher provides a bridge between what the child can and cannot do by providing the necessary prompts or cues. Through the use of modeling and prompting at a level slightly higher than the child's, the adult enables the child to perform more independently at higher levels. For example, when reading "The Three Little Pigs" to the child, the adult might prompt the child with questions such as "Uh-oh, it's the wolf again. What do you think he's going to do?" For scaffolding to be effective, the teacher must be aware of the child's abilities in order to provide appropriate prompts and cues. Scaffolding can also be used to facilitate self-help skills such as placing a cup on the table after drinking. By providing a visual cue such as the lid of a small container secured to the table, the child is directed to place the cup on the lid as opposed to dropping or throwing
the cup on the table.

6. **Milieu Teaching Techniques:** These techniques include several strategies that can be used during functional activities to facilitate communication and language. Mutual focus is first established with the child and then one of the following teaching techniques is used to encourage communicative or language behavior. **Mand modeling** includes providing a model of the target production and a conversational prompt for the child to produce the model (e.g., “Ball. Can you say ball?”). **Time delay** is used by creating a situation for communication and then instead of requesting communicative behavior, the clinician remains physically available and waits expectantly for the child's response. Finally, **incidental teaching** combines questions with prompts and models to expand a child's communicative behavior (e.g., “More. More what Jim? More bubbles?”).
ICRP PROCEDURES AND REQUIREMENTS

ARRIVAL AND DEPARTURE

Children should be signed in and out of each class by a parent or guardian. You must know the person the child is leaving with and their relationship to the child, if not, ask for identification. There is a list of approved transporters in each child's permanent file (located in the main office).

CLEAN UP

1. Make sure that the children wash their hands and face before and after snack. This is your opportunity to include self-help skills (e.g., toileting).
2. Clean the room as you go along; you can encourage the children to help during transition periods, especially those children who need to learn to complete tasks.
3. Make sure that towels are placed in the washing machine located in the kitchen. Do not hang them to dry in the classroom. Please help with the laundry by starting the washer, moving clothes to the dryer, folding clothes, and distributing items to the classroom as needed. Collect all toys/materials that have been mouthed during the class period and spray with disinfectant.
4. Fuzzy toys are not allowed in the classroom (with the exception of the puppets located in the cupboard). Soft toys should be washed in the washing machine on a gentle cycle.
5. Please adhere to the rules posted for proper hand washing and diaper changing.
6. Please give the children their art projects to take home. Do not store them for long periods of time in the classroom. Remember, several groups are using the same space. Throw out leftover paint and play dough (homemade; no commercial allowed).
7. Any used food products left uncovered in the refrigerator will be thrown out along with its container - BEWARE!

The classroom should be cleaned at the end of every class session. The room is considered clean when the following items are completed:

Dishes are washed, dried and put away.
Placemats are disinfected.
The floor is swept and mopped as needed.
The carpet is vacuumed as needed.
The tables and chairs are wiped down.
Dirty diapers are thrown away outside the building.
The toys are disinfected and stored.
The bathroom and classroom sinks are wiped down.
You have collected all of your personal belongings.
FIELD TRIPS

In order to take the learning experience beyond the classroom, field trips may be planned by the ICRP staff once or twice during the semester. The following are guidelines for ICRP field trips:

1. Send out announcements-make sure those parents who do not always transport their children are informed. In other words, give an extra copy to the parent who is doing the car pooling.
2. You must obtain signed permission for each field trip. A general permission is included on the case history form, but signed permission forms are necessary from every child for each individual outing.
3. Ask parents to volunteer for car-pooling.
4. Pre-payment is advisable.
5. Stickers with the ICRP phone number, but not the child's name, should be placed on the child. Nametags can be provided for adults.
6. Keep an eye on all the children not just the ones you have been assigned.

VOLUNTEERS AND OBSERVERS

Volunteers may be working in your classroom. They are there to assist you and under no circumstances should they be given primary responsibility for the children assigned to you. Additionally, other students may be completing observation and/or class projects at the ICRP. At times you may be asked to provide information regarding exactly why you are doing what has been observed. Please do not feel threatened by these requests - you are simply assisting others in the learning process.

CLASS ALLOWANCE

Each classroom is given a $50.00 allowance per month for special purchases needed to implement classroom activities. You will be reimbursed for any classroom purchases when you turn in your receipts to Kathie Smith from this $50.00 base amount. Only $50.00 a month will be available. Please budget accordingly. Receipts are required for reimbursement. You must gain approval for your special items before you purchase them. Specific weekly supply requests can be submitted to Kathie on Friday afternoon for purchase for the following week. Some basic supplies and snacks are available on the snack shelves in the ICRP kitchen.

TEAM MEETINGS

ICRP team members meet weekly as scheduled by your supervisor. Clinicians and supervisors are expected to attend. You will be given a schedule of topics for these meetings at the beginning of the semester. As part of these meetings, clinicians are expected to present at least one case study on the children assigned to them. Individual groups will convene with their respective supervisor to develop plans for the next week and to answer any questions specific to their classroom.
DIAGNOSTIC ASSESSMENTS

As part of your clinical practicum in the ICRP you will participate in one or two diagnostic evaluations. These diagnostic assessments are completed when families contact the ICRP with concerns regarding their child’s speech and language development. The evaluations are typically scheduled on Friday mornings. You, and a fellow student, will meet with a clinical supervisor to plan the assessment. Once the diagnostic evaluation is completed, you will score the tests and write up the test results within a week of the scheduled assessment.

SUPERVISION PAPERWORK AND REPORTING REQUIREMENTS

Examples of the forms you will need to complete paperwork are in the various appendices. Additional forms are located in the stack boxes located in the clinic resource room. The clinician computer disk contains these forms as well.

CONFIDENTIALITY/ HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA)

A complete description of the policies and procedures to insure confidentiality of client is included in Appendix F and will be signed by new clinicians each semester. All paperwork and report writing can be completed on the computers provided at the ICRP. Names of children and identifying information (e.g., birthdates, names of parents, addresses etc.) can never be used outside the ICRP. This information must be omitted and codes used for the child’s name (i.e., the first letter of the child’s first name and the first three letters of their last name) when e-mailing reports to your supervisor or completing work off site.

INDIVIDUALIZED FAMILY SERVICES PLAN (IFSP)

(See Appendix G)

This document is completed on all children under three years of age that are being served through the Arizona Early Intervention Program (AzEIP) and must be completed within thirty (30) days of the initial referral. The information for these forms is completed with the families and based on the family’s observations, concerns and needs. Under no circumstances are you to assume that you know more about the child than the parents. A child should have only one IFSP; if the child is receiving services elsewhere and has a current IFSP, any new desired outcomes (i.e., goals and objectives) need to be added to that current IFSP. IFSP must be updated at least every six months. When completing these forms, please make sure that they are complete--complete means complete. You will be graded on your completeness. Do not - repeat - do not use white out to correct your mistakes. This practice is against the law! Instead draw a single line through your mistake and initial it, then write your correction; e.g. Brown Brown.)
TODDLER INTERVENTION PLANS (TIP)

This document is completed with the family of all children participating in the toddler playgroup that are not receiving services through AzEIP. The TIP identifies the family’s goals and objectives for their child during the semester and how those outcomes will be achieved. This document is written within the first 30 days, based on assessment completed with the family and is updated at the beginning of each semester.

PRESCHOOL INTERVENTION PLANS (PIP)

This document is completed for all children receiving services in the preschool program. The child’s strengths and needs are identified with the families and goals and objectives are written. This document is completed within the first 30 days of the initial referral and updated at the beginning of each new semester.

IFSP/TIP/PIPs are written, in accordance with the parents, to aid you, as a team, in meeting the developmental and educational needs of your client. These goals, objectives, and activities should be written in a functional manner and be developmentally appropriate. Goals and objectives specify who, will do what, in what condition, until what conditions. For example:

1. Daniel will interact with family and friends to make requests and comments.

During daily routines (snack, centers, clean up) Daniel will use gestures and vocalizations to make requests for his favorite toys, cars, bubbles crackers, juice, etc. with his mother, sister, his friend Sue, and his teacher, at least twice during each activity for two weeks. A withholding strategy will be used to facilitate this objective.

2. Daniel will increase joint attention and turn-taking while playing with friends.

While interacting with the clinician and family members on a daily basis, Daniel will respond appropriately with smiles, laughs, and eye gaze until he is able to maintain social exchange for several turns each day of the week.

3. Daniel will correctly produce speech sounds that require lip closure /m, p, b/ in words and phrases.

During circle and center-based play, Daniel will be given placement cues to produce speech sounds that require lip closure, e.g., /m, p, b/. This will continue until he produces these sounds correctly daily during three activities for one month.
4. Daniel will increase oral-motor control to facilitate feeding.

When given easily dissolving foods (e.g., graham and arrowroot crackers), Daniel will close lips, munch, and swallow, resulting in no loss of food during snack, daily for a week. (Adapted from Juliann Crape, Developmentally Appropriate Goals and Objectives, 1997).

Guidelines to help you write functional goals are included in Appendix H. Use the IFSP/TIP/PIP goals and objectives when you write your lesson plans. Have any questions? Ask your supervisor.

**LESSON PLANS**

**Classroom lesson plans** are completed each week by the classroom team. Weekly lesson plan forms for each class are in Appendix I. There are numerous and excellent resources to help you develop these plans. These books are located in the clinic resource room. A copy of your plan should also be placed in the observation room for parents to view. Please collect it at the end of the session. Do not place any of the children's names on this copy.

**Lesson plans for each individual child** are completed to plan how the IFSP/TIP/PIP objectives will be addressed within the activities planned for that week (see forms Appendix I). Before class you should complete the following sections of the lesson plan: objectives from the IFSP/TIP/PIP; environmental context; materials or equipment; strategy; and expected outcome. At the end of each class, the actual outcomes and proposed modification sections of the lesson plans are completed. This then becomes your record of therapy. Your supervisor will indicate when lesson plans are due.

**DATA COLLECTION**

You are required to collect objective data on intervention objectives for each child. Consult with your supervisor to devise appropriate data collection methods. Since it is difficult to obtain data while interacting with young children, you are encouraged to record child behavior on strips of masking tape placed on your leg. This data can be transferred to the child’s lesson plan after class. Undergraduate clinician assistants can be very useful in collecting daily data, however, it is your responsibility to let these students know what data to collect. In addition, it is helpful for clinicians to share information/data on the children immediately following class.

**WEEKLY SUMMARIES**

Weekly Summaries (See Appendix J) are written from daily notes recorded on the child’s lesson plan and data collected each week. The original summary is placed in the child's work file. A copy should be made and given to the child's parent no later than the next class meeting.

**FORMAL STANDARDIZED ASSESSMENT**

Formal assessments of each child's communication and developmental skills may be completed during the first semester that the child is enrolled in one of the Infant Child Research Programs. The
results of the testing are summarized and a written report is given to the parents (see Appendix K for examples). The original report of test results is filed in the child’s permanent file; copies are made for the parents.

The tests that are administered most often to toddlers include the Reynell Developmental Language Scales (RDLS), the Battelle Developmental Inventory (BDI), and the Communication and Symbolic Behavior Scales (CSBS). In addition, the MacArthur Communicative Development Inventory (CDI) and Ages and Stages Questionnaire (ASQ) are assessments based on parental report and are used regularly with toddlers. The tests that are administered most often to preschoolers include the Preschool Language Scale-4 or the Clinical Evaluation of Language Fundamentals - Preschool; the Developmental Profile for Infants and Young Children; and the Assessment of Phonological Processes. Copies of these tests are located in the clinic resource room and may, on occasion, be signed out overnight in order to practice administration of the tests. You will typically accrue three clinical hours for each child assessed.

**LANGUAGE SAMPLE ANALYSIS AND SUMMARY**

In addition to this annual standardized testing, a sample of each child's language/communication may be collected and analyzed if appropriate. This is typically done at the beginning and/or end of each semester. Please refer to the table below as to when the samples are collected. The child will be videotaped here in the classroom or at home while playing with family members, you, or with friends. His/her language is then transcribed and analyzed to provide a description of the child's speech, language and communication skills. A written summary of the language sample analysis is included as part of the standardized assessment report or as part of the end of the semester progress report. The videotape of the interaction used for the language sample should be recorded on the child’s index card and placed on the ICRP shelf in the data lab. You will typically acquire three clinical clock hours during completion of a language or communication sample, analysis and summary.

**LANGUAGE COMMUNICATION SAMPLE SCHEDULE**

<table>
<thead>
<tr>
<th>When should we collect it?</th>
<th>Where should it be collected?</th>
<th>How should it be transcribed?</th>
<th>What will this information be used for?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beginning of Fall</strong></td>
<td>home/ICRP individual setting (usually at home visit)</td>
<td>from videotape or audiotape</td>
<td>To plan goals and objectives for implementation</td>
</tr>
<tr>
<td>(end of August through beginning of September)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>End of Fall</strong></td>
<td>ICRP group setting</td>
<td>on-line*</td>
<td>To evaluate the child's progress on semester goals/objectives</td>
</tr>
<tr>
<td>(end of November through the beginning of December)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Beginning of Spring</strong></td>
<td>home/ICRP individual</td>
<td>from videotape or</td>
<td>To plan goals and</td>
</tr>
<tr>
<td></td>
<td>setting</td>
<td>audiotape</td>
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</tbody>
</table>
A progress report is written at the end of each semester to summarize the initial status of your client, and the goals, objectives and progress on each of these objectives. In addition, recommendations are made for the future intervention.

**GENERAL GUIDELINES**

1. Reports must be written at the ICRP. Any draft of a report that is worked on outside of the ICRP can NOT include any personal identifying information on the child or their family. Computers are available for your use in the resource room. The file progress.rpt contains the set up for progress reports.
2. Please adhere to correct spelling and punctuation.
3. Please double-space your drafts. The bottom margin on the first page, i.e., letterhead, should be set at 1.5”.
4. Final, approved progress reports are printed on letterhead.
5. The original copy is filed in the child’s permanent file. Make a copy for the parents and the child’s working file.

**FORMAT FOR THE PROGRESS REPORT**

**Header**: There is a standard header used that provides identifying information such as the child's name, birthdate, parents name, address, phone, and date of the progress report.

Background Information in the first paragraph state:

- The child’s age
- The class attended
- The purpose of the class
- The length of the class
- The number of sessions the child has attended this semester
- A brief summary of child’s background describing why the child is enrolled in this ICRP
class including any medical diagnosis.
- The general focus/goals for the child

**GOALS, OBJECTIVES AND PROGRESS**

- State goals and objectives in a developmentally appropriate manner.
- Write the progress for each objective after the objective
- Report all information in the past tense.
- Report information in behavioral terms, for example, “did/did not” rather than “could/could not”.
- Justify your rationale for remediation by providing baseline information for each targeted behavior/skill. The results of diagnostic testing or language samples can be used for this purpose. In addition, it helps those reading the report to accurately assess the child’s progress.
- State what the child did and under what conditions (strategies that worked, was criterion met?).
- State what the child did not do (types of errors and strategies that did not work).
- State whether the goal and or objective should be continued and how it should be expanded.

**SUMMARY AND RECOMMENDATIONS**

State the appropriate disposition of the child’s therapy:

- Short sentence regarding child's general progress and performance in class
- Continuation at ICRP
- Staying in the same class, moving to another class or phonological group
- Recommended goals for development
- If termination is recommended give your rationale
- Give referral sources if appropriate
- End by stating what a pleasure it was to work with the child
- End your report by giving ICRP's telephone number: (480) 965-9396

**Signature Block**

Sylvia Hancock, B. S.  Abbey Grace, M.A., CCC-SLP  
Student Clinician  Clinical Associate Professor/Speech Language Pathologist  
AZ SLP# 1111

Examples and instructions for writing progress reports are included in Appendix K.
FILES

Each child has a permanent file and a binder. The main permanent files are located in the administrative assistant's office and contain case history information, original copies of IFSP/TIP/PIPs, reports and test protocols. Children have a binder located beside their permanent file or in the locked classroom cupboard. They are to be kept organized and up-to-date. The binder contains the following information:

- Home visit reports
- Lesson Plans
- Weekly Summaries
- Data collection
- Miscellaneous

COMPUTER FILES

The format for some of the forms and reports are contained in Microsoft Word files for your convenience. Listed below are the files that you may want to use:

Toddler Intervention Plan contains the format for writing the TIP.

Preschool Intervention Plan contains the format for the PIP.

Preschool Assessment Report contains the format for reporting test results for standardized tests administered to preschool aged children.

Toddler Assessment Report contains the format for reporting assessment results for toddlers.

Preschool Weekly Class Plan is the weekly class lesson plan form for the Preschool class.

Toddler Playgroup Plan is the weekly class lesson plan form for the toddler classes.

Individual Lesson Plan contains the form for each child’s individual lesson plan.

Individual Lesson Plan Short Form contains a form for writing an individual lesson plan that your supervisor may have you use later in the semester.

Weekly Summary is the weekly summary form for toddlers and preschoolers.

Preschool Progress Report contains the format for reporting progress made by preschool children.

Toddler Progress Report contains the format for reporting progress made by children in the toddler playgroups.
Note: Hard copies of blank IFSP forms (for children served through AzEIP) are located beneath the graduate student mailboxes.
APPENDIX A: JOURNALING

JOURNALING

Student journaling is a tool that has been adopted by many as a mechanism for facilitating a mentorship–based supervisory relationship. The practice of keeping a journal has long been recognized as a method for exploring one’s own identity beliefs, and feeling. These factors have a powerful influence on the decision-making process both in personal and professional arenas. Journaling may aid the supervisory process by creating a shared vision between the supervisor and the supervisee–partners in the decision-making process (Brown, Hebert-Remson, Budzysky, 1997).

Therefore you are required to keep a journal for this practica. You may use the format given to you or use your own format. However, the information should be substantive. That is, a chronology of therapy is not acceptable. Instead, reflect on what happened and attempt to discern the meaning behind what you are feeling. Attempt to relate these insights to other segments of life experiences.

We have found that a loose-leaf notebook paper is best for this purpose. You can continue to write to your journal entries while your supervisor is the process of evaluating those entries submitted for assessment. Please turn journal in for review on a bi-weekly basis. If you experience difficulty with this task, do not abandon it. Stick with it; work your way through it until you are comfortable. In the long run you find this to be an invaluable experience.

THE PRACTICA JOURNAL FORMAT

The clinical journal will give you the opportunity to learn how your practica experiences relate to your life using four different perspectives. In essence, you will be asked to view the same situation four different ways: Outer experience, reflections, and generalizations (objective experience), inner experience, reflections, and generalizations (subjective experience). And finally, you will be asked to include a section on personal and professional growth development. This section should show the relationship between your experiences and your mission statement.

I. Outer Experience

Use this section to briefly record your daily experiences at your practica site. If one particular experience stands out, simply state it in an objective manner. The experience should be clear, concise and nonjudgmental you will use this experience for reflection and generalization in section two. Asking questions such as: “Whom,” “What,” and “Where?” should help you write this section. Finally, question yourself about the honesty of your perspective.

II. Reflection and Generalizations (objective experience)
This section will help you to get beneath the superficial to the meaning behind the experience. Attempt to view the situation from different levels: individual, group, and organizational. How do these different levels inform your knowledge of the teaming process?

III. Inner Experience (subjective)

In this section of the journal you are expected to be subjective. Relate how the experience affected you emotionally, physically, intellectually, and spiritually. Use emotive words such as pleasure, pain, anger, and joy. In other words, how did the experience make you feel?

IV. Reflection and Generalization (subjective experience)

In this section subjectively record any significance this experience has on your life. What outside sources can you use to understand the experience? Can you relate it to any works of art, music or literature? If you can, include them here.

V. Personal Growth

Record your current stage of personal/professional growth and development in this section. You do not need to record in this section daily, but at least once a month. (Adapted from Denhardt, 1993)


APPENDIX B: GRADING

The following criteria will be used to determine your grade of “pass” or “fail.” Please use it as a reference as the semester progresses, and please feel free to ask questions about how you are being graded. You find valuable information on how terms are defined in this section, so please read it carefully.

You will be graded in three areas: clinical skills, interpersonal and professional management skills. Observations will be conducted on four separate occasions to assess your level of clinical skills and four times (monthly) on your interpersonal and professional management skills. Sometimes, pre- and post-data will be gathered to assess your interactional style in the classroom via videotape or you may be asked to rate your performance independent of the supervisor’s rating. This assessment is not graded, but serves as a diagnostic tool.

CRITERIA FOR “PASSING”

1. Obtain a numerical rating of seventeen (17) or above on four (4) clinical observations.
2. Obtain an overall rating of three (3) or above on the interpersonal rating scale.
3. Obtain an overall rating of three (3) or above on the professional management skills scale.

Scores below this indicate a grade of “Fail.”

Should you earn a failing grade the following policies will apply:

1. You are required to repeat the practica at ICRP. If you were enrolled in the Toddler Group, you are required to repeat the practica in the Preschool Classroom. If you were enrolled in the Preschool Classroom, you are required to repeat the practica in the Toddler Group.
2. Your clinical hours will not be signed until you complete the second rotation.
OBSERVATION FORM: PRACTICA

Student _____________________________ Clinical Faculty____________________________

Date ___________________ Setting ______________________ Observation_______________

<p>| | | |</p>
<table>
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<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
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</table>

Unsatisfactory    Emerging Skill  Well developed skill
(Note: if a given parameter is not appropriate to rate, given the observation context, use NA.)

_____ 1. Interactions with children are both genuine and warm
_____ 2. Builds upon naturally occurring events as opportunities for facilitating communication.
_____ 3. Is able to create a functional need for communication during structured activities
_____ 4. Appropriately responds to and expands the child’s (or children’s) communicative behaviors
_____ 5. Provides appropriate models of desired behavioral responses (linguistic and interactive) during interactions with the child (or children)
_____ 6. Effective use of intervention strategies (e.g., mands, modeling, prompts/cues, scaffolding, creating opportunities for communication)
_____ 7. Is able to modify intervention to facilitate the child’s (or children’s) success
_____ 8. Designs activities that are appropriate to the child’s or (children’s) goal (s) age and abilities
_____ 9. The activity/session is designed and implemented in such a manner that the child (children) experience functional uses and success with the targeted response (s)
_____10. Facilitates interaction among children
_____11. Accurately records and summarizes data

___ Overall Rating

Comments:
**INTERPERSONAL RATING SCALE**

<table>
<thead>
<tr>
<th>Date of Observation</th>
<th>Overall Rating</th>
</tr>
</thead>
</table>

| 1. Shows genuine warmth and affection toward children |
| 2. Shows concern for families and their children |
| 3. Ability to relate to family |
| 4. Ability to relate to peers |
| 5. Ability to relate to supervisor |
| 6. Relates well to other team members |
| 7. Expresses ideas and feelings constructively |
| 8. Exhibits appropriate nonverbal communication |
| 9. Use of silence, observation, understanding, and listening (SOUL) when communicating with families and team members |
| 10. Oral communication |
| 11. Flexibility |
| 12. Demonstrates healthy boundaries when interacting with families and team members |

**Grading Scale**

5-Exemplary performance  
4-Well developed skills  
3-Skills demonstrated, but inconsistent  
2-Emerging skills  
1-Unauthorized performance

Overall Rating__________

**Comments:**
### PROFESSIONAL MANAGEMENT SCALE

<table>
<thead>
<tr>
<th>Date of Observation</th>
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</thead>
<tbody>
<tr>
<td>1. Personal appearance</td>
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<tr>
<td>2. Attendance</td>
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<tr>
<td>3. Punctuality</td>
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<td>4. Adherence to deadlines</td>
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<tr>
<td>5. Initiative and interdependence</td>
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<tr>
<td>6. Planning, preparation and problem solving</td>
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<td>7. Organizational skills</td>
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<td>8. Integration of academics</td>
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<tr>
<td>9. Quality of IFSP/PIP</td>
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<tr>
<td>10. Individual lesson plan</td>
<td></td>
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<tr>
<td>11. Weekly summaries (update)</td>
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<tr>
<td>12. Progress notes</td>
<td></td>
<td></td>
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<tr>
<td>13. Data management (writing, accuracy and, analysis)</td>
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<tr>
<td>14. Confidentiality</td>
<td></td>
<td></td>
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<tr>
<td>15. Classroom management</td>
<td></td>
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<tr>
<td>16. Behavior management</td>
<td></td>
<td></td>
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<tr>
<td>17. Cleanliness and appearance of classroom</td>
<td></td>
<td></td>
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<tr>
<td>18. Response to supervision</td>
<td></td>
<td></td>
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<tr>
<td>19. Staff meeting participation</td>
<td></td>
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<tr>
<td>20. Home visit preparation and facilitation</td>
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</tbody>
</table>

5-Exemplary performance  
4-Well developed skills  
3-Skills demonstrated, but inconsistent  
2-Emerging skills  
1- Unsatisfactory performance

Overall Rating_________________
<table>
<thead>
<tr>
<th>Target Behavior</th>
<th>3 Well developed skill</th>
<th>2 Emerging Skill</th>
<th>1 Unsatisfactory skill</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Interactions with child (ren) are both genuine and warm</td>
<td>Shows warmth and genuine affection for the child (ren); is self-confident; has good eye contact; has fun; and talks to the children-not at or about them; appears relaxed</td>
<td>Enjoys the children but is visibly uncomfortable with them; has infrequent eye contact; interactions; appears uncomfortable; does not know how to handle negative interactions</td>
<td>Seldom interacts with the children, and does not appear interested in them; shows more interest in the execution of activities</td>
</tr>
<tr>
<td>2. Builds upon naturally occurring events as opportunities for facilitating communication</td>
<td>Consistently follows the child’s lead and utilizes it to facilitate communication; sees the need for balance between teacher vs. child initiated activities and implements them</td>
<td>Follows the child’s lead inconsistently and has the tendency to make choices for the children</td>
<td>Makes decisions and choices for the children</td>
</tr>
<tr>
<td>3. Is able to create a functional need for communication during structured activities</td>
<td>Is consistently observed creating opportunities for communication during circle time and snack regardless of the child’s level of functioning</td>
<td>Is aware of the need to create opportunities for communication during structured activities, but only includes children who are verbal communicators and ignores or excludes nonverbal or movement disordered children</td>
<td>Makes no attempt to create opportunities for communication during structured activities</td>
</tr>
<tr>
<td>4. Appropriately responds to and expands the child’s (or children’s) communicative behaviors</td>
<td>Consistently and immediately responds to any communicative attempt with appropriate acknowledgment and expansion</td>
<td>Understands the importance of responding to the children’s communicative attempts, but often fails to do so immediately or appropriately</td>
<td>Seldom responds to the children’s communicative attempts; therefore, the child’s attempts go unrewarded</td>
</tr>
<tr>
<td>Target Behavior</td>
<td>3 Well developed skill</td>
<td>2 Emerging Skill</td>
<td>1 Unsatisfactory skill</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
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<td>-------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5. Provides appropriate models of desired behavioral responses (linguistic and interactive) during interactions with the child (or children)</td>
<td>Consistently models speech and language, by using appropriate semantic, lexical, syntactic, and pragmatic models during interactions</td>
<td>Acknowledges that a model is necessary, but often the attempt fails because of inappropriate language and behavioral responses</td>
<td>Fails to model desired behavioral responses unless reminded to do so by others</td>
</tr>
<tr>
<td>6. Effective use if intervention strategies (e.g., mands, modeling, prompts/cues, scaffolding, and creating opportunities for communication)</td>
<td>Consistently and effectively uses a variety of intervention strategies during structured and free play activities</td>
<td>Primarily uses modeling and mands as intervention strategies; and has to be reminded to use other techniques</td>
<td>Seldom uses intervention strategies; relies heavily on mands</td>
</tr>
<tr>
<td>7. Is able to modify intervention strategies to facilitate the child’s success</td>
<td>Is flexible and knows the appropriate time to attempt different strategies; offers alternative strategies for consideration with particular children</td>
<td>Is willing and attempts to modify behaviors, but appears uncomfortable when implementing them</td>
<td>When required, will attempt different intervention strategies, but is not successful</td>
</tr>
<tr>
<td>8. Designs activities that are appropriate to the child’s or (children’s) goal (s), age, and abilities</td>
<td>Consistently designs activities that are appropriate and functional for all of the children regardless of developmental level; and plans activities that reflect individual goals/objectives on the children’s IFSP/PIP</td>
<td>May need suggestions concerning appropriate activities; may need prompting concerning flexibility and maintaining focus on the children’s goals</td>
<td>Lesson plans are more activity than child-centered, does not regard the children’s stated goals and objectives; shows little flexibility</td>
</tr>
<tr>
<td>Target Behavior</td>
<td>3 Well developed skill</td>
<td>2 Emerging Skill</td>
<td>1 Unsatisfactory skill</td>
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<tr>
<td>9. The activity/session is designed and implemented in such a manner that the child (or children) experience functional use and success with the targeted response(s)</td>
<td>Shows interdependence and initiative in decision making; can spontaneously create functional learning experiences; recognizes the importance of routines and transitions as part of the child’s learning, and implements these activities in an enthusiastic and relaxed manner</td>
<td>Has difficulty making independent decisions and does not always know when to make appropriate use of routines and transitions; is enthusiastic and enjoys the children</td>
<td>Cannot make decisions easily and must be continually encouraged to make decisions to modify inappropriate activities; is clearly more interested in the success of the activity than the children; does not enjoy being with the children and the implementation of activities is; therefore, dull and boring</td>
</tr>
<tr>
<td>10. Facilitates interaction among children</td>
<td>Understands the importance of peer modeling and interactions; independently encourages and redirects children to their peers and is able to create opportunities for such interactions</td>
<td>Understands the importance of peer modeling/interactions but needs encouragement to implement this type of redirection</td>
<td>Seldom designs activities that encourage peer modeling/interactions and does not respond to supervision</td>
</tr>
<tr>
<td>11. Appropriately records and summarizes data</td>
<td>Written assignments are well written, neat, and on time; written information is accurate and critically analyzed</td>
<td>Written assignments are well written and neat, but they may be late and incomplete or inaccurate</td>
<td>Written assignments are not well written, late or incomplete</td>
</tr>
</tbody>
</table>

**OPERATIONAL DEFINITIONS**

It has been our experience that communication between two parties is difficult. In fact, most communicative attempts fail. The purpose of the definitions stated below is a communicative attempt to clarify what is expected of you on the interpersonal and professional management rating scales.
INTERPERSONAL SKILLS

1. Shows Genuine Warmth and Affection Toward Children - The clinician’s interaction with the children should be the foundation of your clinical experience in the classroom. Children are very sensitive and they respond in a positive manner to adults who treat them respectfully. That is, interactions should reflect obvious warmth, caring, and affection. It is readily apparent to their parents and your supervisor when you are not genuinely enjoying the company of children. Some of you may not have had the opportunity to interact with children before now. If that is the case, try to remember the simple things that gave you pleasure as a child. We suggest that you talk to and with the children. Learn to be empathic, that is, take the child’s perspective.

2. Shows Concern for Client/Family - Although clinicians will be working with clients and their families for one semester; they should show interest in the general welfare of the family unit. This is evidenced by calling to the attention of your supervisor factors or stressors that influence the child’s progress in the classroom (e.g., transportation, financial problems, suspected abuse etc.).

3. Ability to Relate to Family - This refers the clinician’s ability to get along with the family. Do you greet parents in a friendly and open manner? Do you ask the appropriate questions about their children upon arrival? Do you relay pertinent information to them upon departure? If you have any concerns or conflicts with parents, please bring them to the attention of your supervisor.

4. Ability to Relate to Peers - Our hope is that clinicians will grow together as a team over the course of the semester. In order to do that, they should establish good working relationships with their peers. At ICRP you can choose to work in one of three ways. The first is independent, which requires a lot of work on your part and results in resentment, burnout, and confusion. Second, you could choose dependency, which results in anger and resentment. The third is interdependency, which results in mutual support. Remember not to do all of the planning, teaching, and cleaning. Likewise, do not neglect to do some of the planning, teaching, and cleaning. When you are supported, say so. When you feel unsupported discuss constructive options with your peers.

5. Ability to Relate to Supervisor - Supervisors are here to assist you in meeting your goal of becoming a competent speech language pathologist or audiologist. Supervisors will treat you in a respectful manner. Therefore, the expectation is that you will treat your supervisors in a respectful manner as evidenced by your attitude toward the practica, for example, punctuality and quality of your work.

6. Relates Well to Other Professionals - Working with other professionals has its advantages and disadvantages. You can gain a wealth of knowledge about the total child and his family from the expertise and perspective of other professionals. Every profession has its turf areas, those areas that they have been trained to perform. Conflict can result if there is a difference of opinion
about these boundaries. In these situations a win-win solution should be pursued. Please remember to get written parent permission before exchanging information about their children.

7. Expresses Ideas and Feelings Constructively - Please feel free to share your ideas and feelings with your peers and supervisor. You are expected to share both positive and negative feelings in a constructive manner. Constructive means giving others the opportunity to respond to your issues. Remember feelings are a barometer of your emotional state. They are not the sum and total of your personality. Eventually, both positive and negative emotions pass.

8. Exhibits Appropriate Nonverbal Communication - Nonverbal communication is the way you communicate using your body and facial expressions. The baseline assessment of your attending behaviors should give you some idea of your skill in this area. Children and their parents view behaviors such as rolling your eyes, pulling on the limbs of children and avoiding physical contact negatively. Be aware that parents are very observant and critical of your performance in the classroom!

9. Silence, Observation, Understanding, and Listening - Silence in this context means giving the child(ren) the opportunity to respond to your stimulus. Although silence can be uncomfortable for us who have command of the language; silence allows children to process the information that they have heard. Observation and Understanding are the opportunity to interact and interpret a child’s communicative intent via her vocalizations or nonverbal behaviors. Take the time to do this. You can gain valuable information from this process. Listening is different from hearing. Listening requires appropriate interpretation, and responses. These responses should reflect both warmth and caring. Remember that children are sensitive as such they laugh, play and cry hard. But most of all, they recall acts of kindness and abuse.

10. Oral Communication -This refers to your diction: articulation, fluency and voice quality. Speak clearly and modulate your volume. Loud voices tend to over stimulate the children while too soft voices command no respect from the children. You will also want to make sure that you can be heard from the observation room.

11. Flexibility - Flexibility is an art. This ability allows you choose when to continue with an activity or discontinue it. No matter how well you have planned an activity something usually does not go as planned. Do not despair. You are at liberty to change your course of action. Do not suffer through confusion and chaos. Change your plan.

12. You are expected to turn in journal entries twice a month. This is an important part of both professional and personal growth, so be diligent.
PROFESSIONAL AND MANAGEMENT SCALE

PROFESSIONALISM

1. Personal Appearance - The setting at ICRP is not as formal as the clinic on the main campus. However, clinicians are expected to dress in a professional manner. Specifically, they are expected to wear clothing that they do not mind getting dirty. Second, skirts and shorts should be long enough to cover the subject when bending over. Blouses and tops should conceal cleavage and nothing should be tight fitting.

2. Adherence to deadlines - Remember the timelines. Turn in reports and paperwork on or before the date due.

3. Attendance - Clinicians are expected to be in the classroom at least thirty minutes before class begins. Clinicians may need to be even earlier if they have an individual session with a client. If you are going to be late or you are ill, please let your supervisor and peers know ahead of time. The academic calendar for the university is followed; therefore, clinicians should not be absent unless they are ill or have an emergency. Functions that you must attend, such as weddings, should be brought to the attention of your supervisor at the beginning of the semester. There are three excused absences per semester.

4. Punctuality - Clinicians are required to be in the classroom at least thirty minutes before class begins and at least thirty to forty-five minutes after class ends for individual sessions and clean-up.

5. Response to supervision - The student accepts praise and constructive feedback.

6. Initiative and interdependence - The student is self-motivated but also has the ability to ask for help when needed from their peers and supervisor.

7. Planning, preparation and problem solving - Clinicians are expected to plan lessons that address the functional needs of their clients. Preparation is evidenced by collecting and having appropriate materials available for each planned activity. In addition, the student is able to solve problems that arise in the classroom after a reasonable amount of time (4-6 weeks).

8. Organizational skills - The student follows the written lesson as closely as possible and maintains a balance between structured and unstructured activities. It is obvious to observers that the clinician has control of the environment.

9. Integration of academics - Knowledge gained from the classroom in speech language pathology/audiology and allied fields can be applied within the context of the classroom, especially those areas that have to do with child psychology and child development (normal and abnormal).
10. Quality of IFSP/PIP - The IFSP/PIP should be a functionally written document that embodies the family’s goals for their child. Please do not use whiteout to correct information on these documents.

11. Individual lesson plans - These plans should be written for each of the clients on a weekly basis. They contain the child’s objectives (from the IFSP/PIP), context(s), materials, proposed strategy, expected outcome, outcome, and comments/planned modifications.

12. Weekly summaries - Are a synopsis of the past week and should be completed and ready to hand out to parents on Monday or Tuesday following class. The original should be filed in the child’s binder.

13. Progress notes - These reports should be written in a clear and concise manner at the end of the semester. These reports may also serve as discharge reports.

14. Data management (writing, accuracy, analysis) - Writing will be graded for its content, style, and grammatical correctness. Equally important is the analysis of the data collected. Do your reports reflect what actually happened in the classroom?

15. Confidentiality - Please guard the anonymity and confidentiality of your clients. This means that you should file information in its proper place after using it. You are not allowed to take files from the premises. This means that working files and test protocols are not at your home or in your car. Finally, clinicians are not at liberty to discuss their clients outside of the context of ICRP.

**MANAGEMENT**

16. Classroom management - It should appear that the lead clinician is in charge of the classroom. The children should be enjoying the planned activities, but they should not be allowed to run rampant in the classroom. In addition, the lead clinician should elicit the advice of his/her peers when in doubt about the merit of continuing or discontinuing an activity.

17. Behavior management - Clinicians should praise appropriate behaviors displayed by the children and should structure the environment in such a manner as to prevent disruptive and oppositional behaviors. When these behaviors do occur, the clinician should have the confidence to apply agreed upon strategies to increase positive behaviors (e.g., sit and watch, and redirection).

18. Cleanliness and appearance of classroom - The classroom should be clean when you leave. A detailed description of a “clean classroom” is discussed in the body of the manual.

19. Response to Supervision - Clinicians are expected to ask questions about anything that concerns them about the operation of the class or any comments made by their supervisor about their
progress. However, clinicians should strive for equality and mature interactions. Maturity is marked by respect for others and precludes tattling and whining. Please discuss your areas of disagreement with your supervisor before coming to unfounded conclusions.

20. Staff Meeting Participation - Clinicians are expected to prepare a brief statement about one of their clients for the staff meeting. They may also ask questions about possible activities and strategies that might be used to facilitate the goals and objectives of their clients.

21. Home visit preparation - Clinicians are responsible for scheduling initial home visits and should be prepared to participate in this meeting by doing video tapping and asking questions about the family’s desires for their child. Subsequent visits are dependent upon the family’s needs. These visits are scheduled throughout the semester with the assistance of your supervisor.
PRACTICA MISSION STATEMENT AND GOAL PLANNING

Student Clinician: _______________________ Class: _______________________
Clinical Faculty: ________________________ Semester: _____________________

Mission Statement:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Practica Goals (list your goals and objectives for yourself at the ICRP this semester – required goals and possible additional objectives are listed on the reverse side)

1. ___________________________________________________________________
2. ___________________________________________________________________
3. ___________________________________________________________________

Please list your strengths and competencies relative to these goals:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please list areas or skills in which you need to improve or need more experience:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

Please describe your practica experiences and the experiences that you have had with children that you feel will help you at the ICRP this semester.

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________
REQUIRED GOALS AND OBJECTIVES

All students will have opportunities to participate in the activities listed below and develop the skills required for those activities.

1. Attend and help facilitate at least one home visit.
2. Plan and implement IFSP/TIP/PIP goals.
3. Plan and implement class and individual lesson plans.
4. Learn how to create opportunities for communication and use language intervention strategies during functional activities.
5. Administer and score standardized assessments of young children’s speech, language and communication, as well as assessments of other developmental domains. Assessments may include: Sequenced Inventory of Communication Development (SICD), Battelle Development Inventory (BDI), Communication and Symbolic Behavior Scale (CSBS), CELF-P, Preschool Language Scale (PLS), MacArthur Communicative Development Inventory (CDI): Assessment of Phonological Processes, Goldman Fristoe Test of Articulation, and others.
6. Collect and analyze at least one spontaneous language sample.
7. Increase interpersonal, critical thinking and self-reflective skills through journaling.
8. Improve writing skills through writing assessment reports, weekly progress notes, and final progress reports.

Additional Optional Objectives

Listed below are areas in which you may be able to gain additional experience during your practica at the ICRP. Please place a check mark next to the area(s) that are of particular interest to you.

____ Augmentative Communication
____ Challenging Behaviors
____ Curriculum Planning and Implementation
____ Drug Exposed Children
____ Family Counseling
____ Infant Mental Health/Temperament
____ Movement Disorders/Sensory Integration
____ Oral Motor/Feeding
____ Pervasive Developmental Disorders (Autism)
____ Phonological Awareness/Phonological Processes
____ Team Building, Interpersonal Skills and Leadership
____ Written Communication Skills
____ Other (please describe)
APPENDIX C: SNACKS

Please note that we refrain from sugared snacks as much as possible!

Ants on a log (celery stuffed with cream cheese with raisins on top)
Crackers with cheese or no-sugar brand peanut butter
Fruit (apples, bananas, oranges, pears, fruit salad)
Yogurt (low sugar or plain with fruit)
Pepperidge Farm goldfish crackers
Popcorn
Raw vegetables (plain with healthy dip)
Whole wheat no salt pretzels or bread sticks
Applesauce
Graham crackers
Rice cakes with no-sugar brand peanut butter
Mild salsa and chips
String Cheese and crackers

Drink Options

Natural fruit juices
Apple juice
Birthdays

Good choices include muffins (for example, carrot, banana) or cupcakes.

Many of our children have dietary restrictions and/or allergies. We will make you aware of these restrictions as they arise.

REMEMBER: HEALTHY SNACKS NEED NOT BE EXPENSIVE
APPENDIX D: HOME VISIT FORMS
CHILD: _________________________________________ PARENTS: ______________________________ DATE: ____________

CLINICIAN: ______________________________________ SUPERVISOR: ___________________________ SEMESTER: ________

1. What is going well for child/family (Strengths)

2. Do you have special concerns or issues that you would like to discuss? (Needs)

3. What important thing (s) would you like to have happen or change for your child or family in the next 6-12 months? (Goals)

4. How would you like ICRP to be involved? (Level of Involvement)

5. Student analysis of the home visit (What should be done?):
Overall goal

State the purpose and plan of the home visit.

Summary

Describe what occurred during the home visit: what concerns were discussed, what behaviors were observed, and what goals or objectives were addressed.

Plan

State the outcome and plans made as a result of this home visit. A copy of this summary is given to the family and the original can be placed in the child’s ICRP file.
### APPENDIX E: INTERVENTION STRATEGIES

**Examples of Specific Intervention Strategies Embedded in Toddler and Preschool Routines**

<table>
<thead>
<tr>
<th>Facilitating Strategies</th>
<th>Event</th>
<th>Goal and Example of Use During a Toddler Routine</th>
<th>Goal and Example of Use in Preschool Classroom</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Creating Opportunities</strong></td>
<td>(Sabotage Strategies - Constable, 1983)</td>
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<tr>
<td>Violating routine events: Omit or incorrectly perform a familiar and/or necessary step in an activity or routine.</td>
<td>Outdoor play</td>
<td>Goal: Grant will use gestures and looks to request objects during play. Implementation: After several turn rolling the ball back and forth, hold the ball and wait for Grant to reach and look to indicate that he wants the ball.</td>
<td>Goal: Shaun will use the target sound /g/ at the beginning of words. Implementation: While pushing Shaun on a swing, catch the swing each time it comes back toward you and hold it. As you hold the swing say “Go” then let go of the swing. After several turns don’t say anything and hold the swing while waiting for Shaun to let you know he wants to keep swinging.</td>
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<tr>
<td>Withholding objects and turns: Most activities require the use of several materials, and many require turn-taking. During such an activity withhold an objet or turn in an apparent oversight</td>
<td>Snack</td>
<td>This strategy is not appropriate to use with young toddlers.</td>
<td>Goal: Tyler and Jeff will initiate communication to request things they want and need. Implementation: During snack time, hand cups out but “forget” to give a cup to Tyler and Jeff.</td>
</tr>
<tr>
<td>Violating object function or object manipulation: When child is familiar with action schemes for specific objects or object roles that compose routine events, intentionally violate those routines.</td>
<td>Freeplay</td>
<td>Goal: Jessie will use words to comment on activities during play. Implementation: While building a block tower with Jessie; hand her each block to stack. After handing her several blocks, hand her a Barney figure. Wait for her to comment by showing or labeling figure.</td>
<td>Goal: Brittany will use two-word phrases to indicate what people or objects are doing. Implementation: Play with Jack-in-the-Box which plays the tune to “All Around the Mulberry Bush”. After going through the song several times and letting the clown pop up as you sing “Pop goes the weasel”, hold your thumb over the lid so the clown cannot pop up and sing the song emphasizing “Pop goes the weasel”.</td>
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<tr>
<td>Hiding objects: Hide objects necessary or desirable for an activity.</td>
<td>Freeplay</td>
<td>Goal: Madison will increase her expressive vocabulary by spontaneously producing target words during play. Implementation: When playing in sand at the sensory table, hide objects designed to elicit target words through out the sand. As objects are uncovered, point and exclaim “Look”. Wait for Madison to label the object. Provide the model for the word as needed.</td>
<td>Goal: Lisa will ask questions beginning with wh-question words “what” and “where”. Implementation: Remove Lisa’s favorite truck from the blocks and vehicles area. When Lisa goes to that center and begins to look for the truck, direct her search so that she eventually locates the toy. Model the question “Where’s the truck?” as you search.</td>
</tr>
<tr>
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<tr>
<td>2. Providing choices (Ostrosky &amp; Kaiser, 1991) - Provide child with two or more options for objects or activities.</td>
<td>Opening Songs or Circle Time</td>
<td>Goal: Cody will use gestures, looks and vocalizations to request items during play group. Implementation: As songs begin, hold out two different instruments. Ask Cody, “Do you want bells or drums?”. Wait for Cody to indicate his choice.</td>
<td>Goal: Mike will point to a picture to request activities. Implementation: When Mike is choosing which free play center he wants to play in, hold up two pictures depicting different centers and ask him, “Do you want to play with blocks or cars?”. Wait for his choice.</td>
</tr>
<tr>
<td>3. Interactive modeling: (Camarata, Nelson &amp; Camarata, 1994; Fey, 1986; Wilcox, 1984; Wilcox, Kouri, &amp; Caswell, 1991) - Follow into child’s established focus of attention. Do not require imitation of the modeled utterance. These strategies may be most effective with children who’s MLU’s are over 2.0.</td>
<td>Outdoor play</td>
<td>Goal: Matthew will use a greater number of words to indicate what he wants and needs. Implementation: During outside play Matthew walks over to the swing set and starts to climb up on one of the swings. Adult: “Matthew, want on the swing?” Matthew: Continues to climb onto swing. Adult: “climb on the swing.” Matthew: Is now sitting on the swing Adult: “Want me to push swing?” Matthew: Nods head. Adult: “push swing” as she pushes the swing</td>
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<td></td>
<td>Small group activity</td>
<td>Goal: David will begin to use the preposition “in” to communicate where objects are located. Implementation: At the art table, David says “crayon basket” as he holds a basket of crayons. Respond with “Yes, the crayons are in the basket”.</td>
<td></td>
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<td></td>
<td>Snack</td>
<td>Goal: Mark will use the past-tense marker “ed” to talk about events that have already happened. Implementation: Mark drops a cracker on the floor and says “drop cracker” Answer “Yes, you dropped the cracker on the floor”.</td>
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</tbody>
</table>

**Focused stimulation:** Set up situations, which obligate use of the target form. Produce many utterances, which demonstrate use of the target form in meaningful and functional contexts. May use self-talk, parallel talk, expansions, and recasts.

**Modeling with expansion:** Repeat child utterances filling in missing elements.

**Modeling with recast:** Produce utterances which maintain semantic content of immediately preceding child utterance, but change semantic, syntactic, or morphological elements.
<table>
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<tbody>
<tr>
<td>4. <strong>Vertical Structuring</strong> (+expansion): (Fey, 1986) - Approach child when engaged in an activity, ask a question designed to elicit a multi-word response. If child produces multiword target, expand the utterance. If child does not produce the targeted production, ask question to elicit first component of response; ask second question to elicit another part of utterance; then expand child's response by producing an utterance with the semantic-syntactic relationship coded vertically by child.</td>
<td>Snack</td>
<td>Goal: Lori will use two-word phrases to communicate. Implementation: Lori has been making the baby doll eat her cracker during snack. Adult: What's the baby doing? Lori: Looks at adult without responding. Adult: “Who’s this?” &amp; points to baby. Lori: “baby” Adult: “What’s that?” &amp; points to cracker. Lori: “cracker” Adult: “Yes, baby’s eating cracker”</td>
<td>Goal: Ellen will use more complex sentences by joining two simple sentences with the word “and”. Implementation: Adult: “what are you eating for snack?” Ellen: Looks at adult without responding. Adult: “What’s this?” &amp; points to carrots on plate. Ellen: “carrots” Adult: “What’s this?” &amp; points to celery. Ellen: “celery” Adult: “That’s right, you’re eating carrots and celery. Yum”</td>
</tr>
<tr>
<td>5. <strong>Scaffolding</strong>: Assess a child’s abilities in a particular situation, then provide models and prompts at level slightly higher to facilitate more sophisticated child behavior.</td>
<td>Freplay</td>
<td>Goal: Matt will pair looks with reaches to request objects and activities during play. Implementation: Matt reaches for adult’s hand and places it on the See N Say for the adult to pull the string and activate the toy. After several repetitions, the adult bends down to intersect Matt’s gaze when Matt reaches for adult’s hand, and says “Yes, you want the See N Say” and then activates the toy.</td>
<td>Goal: Kim will use is + “ing” constructions to describe events that are occurring. Implementation: Kim is playing with a farm set, pretending to feed various farm animals. Adult: As Kim feeds the pig. “What’s the pig doing” Kim: “pig eating” Adult “Pig is eating.” As Kim feeds the cow, “What’s the cow doing?” Kim “cow eating” Adult: “Cow is eating,” As Kim feeds the duck, “What’s the duck doing? Duck...” Kim: “is eating”</td>
</tr>
<tr>
<td>Facilitating Strategies</td>
<td>Event</td>
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<tr>
<td>Mand-model: (Hart &amp; Risley, 1975; Kaiser, Yoder &amp; Keetz, 1992)</td>
<td>Freplay</td>
<td>Freplay: Goal: Ann will use gestures, looks and vocalizations to request objects and activities during play. Implementation: Adult is bouncing Ann on large therapy ball. Adult stops, looks at Ann and waits for Ann to do something to indicate that she wants more bouncing. If she does not respond, adult prompts a request by saying “more?” and then bouncing child.</td>
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<tr>
<td>Time delay: Establish mutual focus with child. Create or wait for a situation in which child needs assistance to continue an ongoing activity. Instead of requesting communicative behavior be physically available and maintain “expectant” eye contact. If child fails to produce an appropriate communicative behavior provide a conversationally based imitative prompt.</td>
<td>Opening songs or circle time</td>
<td>Opening songs or circle time: Goal: Jim will begin to use two-word phrases. Implementation: During opening circle blow bubbles then pause for a few moments. Jim: “more” Adult: “more. More what Jim? More bubbles”. Jim: “more” Adult: “O.K., more bubbles” and then blow more bubbles.</td>
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<tr>
<td>Incidental teaching: Carry out the following steps: (a) Focus attention on child who has initiated an interaction; (b) Ask child to expand communicative behavior; (c) Prompt or provide a model of an appropriate expansion; (d) Acknowledge by imitating and complying with child’s communicative behavior</td>
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</table>

Adapted from Wilcox and Shannon, 1995
APPENDIX F: HIPAA PRIVACY PRACTICES

Arizona State University Infant Child Research Programs follows the guidelines of the Health Insurance Portability and Accountability Act (HIPAA) for confidentiality and disclosure of you and your child’s information.

Arizona State University Infant Child Research Programs’ policy is as follows:

**USE AND DISCLOSURE**

Arizona State University Infant Child Research Programs does not use or disclose you or your child’s protected health information without getting specific written consent or authorization from the parent or guardian. Arizona State University Infant Child Research Programs only discloses or uses the minimum amount of information necessary to accomplish the intended purpose of the disclosure or use.

**MANDATORY DISCLOSURES**

Arizona State University Infant Child Research Programs will disclose protected information without first getting written permission from the child’s caregiver during the situation of an investigation by the U.S. Department of Health and Human Services or at the caregiver’s request.

**CONSENT**

Arizona State University Infant Child Research Programs obtains written consent before revealing protected health information about treatment, payment, and healthcare operations to primary care physicians and/or insurance companies. Arizona State University Infant Child Research Programs written consent form is included within this packet.

**AUTHORIZATION**

Arizona State University Infant Child Research Programs uses written authorization in cases of releasing information to a third party (e.g., non-primary care physicians, school districts, etc.) and research activities (e.g., ASU speech and hearing student theses, student and professor conducted studies). To be involved in a study you will be informed of all elements of the study and will sign an informed consent form (I.R.B). A consent form is used to document the information provided to a subject to gain his/her agreement to participate in a study. It is the culmination of a process in which the investigator explains the study thoroughly and answers any questions a subject may have about it. You will receive a copy of your signed consent form for your records.

**OPPORTUNITY TO AGREE OR OBJECT**

Arizona State University Infant Child Research Programs allows families the opportunity to agree or object before using or disclosing their protected health information.

**EMPLOYEE/STUDENT AGREEMENT GUIDELINES**

Arizona State University Infant Child Research Programs has each employee and student sign a
written contract agreeing to follow the guidelines regarding any protected health information.

**RIGHT TO COMPLAINT**

Families who are served through Arizona State University Infant Child Research Programs have the right to complain in person, by telephone, in writing, or electronically regarding Arizona State University Infant Child Research Programs’ privacy policies and procedures, Arizona State University Infant Child Research Programs’ compliance with those policies, or compliance with the HIPAA Privacy Rule in general.
CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FORM

By signing below, you consent to the use and disclosure of your protected health information by the Arizona State University Infant Child Research Programs, our staff, our students, and our business associates for treatment, payment, and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices (“Notice”). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting Arizona State University Infant Child Research Programs at (480) 965-9396 and requesting a revised Notice. We will also post any revised Notice in the Arizona State University Infant Child Research Programs Parent Manual. You have the right to request that we restrict uses or disclosures of you and your child’s protected health information, which we are otherwise permitted to make for treatment, payment, and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you have the right to revoke the consent in writing, except to the extent that we have taken action in reliance to it.

______________________________  ______________________________
Signature                        Date
ICRP DE-IDENTIFICATION CHECKLIST

All of the following identifiers of the child or of relatives, or household members of the child have been removed or are not present:

_____ 1. Names
_____ 2. All geographic subdivisions smaller than a State including street address, city, county, precinct, and zip code
_____ 3. All elements of dates (except year) or dates directly relating to an individual including birth date, admission date, discharge date, date of death, and all ages over 89
_____ 4. Telephone numbers
_____ 5. Fax numbers
_____ 6. Electronic mail address
_____ 7. Social Security numbers
_____ 8. Medical record numbers
_____ 9. Health plan beneficiary numbers
_____ 10. Account numbers
_____ 11. Certificate/license numbers
_____ 12. Vehicle identifiers and serial numbers, including license plate numbers
_____ 13. Device identifiers and serial numbers
_____ 14. Web universal Resource Locators (URLs)
_____ 15. Internet Protocol (IP) address numbers
_____ 16. Biometric identifiers, including finger and voice prints
_____ 17. Full-face photographic images and any comparable images
_____ 18. Any other unique identifying number, characteristic, or code
AUTHORIZATION FOR RELEASE OF INFORMATION

Section A: Must be completed for all authorizations

I hereby authorize the use of disclosure of my child’s individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Child’s name: ________________________________
Persons/organizations providing the information ________________________________
Persons/organizations receiving the information ________________________________

Specific description of information (including date(s)): ________________________________

Section B: Must be completed only if a health plan or a health care provider has requested the authorization.

The health plan or health care provider must complete the following:

What is the purpose of the use or disclosure? ________________________________
Will the health plan or health care provider requesting the authorization receive financial or in-kind compensation in exchange for using or disclosing the health information described above? Yes ___ No ________

The child or the child’s guardian must read and initial the following statements:

I understand that my health care and the payment for my health care will not be affected if I do not sign this form. Initials: __________
I understand that I may see and copy the information described on this form if I ask for it, and that I can receive a copy of this form after I sign it. Initials: ________

Section C: Must be completed for all authorizations

The child’s or the child’s guardian must read and initial the following statements:

I understand that this authorization will expire on ______/_____/____ (DD/MM/YYYY) Initials: ______
I understand that I may revoke this authorization at any time by notifying the ICRP in writing, but if I do it won’t have any affect on actions they took before they received the revocation. Initials: ______

________________________________________________________________________
Signature of the child’s guardian Date

(Form MUST be completed before signing)

Printed name of the child’s guardian: ________________________________
Relationship to the child: ________________________________

*YOU MAY REFUSE TO SIGN THIS AUTHORIZATION*
THE FAMILY’S RIGHTS AND RESPONSIBILITIES

We respect your rights as a parent and recognize that you and your child, as individuals, have unique healthcare needs. Therefore, we respect your personal dignity and want to provide care based upon your individual needs.

Not only do you have rights and responsibilities, but these rights and responsibilities also apply to the people who are legally responsible for making your healthcare decisions. These people may include parents of children under the age of 18, legal guardians, and those you have given decision-making responsibility in a Durable Power of Attorney for Health Care.

Your Rights

1. The right to communicate with family members and/or significant others.

2. The right to considerate and respectful care, regardless of race, color, religion, sex, age, physical or mental handicap, or national origin.

3. The right to agree to treatment before your child’s clinician begins any procedure or test and any options.

4. The right to complete, up-to-date information about your diagnosis, treatment, and prognosis.

5. The right to personal privacy. We will discuss your case only with authorized persons.

6. The right to privacy of your child’s records. Without your consent, we will not release your clinic record unless authorized by law or to those responsible for paying all or part of your bill. You have the right to restrict the release of your medical information.

7. The right to express concerns about any aspect of your care without fear of retaliation. Our procedure for sharing your concerns is available upon request.

8. The right to refuse to participate in therapy activities, recommendations, and assignments.

Your Responsibilities

1. Give a complete and accurate history of information needed about your condition for appropriate therapy and testing.

2. Follow recommendations and complete assignments given in therapy sessions.

3. Accept responsibility for refusing treatment and recommendations.

4. Attend all scheduled therapy sessions. Call the ASU Infant Child Research Programs and cancel when you are unable to attend.
LETTER TO PARENTS CONCERNING HIPAA

Dear Parents:

Healthcare providers have always protected the confidentiality of health information by locking medical records away in file cabinets and refusing to reveal your health information. Today, state and federal laws also attempt to ensure the confidentiality of this sensitive information.

The federal government recently published regulations designed to protect the privacy of your health information. This “privacy rule” protects health information that is maintained by physicians, hospitals, other health care providers, and health plans. As of April 14, 2003, health care providers will need to comply with the privacy rule’s standards for protecting the confidentiality of your health information.

This new regulation protects virtually all healthcare consumers regardless of where they live or where they receive their health care. Every time you see a provider, are admitted to the hospital, fill a prescription, or send a claim to a health plan, your provider, the hospital, and health plan will need to consider the privacy rule. All health information including paper records, oral communications, and electronic formats (such as e-mail) are protected by the privacy rule.

The privacy rule also provides you certain rights, such as the right to have access to your medical records. However, there are exceptions; these rights are not absolute. In addition, we will be taking even more precautions at the ASU Infant Child Research Programs to safeguard your health information such as training our employees and students and employing computer security measures. Please feel free to ask any of the staff at the ASU Infant Child Research Programs about exercising your rights or how your health information is protected in our facility.

The Notice of Private Practices attached to this letter explains our privacy practices. It contains very important information about how your protected health information is handled by ASU Infant Child Research Programs. It also describes how you can exercise your rights with regard to your protected health information.

Please let us know if you have any questions about our Notice of Privacy Practices. You may contact Kathie Smith at (480) 965-9396 or discuss any questions you may have with the clinical faculty supervisor for your treatment.

Thank you.

The ICRP Staff
APPENDIX G: IFSP, TIP, AND PIP FORMS
**AZEIP INITIAL PLANNING PROCESS**

**Child and Family**

<table>
<thead>
<tr>
<th>Child’s Name</th>
<th>Birth date</th>
<th>Today’s Date</th>
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<table>
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<th>Nickname/AKA</th>
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<th>Gender</th>
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<th>Ethnicity</th>
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### Parents

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Birth Date</th>
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### Other children and adults in home

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Birth Date</th>
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<table>
<thead>
<tr>
<th>Relationship to Child</th>
<th>Date of Birth</th>
<th>Message Phone</th>
<th>Work Phone</th>
<th>Social Security No.</th>
<th>Occupation</th>
<th>Legal Guardian (if different from above)</th>
<th>Emergency Contact</th>
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</table>

<table>
<thead>
<tr>
<th>Name</th>
<th>Name</th>
<th>Relationship</th>
<th>Phone Number</th>
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</table>

**Directions to Home:**

_________________________________________________________________________________________________________

_________________________________________________________________________________________________________

Referral Date _______________ Referral Source ______________________ Referral Source Phone Number _________________

Persons completing this form: ________________________________


### Daily Routines, Activities and Interactions

<table>
<thead>
<tr>
<th>Date</th>
<th>Describe a typical day with your child. What activities/routines are your child/family involved in? Where/with whom does your child spend time? How often/how much time (day/evening/weekend/frequency)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Describe the people, toys, activities, routines and places your child enjoys most.</td>
</tr>
<tr>
<td>Date</td>
<td>Describe the people, toys, activities and places your child is most frustrated by.</td>
</tr>
<tr>
<td>Date</td>
<td>Are their activities or routines that your family is interested in doing now, but are not because of your child’s special needs? Are there future activities or routines that your family is interested in planning for (for example family trip, play group, attending baseball games) and wonder how your child’s special needs will be met? If so, please describe.</td>
</tr>
</tbody>
</table>
# Family Resources, Priorities, Concerns and Interests

<table>
<thead>
<tr>
<th>I want to know more about, or am interested in…</th>
<th>I have questions/concerns about my child’s…</th>
<th>Resources that help our family…</th>
<th>In addition to what you have already shared, is there anything else you would like to tell us that would be helpful in planning supports and services for your child and family?</th>
</tr>
</thead>
<tbody>
<tr>
<td>For example; meeting with other families who have similar concerns, ideas for involving other family members and friends, information about my child’s disability.</td>
<td>For example; feeding, calming, communication, movement, vision or hearing.</td>
<td>For example; relatives, friends, religious affiliations, community groups/agencies, playgroups and community events.</td>
<td></td>
</tr>
</tbody>
</table>
Together we gather information about your child’s development. This information is important in determining your child’s eligibility for early intervention. If your child is eligible, this information will be important for development of a plan. Two important ways that we do this are through conversation about and observation of what your child can do, and how they have developed over time. There are five general areas of development: communication, cognitive, physical, social or emotional, and adaptive, self-help or problem solving.
Medical History/Health

Prenatal & Birth History  □ Birth Child  □ Adopted

Pregnancy

Hospital where child was born: ____________________________ Length of Pregnancy (Weeks) __________ Birth Weight __________

Labor and delivery

Was your child in the intensive care nursery? (Where) _________________________ Length of hospital stay for your child __________

Health Plan ______________________________________ Primary Care Physician (PCP) __________________________

Address of PCP __________________________________________ Phone __________________________

Insurance Company Name ______________________________________ Group # __________________________

Name of Insured ______________________________________ Insured Id # __________________________

Other Doctors Currently Caring for Child: Address & Phone Specialty

Diagnoses? If yes, when? Does family agree with the diagnosis? ______________________________________________________________

IPP 2003
Medical History/Health Continued

General Health _______________________________________________ Immunizations Current? _______________________________________

Health concerns such as allergies, ear infections? _________________________________________________________________

Has your child had any serious illnesses or accidents, prolonged fever, convulsions or seizures? __________________________

__________________________________________________________

How does your child eat?    □  Breast fed    □  Bottle    □  Cup    □  Spoon    □  ng/g Tube    □  Finger foods

Is your child growing and gaining weight? _________________________________________________________________

Is your child on a special diet or nutritional supplements? ______________________________________________________

Is your child taking any medications? (list) ______________________________________________________________

Has your child had a vision or hearing screening within the past 6 months? (include dates) ___________________________

Major Hospitalization

<table>
<thead>
<tr>
<th>Where</th>
<th>When</th>
<th>Reason</th>
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<tbody>
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</tr>
</tbody>
</table>

IPP 2003
Summary of Child's Present Levels of Development

As we plan how to provide you and your child with supports/services, we prepare a summary of your child's health, growth and development. It is important for us to think about your child's vision, hearing, and nutritional status. Other information that might effect planning include birth history, additional diagnosis, medications, issues that might effect your child’s performance, etc.. You have already helped us gather this information. Possible sources of information for this summary include conversations we have had with you, observations of your child in daily routines, formal assessments and medical reports.
**Child/Family Desired Outcome # ________**

<table>
<thead>
<tr>
<th>Date</th>
<th>What does your family want to see happen or changed as a result of early intervention and how will we know we’ve made progress? (include timelines)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>What is happening now related to this outcome? (including child and/or family resources and concerns)</td>
</tr>
<tr>
<td>Date</td>
<td>Ideas/activities <em>(things we are/will do to make this happen)</em></td>
</tr>
</tbody>
</table>

**REVIEW/CHANGE**

<table>
<thead>
<tr>
<th>Dates</th>
<th>We will need to continue</th>
<th>We have revised</th>
</tr>
</thead>
</table>

**DATES**

<table>
<thead>
<tr>
<th>Dates</th>
<th>Completed (reached our outcome)</th>
<th>Team members have been informed.</th>
</tr>
</thead>
</table>

**Natural Environments**: Early Intervention services must be provided in natural environments (settings that are natural/typical for the child’s age peers who have no disabilities) to the maximum extent appropriate, and can only be provided in settings other than natural environments when outcomes can’t be achieved satisfactorily in natural environments. IDEA requires justification to support the IFSP team decision that outcome/strategies cannot be achieved satisfactorily in natural environments.

1) Why outcomes/strategies cannot be achieved in natural environments.

2) How will intervention be generalized to the natural environment?

3) Plan/timeline to move service into natural environment.

IPP 2003
## Transition Plan and Timeline

### Individual Transition Plan for: ____________________________ Date: ________________

<table>
<thead>
<tr>
<th>Transition Event</th>
<th>A Closer Look</th>
<th>Timeline</th>
<th>Date Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents informed of available programs and services available after a child’s third birthday.</td>
<td>Programs may include: community preschool/daycare, Head Start, school district preschool, etc… Family encouraged to brainstorm questions regarding transition process.</td>
<td>Throughout enrollment of AzEIP.</td>
<td></td>
</tr>
<tr>
<td>Sign releases of information.</td>
<td>A release of information is required to share records between programs.</td>
<td>At or before the pre-transition meeting.</td>
<td></td>
</tr>
<tr>
<td>Transition Planning Conference</td>
<td>Transition Planning Conference District Representative is invited to describe various program options, answer questions and share records when necessary.</td>
<td>3-6 months prior to child’s 3rd birthday</td>
<td></td>
</tr>
</tbody>
</table>
## Transition Plan and Timeline continued

<table>
<thead>
<tr>
<th>Transition Event</th>
<th>A Closer Look</th>
<th>Timeline</th>
<th>Date Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offer visits to program option sites</td>
<td>Visits to program sites should be arranged with the family by district representative.</td>
<td>3-6 months prior to child's 3rd birthday</td>
<td></td>
</tr>
<tr>
<td>Multidisciplinary Evaluation Team explains results of the assessment and Procedural Safeguards.</td>
<td>Eligibility or non-eligibility for special education and related services is determined. If eligible, family makes decision whether or not they want special education and related services.</td>
<td>By child’s 3rd birthday.</td>
<td></td>
</tr>
<tr>
<td>If program other than special education and related services is chosen by family, referral made to appropriate community program(s).</td>
<td>Other referrals may also be made at this time, but procedures may vary. Service coordinator and family may release records to selected program(s).</td>
<td>By child’s 3rd birthday.</td>
<td></td>
</tr>
</tbody>
</table>

IPP 2003
<table>
<thead>
<tr>
<th>Supports/Services</th>
<th>Outcome #</th>
<th>How often &amp; how long each time?</th>
<th>Who will do this?</th>
<th>In what activity setting will this take place? Justification must be written on outcome page.</th>
<th>Who will pay?</th>
<th>Start Date</th>
<th>End Date</th>
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</thead>
<tbody>
<tr>
<td>Other related services needed:</td>
<td></td>
<td></td>
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</table>

IPP 2003
Parents’ Informed Consent for Early Intervention Services:
I have participated in the development of this IFSP and understand the content. I understand I can accept or refuse any or all of the services identified on the IFSP. I understand that my consent for services may be withdrawn at any time.

Please check and sign below:

1. ____ I understand my rights under this program and received a written copy of the AzEIP Procedural Safeguards for Families Booklet.
2 a. ____ I give permission to carry out this Individualized Family Service Plan as written.
2 b. ____ I do not accept this Individualized Family Service Plan as written, however I do give permission for the following supports/services to begin:
3. ____ I have received copies of the AzEIP Family Satisfaction Surveys.

Parent/Surrogate Signature _______________________________ Date________ Parent/Surrogate Signature ____________________ Date________

Date this IFSP was revised with a meeting: ____/____/____  ____/____/____  ____/____/____  ____/____/____
Note: Parent must indicate their approval for changes made to the IFSP by initialing and dating the changes (unless per phone request by parent.)

List all IFSP Team Members, present or not, who have contributed to the development of this IFSP, using additional page if needed.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship/Agency</th>
<th>Phone</th>
<th>Present</th>
<th>Report given</th>
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Address

IPP 2003
**IFSP Team Page continued**

<table>
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<th>Report given</th>
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<td>Name</td>
<td>Relationship/Agency</td>
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<td>______</td>
<td>______</td>
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<tr>
<td>Name</td>
<td>Relationship/Agency</td>
<td>Phone</td>
<td>______</td>
<td>______</td>
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<tr>
<td>Address</td>
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<td></td>
<td>______</td>
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</tbody>
</table>

**IPP 2003**
Arizona Early Intervention Program
Individualized Family Service Plan (IFSP)

Name_________________________________________ Birth date_____________ Today’s Date________________________

Responsible Person(s) __________________________________________ Relationship __________________________________________

Address________________________________________________________________________________ Phone_________________

Street         City    Zip code
Foster Care N_____ Y_____ ACYF _____ DDD _____ Language of the home ________________ Child____________________

Social Security # _____________________________ ASSISTS ID#___________________ AHCCCS ID# _______________________

Arizona Long Term Care (ALTCS) Eligible Y_____ N _____ Insurance (TPL) Y_____ N _____

Insurance Company Name ___________________________________________ Group # _________________________________

Name of Insured __________________________________________ Insured Id # _________________________________

Health Plan __________________________________________ Primary Care Physician (PCP)_______________________________

Address of PCP________________________________________________________________ Phone ___________________

Primary Agency_____________________________________________________ Phone_______________________________

Service Coordinator __________________________________________________Phone ______________________________

_____Initial IFSP _____6 mos. _____Annual _____Other School Dist. __________ Transition Conference Date: __________

IPP 2003 RidMh
<table>
<thead>
<tr>
<th>Initiation Date</th>
<th>What I’d Like to Do: (goal)</th>
<th>What Activities Will Help Me (include steps)</th>
<th>Timelines (review dates, comments, changes)</th>
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<tbody>
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</table>
PRESCHOOL INTERVENTION PLAN
Infant Child Research Programs (ICRP)

Date _________________

Parent's Name ______________________________________________________

Child's Name _______________________________________________________

Address ____________________________________________________________

DOB ____________________  Phone _________________________________

By signing below I acknowledge that I have participated in the development of the goals, objectives, and activities outlined by the ICRP Preschool staff and agree with the implementation of said objectives.

<table>
<thead>
<tr>
<th>PIP Team/Signatures</th>
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**Educational Strengths and Needs**

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<th>Needs:</th>
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<tr>
<td>Long Term Goals</td>
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<td></td>
</tr>
<tr>
<td>1.</td>
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<td>6.</td>
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<td>Long Term Goal #</td>
<td>Short Term Objectives and Evaluation Criteria</td>
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APPENDIX H: DEVELOPING FUNCTIONAL GOALS

HOW TO WRITE FUNCTIONAL GOALS

<table>
<thead>
<tr>
<th>Child</th>
<th>will</th>
<th>(verb)</th>
<th>(global)</th>
<th>during</th>
<th>(routine)</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td>increase</td>
<td>participation</td>
<td>circle time</td>
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<td>participate</td>
<td>social skills</td>
<td>snack time</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>transitions</td>
<td>opening activities</td>
<td>freeplay</td>
<td></td>
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<td></td>
<td></td>
<td>independence</td>
<td>outdoor play</td>
<td>transitions</td>
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<td></td>
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<td>attention</td>
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HOW TO WRITE FUNCTIONAL OBJECTIVES

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<tr>
<th>Child</th>
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<th>(verb)</th>
<th>during</th>
<th>(routine)</th>
<th>(scaffolding)</th>
<th>(criteria)</th>
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<tr>
<td>respond</td>
<td></td>
<td>respond</td>
<td>circle time</td>
<td>given verbal cues</td>
<td>on 3 consecutive occasions</td>
<td></td>
</tr>
<tr>
<td>locate</td>
<td></td>
<td>locate</td>
<td>snack time</td>
<td>given 1 visual cue</td>
<td></td>
<td></td>
</tr>
<tr>
<td>assist</td>
<td></td>
<td>assist</td>
<td>opening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>participate</td>
<td></td>
<td>participate</td>
<td>activities</td>
<td></td>
<td>at least 3 days per week</td>
<td></td>
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<td>select</td>
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<td>freeplay</td>
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GOAL COMPARISONS

VOCABULARY

Traditional Goals:

- ____ will increase receptive/expressive vocabulary by 50 words by the end of the school year.
- ____ will improve his/her receptive/expressive vocabulary skills.
- ____ will identify 1 to 4 objects or pictures by label.

Functional Goals:

During the preschool day ____ will participate in a variety of teacher directed large and small group activities such as circle, snack, art, and small group time.

- ____ will be able to request items necessary to participate in and/or complete activities with minimal assistance. Request will be ____ to ____ words in length with minimal cueing.
- Using total communication, ____ will request the items necessary to participate in and/or complete an activity with ____ assistance.
- ____ will {expand sentences}, {increase vocabulary} by repeating simple songs, poems or nursery rhymes. ____ may only be using ____ words per line with partial adult assistance.
• ____ will learn ____ body parts by singing songs, listening to stories, participating in finger plays, simple games and other activities which involve understanding and use of body parts.

• At the end of an activity ____ will assist in placing crayons, toys, blocks etc. in their proper place by matching similar objects, shapes, and colors.

ROUTINES

Beginning/Ending Routine:
____ will participate in a beginning/ending routine which will consist of the following steps:

• When entering the classroom, ____ will visually regard a peer/adult in response to a greeting with partial adult assistance.

• Using total communication, ____ will request assistance to remove her backpack with minimal adult facilitation.

• ____ will hang his/her backpack in the cubbie with partial adult assistance.

• ____ will choose an appropriate activity using total communication with minimal assistance.

• ____ will play with the activity for ____ minutes or to its natural conclusion with minimal assistance.

Snack Routine:
____ will participate in a snack routine which will consist of the following steps:

• ____ will participate in an oral stimulation routine of the following steps:
  1. Tactile stimulation on the outside of the mouth, around the lips and under the chin.
  2. Refine down to the lips and into the oral cavity, providing a slight vibration to the four quadrants.
  3. Provide slight vibration to the sides of the tongue and the upper and lower surfaces.

• ____ will wash his/her hands prior to participating in the snack when given a verbal reminder.

• ____ will request the items needed to participate in snack such as napkin, cup, snack item, drink using total communication. Request will consist of ____ words.

• ____ will use two hands together to hold his/her cup with partial adult assistance.

• When drinking, ____ will close his/her lips around a cut-out cup. Small amounts of liquid will be provided so that ____ will need to request “more”, using total communication.

• ____ will pour his/her own drink from an appropriate sized container with minimal adult assistance.
• _____ will request more of a desired item with minimal adult assistance.

• _____ will respond yes/no when offered an item.

• _____ will participate in interaction with his/her peers during snack. Participation may include visual attention, and/or comment using total communication with partial adult facilitation.

• _____ will participate in conversation at the table during snack by {listening, responding, interacting, initiating} with peers with minimal adult facilitation.

• When finished, _____ will clean his/her own snack area with minimal adult assistance, by throwing napkin, cup, and any leftover snack items in the garbage.

• _____ will be able to assist in washing area using a sponge with partial adult assistance.

• _____ will be able to complete categorization frames by verbally participating in group activities at circle, snack or art which consist of the following pattern:
  A ____ is a ____.
  A ____ is a ____.
  A ____ is a ____.
  But a ____ is not a ____.

• _____ will participate in a show and tell routine which will consist of one of the following steps on a given day:
  1. Verbally stating 2-3 attributes with minimal adult assistance concerning the item they brought for the “surprise box”.
  2. Listening to the attributes given by another student and be able to make inferences about what is in the “surprise box”.
  3. Be able to give a logical response based on the attributes (clues) given by the person doing the “surprise box”.

• While listening to a story or song, _____ will be able to inferences/predictions about what will happen next or who is being talked about.

**FOLLOWING DIRECTIONS/ SEQUENCING/ BASIC CONCEPTS**

Traditional:

• _____ will be able to follow _____ to _____ directions in the order given.

• _____ will increase in the understanding and use of basic concepts.

• _____ will be able to sequence a four card story.

Functional:
• ____ will be able to participate in simple games with peers by taking turns appropriately with minimal adult facilitation.

• ____ will demonstrate an understanding and use of basic concepts while participating in freeplay, outdoor play, literacy center activities with partial adult assistance.
  1. ____ will be able to place himself in the position described.
  2. ____ will be able to place an object in the position described.
  3. ____ will be able to describe where an object has been placed.

• ____ will verbally respond appropriately to comments and requests made by peers during play sequences with minimal adult assistance.

• ____ will play cooperatively with peers (i.e., throw a ball back and forth) with minimal assistance.

**OT/PT/APE**

**Traditional:**
• ____ will tolerate standing in the flexi-stander for 25 minutes daily.

• ____ will improve upper extremity function in weight bearing and fine motor skills by side sitting assisted with placement and position.

• ____ will improve shoulder girdle stability/strength throughout hips by wheelbarrow walking a distance of 10 to 12 feet.

• ____ will improve sensorimotor skills by increasing tolerance and awareness of sensory input during therapeutic activities.

• ____ will hop on his/her favorite foot.

• ____ will hit a switch on request 4 of 5 times.

**Functional:**
• While participating in large and small group activities, ____ will use a variety of sitting and standing positions which may include: supportive side sitting, long sitting, use of corner chair, rifton chair with tray or pull to stand against table using a half-kneel approach with partial adult assistance.

• While participating in table activities, painting at the easel, or using the computer, ____ will be in a stander 2-3 times a week for up to 30 minutes.

• ____ will transition between areas a variety of gross motor patterns such as walking, wheelbarrow walking, log rolling etc., based upon a choice made by ____ using total communication with partial assistance.

• ____ will tolerate different tactile media such as finger-paint, shaving cream, lotion, pudding etc., presented by the teacher. He/She will hold it briefly and/or visually attend without withdrawing,
screaming or throwing it.

• ____ will be able to role play or act out a familiar nursery rhyme or story, sequencing it correctly with partial adult assistance.

• ____ will be able to retell a story or an activity sequence using visual cues.

• After listening to the teacher or a peer sequence the daily routine using visual cues, ____ will be able to tell what their favorite activity was.

• During closing circle, ____ will be able to sequence the daily activities using visual cues with minimal assistance.

SOCIAL

Traditional:

• ____ will indicate yes/no consistently.

• ____ will use developing language skills to communicate needs/awareness/feelings to others.

Functional Goals:

• ____ will initiate an imaginative play sequence with a peer and carry it through to its conclusion with minimal adult assistance.

• ____ will choose an appropriate toy or activity and play with it to a logical conclusion and return it to the shelf with minimal adult assistance.

• ____ will parallel play with like materials, or toys with a peer with minimal adult assistance.

• Using total communication, ____ will make a request to a peer or adult showing a desire to play.

• When asked if they wish to continue an activity, ____ will respond yes/no using total communication.

• ____ will maintain an interactive role with peers after adult facilitation to initiate the play sequence.

• ____ will assume a role using dress-ups or puppets with minimal assistance.

TRANSITION ROUTINES

____ will be able to transition between activities and centers during the preschool day.

• While transitioning between activities ____ will narrow his/her base of support when crawling with partial adult assistance.

• Upon reaching his/her destination ____ will be assisted with verbal prompt and moderate physical assistance into different sitting positions to discourage “W” sitting.

• ____ will use a variety of movements such as bear-walk, log rolling, hopping etc., to move from
one activity or center to another.

- ____ will transition from floor activities to standing by moving through the following steps:
  1. Move into a half-kneel from a 4-point position with minimal assistance.
  2. Move through the half-kneel to stand with verbal cuing and minimal physical prompting when without crutches.
  3. Move through the half-kneel to stand with crutches independently.

TOILET ROUTINES

____ will participate in a toileting routine which will consist of the following steps:

- ____ will go into the bathroom with peers.

- Using total communication ____ will indicate wet or soiled diapers.

- ____ will indicate a need to use the bathroom.

- ____ will pull clothes down with minimal adult assistance.

- ____ will be able to use the toilet with partial adult assistance.

- ____ will pull clothes up with minimal adult assistance.

- ____ will wash his/her hands when toileting is completed with partial adult assistance.

APPENDIX I: CLASS AND INDIVIDUAL LESSON PLANS
# TODDLER PLAYGROUP WEEKLY PLAN

**THEME:** ____________  **PLAYGROUP:** ______________

<table>
<thead>
<tr>
<th>CURRICULUM AREAS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Opening Songs</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Areas for Exploration:</strong></td>
<td></td>
</tr>
<tr>
<td>Art</td>
<td></td>
</tr>
<tr>
<td>Sensory</td>
<td></td>
</tr>
<tr>
<td>Constructive Play</td>
<td></td>
</tr>
<tr>
<td>Literacy</td>
<td></td>
</tr>
<tr>
<td>Dramatic Play</td>
<td></td>
</tr>
<tr>
<td><strong>Movement</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Snack</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Closing Songs</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Home Connections:**
# MWF PRESCHOOL WEEKLY CLASS PLAN

## Unit: ___________________________  Theme: ____________________________________

Dates: ____________________________  Planned By: ________________________________

<table>
<thead>
<tr>
<th>CURRICULUM AREAS</th>
<th>MONDAY</th>
<th>WEDNESDAY</th>
<th>FRIDAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIRCLE TIME</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BEGINNING</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>FINAL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>CENTER-BASED ACTIVITIES</td>
<td></td>
</tr>
<tr>
<td>ART/ MANIPULATIVES</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SENSORY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BOOK AND COMPUTER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LITERACY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DRAMATIC PLAY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>OUTDOOR PLAY/ LARGE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUSCLE MOVEMENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUSIC</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNACK</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPECIAL ACTIVITY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>COGNITIVE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRANSITIONS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VOCABULARY/ GRAMMAR</td>
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</tbody>
</table>
# TTH PRESCHOOL WEEKLY CLASS PLAN

Unit: _____________________________ Theme: ____________________________________

Dates: ____________________________ Planned By: ________________________________

<table>
<thead>
<tr>
<th>CURRICULUM AREAS</th>
<th>TUESDAY</th>
<th>THURSDAY</th>
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<tbody>
<tr>
<td>CIRCLE TIME</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BEGINNING</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FINAL</td>
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</table>

<table>
<thead>
<tr>
<th>CENTER-BASED ACTIVITIES</th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ART/ MANIPULATIVES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SENSORY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BOOK AND COMPUTER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LITERACY</td>
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<td></td>
</tr>
<tr>
<td>DRAMATIC PLAY</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OUTDOOR PLAY/LARGE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUSCLE MOVEMENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MUSIC</td>
<td></td>
<td></td>
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<tr>
<td>SNACK</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPECIAL ACTIVITY</td>
<td></td>
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<tr>
<td>COGNITIVE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TRANSITIONS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VOCABULARY/GRAMMAR</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## INDIVIDUAL LESSON PLAN

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>CONTEXT(S)</th>
<th>MATERIALS</th>
<th>PROPOSED STRATEGY</th>
</tr>
</thead>
</table>

UNIT NAME: ___________________________  CLASS: ___________________________

THEME: __________________________________  DATE: __________________________

CLIENT’S NAME: ___________________________  PLANNED BY: ___________________________
<table>
<thead>
<tr>
<th>EXPECTED OUTCOME</th>
<th>OUTCOME</th>
<th>COMMENTS/PLANNED MODIFICATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
INDIVIDUAL LESSON PLAN: SHORT FORM

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>OUTCOME</th>
<th>COMMENTS/ MODIFICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## INDIVIDUAL LESSON PLAN EXAMPLE

**UNIT NAME:** Giving, The Best Gift of All  
**THEME:** Happy Holidays!  
**CLIENT’S NAME:** Tammy Toddler  
**CLASS:** Preschool  
**DATE:** 12/9/96  
**PLANNED BY:** Peggy Chambers

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>CONTEXT (S)</th>
<th>MATERIALS</th>
<th>PROPOSED STRATEGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Tammy will spontaneously use 3-4 word utterances to express her needs and wants.</td>
<td>Art</td>
<td>Candy, frosting</td>
<td>Clinicians will use a withholding strategy to elicit spontaneous production of requests for art items. Expansions will be utilized to model increased utterance length. Clinician will use verbal reminders and prompts to facilitate compliance with 2-step commands during clean-up time.</td>
</tr>
<tr>
<td>1b. Tammy will correctly follow at least three 2-step commands each day.</td>
<td>Clean-up time</td>
<td>All toys</td>
<td>clinician will use physical prompts and reminders to encourage Tammy to attend to the circle time to its conclusion.</td>
</tr>
<tr>
<td>2. Tammy will attend to activities for a reasonable amount of time (to their logical ending points) at least 2 times a day.</td>
<td>Circle</td>
<td>Chair</td>
<td>Clinician will encourage Tammy to attempt toileting twice a day.</td>
</tr>
<tr>
<td>3. Tammy will improve her self-help skills in the areas of dressing and toileting.</td>
<td>Bathroom time</td>
<td>Cookie cutters, rolling pins</td>
<td>Clinician will encourage Tammy to participate in sensory table activities for fine motor development.</td>
</tr>
<tr>
<td>4. Tammy will increase her fine motor skills through participating in fine motor activities.</td>
<td>Sensory table</td>
<td>All activities</td>
<td>Clinician will remind Tammy to close her mouth when necessary and will call attention to bruxism as it occurs.</td>
</tr>
<tr>
<td>5. Tammy will reduce her open-mouth posturing and tongue thrusting.</td>
<td>All activities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EXPECTED OUTCOME</td>
<td>OUTCOME</td>
<td>COMMENTS/PLANNED MODIFICATION</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>1. Tammy will request art items following a withholding strategy and will imitate clinician’s expanded utterances.</td>
<td>Tammy needed prompts to request items necessary for making a gingerbread house. She often required a cue “Say XXX”.</td>
<td>She continues to require prompts unless snack is involved. Tammy needs continued work on expanding utterances.</td>
<td></td>
</tr>
<tr>
<td>1b. Tammy will follow 2-step commands during clean-up times.</td>
<td>Tammy needed only one verbal reminder to clean up the dramatic play area on Monday.</td>
<td>Tammy still requires verbal reminders or physical assistance on this objective when clean-up time is involved.</td>
<td></td>
</tr>
<tr>
<td>2. Tammy will attend to circle to its conclusion and remain in her seat with minimal prompts or reminders.</td>
<td>Tammy did a nice job remaining in her seat during both circles times on Monday. She attended to conclusion both times.</td>
<td>Tammy has made great progress in meeting this objective. She still needs monitoring at times.</td>
<td></td>
</tr>
<tr>
<td>3. Tammy will use the toilet once this week.</td>
<td>Tammy was wearing a diaper due to recent gastro-intestinal illness. No toileting was attempted.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Tammy will practice fine motor skills through participation in sensory table activities.</td>
<td>Tammy used the rolling pin and cookie cutters at the sensory table.</td>
<td>Tammy needs continued work on fine-motor skills. Cutting should be encouraged along with lacing cards, beads, etc.</td>
<td></td>
</tr>
<tr>
<td>5. Tammy will respond to verbal prompts by closing her mouth.</td>
<td>No reminders were necessary.</td>
<td>Should continue to monitor.</td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX J: WEEKLY SUMMARY
### Arizona State University (ASU)
### Infant Child Research Programs (ICRP)
### TODDLER PLAYGROUP WEEKLY SUMMARY

**Child:** ____________________________  **Class:** ________________  **Dates Attended:** ____________

**Weekly Theme:** ____________________________  **Clinician:** ________________  **Clinical Faculty:** ____________

<table>
<thead>
<tr>
<th>What we worked on...</th>
<th>How often your child does each of the following</th>
<th>How independently your child does each skill</th>
<th>Clinical Faculty:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>most of the time</td>
<td>rarely needs our help</td>
<td></td>
</tr>
<tr>
<td></td>
<td>some of the time</td>
<td>some times needs help</td>
<td></td>
</tr>
<tr>
<td></td>
<td>not yet</td>
<td>still needs help most of the time</td>
<td></td>
</tr>
</tbody>
</table>

**Comments:**

**Additional Comments:**
ICRP Weekly Summary Example

Child: Tammy Toddler          Class: Preschool        Dates Attended: 12/6/96

Weekly Theme: Winter          Clinician: Peggy Chambers  Clinical Faculty: Jean Brown

<table>
<thead>
<tr>
<th>What we worked on . . .</th>
<th>How often your child does each of the following</th>
<th>How independently your child does each skill</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>most of the time</td>
<td>some of the time</td>
<td>not yet</td>
</tr>
<tr>
<td>Using 3-4 word utterances</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Following 2-step commands</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attending to activities for a reasonable amount of time</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Improving self-help skills in toileting and dressing</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increasing fine motor skills</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Additional Comments:

We missed Tammy this week and were glad to see her on Friday. She was very quiet on Friday, but she said her name during circle time. She did a nice job at the art center and enjoyed the soap painting. She helped me mix the colors into the paint.
APPENDIX K: SAMPLE REPORTS
TODDLER ASSESSMENT REPORT EXAMPLE 1

NAME: Junior Doe
DATE OF ASSESSMENT: 2-1-88
PARENTS: John and Jane Doe
DATE OF BIRTH: 1-1-90
ADDRESS: 123 Street Dr.
City, AZ 12345
AGE: 2 year, 1 month
TELEPHONE: (123) 456-7890
STUDENT CLINICIANS: Sinead Coughlan, B.S., Leah Hine, B.S.
CLINICAL RESEARCH FACULTY: Heather L. Weintraub, M.A. CCC-SLP

REASON FOR REFERRAL

Junior Doe is a 2-year 1-month-old boy, who was referred to the Infant Child Research Programs (ICRP) at Arizona State University (ASU) due his mother’s concerns regarding his limited babbling and verbal vocabulary. He is currently not receiving any services. Mrs. Doe reported by phone, prior to the assessment, that Junior has been exposed to English and some Spanish. She stated on a Language Proficiency Questionnaire (sent out prior to the assessment) that the family speaks English 90% of the time at home and that his exposure to Spanish is limited to playtime with his father.

BACKGROUND INFORMATION

Birth and medical history

Junior is generally a healthy child with current immunizations. Mrs. Doe reported that Junior’s birth and past medical history were unremarkable. Junior weighed 7 pounds, 11 ounces at birth. Junior had one ear infection at 6 months of age that was resolved with antibiotics. His mother reports no concerns regarding his hearing and vision. His hearing and vision have not been formally screened or tested.

Developmental milestones

According to parent report, Junior sat alone at 6-months and walked unassisted at 13-months. Junior began limited babbling at 9-months and said his first word at 15-months.

Family and education history

Junior lives with his mother, father, sister, and brother. Mrs. Doe reported that his five-year old brother was diagnosed with an expressive language disorder and has received speech therapy since age three and a half. Junior is currently not enrolled in any educational programs.

FORMAL EVALUATION

General development

The Ages and Stages Questionnaire (ASQ) – Second Edition, a parent-completed screening system, was used to assess general development in the following areas: communication (vocalizing, listening, and understanding), gross motor (body, leg, or arm movement), fine motor (hand & finger movement), problem solving (learning & playing with toys) and personal-social (solitary/social play & skills). The following scores were determined from Mrs. Doe’s report of Junior’s abilities.
Results of the ASQ, determined by parent-report, showed that Junior was within normal limits for gross motor (body, leg, or arm movement), fine motor (hand & finger movement), problem solving (learning & playing with toys) and personal-social (solitary social play & skills) development. Junior’s score in the communication domain totaled 25, which was below the age cut-off expected for his age (18.0).

LANGUAGE COMPREHENSION AND DEVELOPMENT

The Preschool Language Scale-4 (PLS-4)

<table>
<thead>
<tr>
<th>Domain</th>
<th>Raw Score</th>
<th>Age Level</th>
<th>Standard Score</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory Comprehension</td>
<td>23</td>
<td>1-8</td>
<td>74</td>
<td>34</td>
</tr>
<tr>
<td>Expressive Communication</td>
<td>19</td>
<td>1-1</td>
<td>73</td>
<td>4</td>
</tr>
<tr>
<td>Total Language Score</td>
<td>167</td>
<td>1-4</td>
<td>82</td>
<td>12</td>
</tr>
</tbody>
</table>

The PLS-4 was used to evaluate overall language functioning and is broken down into Auditory Comprehension and Expressive Communication. Junior performed within normal limits for Auditory Comprehension. In regards to Auditory Comprehension, Junior was able to identify familiar objects from a group of objects (for example, “give me the ball”), identify pictures of familiar objects (for example, “show me the cookie”), and understand inhibitory words (such as “wait”). Junior was not able to understand the following receptive items expected for children between the ages of 18 to 23 months: understanding verbs in context (“The bear is thirsty. Give him something to drink”) and identifying body parts. However, his mother stated that he was able to identify nose, eyes, and mouth during play at home.

In the area of Expressive Communication, Junior exhibited skills in the 12 to 17 month range. Junior demonstrated the ability to vocalize without accompanying arm and leg movements (e.g. vocalizes without involuntary movements), participate in a play routine with his mother for one or more minute, (e.g., maintained attention with his mother for more than one minute), babble two syllables together (e.g., “papa”); and demonstrate a vocabulary of at least one word (His mother reported the use of the word “papa” at home). Junior also initiated a turn-taking game (e.g., Junior gave the bubbles to his mother) and demonstrated the ability to extend and show a toy to his mother (e.g., Junior showed the ball to his mother). Junior was not able to complete the age-appropriate expressive task of producing five consonant sounds (his mother reported that he is able to produce /p, m, d/, and /k/).

CLINICAL ASSESSMENT

Junior and his mother engaged in play during a 15-minute mother-child play sample. The play sample was video taped and then informal observational data regarding his behavior, general development, and play skills were collected.
Behavior

Junior appeared to be a happy, cooperative, and bright boy. Initially, he appeared to be shy, but quickly warmed to the testing environment and participated willingly. Junior demonstrated a strong attachment to his mother. He used his mother as a base, moving from her to explore the toys in the environment and then returning for comfort. As expected for an 18-month-old, Junior required verbal prompting to remain on task during the assessment.

General development

Junior participated in gross motor activities that are typical for an 18-month-old. He was able to sit down, stand up, walk, squat to pick up toys and move through the testing environment without difficulty. Junior also demonstrated fine motor skills typical of a child his age. He used a neat pincer grasp to pick up objects during play (e.g., during manipulation of the bubble wand).

Communication

Junior demonstrated many pre-linguistic abilities during the assessment and during the mother-child play sample. Junior was able to request assistance (e.g., he handed the bubbles to his mom and made eye contact in a request for help), request attention by vocalizing (vocalized “ah” when his mother was not paying attention to him), and direct his mother’s attention by gesturing with occasional vocalizations (such as pointing and vocalizing about a picture in the room). He also indicated his wants and needs in nonverbal ways, such as pointing at a desired object or waving towards him when he wanted the ball to be thrown back to him. Junior’s mother also reported that Junior uses some manual signs to communicate at home (“more”, “cookie”) and that he says “papa”, “gigi” as an approximation for his sister’s name and “ba” as an approximation of “ball”. She stated that Junior produces the /m/ sound, roars for a dinosaur, and uses “uh” (sometimes accompanied by a hand gesture) for things such as “I want” and “give me”. His mother stated that Junior’s verbalizations are inconsistent; he can go through a day without producing any vocalizations.

During the mother-child play sample, Junior’s mother used a variety of strategies to encourage Junior’s language development. She labeled objects and actions, clearly articulated her words and incorporated the use of sign language. She also used the following teaching strategies; parallel talking (e.g., she described what Junior was doing while playing), labeling items (e.g., as Junior pulled out the toys his mother labeled each one), scaffolding (e.g., during play with the puzzle she decreased her prompts as Junior became more familiar with the activity), open-ended questions allowing opportunities for Junior to respond (e.g., “What’s that?”), and mand-modeling (e.g., while introducing a new toy, the mother asked “Tell me what this is”? and after a short pause, she prompted by adding another cue such as; “oink-oink”). Junior followed one-step directions very well and demonstrated appropriate receptive abilities (e.g., when his mother asked “Where is the cow”? Junior handed her the correct item).

Interaction/ Play Skills

Junior alternated between playing independently and playing with his mother. Junior played with the barn, the farm animals, the bubbles, and the dishes. During the play sample, Junior played attentively with the barn and animals for 10 minutes demonstrating an age-expected attention span. He also used the
toys appropriately during play (e.g., he put the animals to bed in the barn and attempted to blow the bubbles). Junior imitated play actions performed by his mother (e.g., following his mother’s model of pretending to eat the banana). Junior also demonstrated appropriate eye contact throughout the sample. When his mother called his name or introduced a new toy, Junior responded by looking at her or the object. He used eye contact to request help and to give objects to his mother.

Oral Motor Skills

During the evaluation, an oral motor and feeding screening was completed, using a variety of snacks including cinnamon sticks, fruit snacks, peanut butter, and juice. Junior ate each item without difficulty. He was able to drink from the straw and the open cup (indicating that he has appropriate lip closure). The oral screening revealed that Junior’s oral structures and functions, respiration, phonation, resonance, movements of the lips, tongue, teeth, hard palate, and soft palate were all within normal limits and adequate for speech (e.g., his smile appeared symmetrical, there was adequate lip closure and rounding, and there was no drooling noted).

CONCLUSIONS AND RECOMMENDATIONS

Junior appears to be a happy and energetic boy. The following developmental strengths were observed during informal and formal assessments:

Junior is demonstrating age-appropriate receptive language skills. During testing, he followed simple directions by identifying pictures and objects. Expressively, Junior is able to use gestures and vocalizations to express his wants and needs.

Junior participates in play and cognitive activities that are appropriate for his age. He can play with a variety of toys and is able to perform cognitive skills such as completing a puzzle independently.

The following developmental concerns were observed:
1. Expressively, Junior is exhibiting a limited vocabulary and sound repertoire. He continues to use non-verbal modes of communication, such as pointing and gesturing to communicate his wants and needs.

2. Junior demonstrates a significant expressive language delay characterized by a limited sound repertoire and vocabulary.

The following is recommended:
1. It is recommended that Junior receive Speech/Language services, with a focus on increasing his expressive vocabulary and sound repertoire.
2. A full audiological evaluation is also recommended to rule out hearing loss as a contributor to Junior’s expressive language delay. If his parents are interested, they can contact the ASU main speech and hearing clinic at 965-2373 to arrange an audiological evaluation.

We enjoyed having the opportunity to work with Junior and his mother during this assessment. Please feel free to contact us at (480) 965-9396 if there is any other information we can provide.
TODDLER ASSESSMENT REPORT EXAMPLE 2

NAME: Tara Toddler   DATE OF ASSESSMENT: 4/1/99
PARENTS: Tommy and Tosha Toddler   BIRTHDATE: 1/1/96
ADDRESS: 1234 USA Circle   AGE: 3 years, 4 months
TELEPHONE: (000) 123-4567
STUDENT CLINICIANS: Julie Kleinheinz & Karina Sandweg
SUPERVISOR: Heather Weintraub, M.A. CCC-SLP

REASON FOR REFERRAL
Tara Toddler is a 3-year 10-month-old girl, who was referred to the Infant Child Research Programs (ICRP) at Arizona State University (ASU) by the ASU Child Development Lab and the ASU Speech and Hearing Department. Tara failed a speech and language screening that was conducted at Tara’s school by student clinicians from the Speech and Hearing Department on September 25, 2002. The screening highlighted a potential delay in expressive and receptive language skills. Mrs. Toddler reported by phone, prior to the assessment, that Tara is bilingual (Cantonese/English) and is more fluent in Cantonese than English. She stated that the family speaks Cantonese 99% of the time at home. She also commented that Tara sometimes experiences difficulties with syntax in both languages and is occasionally dysfluent when she is searching for the right word.

BACKGROUND INFORMATION
Birth and medical history
Mrs. Toddler reported that during her pregnancy with Tara she experienced high blood pressure and occasional seizures due to a disorder with magnesium. Tara was born two weeks early and weighed 6 pounds, 3 ounces. Mrs. Toddler reported that Tara is generally healthy. Since birth she had infrequent ear infections that resolved quickly. Tara was hospitalized for 5 days following a head injury (a skull fracture with no fluid and some soft tissue damage) resulting from a large object falling on her head. The MRI performed at that time did not show any apparent damage or problems. Upon release from the hospital, Tara experienced a high fever and then was hospitalized for an additional two days.

Family and education history
Tara lives with her mother, father, and half-sister. Mrs. Toddler reported that there is no family history of hearing, speech, language, or learning disorders. Last year, Tara attended preschool at the ASU Child Study Lab three days a week for 2.5 hours a day. Currently, Tara attends all-day preschool at the ASU Child Development Lab five days a week.

FORMAL EVALUATION
General development
The Ages and Stages Questionnaire (ASQ) – Second Edition, a parent-completed screening system, was used to assess general development in the following areas: communication (vocalizing, listening, understanding), gross motor (body, leg, or arm movement), fine motor (hand & finger movement), problem-solving (learning & playing with toys) and personal-social (solitary social play & skills). The following scores were determined from Mrs. Toddler’s report of Tara’s abilities.

<table>
<thead>
<tr>
<th>Area/Domain</th>
<th>Raw Score</th>
<th>Age-expected Cut-off Score</th>
</tr>
</thead>
</table>
Results of the ASQ, determined by parent-report, showed that Tara is within normal limits for gross motor (body, leg, or arm movement), fine motor (hand & finger movement), problem solving (learning & playing with toys) and personal-social (solitary social play & skills). Tara’s score in the communication domain, totaled 15, which is below the age cut-off expected for her age (39.1). However, when questioned following the evaluation, Mrs. Toddler agreed that Tara was able to meet the criteria for several of the items that she had checked that Tara could not do at home. For example, Mrs. Toddler reported that Tara does not use word endings such as “s”, “ed”, and “ing”; however, during the evaluation, Tara used the plural “s” and “ing” word endings. When brought to Mrs. Toddler’s attention, she agreed and was surprised that Tara used these word endings. Mrs. Toddler also reported that Tara does not use “a”, “the”, “am”, “is” and “are”, but it was noted that Tara used words such as “a”, “the”, “am” and “is” during free-play conversation with her mother.

Language Comprehension and Expression

<table>
<thead>
<tr>
<th></th>
<th>Raw Score</th>
<th>Age Level</th>
<th>Standard Score</th>
<th>Percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory Comprehension</td>
<td>50</td>
<td>4-3</td>
<td>112</td>
<td>79</td>
</tr>
<tr>
<td>Expressive Communication</td>
<td>48</td>
<td>3-11</td>
<td>104</td>
<td>61</td>
</tr>
<tr>
<td>Total Language Score</td>
<td>98</td>
<td>4-1</td>
<td>108</td>
<td>70</td>
</tr>
</tbody>
</table>

* When reviewing these scores, it should be noted that the PLS-4 was not completed due to fatigue secondary to the length of testing. A ceiling (cutoff) score was not achieved in either subsection, suggesting that Tara could have achieved higher scores. In addition, it should be noted that the items on the PLS-4 were first presented in English and if the item was missed, the questions was translated into Cantonese. This type of translation is not within the limits of this evaluation tool and therefore may skew its results. Taking into consideration that Tara is bilingual, we asked Mrs. Toddler to translate any missed questions into Cantonese.

The Preschool Language Scale - Fourth Edition (PLS-4) was used to evaluate overall language functioning and is broken down into Auditory Comprehension and Expressive Communication. Tara performed within normal limits for both Auditory Comprehension and Expressive Communication. In regards to Auditory Comprehension, Tara was able to identify colors, make inferences (Tara was told, “Charlie played outside and got his shoes wet.” She was then asked, “What was it like outside?” Tara pointed to the picture of a rainy day.), point to objects in categories (for example, animals: dog, horse, cat), understand picture analogies (i.e. completing the sentence “You sleep in a bed; you sit in a ______.”) and correctly identified concepts (such as “under”, “next to”, “in back of”, “night”, “day”, “shapes”, “tall”, “long”, “short”, etc.) Tara was not able to distinguish between the pronouns “his” and “her”, a concept that is expected at her age.

In the area of Expressive Communication, Tara answered questions logically (e.g. When told, “She is sleepy. What would you do if you were sleepy?” Tara responded, “go to bed.”), described physical states (such as thirsty, hungry), completed analogies (for example, for the sentence “Ice cream is cold, a fire is ______”), named objects that were described orally (“What do you use when you take a bath.”) and responded correctly to “where” and “why” questions. It was noted that Tara had difficulty naming colors in both English (i.e.:
“yellow”, “blue”) and Cantonese but was able to point to the color when asked, (such as, “Show me the bear that is yellow.”). She named five colors, as was required by the evaluation, but only after the clinician asked in several different contexts using objects and pictures around the room.

CLINICAL ASSESSMENT

Behavior
Tara as appeared to be a happy, cooperative and bright little girl. At first, she was quiet and shy but within a half-an-hour she warmed up and began to communicate more actively. She was easy to engage in different activities and exhibited good attention level and span. Tara maintained eye contact and demonstrated appropriate turn-taking skills.

Communication
Tara used sentences, words, gestures, and eye contact to communicate her thoughts and feelings during the evaluation. Her receptive communication (auditory comprehension) appeared to be within normal limits for a child her age, as evidenced by her ability to follow directions and answer age-appropriate questions correctly. Expressively, Tara used a wide variety of words and different grammatical morphemes (structures). During the testing, play, and snack time, Tara was articulate, voicing her opinions with ease. She listened carefully and followed directions properly and accurately. She negotiated for extra playtime to finish her game and to eat her snack a little later. Tara’s speech intelligibility was rated to be 85% intelligible to an unfamiliar listener in known context. This may have been due to her using a very soft voice when speaking and inconsistent use of several grammatical morphemes during the playtime with her mother.

Tara was videotaped at the Infant-Child Research Program (ICRP) during 15 minutes of play with her mother in order to assess her language abilities in a conversational-play setting. Tara’s complete and intelligible utterances were transcribed and analyzed in order to assess her communication abilities. Tara’s Mean Length of Utterance (MLU), a measure of the length and complexity of her words and grammatical complexity, was calculated to be 5.15. This MLU places Tara 1.3 standard deviations above the mean for children 3 years, 10 months of age. The predicted MLU for a child of Tara’s age is 4.09 with a range of 3.21-4.97. Tara’s MLU also places her in Brown’s Stage V++ of language acquisition. This stage is characterized by a MLU of 5.00-5.99 and use of advanced grammatical morphemes. Tara’s upper bound length (largest number of morphemes in an utterance) was 16, and her lower bound length (smallest number of morphemes in an utterance) was 1.

A grammatical morpheme analysis was performed to examine which morphemes Tara uses and to compare that to all of the contexts she should have used them (obligatory contexts). She demonstrated the correct use of plural –s, prepositions (in/on), contractible copula (for example, “That’s loud.”), and contractible auxiliary (“He’s thinking.”) with 100% accuracy. Tara demonstrated inconsistent use of the present progressive form –ing (“He’s thinking.”), articles (a/the) (“The bed.”), regular third person singular (“Daddy needs to take a bathtub”), uncontractible copula (“This is the music.”), and uncontractible auxiliary (“I was just thinking.”), and the irregular third person (“And it goes right here.”). During the videotaped sample, Tara did not illustrate the use of nor were there any obligatory contexts for possessive ‘s (e.g. “the dog’s bowl”), regular past –ed (for example, “she danced”), and the irregular past tense (such as, “he went”).

A Type-Token Ratio (TTR) was calculated for Tara’s language sample in order to evaluate the diversity of Tara’s spontaneous vocabulary use. A TTR compares the number of different words to the total
number of words produced in the sample. Tara produced 89 different words and 237 total words, which computes to a TTR of 0.38. This ratio indicates that Tara’s vocabulary during the videotaped session was slightly less diverse than to be expected for her age.

Tara used word combinations to serve a variety of functions. An analysis of Dore’s Primitive Speech Acts indicated that Tara’s utterances were used to make requests (“Mommy, you read it.”), respond to requests (“OK, but then I want to finish this game.”), make descriptions, (“Baby in there.”) make statements (“That’s for the baby.”), and make acknowledgements (“Yeah, he’s thinking.”). Overall, Tara demonstrated adequate expressive and receptive skills, which she applied to all the different contexts used during the evaluation, play, and snack time.

Pragmatic skills
During the videotaped mother-child play sample, Tara played independently but continually communicated with her mother throughout the play sample. She appropriately and continually looked at her mother while speaking to her and demonstrated appropriate turn taking skills. Later, Tara enjoyed interacting with the clinicians eating snack and singing songs with finger play. During playtime with her mother, Tara used her language to describe the actions of the characters she used to play with her mother. Tara asked and answered questions with ease, changed activities from playing to reading a book, and spoke with several different people during the evaluation.

Interaction/ Play Skills
Tara was attentive to directions during the testing, and she loved to play with the adults present in the room. She included her mother in most activities and even drew and cut a picture of her mother during part of the session. During the scheduled playtime, Tara interacted with her mother by telling her what was going on in the playhouse. At one point, Tara also pretended to be the mom and dad of the house, altering her voice a little to match each of the characters. Tara’s mother was content to watch for most of this time. During snack time, Tara was happy to eat gummy fruit and raisins, firmly and politely refusing any other kinds of food from the clinicians. She commented on having only a couple of friends at school and knowing only one name because she had not asked the other girl about her name. This shows her awareness of social context in the preschool environment and how to relate to other people around her.

Oral Motor & Feeding Skills
During the evaluation an oral motor and feeding screening was completed, using a variety of snacks including Teddy Grahams, gummy fruits, raisins, and juice. Tara ate each item without difficulty. She did not show interest in drinking from a straw but was able to drink from a large sippy cup that she brought from home without anterior spillage. The evaluation was performed by observing Tara’s breathing and chewing patterns, by watching her tongue move inside her mouth as requested, and by watching and listening to Tara’s production of the sounds /p/, /t/, and /k/ in isolation, groups, and different combinations (i.e. “buttercup” and “pattycake” repeated many times). Tara’s respiration, phonation, resonance, movements of the lips, tongue, teeth, hard palate, and soft palate were all within normal limits.

Voice and Fluency
Tara demonstrated voice and fluency within normal limits expected for a child her age. No dysfluency was noted during the assessment, although her mother reported hesitations, most likely associated with word finding, at home.
CONCLUSIONS AND RECOMMENDATIONS

Tara appears to be a happy and energetic girl, who is developing typically for her age. Our assessment shows that Tara’s language, both receptive and expressive are within normal limits. Considering that Tara receives input in both English and Cantonese, a slightly lower-than-average vocabulary in English is expected. We do not recommend speech and language therapy at this time. The following developmental strengths were observed during formal and informal assessments:

1. Expressively, Tara answered questions logically, described physical states, completed analogies, names objects that were described orally, and responded correctly to “where” and “why” questions.
2. Receptively, Tara understood concepts such as colors, shapes, sizes, spatial relations (under, next to, back of), and time.
3. Tara’s fine and gross motor skills were rated well above the normal range.
4. Tara was happy, cooperative, and followed directions easily.

Although no concerns are noted at this time, the following are some suggestions for school and home:

1. The language analysis indicates that she may need to be exposed to a more extensive vocabulary in English and Cantonese. Her parents and teachers can achieve this by reading to her in both languages and playing games like color, shapes, animal, and furniture bingo with her.
2. In addition, we would recommend working on the possessive form of words (e.g. the family’s car), as well as the regular (I danced, she played) and irregular (they went, he ran) past tense verb forms. Tara’s parents and teachers should model correct forms for her (“I danced, played, and went to school.”), as well as using cueing exercises (“Tara, repeat with me: ‘yesterday, I danced, played, and went to school.’”).
3. We would also recommend that Tara’s parents and teachers provide opportunities for her to be exposed to the correct use of the third person singular (regular and irregular) forms of the verbs (she runs, he goes). This can be achieved by modeling the correct form (“The girl runs fast” or “The cat goes on the couch.”)
4. Tara’s parents and teachers should provide opportunities for her to practice distinguishing between genders (i.e. boys vs. girls) and using the pronouns “his” and “her” in the correct context. For example, point out differences in clothing (“Her shoes are black, but his shoes are brown.”), and then ask her to point out the boy and the girl.

Please contact us at (480) 965-9396 if there is any other information that we can provide.

Julie Kleinheinz, B.A.  
Student Clinician  

Karina Sandweg, A.A.S., B.A.  
Student Clinician  

Heather L. Weintraub, M.A., CCC-SLP  
AZ License #SLP 1714  
Clinical Research Faculty
TODDLER ASSESSMENT REPORT EXAMPLE 3

NAME: Jane Smith
PARENTS: Jack and Jill Smith
ADDRESS: 123 E. West Street
           Hill, AZ 54321
DATE OF ASSESSMENT: 2/1/03
BIRTHDATE: 8/1/01
AGE: 18 months
TELEPHONE: 987-654-3210

REASON FOR REFERRAL

Jane, an 18 month year old girl, was brought to the Infant Child Research Programs (ICRP) at Arizona State University (ASU) by her parents, Jill and Jack, due to concerns regarding her speech and language development. Jill reported that Jane understands many words and directions, but is not using more than two words to communicate. She reported that Jane uses mostly gesture and vocalizing to communicate her wants and needs at home. She also voiced some concerns about her developing language at a slower rate than the other toddlers at her daycare. Jill felt that it was important to have Jane evaluated early because of a history of speech and language delay and disorder within the family.

BACKGROUND INFORMATION

Birth and medical history
Jane’s parents reported a birth and medical history free of complications. Jane had two ear infections, which were each cleared with one round of antibiotics.

Family and education history
Jane currently lives with both of her parents. However, when Jane was five months old, her father was sent overseas on military deployment for the eleven months. Jill reported that she experienced both a language delay and an articulation disorder as a child. Both the language delay and the articulation disorder were treated through speech therapy. The mother additionally reports that her brother (Jane’s uncle) has been diagnosed with a language learning disability. Jane is enrolled in a home daycare where there are other toddlers her age. Jill described her daycare provider as a skillful caretaker, who promotes Jane’s language development throughout her daily routines.

Prior testing
It has been reported that Jane passed her newborn hearing screening. No other audiological testing has been performed to date.

FORMAL EVALUATION

General development

The Ages and Stages Questionnaire (ASQ) – Second Edition, a parent survey, was used to screen general development in the following areas: communication (understanding and expressing), gross motor (body, leg, and/or arm movement), fine motor (hand and finger movement), problem-solving (learning and playing with toys) and personal-social (solitary social and play skills). The following scores were determined from Mrs.
Smith’s report of Jane’s ability:

<table>
<thead>
<tr>
<th>Area/Domain</th>
<th>Raw Score</th>
<th>Age-expected Cut-off Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td>Gross Motor</td>
<td>55</td>
<td>25</td>
</tr>
<tr>
<td>Fine Motor</td>
<td>50</td>
<td>25</td>
</tr>
<tr>
<td>Problem Solving</td>
<td>50</td>
<td>25</td>
</tr>
<tr>
<td>Personal-Social</td>
<td>60</td>
<td>25</td>
</tr>
</tbody>
</table>

Results from the ASQ revealed Jane’s abilities are within normal limits in all domains except for communication. Since this instrument is used for screening purposes only, further speech and language evaluation was warranted (see below).

**Language Comprehension and Expression**

The MacArthur Communicative Development Inventory (CDI): Words and Gestures, a parent survey of receptive and expressive vocabulary (the words their child understands and says), was mailed out to the parents and returned via fax, prior to the evaluation. During the evaluation, the Communication and Symbolic Behavior Scale (CSBS) and the Preschool Language Scale 4 (PLS-4) were administered.

**MacArthur CDI**

The results from the MacArthur revealed Jane understands many more words and phrases than she uses, as expected for a child her age. In the expressive section, no words were identified. In the receptive section, 162 words were identified. Jane was able to understand most nouns and some adjectives. Jill also reported that Jane could understand some short phrases like, “Are you hungry,” “Let’s go bye bye,” and “Do you want more?” Jane had more difficulty understanding question words (how, what, when), quantifiers (none, some) and pronouns (they, she, we). Norms for the MacArthur are based on 16-month year old children, so the percentile ranks could not be calculated.

**CSBS Behavior Sample**

<table>
<thead>
<tr>
<th>Composite Scores</th>
<th>Weighted Raw Scores</th>
<th>Standard Scores</th>
<th>Percentile Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Composite</td>
<td>37</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td>Speech Composite</td>
<td>26</td>
<td>11</td>
<td>63</td>
</tr>
<tr>
<td>Symbolic Composite</td>
<td>21</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td>Total</td>
<td>84</td>
<td>102</td>
<td>55</td>
</tr>
</tbody>
</table>

The CSBS was administered to assess Jane’s communicative, social-affective, and symbolic abilities. The CSBS uses a behavioral sample to measure a child’s emotion, understanding of words, rate of communication, use of eye gaze for communication purposes, use of gestures, sounds, words, and objects.

Jane demonstrated intentional communication through her use of gestures, sounds, and eye gaze. These strategies for communication helped Jane establish joint attention (i.e., getting her mom to look at an
object, such as a balloon) and regulate the behaviors of others (i.e., getting her father to perform an action such as opening the jar of cheerios). In addition, Jane demonstrated symbolic play behavior with toys (spoon, cup, tissue, bowls, lids) placed out on the table in front of her. This provided Jane with the opportunity to pretend to feed herself, a doll, and the other people in the room. She used action schemes towards her mom (i.e., feeding her mom with the spoon), and toward a doll (wiping Big Bird’s face). However, Jane did not sequence any action schemes together, such as stirring with the spoon, then feeding herself or her mother.

Jane’s total score from this specific assessment tool are within normal limits at this time. Her standard score places her around the mean of the norm, and her percentile rank reveals her performance is just above average for children her age.

<table>
<thead>
<tr>
<th></th>
<th>Raw Score</th>
<th>Age Level</th>
<th>Standard Score</th>
<th>Percentile Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory</td>
<td>22</td>
<td>18 months</td>
<td>91</td>
<td>27</td>
</tr>
<tr>
<td>Expressive</td>
<td>22</td>
<td>16 months</td>
<td>81</td>
<td>10</td>
</tr>
</tbody>
</table>

The Preschool Language Scale-Fourth Edition (PLS-4) was administered to evaluate Jane’s Auditory Comprehension (how well she understands language) and Expressive Communication (what verbal output the child uses). Jane’s performance on the auditory comprehension portion was within normal limits for a child her age. She was able to follow routines (e.g. feeding her mother, putting her shoes on), understand simple commands (e.g. stop, wait, my turn), and identify some clothing items. Jane was not able to identify familiar objects from a group when asked to by her mother or the clinician. Jane was presented with a cup, a spoon, and a car, and did not identify, pick up or hand any of the objects when asked. Although, this is a task that is expected at her age, both parents reported that Jane does this at home with some accuracy, and the testing conditions (e.g. the temperature in the room) may have affected her performance.

The Expressive Communication portion, Jane performed slightly below the norm, but within normal limits for a child her age. Jane was able to participate in play routines for longer than two minutes, babble two-syllables together (e.g. mama, dada) and produce a variety of consonant sounds (e.g. /p,b,m,n,d,h/). Jane was not able to imitate words or produce different types of consonant-vowel combinations (CVC, such as “pop” vs. CVCV, such as “mama”, where C=consonant, V=vowel).

**CLINICAL ASSESSMENT**

**Behavior**

Jane was extremely cooperative during the assessment and participated in all of the activities without protest. She smiled, made eye contact with the clinicians, and waved good-bye at the end of the session. She put all of her trash in the trashcan and cleaned up her water spills. If a door was left open she immediately went over and closed it. Her mother reports that she keeps her room very clean and does not like items out of their place.

**General development**

Jane’s gross and fine motor skills are developing within normal limits of a child her age. She was able to stand up from a sitting position on the floor with stability and to pick cheerios out of a jar. “W” sitting
was noted during the assessment. This is a term used to describe when children sit on the floor with their legs turned out, typically because they need a broader base for lower trunk stability. Although this sit may be typical for some children, it should be monitored with Jane over the next six months, as it could be a sign of low tone in the musculature. Her parents should encourage her to sit in other positions (i.e., cross-legged, legs outstretched, kneeling) to promote overall motor development.

Communication

Jane communicates very well through gestures. She answers “yeah” to questions and shows intent to communicate by initiating eye contact. She uses intonation with jargon, which is the stage of linguistic development just before words begin to emerge. No formal assessment of articulation and phonology was administered due to Jane’s age. Informal assessment revealed that she is babbling (using sounds), using syllables (consonant-vowel combinations), and has a varied sound repertoire. Syllables noted during the assessment were “ma,” “ba,” and “kae.” Jane’s consonant inventory consists of the following phonemes: /p,b,m,n,g,k/. Jane has the ability to claim ownership non-verbally. She did this during the assessment by picking up objects, holding them close and gesturing for Jill to help her open a jar. Jane was able to communicate her wants and needs with her parents and the clinicians with a combination of eye gaze, gestures, and some vocalizations. She demonstrated turn-taking ability by passing the bubbles to the clinician. Jill reports Jane vocalizes and uses gestures at home to request and label objects. Receptively, Jane was able to follow simple directions expected for her age, such as “find me the car”, “shut the door”, “shut the drawer”.

Interaction/ Play Skills

Jane was attentive to directions from her parents and the clinicians. She smiled when an activity pleased her and appeared grumpy when she needed a snack. She was able to maintain joint attention during several activities. She stayed focused on the bubbles and the balloon for about two minutes each activity and coordinated her attention from the object to the clinician or her mother. Jane exhibited age-appropriate play skills, choosing to play with feeding utensils and bubbles during the assessment.

Oral Motor Skills

Informal assessment of the oral musculature showed structures to be adequate for speech production. Jane was able to made pucker faces, snorting sounds, and stuck her tongue out to lick her face during a snack. Her mother reports she eats a variety of foods and is not a picky eater. She drinks mostly from a sippy cup and likes to drink from a straw, however, the parents report she still has some difficulty with an open cup.

Voice and Fluency

Informal assessment of voice and fluency posed no concern at this time.

**CONCLUSIONS AND RECOMMENDATIONS**

The following strengths were observed during Jane’s assessment:

1. Jane’s receptive comprehension is within normal limits for a child her age. She understands simple
directions and responds to her parents appropriately.

2. Jane plays with toys in an age appropriate manner and exhibits an age-appropriate attention span.

3. Jane exhibits good eye contact and uses non-verbal communication to convey her wants and needs.

4. Jane has the ability to transition between activities without protest.

The following developmental skills should be monitored:

1. Jane is primarily using gestures, vocalization and intonation to express her wants and needs. She currently has a verbal vocabulary of just two words. She should continue to increase her verbal vocabulary, including words of objects (ball, block), family names (dada) and simple actions (go, up, out) in the next 3-4 months.

2. Jane sits on the floor in a “W” position. Although this is typical for some children, it should be monitored over the next six months.

Overall, Jane’s language skills are within normal limits for a child her age. Jane exhibits the use of conventional means for communication (her use of gestures, sounds, and syllables) and demonstrates intent to communicate with others. She is imitative and social. These skills are building blocks to more verbal communication. Due to the family’s history of speech impairment and learning disabilities, Jane is at risk for speech and language delay. We recommend careful monitoring her speech and language acquisition in the next 4-5 months. Jane’s parents may also choose to enter her in a toddler program to promote language acquisition at any time. In addition, Jane’s parents are encouraged to try the following strategies at home to promote her speech and language skills:

Providing appropriate models and labels for everything Jane plays with or interacts with – following her lead (when appropriate) to ensure her full attention.

Creating opportunities for her to communicate (for example, abruptly stop tickling her or swinging her on the swing and encourage her to vocalize “mmm” or “more” to get the action back once more).

Allow Jane to make choices, such as “do you want a cookie or juice”. In this way, you have provided the model words, and she can imitate in an answer.

Enclosed are some sample activities Jane’s parents may use at home to promote language use.

Please feel free to contact us at (480) 965-9396 if there is any other information that we can provide.

Heather Weintraub, MA, CCC-SLP
Clinical Supervisor

Christa Buckley, BA
Graduate Student Clinician

Tara Moore, BA
Graduate Student Clinician
BACKGROUND INFORMATION

Erlene, age 35 months, has been involved in the Infant Child Research Programs (ICRP) at Arizona State University (ASU) since August 2000. This semester was Erlene’s second semester (Spring 2001) in the Toddler Playgroup. This group met one time a week for two-hour sessions and was designed to facilitate early communication and language skills through play-based activities. An Individualized Family Service Plan (IFSP) was updated with Erlene’s mother in January 2001 in order to review and update goals and objectives for intervention and to address both Erlene’s and her family’s current strengths and needs in supporting and promoting her communication and language development. Erlene attended 13/14 sessions this semester. This report describes the progress that Erlene made during the Spring 2001 semester on the objectives that were selected by her parents and the playgroup clinicians.

OBJECTIVES AND PROGRESS

I. Erlene will spontaneously use each selected target word in at least 2 different contexts during 2 out of 4 successive playgroup sessions, or more than twice, in two different activities or routines, per parental report. 10 target words will be chosen.

Although target words were modeled at home and during playgroup, Erlene did not imitate or spontaneously produce many of the target words. In total, Erlene spontaneously produced 6 out of the 29 words that her mother chose as targeted words. Although Erlene did not produce many target words, she did significantly increase her verbal vocabulary this semester. In the beginning of the semester, Erlene used an average 3-4 words or phrases to request or comment during playgroup. By the end of the semester, she was using an average of 10 words or phrases to request or comment about activities in playgroup. Although Erlene’s mother reports that she is using object labels (as in “cheese”), action words (as in “jogging”), names of family / friends (as in “Joe”), and descriptives (as in “blue”), most of her verbalizations in class have taken the form of rote phrases, such as “I want”, “don’t know” and “no more”. This may have been due to her level of comfort in the classroom during the majority of the semester. As Erlene become more comfortable towards the end of the semester, she began to spontaneously communicate and would imitate many new words upon request. A goal for increasing spontaneous production of a variety of types of words (action words, object labels, names of peers) is recommended for the next semester.

Based upon parent report on the MacArthur Communicative Developmental Inventories: Words and Sentences, Erlene’s vocabulary grew from 52 words (+24 signs) on 12-1-00 to 70 words on 2-1-01. At
that time, Erlene’s mother reported that the longest phrase Erlene used was 5 words, an increase from 3 word phrases on 12-1-00.

II. Erlene will spontaneously produce consonant-vowel-consonant (CVC) syllable constructions (i.e. “bus”, “bed”, “nose”) on five occasions per session for three out of five consecutive playgroup sessions.

Final consonant production in CVC constructions was modeled during structured and unstructured playtimes this semester. With the exception of 6 occasions, Erlene did not imitate final consonants in imitation of clinician models. When she did imitate, Erlene produced final /p, k and d/ in the words “help”, “pink” and “red”. Spontaneously, Erlene continues to delete final consonants in CVC (as in “red”) and CVVC (as in “no more”) constructions. This goal should continue to be addressed next semester. As Erlene continues to increase her comfort level in the classroom we hope that her willingness to try new words and sounds will also increase.

III. Erlene will play independently in the classroom, without the presence of her parents, for three out of five consecutive playgroup sessions.

This goal was met on 4-1-01. At the beginning of the semester, Erlene had a very difficult time separating from her mother, even when her mother remained in the classroom. Although Erlene communicated to her mother verbally and nonverbally, she was very reluctant to communicate with the clinicians in the playgroup. Erlene’s mother, Ella, began by leaving the classroom for the final 20-30 minutes of playgroup and attempted to increase the amount of time she was out of the classroom every week. As the semester continued, Erlene increased her anxiety and became very worried about her mother leaving the group. It was decided between the clinicians and Ella that Erlene’s anxiety about her mother leaving was worse than her anxiety when her mother left. Therefore, in March, Ella began leaving the classroom within the first 30 minutes of play. Although Erlene cried initially, she usually calmed down within a few minutes and was able to play happily for the rest of the session. Towards the end of the semester, Erlene began to form relationships with the clinicians in the group and was willing to go to them for help and comfort.

**SUMMARY AND RECOMMENDATIONS**

It has been a pleasure having Erlene in playgroup again this semester. Erlene significantly increased her verbal vocabulary this semester and achieved 1 of 3 goals. It was wonderful to see her confidence and independence improve this semester. Although Erlene does not always participate, she appears to really enjoy song/book time and is always eager to join the group on the carpet. Erlene also appears to really enjoy sensory activities and loves the art activities! She is always the first to want to paint or draw. In the last few weeks of group, Erlene began to be more interested in her peers and began to play games such as “peek-boo” with them.

Erlene is enrolled in the Toddler Playgroup for the summer 2001 semester and we look forward to interacting with her and her family again. Goals should continue to focus on increasing her verbal vocabulary and speech intelligibility. Please feel free to contact me at (480) 965-9396 if there is any other information that I can provide.
Heather L. Weintraub, MA, CCC-SLP
Speech-Language Pathologist
Clinical Faculty Research Associate
BACKGROUND INFORMATION

John, age 36 months, has been involved with the Infant Child Research Programs (ICRP) at Arizona State University (ASU) since January 2003. This semester was John’s first semester in the Toddler Playgroup. This group met once a week for two hour sessions and was designed to facilitate early communication and language skills through play-based activities. The program also included monthly home visits designed to support the Doe’s efforts to facilitate John’s communication and to address any concerns or questions they might have had regarding John’s speech and language development. Four home visits were scheduled over the course of the semester. Typical home visits included a discussion of strategies found to be effective in playgroup and at home, a play session in which John’s mother and clinicians modeled and utilized these strategies, and a conversation to address future plans, progress, and questions. John attended 13 out of 15 playgroup sessions this semester. Goals targeting John’s verbal communication were established with John’s mother during a home visit in January 2003. This report describes the progress John made during the spring 2003 semester on the objectives selected by his family and the playgroup clinicians.

OBJECTIVES AND PROGRESS

I. John will imitate clinicians’, peers’, and family members’ verbal models during classroom routines and home visits, in 2 out of 3 opportunities, in 2 out of 3 sessions.

This goal was met on home visit sessions. At the beginning of the semester, John imitated some of his mother’s verbal models when given prompts (such as “say cut”), but rarely imitated the clinician’s verbal models during playgroup or on home visits. In order to encourage imitation, John’s mother and clinicians used strategies such as providing models for common words, offering verbal choices (e.g. “cut or glue”), and mand models (e.g. tell me “push”) in playgroup and on home visits. By the end of the semester, John imitated most of what was modeled on home visits and sometimes imitated during playgroup when he was given prompts. It was observed that many of John’s imitations followed a verbal choice given by his mother or one of his teachers (e.g. “juice or water?”) and that John generally imitated one and two word utterances. While John consistently imitated during home visits, his imitations were much less consistent in the playgroup setting. On average, John imitated in 2/3 opportunities on home visits and 1/3 opportunities during snack time, and in 0/3 opportunities during free play. It is hypothesized that John imitated more frequently during snack time, due to its structured nature. During snack time, John was required to produce words, either in imitation or spontaneously, to receive a desired action, item, etc. In order to increase John’s imitations in additional contexts, it is recommended that this goal be expanded to target imitation of single words in a variety of unstructured contexts (e.g. freeplay, song time).
II. John will verbally communicate his wants and needs (such as requesting food, a toy, or help with an item), when given prompts (such as “want more?”), in 3 out of 5 opportunities, in 2 out of 3 sessions.

This goal was met on home visit sessions and during snack time in playgroup. At the beginning of this semester, John mainly used gestures, such as pointing and reaching, to communicate his wants and needs. During playgroup, clinicians used strategies such as providing verbal choices (e.g. “Do you want water or juice?”) and prompts (e.g. “Want more?”) to facilitate his verbal communication. These strategies and others, such as withholding (waiting for John to verbally request an item or action) and requesting clarification, were also modeled during home visits. By the end of the semester John was communicating verbally, in certain contexts, such as during home visits and during snack time in playgroup, when these strategies were implemented. Towards the end of the semester, John communicated his wants and needs in 4/5 opportunities at home, in 3/5 opportunities during snack time, and in 1/5 opportunities during other group activities, when given prompts. By the end of the semester, John also began to request items spontaneously during snack time and a turn during song time.

These observations were consistent with the results of the MacArthur Communicative Development Inventory: Words and Sentences (CDI), elicited by parent report on February 1st. The CDI indicated that John used primarily single words and that his vocabulary consisted mainly of nouns (70 nouns, 4 pronouns, 10 descriptive words, 9 social words, 3 action words, and 1 question word were reported). Although the CDI is a standardized assessment tool, normed scores were not available for John due to his age (which was above the age requirements for this protocol). John’s mother reported approximately 111 spontaneous words in John’s total vocabulary, indicating that John continues to demonstrate a limited vocabulary for a child his age.

It is recommended that therapy continue to target increasing John’s expressive vocabulary by expanding his repertoire to include action words (such as “go”, “run”, “hop”), descriptive words (such as colors, “big/little”, etc.) and personal pronouns (“I”, “me”, “mine”, “my”). Therapy should also focus on increasing John’s use of spontaneous verbal communication in a variety of contexts (such as free play, song time, playground). Strategies such as time delay (e.g. presenting an item and waiting for John to comment or request), foils (creating a situation that requires clarification, such as handing John the wrong toy), and environmental manipulation (e.g. placing desired items in hard to open containers or hard to reach places), should continue to be used to create opportunities for spontaneous communication.

SUMMARY AND RECOMMENDATIONS

It has been a pleasure having John in playgroup this semester. It has been wonderful seeing the progress he has made. John now enters the room in a confident manner; he participates in most of our activities, and has begun to make some new friends. During the semester, John increased his rate of vocalization and improved his ability to communicate through imitated and spontaneous verbalizations.

John is enrolled in a twice a week playgroup for the summer 2003 semester and we look forward to interacting with him and his family again. It is recommended that goals continue to focus on increasing John’s expressive language skills. Therapy should focus on the following:

1. Imitation of single words in a variety of unstructured contexts (e.g. free play, song time).
2. Spontaneous production of familiar (i.e. easily imitated) one to two word utterances during structured and unstructured activities.
3. Increasing new vocabulary to include pronouns, adjectives and verbs, when given minimal prompts.

Please feel free to contact us at (480) 965-9396 if there is any other information that we can provide.

_________________________                                 _______________________________
Stacey Burk, B.S.     Heather Weintraub, M.A., CCC-SLP
Student Clinician     Speech-Language Pathologist
                      Clinical Faculty Research Associate
TOODDLER PLAYGROUP PROGRESS REPORT EXAMPLE 3

NAME: Jack Smith     DATE: 4/1/02
PARENTS: Jack and Jill Smith    BIRTHDATE: 11/1/99
ADDRESS: 45678 W. Street Court Town, AZ 65432 AGE: 29 months
TELEPHONE: (000) 123-4567
CLINICIAN: Heather Weintraub, M.A. CCC-SLP

BACKGROUND INFORMATION

Jack, age 29 months, has been involved with the Infant Child Research Programs (ICRP) at Arizona State University (ASU) since September 2001. This semester was Jack’s second semester (Spring 2002) in the Toddler Playgroup. This group met once a week for two-hour sessions and was designed to facilitate early communication and language skills through play-based activities. An Individualized Family Service Plan (IFSP) was updated with Jack’s mother in January 2002 in order to review and update goals and objectives for intervention and to address both Jack and his family’s current strengths and needs in supporting and promoting his communication and language development. Jack attended 11/14 playgroup sessions this semester. This report describes the progress Jack made during the spring 2002 semester on the objectives selected by his parents and his playgroup clinician.

OBJECTIVES AND PROGRESS

I. Jack will imitate fingerplays, actions, sounds/words during songs at the songtime, on 2 occasions, during three out of five consecutive playgroup sessions.

Although Jack appears to enjoy songtime and comes willingly to sit on the rug with his classmates, he imitated just a few movements at songtime this semester (waving and clapping). He did participate in group activities by requesting turns to pick songs (by saying “me”), pointing to pictures in books and by passing objects to his friends upon request (such as “Jack, please give the spider to Jill”). Jack also willingly allowed his clinicians to help him make motions during songs. It is recommended that this goal be continued next semester.

II. Jack will use 10 novel words (nouns, verbs, personal pronouns) per session, in three out of five consecutive playgroup sessions.

This goal was achieved on 4-1-02. Based upon parent report on the MacArthur Communicative Developmental Inventory: Words and Sentences (CDI), Jack’s vocabulary grew from 68 words and 14 signs on 12-1-01 to 94 words and 5 signs on 3-1-02. Jack is now consistently requesting with single words and/or signs during structured (songtime, snack) and unstructured activities (sensory play). He spontaneously uses a variety of words, such as object labels (such as “ball”), action words (such as “push”), names of family/peers (such as “mommy”), personal pronouns (such as “me” and “mine”) and descriptive words (such as “black”). Jack is not yet using personal pronoun “I” in short statements, such as “I want” or “I go”. In the last few weeks, Jack has begun to combine words into two-word sentences. It is recommended that Jack continue to have expressive language goals that focus on increasing verbal vocabulary and sentence length.
III. Jack will produce consonant-vowel-consonant (CVC) and consonant-vowel- consonant-vowel (CVCV) (alternative vowels) at least five times, during three out of five consecutive playgroup sessions.

This goal was achieved on 4-1-02. Jack produces many CVCV words with alternating vowels, such as “bubble” and “cookie”. Although Jack is now able to spontaneously produce the final consonant in CVC construction at least five times per session, he continues to delete final consonants in most instances. He is usually able to produce final /p, b and s/, at least in imitation. It is recommended that deletion of final consonants continue to be targeted as a goal next semester.

**SUMMARY AND RECOMMENDATIONS**

It has been a pleasure having Jack in playgroup again this semester. Jack significantly increased his verbal vocabulary and sentence length this semester and achieved 2 of 3 goals. Jack appeared to really enjoy coming to playgroup and willingly participated in the structured and unstructured activities. As the semester progressed, Jack became more outgoing and interactive with his clinicians and friends in playgroup. Jack expanded his play this semester and appeared to enjoy a variety of activities, including the sensory table, coloring, cars/trucks, and cooking in the kitchen area.

Jack is enrolled in the Toddler Playgroup for the summer 2002 semester and we look forward to interacting with him and his family again. Goals should continue to focus on increasing his verbal vocabulary and sentence length and decreasing use of final consonant deletion.

Please feel free to contact me at (480) 965-9396 if there is any other information that I can provide.

Heather Weintraub, M.A., CCC-SLP
Speech-Language Pathologist
Clinical Faculty Research Associate
PRESCHOOL ASSESSMENT REPORT EXAMPLE

NAME: John Doe
DATE: 1/1/00
PARENTS: Jack and Jill Doe
BIRTHDATE: 5/1/97
ADDRESS: 1234 W. Culdesac Dr.
City, AZ 45678
AGE: 3; 5
TELEPHONE: (123) 456-0789
CLINICIAN: Jean C. Brown, DPA, CCC-SLP

Background Information:

John’s, communicative abilities were assessed on October 20, 2000 as part of his participation in the Infant Child Research Programs (ICRP) at Arizona State University (ASU). John was three years, eight months at the time of the assessment. This is John’s and his twin brother, Josh, first semester in the Preschool Class. They had previously attended the Toddler Playgroup at ICRP.

The following is a summary of the tests administered, John’s scores and his strengths and needs as they relate to each test.

Speech Language Assessment:

<table>
<thead>
<tr>
<th>Battelle Developmental Inventory (BDI)</th>
<th>Raw Score</th>
<th>z-Score</th>
<th>Age Equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal-Social</td>
<td>106</td>
<td>-1.18</td>
<td>33 months</td>
</tr>
<tr>
<td>Adaptive</td>
<td>58</td>
<td>-2.33</td>
<td>27 months</td>
</tr>
<tr>
<td>Motor</td>
<td>114</td>
<td>+.47</td>
<td>46 months</td>
</tr>
<tr>
<td>Communication</td>
<td>52</td>
<td>-1.64</td>
<td>32 months</td>
</tr>
<tr>
<td>Cognitive</td>
<td>46</td>
<td>-.36</td>
<td>40 months</td>
</tr>
<tr>
<td>BDI Total</td>
<td>376</td>
<td>-1.34</td>
<td>36 months</td>
</tr>
</tbody>
</table>

The BDI assesses general development across five areas including personal-social, interactional abilities, adaptive or self-help skills gross and fine motor skills, communication e.g., receptive and expressive language abilities, and cognition. John achieved a total raw score of 376 on the BDI, which yielded a z-score of –1.34 standard deviations below the mean when compared with same aged peers and an age equivalency of 36 months (CA: 41 months). Average standard scores range from –1.5 to + 1.5. John had strengths in the areas of gross and perceptual motor development as well as cognitive abilities. He had difficulty with adaptive and communication skills.

The **Personal-social Domain** of the BDI assessed John’s ability to engage in meaningful social interactions. John achieved a raw score of 106, which yielded a z-score of –1.18 standard deviations below the mean when compared with same aged peers, and an age equivalency of 33 months (CA: 41 months). Average standard scores are between –1.5 and + 1.5. John’s strengths included adult interactions and expression of feelings and affect. He had difficulty with social roles, that is, knowing whether he was a male or a female or knowing the difference between males and females.
The **Adaptive Domain** of the BDI assessed John’s ability to process information and his development of skills that were related to self-help and daily living skills. He achieved a raw score of 58, which yielded a z-score of –2.33 standard deviations below the mean when compared with same aged peers, and an age equivalency of 27 months (CA: 41 months). Average standard scores are between –1.5 and +1.5. John’s strengths included attention and eating. He had difficulty with dressing and toileting skills.

The **Motor Domain** of the BDI assessed John’s ability to use and control large and small muscles in his body (gross and fine motor development). He obtained a raw score of 114, which yielded a z-score of +.47 standard deviations above the mean. His age equivalency was 46 months above his chronological age of 41 months. Strengths on the gross motor tasks included throwing a ball and walking heel-to-toe for four or more steps. He had difficulty hopping on one foot and standing on each foot alternately with his eyes closed. It should be noted that both of these skills are above his chronological age. John’s strengths on fine motor skills included holding a piece of paper with one hand while drawing or writing with his dominant hand; using scissors to cut paper; and opening a small padlock with a key. In addition, he copied a vertical line, a circle, and a cross. He had difficulty folding a piece of paper two times, once horizontally and once vertically.

The **Communication Domain** of the BDI assessed John’s understanding and processing of language (receptive) and his use of language. His total raw score for communication was 52, which yielded a z-score of -1.64 standard deviations below the mean when compared with same aged peers, and an age equivalency of 32 months (CA: 41 months). Average scores are between –1.5 and +1.5. Receptively, his strengths included understanding possessive forms; responding to adverbs such as softly and loudly; and understanding words such as biggest and longest. He had difficulty responding to who, where, and when questions. Expressively his strengths included using pronouns such as I, you, and me; using two and three-word utterances meaningfully; and asking questions that begin with who, what, where, why, and how. He had difficulty with plural forms and relating past experiences.

The **Cognitive Domain** of the BDI assessed John’s perceptual discrimination, memory reasoning academic skills and conceptual development. He obtained a raw score of 46 which yielded a z-score of -0.36 standard deviations below the mean and an age equivalency of 40 months when compared to same aged peers (CA: 41 months). Average standard scores are between –1.5 and +1.5. His strengths included perceptual discrimination: placing a square and circle in a form board, and matching geometric figures. Reasoning and academic skills was also a strength for him. He pulled a string to obtain a toy or ring; reached around a barrier to obtain a toy and responded to one and one more. He had difficulty with memory tasks such as recalling familiar objects.

Preschool Language Scale-3 (PLS-3)

<table>
<thead>
<tr>
<th>Raw Score</th>
<th>Standard Score</th>
<th>Percentile Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory Comprehension</td>
<td>28</td>
<td>90</td>
</tr>
<tr>
<td>Expressive Communication</td>
<td>23</td>
<td>84</td>
</tr>
<tr>
<td>Total Language Score</td>
<td>--</td>
<td>87</td>
</tr>
</tbody>
</table>
The PLS-3 is used to assess receptive and expressive language skills in infants and young children. There are two subscales, Auditory Comprehension and Expressive Communication. On the PLS-3 the mean is a 100 with a standard deviation of plus or minus 15; therefore average scores range between 85 and 115.

**Auditory Comprehension:**

On the Auditory Comprehension subdomain, John obtained a raw score of 28 and a standard score of 90, which yielded a percentile rank of 30. This score is within a plus and minus one standard deviation, and represents an average score. John understood descriptive concepts such as heavy, empty, and the same. He identified pictures (e.g., caterpillar, doctor, groceries, and triangle). He had difficulty with spatial concepts (e.g., under, and next to).

**Expressive Communication:**

On the Expressive Communication domain, John obtained a raw score of 23 and a standard score 84, which yielded a percentile rank of 14. This score is between –1.5 and –1 standard deviations and represents a mild disorder. John answered what, where, and yes/no questions (e.g., “What does he?” ‘Is he sleeping?” “Where is the boy?”); used verb + ing (e.g., eating and sleeping); and used pronouns spontaneously (e.g., I, he,) he had difficulty with the production of four and five word sentences and the use of possessives (e.g., the cat’s, the dog’s).

**Language Sample Analysis**

An informal language sample was collected on line in the Preschool classroom. His peers and teachers served as his communicative partners. Fifty complete and intelligible utterances wee used for the analysis.

**Semantic Analysis:**

The Type-Token Ratio (TTR), which is the relationship between the total number of different words used (Type) and the total number of words used (Token), was used for the semantic analysis or the diversity of John’s spontaneous vocabulary. John produced 48 different words and 112 total words, which yielded a TTR of .43. The predicted ratio for his age group is .45. This ratio indicated that John’s vocabulary is not as diverse as it should be when compared with same aged peers. He used the following word classes: nouns 17% (e.g., alligator, dot, lock, and paper); verbs 21% (e.g., go, want, make, and need), adjectives 2% (e.g., some and monster hands); adverbs 17% (e. g., outside, there, and here); prepositions 3% (e.g., in and on); pronouns 32% (e.g., you, I, my, your, and me); conjunctions 0%; negative affirmatives 8 % (e.g., yeah, no, uh-huh, and no); articles 0% and Wh-words 0%.

**Syntactic Analysis:**

John’s Mean Length of Utterance (MLU), a measure of the length and complexity of his utterances, was calculated to be 2.37. This MLU places him –1.45 standard deviations below the mean when compared with same aged peers (average scores range from –1.5 to +1.5). The predicated MLU for his age is 3.78 with a range of 2.96 to 4.90. John’s MLU placed him Brown’s Stage II which is characterized by the use of grammatical morphemes (e.g., present progressive-ing, regular plural –s and the preposition on) in multi-utterances. His supper bound length (largest number of morphemes in an utterance) was four and
his lower bound length (smallest number of morphemes in an utterance) was one.

A grammatical morpheme analysis was completed to assess the morphemes John used and to see if the morphemes were use correctly. He used the prepositions in and on and they were 100% correct when used. He did not use the present progressive form of verbs (e.g., running), nor did he use plural-s (e.g., ducks). In addition he did not use possessives (e.g., cat’s) All of these morphemes should be targeted for therapy.

Summary and Recommendations

John’s overall development is within normal limits. He had difficulty with peer interaction adaptive skills (e.g., dressing and toileting). Although, his communication skills are still delayed he is making progress. He had difficulty with expressive language skills, particularly syntax, phonology, and pragmatics or the use of language. The pragmatics should be addressed in the context of making him feel more at ease in unfamiliar settings and with his peers. Recommendations for the Individualized Education Plan (IEP) include:

1. Increasing peer interaction
2. Using plural –s, the copula is, and the present progressive form of verbs
3. Being toilet trained

Thank you for the privilege of serving you and your son. If you have any questions or information that you would like to add or delete from the report, please contact us at (480) 965-9396.

Jean C. Brown, DPA, CCC-SLP
Speech-Language Pathologist
PRESCCHOOL PROGRAM PROGRESS REPORT EXAMPLE

NAME: Jack Ryan     DATE: 12/01/2000
PARENT: Jacob and Jill Ryan     BIRTHDATE: 03/10/1997
ADDRESS: 12345 N. 3rd Avenue     AGE: 44 months
Scottsdale, AZ 85255     TELEPHONE: (987) 654-3210
CLINICIAN: Julie Kleinheinz, B.A.
SUPERVISOR: Jean C. Brown, Ph.D., CCC-SLP

BACKGROUND INFORMATION

Jack Ryan, age 44 months, attended Tuesday and Thursday preschool class at the Infant Child Research programs (ICRP) at Arizona State University during the fall 2000 semester. He had previously attended the Toddler Playgroup at the ICRP during fall semester of 1999 and spring semester of 2000. (Add something about attendance here) Jack’s parents enrolled him in preschool classes to facilitate his speech and language production. An Individualized Education Plan (IEP) was developed for Jack by his parents and the preschool staff. The following goals were selected:

1. Jack will increase his expressive language skills.
2. Jack will improve his pragmatic skills.
3. Jack will improve his social-emotional skills.

OBJECTIVES AND PROGRESS

1.a. Jack will correctly produce initial and final consonants /p,b,m/ in CVC (e. g, mop & beep) & CVCVC (ex: pickup & popup) syllable constructions 5 times for 3 out of 5 consecutive sessions.

Jack partially achieved this objective. The clinician used focused stimulation creating situations that required Jack to produce the target phonemes (sounds) /p,b,m/. Modeling with recast, e.g., repetition of Jack’s utterances by changing some element, and modeling with expansion, i.e., repeating Jack’s utterances by adding different words, were used by the clinician while playing with trucks with Jack during free play. Later in the semester the clinician used verbal cues such as, “Jack look, can you say pig?” while using touch cues (touching two fingers to closed lips) emphasizing the target /p/ sound. By the end of the semester, Jack was producing initial consonants /p,b,m/ in most instances (e.g. “piece”, “banana”, “missing”) but continued to delete the majority of final consonants /p,b,m/. This objective should be continued next semester focusing on word final position of consonants /p,b,m/.

1.b. Jack will correctly use the pronoun “I” when referring to himself during snack time and play-based activities 8 times per session for 3 out of 5 sessions.

Jack achieved this objective. The clinician used a withholding strategy to obligate Jack to use words to make requests at snack time as well as used modeling with recast (repeated Jack’s utterance making a change i.e., if Jack said “me want juice” the clinician said “I want juice”). Jack began using the pronoun “I” consistently over 3 sessions by late-September. For example, he used utterances such as “I do”, “I want Goldfish” and “I want you to play with me”. This goal does not need to be continued next semester.
1.c. Jack will spontaneously use complex grammatical markers (plural –s, possessive –s, verb + ing) 5 times per session for 3 out of 5 consecutive sessions.

Jack partially accomplished this objective. The clinician used modeling with expansions (clinician added more information to Jack’s words, e.g., if Jack said, “I putting on new shoe” the clinician would respond, “Yes, you are putting on your new shoes.”) Jack started using the verb + “ing” more consistently by the end of the semester saying for example, “We’re missing a piece” or “I’m going to erase him”. Jack continued to demonstrate inconsistent use of plural “s” and possessive “s” which may be due to his deletion of most final consonants. However, when the clinician used verbal touch cues and modeled a final consonant /s/ Jack was able to produce the sound about 3 out of 10 times. This objective should be carried over into the next semester for further reinforcement.

2. Jack will maintain topics, take turns speaking and maintain correct voice volume during play-based activities 2 times each session over 5 sessions.

This objective was met. The clinician used structured play activities (i.e., building a wall together out of blocks) that encouraged Jack to interact with others and give him the opportunity to practice his pragmatic skills of topic maintenance; turn-taking and modulating his volume. Verbal and nonverbal cues were used as reminders to maintain a low volume. Overall, Jack did a great job with pragmatics and accomplished this objective by holding conversations with the clinician about trips with his family, stories about his dog, Spot, or his friend, Jo Jo. At times, Jack would use an inappropriately loud voice volume when he became frustrated with peers (e.g., when a peer knocked over his block wall), when he disagreed with a peer on something (i.e., what he put in his pretend broccoli soup), or with the clinician when she did not respond to his communication right away. Appropriate voice volume should be modeled, explained and reinforced next semester.

3.a. Jack will separate easily and in a relaxed manner from his caregiver after outdoor playground time each session for 3 consecutive sessions.

Jack accomplished this objective. The clinician assigned jobs to Jack (i.e., taking the cups out to the playground or being line leader) to distract Jack from thinking about being separated from his caregiver. Jack accomplished this goal by late-October when he separated from his grandmother in a relaxed manner over three sessions. Jack’s grandmother did report that sometimes Jack did not want to come to school some mornings but once he got to school he did a good job adjusting. This objective might need to be reassessed next semester.

3.b. Jack will initiate conversation or play with peers on two occasions per session for 3 of 5 consecutive sessions.

Jack partially met this objective this semester. The clinician provided opportunities for group play (e.g. board games or building train tracks) or group activities (e.g. art project) to encourage interaction, turn taking and social communication with peers. At the beginning of the semester, Jack preferred to play by alone or alongside peers and did not communicate with his peers. In October, Jack began to engage in play with peers playing hide and seek, going on a bear hunt and playing in the “mouse house”. Jack began to talk to peers occasionally in October and November. He used words to make requests to peers (i.e., “Don’t mush my sandcastle” and “Pass the bears please”), or to disagree (e.g., “No, that’s broccoli
soup.”). This goal should be continued and reinforced next semester.

**LANGUAGE SAMPLE**

An online language sample was obtained on November 19, 2002 to document Jack’s progress over the semester. From a language sample obtained on September 19, 2002, Jack’s Mean Length of Utterance (MLU), a measure of the length and complexity of his utterances, was calculated to be 3.68 or Brown’s Stage Late IV / Early V. This MLU placed him –0.12 standard deviations below the mean. The predicted MLU for his age group was 3.78 with a range of 2.96 – 4.60. By the end of the semester, Jack had an MLU of 4.12, which placed him 0.03 standard deviations above the mean for 44-month-old children and within the normal range of development (3.21-4.97). This language sample revealed that Jack is using word meaning (semantics) appropriately. For example, he named objects (“pen”, “kitty”), used action words (“build”), words denoting possession (“my caterpillar”), and denoting recurrence (“I need more flour”). In terms of syntax, Jack put words and morphemes together to form expanded sentences one to eight words or morphemes long. He used prepositions “in” and “on”, articles “a” and “the”, contractible copula (e.g., “That’s his hair”), and contractible auxiliary (e.g., “We’re missing a piece”). Jack’s social language was also appropriate in terms of relating recent experiences, maintaining conversations and explaining his actions. Overall speech intelligibility was judged as fair.

**SUMMARY AND RECOMMENDATIONS**

Jack made significant progress this semester. Jack arrives more confidently to class and separates easier from his caregiver. He also used word initial consonants /p,b,m/ on a consistent basis, mastered the use of pronoun “I” when referring to himself and maintained adequate voice volume in most situations. In terms of expressive language, Jack could use further work on production of word final consonants and adding morphological markers plural “s” and possessive “s”. In terms of social-emotional skills, Jack communicates well with adults and is ready to transition into playing and communicating more with peers.

It was a pleasure to work and learn with Jack this semester. Please contact us at (602) 965-9396 if there is any other information that we can provide.

________________________   ________________________
Julie Kleinheinz, B.A.     Jean Brown, Ph.D., CCC-SLP
Student Clinician     Clinical Associate Professor
APPENDIX L: CODE OF ETHICS

Last Revised January 1, 2003


Index terms: ASHA reference products, ethics (professional practice issues), ethics and related papers

Document type: Ethics and related documents

Preamble

The preservation of the highest standards of integrity and ethical principles is vital to the responsible discharge of obligations by speech-language pathologists, audiologists, and speech, language, and hearing scientists. This Code of Ethics sets forth the fundamental principles and rules considered essential to this purpose.

Every individual who is (a) a member of the American Speech-Language-Hearing Association, whether certified or not, (b) a nonmember holding the Certificate of Clinical Competence from the Association, (c) an applicant for membership or certification, or (d) a Clinical Fellow seeking to fulfill standards for certification shall abide by this Code of Ethics.

Any violation of the spirit and purpose of this Code shall be considered unethical. Failure to specify any particular responsibility or practice in this Code of Ethics shall not be construed as denial of the existence of such responsibilities or practices.

The fundamentals of ethical conduct are described by Principles of Ethics and by Rules of Ethics as they relate to the conduct of research and scholarly activities and responsibility to persons served, the public, and speech-language pathologists, audiologists, and speech, language, and hearing scientists.

Principles of Ethics, aspirational and inspirational in nature, form the underlying moral basis for the Code of Ethics. Individuals shall observe these principles as affirmative obligations under all conditions of professional activity.

Rules of Ethics are specific statements of minimally acceptable professional conduct or of prohibitions and are applicable to all individuals.

Principle of Ethics I

Individuals shall honor their responsibility to hold paramount the welfare of persons they serve professionally or participants in research and scholarly activities and shall treat animals involved in research in a humane manner.

Rules of Ethics

A. Individuals shall provide all services competently.
B. Individuals shall use every resource, including referral when appropriate, to ensure that high-quality service is provided.
C. Individuals shall not discriminate in the delivery of professional services or the conduct of research and scholarly activities on the basis of race or ethnicity, gender, age, religion, national origin, sexual orientation, or disability.

D. Individuals shall not misrepresent the credentials of assistants, technicians, or support personnel and shall inform those they serve professionally of the name and professional credentials of persons providing services.

E. Individuals who hold the Certificates of Clinical Competence shall not delegate tasks that require the unique skills, knowledge, and judgment that are within the scope of their profession to assistants, technicians, support personnel, students, or any nonprofessionals over whom they have supervisory responsibility. An individual may delegate support services to assistants, technicians, support personnel, students, or any other persons only if an individual who holds the appropriate Certificate of Clinical Competence adequately supervises those services.

Ethics

F. Individuals shall fully inform the persons they serve of the nature and possible effects of services rendered and products dispensed, and they shall inform participants in research about the possible effects of their participation in research conducted.

G. Individuals shall evaluate the effectiveness of services rendered and of products dispensed and shall provide services or dispense products only when benefit can reasonably be expected.

H. Individuals shall not guarantee the results of any treatment or procedure, directly or by implication; however, they may make a reasonable statement of prognosis.

I. Individuals shall not provide clinical services solely by correspondence.

J. Individuals may practice by telecommunication (for example, telehealth/e-health), where not prohibited by law.

K. Individuals shall adequately maintain and appropriately secure records of professional services rendered, research and scholarly activities conducted, and products dispensed and shall allow access to these records only when authorized or when required by law.

L. Individuals shall not reveal, without authorization, any professional or personal information about identified persons served professionally or identified participants involved in research and scholarly activities unless required by law to do so, or unless doing so is necessary to protect the welfare of the person or of the community or otherwise required by law.

M. Individuals shall not charge for services not rendered, nor shall they misrepresent services rendered, products dispensed, or research and scholarly activities conducted.

N. Individuals shall use persons in research or as subjects of teaching demonstrations only with their informed consent.

O. Individuals whose professional services are adversely affected by substance abuse or other health-related conditions shall seek professional assistance and, where appropriate, withdraw from the affected areas of practice.

Principle of Ethics II
Individuals shall honor their responsibility to achieve and maintain the highest level of professional competence.

Rules of Ethics

A. Individuals shall engage in the provision of clinical services only when they hold the appropriate Certificate of Clinical Competence or when they are in the certification process and are supervised by an individual who holds the appropriate Certificate of Clinical Competence.

B. Individuals shall engage in only those aspects of the professions that are within the scope of their competence, considering their level of education, training, and experience.

C. Individuals shall continue their professional development throughout their careers.

D. Individuals shall delegate the provision of clinical services only to: (1) persons who hold the appropriate Certificate of Clinical Competence; (2) persons in the education or certification process who are appropriately supervised by an individual who holds the appropriate Certificate of Clinical Competence; or (3) assistants, technicians, or support personnel who are adequately supervised by an individual who holds the appropriate Certificate of Clinical Competence.

E. Individuals shall not require or permit their professional staff to provide services or conduct research activities that exceed the staff member’s competence, level of education, training, and experience.

F. Individuals shall ensure that all equipment used in the provision of services or to conduct research and scholarly activities is in proper working order and is properly calibrated.

Principle of Ethics III

Individuals shall honor their responsibility to the public by promoting public understanding of the professions, by supporting the development of services designed to fulfill the unmet needs of the public, and by providing accurate information in all communications involving any aspect of the professions, including dissemination of research findings and scholarly activities.

Rules of Ethics

A. Individuals shall not misrepresent their credentials, competence, education, training, experience, or scholarly or research contributions.

B. Individuals shall not participate in professional activities that constitute a conflict of interest.

C. Individuals shall refer those served professionally solely on the basis of the interest of those being referred and not on any personal financial interest.

D. Individuals shall not misrepresent diagnostic information, research, services rendered, or products dispensed; neither shall they engage in any scheme to defraud in connection with obtaining payment or reimbursement for such services or products.

E. Individuals’ statements to the public shall provide accurate information about the nature and management of communication disorders, about the professions, about professional services, and about research and scholarly activities.

F. Individuals’ statements to the public—advertising, announcing, and marketing their professional services, reporting research results, and promoting products—shall adhere to prevailing professional standards and shall not contain misrepresentations.
Principle of Ethics IV

Individuals shall honor their responsibilities to the professions and their relationships with colleagues, students, and members of allied professions. Individuals shall uphold the dignity and autonomy of the professions, maintain harmonious inter-professional and intra-professional relationships, and accept the professions’ self-imposed standards.

Rules of Ethics

A. Individuals shall prohibit anyone under their supervision from engaging in any practice that violates the Code of Ethics.
B. Individuals shall not engage in dishonesty, fraud, deceit, misrepresentation, sexual harassment, or any other form of conduct that adversely reflects on the professions or on the individual’s fitness to serve persons professionally.
C. Individuals shall not engage in sexual activities with clients or students over whom they exercise professional authority.
D. Individuals shall assign credit only to those who have contributed to a publication, presentation, or product. Credit shall be assigned in proportion to the contribution and only with the contributor’s consent.
E. Individuals shall reference the source when using other persons’ ideas, research, presentations, or products in written, oral, or any other media presentation or summary.
F. Individuals’ statements to colleagues about professional services, research results, and products shall adhere to prevailing professional standards and shall contain no misrepresentations.
G. Individuals shall not provide professional services without exercising independent professional judgment, regardless of referral source or prescription.
H. Individuals shall not discriminate in their relationships with colleagues, students, and members of allied professions on the basis of race or ethnicity, gender, age, religion, national origin, sexual orientation, or disability.
I. Individuals who have reason to believe that the Code of Ethics has been violated shall inform the Board of Ethics.
J. Individuals shall comply fully with the policies of the Board of Ethics in its consideration and adjudication of complaints of violations of the Code of Ethics.
APPENDIX M: STUDENT OUTCOMES

SHS 580: Early Childhood Programs
Student Outcomes

Student Name: _________________________ Date: _____________________

✓ -Competency met by achieving a passing grade on all three domains: Clinical, Interpersonal, and professional management skills
X -Competency not demonstrated. Student had a failing grade on the three domains.
Student will need to demonstrate this competency elsewhere (i.e., repeating the practicum) or through subsequent project within the current practicum (Remediated)
-If the competency was met at a different time within this practicum explain how in the remediated column.

The student is able to:

<table>
<thead>
<tr>
<th>Knowledge or Skill</th>
<th>How</th>
<th>Met</th>
<th>Remediated</th>
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<tr>
<td>(IV-G) Evaluation: (b) Collect case history information and integrate information from all sources</td>
<td>Reading charts, caregiver interviews, planning and conducting home visits</td>
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<td>(c) Select and administer appropriate evaluation procedures, such as behavioral observations, non standardized tests, and instrumental procedures</td>
<td>Informal observations, language samples, and formal assessments</td>
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<td>(d) Adapt evaluation procedures to meet child’s needs</td>
<td>Individualized Family Service Plan (IFSP) Writing Preschool Intervention Plan (PIP)</td>
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<td>(e) Interpret, integrate, and synthesize diagnoses and make appropriate recommendations for intervention</td>
<td>Assessment reports and parent conferences</td>
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<td>(f) Complete administrative and reporting functions necessary to support assessment</td>
<td>Timely parent conferences, well-written and comprehensive documents that are filed and given to identified stakeholders and appropriate referrals</td>
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<td>(IV-G) Intervention (a): Develop setting-appropriate intervention plans with measurable and achievable goals that meet child’s needs</td>
<td>IFSP/PIP, weekly lessons plans, and weekly summaries</td>
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<td>(b) Implement intervention plans involve caregivers in the intervention process</td>
<td>IFSP/PIP, weekly summaries parent conferences as needed</td>
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<td>(c) Select or develop and use appropriate materials and instrumentation for</td>
<td>Weekly teaming, staffing and planning meetings,</td>
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<td>prevention and intervention</td>
<td>case studies</td>
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<td><strong>(d)</strong> Measure and evaluate child’s performance and progress</td>
<td>Ongoing and accurate data collection, lesson plans and weekly summaries</td>
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<td><strong>(e)</strong> Modify intervention plans, strategies, materials or appropriate instrumentation as appropriate to meet the needs of the child</td>
<td>Ongoing and accurate data collection, lesson plans and weekly summaries</td>
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<td><strong>(f)</strong> Complete administrative and reporting functions necessary to support intervention</td>
<td>Lesson plans and weekly summaries, progress reports</td>
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<td><strong>(g)</strong> Identify and refer children for appropriate services</td>
<td>Assessments, parent conferences, weekly staffing</td>
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**IV-G Interaction and Personal Qualities:**

- **(a)** Communicate effectively the needs values, preferred mode of communication and cultural/linguistic background of the child/family, caregivers, and relevant others
  - Home visits, parent conferences, response to supervision, and journaling

- **(b)** Collaborate with other professionals in case management
  - Team meetings, IFSP/IEP meetings transition meetings

- **(c)** Provide counseling regarding communication and swallowing disorders to family, caregivers, and relevant others
  - Home visits, initial conferences, weekly summaries, final parent conferences

- **(d.)** Adhere to ASHA code of Ethics and behave professionally
  - Orientation, weekly staffing

Instructor’s Name: _____________________ Signature: _______________________

*MAKE A COPY FOR THE STUDENT AND SEND THE ORIGINAL TO CISSY LONGMORE TO BE PLACED IN THE STUDENT’S FILE.*