

EATON RESA
ASD ELIGIBILITY MANUAL
GUIDANCE FOR THE DETERMINATION OF
AUTISM SPECTRUM DISORDER

2015-2016



The contents herein were compiled and written by a Multidisciplinary ASD Committee under the guidance of an ERESA Special Education Department Supervisor. Thanks to everyone who participated in the development of this manual. Specific procedural and eligibility criteria are based on MARSE rules and the DSM-5 (2013) publications. Federal and state rules, as well as diagnostic criteria, are subject to change and may not be represented by this document if they are updated after its release. Every effort will be made to ensure that this document reflects the most recent updates in as timely a fashion as possible. Please request permission to reproduce portions of this document for the purpose of developing educational eligibility determination guidance materials by contacting ERESA's Special Education office at 517-541-8937.

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Pre-Referral Process

The Eaton County RESA recommends a pre-referral process to be implemented as an integral part of the referral procedures for any suspected disability. The purposes of this process are to:

- Identify a problem,
- Identify a student's strengths and needs,
- Identify potential diagnostic/prescriptive interventions, and
- Implement those interventions with the anticipated outcome of resolving a student's academic and/or behavioral challenges in the general education setting.

Following this process helps ensure that students are being educated in the least restrictive environment as required by Act 451 of 1976 and the Individuals with Disabilities Education Act of 2004 (IDEA 2004), and reduces the frequency of inappropriate referrals to special education. It is important that appropriate comprehensive educational interventions have been implemented and documented for a minimum of 45 school days prior to referring a student for special education services.

The pre-referral process is most effectively conducted by a student study team composed of general and special education teachers and related services personnel operating at the local building level. Depending on the district and program, students will be referred to a "student support team," "child study team," "building team," "diagnostic/prescriptive team," "MTSS Team," or other team with a similar function. Regardless of the name, the committees function in a similar manner. It is important to remember that information generated during the implementation of this process provides a source of information for the multidisciplinary evaluation team and individualized education planning team to use in determining if special education services are necessary for an individual student and what interventions will be most effective in remediating concerns. It is appropriate for all educational staff working with the student to be involved in the documentation of the student's classroom performance and the educational alternatives utilized to increase his or her ability to function in general education.

Members of a student study team vary by districts and buildings, but generally include evaluation staff. Teacher consultants for ASD, autism classroom staff, or other staff knowledgeable in ASD are generally not involved in these building based teams but should be consulted for assistance in reviewing information collected or conducting an informal classroom observation. This assistance will help the student study team in determining whether there is reason to suspect that the student has an Autism

Spectrum Disorder, what pre-referral strategies should be attempted, and whether a referral for a multidisciplinary evaluation should be made. At least one member of the multidisciplinary evaluation team should be present to assist with this decision.

The student study team may complete checklists, conduct observations, and review previous records. Parent input and participation should also be included. If other medical, genetic and/or behavioral conditions exist, information should be gathered about these conditions as well. Appendix B at the end of this manual contains some helpful data collection tools that can assist with this process.

Pre-Referral Strategies

Prior to a referral, strategies that are meant to address the communication, behavior, sensory processing, social, and/or learning differences that the student may have exhibited in the learning environment should be implemented and documented for their effectiveness. It is important to remember that if a strategy frequently used for students with ASD works for a particular student, it does not serve as evidence that the student has ASD. There are many strategies and techniques available that are common elements of good teaching which benefit students with a variety of needs and impairments in both general and special education settings. The strategies mentioned in this manual are starting suggestions and do not constitute an exhaustive list. See Appendix A to view these strategies in a convenient checklist format that can serve both as an efficient reference tool of evidence-based strategies and as a form to document interventions attempted.

Autism Research Institute provides an online progress monitoring tool for assessing improvement in ASD skill deficits which can be located here (Bernard Rimland, Ph.D. & Stephen M. Edelson, Ph.D.):

<http://www.surveygizmo.com/s3/1329619/Autism-Treatment-Evaluation-Checklist-revised>

Please note: It is not expected that a specific number of strategies be checked before referring a child for an evaluation. The information presented here is to ensure that the MARSE Rules for a complete and comprehensive evaluation and data collection in order to appropriately determine eligibility are met.

Review of Existing Evaluation Data (REED)/Consent to Evaluate

When the child study or MTSS team determines that further information is needed or a special education evaluation is appropriate, a REED is initiated by general education. These forms provide the REED Team with an efficient means of compiling all available data concerning problems with learning, as well as documentation of written permission and informed consent from the parent(s) to complete the special education evaluation if it is determined necessary. The REED Team should exhibit sensitivity to unknown or anticipated reactions by parents or other legal caregivers upon initiating a discussion about a student suspected of having ASD. Great care must be taken to assess the parents' initial understanding of autism and to impart full knowledge of what an evaluation of their child's unique strengths and needs entails. It is essential to discuss with parents the function of a school-based ASD evaluation and the process by which the team will consider information provided from outside evaluations. Refer to Navigating Services for Young Children with Autism Spectrum Disorder at the following link: http://www.resa.net/downloads/autism_spectrum_disorder/navigating_services_mi_20140520_152605_3.pdf.

It is necessary to ensure that parents understand the difference between an educational eligibility assessment and medical diagnosis, so they may begin the process of an external medical evaluation if they wish to pursue benefits and services available only to students who carry a medical diagnosis.

Eligibility Evaluation Considerations

The initial evaluation of a student suspected of having ASD and the determination of this student's eligibility for special education as a student with an ASD are complex tasks. This process requires the consideration of information obtained by a multidisciplinary evaluation team (MET) composed of:

- A certified school psychologist, or a fully licensed psychologist
- A school social worker (SSW)
- A speech and language pathologist (SLP)

In addition, other possible members of the MET team that may be included, but are not required are:

- Special education teachers

- Teacher consultants
- General education teachers
- Occupational therapists
- Physical therapists
- Other professionals who support and/or provide services for the student of concern

It is beneficial for at least one member of the REED Team to have knowledge of Autism Spectrum Disorder and experience with sufficient numbers of students with ASD at the same chronological and/or developmental age to ensure an accurate differential diagnosis. It is easy to over- and under-identify Autism Spectrum Disorder when professionals have limited experience assessing students with ASD.

Roles of Participants

Parent(s): It is crucial to involve parents in the evaluation process to obtain detailed information on the student's history of development, current social and behavioral functioning outside of school, and medical or support services being provided to the student. Although reasonable, documented efforts must be made to gain the parent(s) participation in the REED meeting, a REED meeting can be held without the parent in attendance as long as a member of the REED team thoroughly reviews the results with the parent so that informed consent is ensured concerning a decision to evaluate.

Certified School Psychologist/Licensed Psychologist: The psychologist provides information which may include assessment of the student's cognitive abilities, achievement levels, behavior (shared with SSW), autism spectrum characteristics (shared with SSW), and adaptive behavior. The psychologist also conducts an observation of the student in multiple settings. When testing and observations are complete, the psychologist provides information detailing the valid and reliable diagnostic techniques and assessments used, including enough information to address whether the cognitive and/or academic profile of strengths and deficits adversely affects the student's educational performance. Skills formally assessed may need to be observed in multiple settings to document whether or not the student actively uses the skills demonstrated in the testing situation.*

School Social Worker: The SSW provides information which includes, a developmental history (shared with school psychologist) and the student's social and emotional functioning and possible impact on his or her educational and behavioral functioning (shared with school psychologist). The SSW also interviews the parents and documents their concerns, early developmental history, and possible sensory

and other impactful issues. It is appropriate for the SSW to assist parents with the completion of any rating scales given to the parents during the course of the evaluation when needed. The SSW conducts observations of the student in multiple social contexts and settings and utilizes formal assessment instruments when appropriate. *

Speech and Language Pathologist (SLP): The SLP provides information indicating the student's language and communication skills and deficits, including pragmatics and social interaction skills. The SLP will complete standardized testing and/or informal assessments of social communication, expressive language, and receptive language. Use of alternative means of communication (nonverbal signals, gestures, use of objects and/or pictures to communicate) may be assessed and documented. Observations of the student's use of communication skills should be conducted in multiple settings alongside the school psychologist and school social worker. *

Other possible participants:

Special Education Teachers/General Education Teachers: Teaching staff provide specific information regarding the student's performance in the academic, behavioral, and social areas indicating the student's strengths and deficits. This information must be documented in the evaluation report.

Teacher Consultants: A teacher consultant or other consultant specializing in ASD can support the team in the evaluation process with their specialized knowledge or training. The consultant may facilitate the discussion around the determination of eligibility using the four-quadrant model and possibly observe the student in the learning environment. This information may be incorporated into the evaluation process but does not need to be a stand-alone report.

Occupational Therapist (OT): The OT provides information which may include assessment of fine motor, motor planning and sensory status. The OT may formally assess the student, including the use of checklists completed by a parent and staff, or informally assess via observation and/or interaction.

Physical Therapist (PT): The PT provides information which may include assessment of gross motor skills. They may be included in the evaluation when there are concerns about a physical delay or difference that may or may not be related to autism spectrum disorder. A PT can also assist in ruling out other orthopedic or neurological conditions that may be responsible for a delay or difference in motor skills. The PT may formally assess the student, including the use of checklists completed by parent and/or staff, or informally assess via observation and/or interaction.

**The ASD Team comprised of the psychologist, school social worker, and speech and language pathologist should convene together after initial data collection to collaborate and develop the evaluation report. ALL ASD reports should be collaborative and include all relevant information obtained during the course of the evaluation.*

Essential Components of a Comprehensive Autism Spectrum Disorder Evaluation

- Minimum three-person team (School Psychologist, SLP, SSW)
- Focus is on child in lieu of a characteristic-driven assessment
- Evaluation information gathered may include the following:
 - Developmental history
 - Communication skills and characteristics
 - Social Skills
 - Behavior concerns
 - Adaptive behavior skills
 - Cognitive abilities
 - Sensory-motor skills and concerns
 - Educationally relevant medical information.
- Balanced qualitative and quantitative assessments (deficits impacting learning do not have to be primarily academic or based on standardized scores)
- Collaborative observations in multiple settings
- Collaborative data collection
- Collaborative decision making
- Use of quadrant model for compilation of data and collaborative problem solving/decisions
- Collaborative unified team evaluation report that includes any interventions that were implemented and the outcome of progress from appropriate use of those interventions, as well as findings in relation to each of the ASD eligibility criteria (see eligibility determination form)
- Findings and summary of report content shared with parents/caregiver prior to IEP meeting
- Findings and summary of report shared with relevant school personnel prior to IEP meeting

See Appendix G for the Centralized Evaluation Team Quadrant Documentation Form for collaborative decision making. This form also serves as a useful tool for organizing evaluation reports.

Autism Spectrum Disorder Eligibility Criteria

The evaluation of Autism Spectrum Disorder (ASD) requires a team of professionals. Time must be taken to ensure that information regarding all aspects of a student's development and needs are gathered. The goal of a school-based evaluation for ASD is not to provide a clinical diagnosis for students, but to determine eligibility for special education services based upon the impact of manifested characteristics on the student's ability to succeed in a learning environment. Because the determination of ASD is partly a subjective process, it is essential that at least one member of the evaluation team have a broad experience with individuals on the spectrum to avoid under-or over-identification of students.

Staff involved in the evaluation process must rely on their professional judgement, because the determination of ASD requires the evaluator to distinguish the difference in manifestation of many of the characteristics common to ASD from characteristics similar in appearance that also are common to other known disabilities. These are qualitative components that cannot be quantified by test results. Often, formal assessment scores are not as revealing as the analysis of the child's pattern of responses and behavior during the structured test session. Therefore, the examiner should be familiar with test behaviors common to individuals with ASD, as well as those behaviors that overlap other disorders.

Special considerations in the choice of standardized instruments and methods of administration are often required to elicit data that has evaluative meaning. A table of common instruments can be found in Appendix F. Consider the following suggestions when evaluating a student suspected of having ASD:

- Allow extra time for the student to become familiar with the environment and the examiner prior to administration
- Evaluate the student in a familiar environment and/or in the presence of a familiar person (classroom aide, teacher, etc. - if only parent is available or helpful, review standardized rules)
- Adapt language to the student's ability level and communication method (short, direct statements, use of signs or PECS, etc. - if too varied from standardized rules, note this for scores)
- Consider the use of concrete reinforcers (contingent on responding rather than on correct responses) for particularly unmotivated or distractible students
- Modify test response methods for students unable or unwilling to respond using traditional methods (i.e. - placing a block on the selected stimulus vs pointing in response)
- Use several short, organized evaluation periods rather than fewer extended sessions, allowing breaks when needed

In completing a comprehensive evaluation, there are multiple areas that need to be assessed to acquire a complete picture of a specific student's strengths and needs. A person with ASD exhibits impairment in two domains:

1. social/communication deficits
2. fixated interests and repetitive behaviors

They must display severe and pervasive impairment in both categories, which are distinctly atypical relative to the individual's developmental and intellectual levels. The number and severity of behaviors determine the severity level and the amount of support warranted (see DSM-V for guidance).

Not all children manifest symptoms of autism early and manifestations in infancy can be very subtle and difficult to differentiate from other budding disorders. As a result, identification during this developmental stage can be inaccurate and, therefore, does not typically occur before age 2. By age 3, many children who have autism have characteristics that should be observable and clearly inappropriate and nonfunctional. Still, only about 50% are identified before Kindergarten (Centers for Disease Control & Prevention, 2012). Difficulties must be severe enough to significantly and pervasively impair social, occupational, or other important areas of current daily functioning and impairment must include areas directly affecting learning to determine the student eligible for an educational disability.

Validity of ASD determination is based on the use of multiple sources of information across a variety of contexts, as its definition refers to pervasive and sustained behaviors. This section will detail the specific areas and the information to collect in each area.

Developmental History

Developmental history information is beneficial when considering differential diagnoses and looking at other potential impairment categories. The following information is necessary for any initial evaluation of ASD and should be updated as needed during subsequent evaluations:

- Parents' perception of concern and child's age when concerns began
- Health and medical history
- Prenatal and birth history
- Developmental milestones
- Social and play development
- Language acquisition and use of functional communication
- Educational history

- Evidence of skill regression in any area
- Evidence of a reduction in number or severity of criteria over time
- Family history of developmental delays and other disabilities

Communication

A thorough assessment of a student's functional communication is essential when determining the presence of ASD. Information on communication skills facilitates programming decisions and establishes a baseline for later assessments. While the verbal communication skills of many students with ASD improve over time, these students continue to struggle with using their communication skills for the purpose of regulating social interactions. It is generally the case that as students become more communicatively competent, their pragmatic deficiencies become more obvious (Starr et al., 2003). The following components of expressive, receptive, and pragmatic communication require assessments as well as observations in multiple settings:

- Hearing
- Nonverbal communication such as pointing to desired item, shaking head or nodding
- Functional use of language such as requesting items or information, responding to requests, and commenting
- Responses to the communication of others
- Atypical communication such as echolalia, use of others' hands as "tools" to request items, perseveration, pronoun reversals and idiosyncratic remarks
- Conversational abilities such as topic maintenance and selection, and appropriate give and take
- Semantic and/or conceptual difficulties
- Intensity, pitch or intonation of voice
- Initiation of spontaneous communication in functional activities across social partners and settings
- Comprehension of verbal and nonverbal communication in academic, social, and community settings
- Communication of a range of social functions that are reciprocal and promote the development of friendships and social networks
- Verbal and nonverbal means of communication, including natural gestures, speech signs, pictures, written words, functional alternatives to challenging behaviors and other augmentative and alternative communication systems

Social Skills

Difficulties in reciprocal social interactions and understanding and use of nonverbal behaviors are key features of ASD, and arguably more critical to its determination than the presence of unusual behaviors (Gillham et al., 2000). Reciprocal social behavior requires a child to be cognizant of the emotional and interpersonal cues of others, to appropriately interpret those cues, to respond appropriately to what that child interprets, and to be motivated to engage in social interactions with others. Based on this conceptualization of social behavior, the following areas require assessment and observation in multiple settings:

- Imitating others' actions
- Attachment to caregiver(s)
- Problems relating to other people
- Establishing joint attention
- Social interaction with familiar and unfamiliar adults and peers in familiar and unfamiliar environments (considered separate from the presence of a shy personality)
- Presence of peer relationships appropriate to developmental level
- Spontaneous seeking to share enjoyment, interests, or achievements with others by exhibiting behaviors such as showing, bringing, or pointing out objects of interest
- Skills in the area of social and emotional reciprocity, such as turn taking and changing thoughts and actions based on verbal and nonverbal feedback of communication partners

Behavioral Concerns

Behaviors that are restricted in range, repetitive, and/or stereotyped are risk factors for ASD and should be noted throughout the assessment process. The severity, frequency and impact on educational performance of student's behaviors must be established. Also, the observed behaviors must be indicated as not being attributed to other known or suspected disorders that are characterized by these same behaviors. The following behaviors require observation and documentation:

- Interests and preoccupations that are more intense or focused than what would be considered typical for the student's developmental level
- Persistence in carrying out specific nonfunctional routines or rituals, including an inability or unwillingness to modify those routines or rituals and displaying difficulty when transitioning between activities that are considered atypical for the current developmental level

- Stereotyped and repetitive motor mannerisms such as hand flapping, flicking fingers in front of eyes and rocking torso back and forth in the absence of other relevant disorders
- Persistent preoccupation with parts of objects such as visually inspecting the wheels of a toy car while spinning them or poking at the eyes on a doll for perceived pleasure

Adaptive Behavior

Adaptive behavior is defined as the development and application of abilities required for the attainment of personal independence and social sufficiency (Stone et al., 1999). Adaptive behaviors are strong predictors of outcome, since they require the student to use whatever capacities he or she possesses to function within the everyday environment. These skills are particularly important in individuals with ASD because it is adaptive abilities, rather than cognitive level, that contribute most to the individual's ability to function successfully and independently in the world (Paul et al., 2004). Adaptive behavior scores obtained on very young children may also prove more stable than cognitive scores throughout childhood and are better able to predict language acquisition in nonverbal children than performance IQ scores (Stone, Ousley et al., 1999).

Research has shown that adaptive behavior is critical to assess when differentiating ASD from other developmental disorders. Adaptive behavior tends to be impaired relative to cognitive abilities in individuals with ASD. Individuals with ASD typically show an uneven pattern of skill development across adaptive behavior domains with lowest skills in social domains, highest skills in daily living domains, and intermediate skills in communication (Stone, Ousley et al., 1999).

Discrepancies between mental age and adaptive behavior scores are greater in students with ASD than in students with cognitive impairment, particularly in the areas of socialization and communication. Adaptive behavior scores are generally lower in students with autism relative to IQ-matched comparison groups, meaning that even students considered to have "high functioning" ASD show significant deficits in adaptive behaviors (Carter et al., 1998). Children with ASD do not function in their environment as well as other children with similar cognitive capabilities, and social functioning is specifically impaired, even relative to global functioning (Liss et al., 2001).

Adaptive behavior assessments also assist with the development of goals and programming, and can serve to monitor a student's development over time and across settings. The following areas of adaptive behavior require assessment:

- Communication skills
- Social skills, including play skills
- Daily living/self-help skills (dressing, eating, job skills, money management, etc.)
- Motor skills (if motor concerns are present)

Cognitive Factors

In assessing a student for ASD, knowing the child's developmental or mental age provides a context for evaluating behavior characteristics, including the presence or absence of symptoms specific to ASD. Information about the student's cognitive level assists the team in determining whether symptoms can be explained on the basis of a global delay, or whether there is an uneven or atypical developmental pattern that is present (Vig and Jedrysek, 1999). Assessment of cognitive ability, therefore, can help in differential diagnosis of ASD, cognitive impairment, or a combination of the two. Research has shown that 75% of students with Autism Spectrum Disorder obtain verbal IQ scores in the cognitively impaired range on formal assessments (Ritvo et al., 1989). Though standard measures of intelligence may have low validity with some students due to the nature of their disability, these tests still provide some measure of future academic success. Information on the child's cognitive skills also establishes a baseline for later assessments to measure development and progress. Making a determination of ASD without carefully evaluating the student's cognitive strengths and deficits can lead to inappropriate treatment and ineffective educational intervention.

To date, there is no single cognitive impairment or pattern of cognitive development that occurs in all individuals with ASD. However, research shows that individuals with ASD display high rates of uneven cognitive development (Joseph et al., 2002) and they tend to develop certain developmental skills normally acquired later (written language, memory, rule acquisition) before skills generally acquired earlier (joint attention and social reciprocity). This constitutes "deviant" (disordered) development rather than "delayed" development (Liss et al., 2001). It is critical to note the presence or absence of these patterns when assessing cognitive skills.

It is typical for students who are younger, or functioning at a younger stage of development, to exhibit a significant discrepancy between their verbal and nonverbal cognitive abilities. This discrepancy tends to lessen with age for children who develop functional language. These students tend to exhibit nonverbal strengths on visuoperceptual and visuomotor subtests, in contrast to students with average to above average IQ scores who exhibit deficits in visuomotor tasks (graphomotor skills, writing skills, and

attention) (Mayes and Calhoun, 2003). When verbal and full-scale IQ scores are above 70, most students with autism will not show a significant discrepancy between verbal and performance abilities (Filipek et al., 1999). However, verbal skills may still be higher than performance skills to a lesser degree in the presence of ASD when IQ is average.

Cognitive factors to evaluate include:

- Processing
- Memory
- Reasoning and concept formation
- Attending
- A profile of strengths and deficits and the presence of splinter skills
- Evaluating patterns of response (Does the child perseverate on missed items?)
- Evidence of delayed or deviant patterns of cognitive functioning

Sensory-Motor Factors

It must be noted here that the presence of specific sensory issues is not part of the criteria for ASD as indicated in the updated DSM-5.

Students with Autism Spectrum Disorder do sometimes react differently to sensory stimuli. Research indicates that the level of sensory symptoms present in individuals is not necessarily related to their overall mental age or IQ. Therefore, it cannot be fairly assumed that students with higher levels of cognitive functioning have fewer sensory symptoms than students functioning at lower levels of cognitive development and vice versa (Rogers et al., 2003). Evaluating student responses to various stimuli in multiple environments may be helpful in making the determination of ASD. Rinner (2001-02) stated that using a sensory processing frame of reference is important to understanding behavioral manifestations that may mistakenly be viewed in isolation from precipitating events. Paying attention to sensory issues also expands the possibilities for helpful intervention.

In addition to sensory issues, fine and gross motor skills may need to be evaluated, first through a preliminary screening, and then through a formal assessment if warranted. Some key areas to assess, observe and document when looking at sensory differences include:

- Motor planning
- Tactile sensitivities such as being drawn to certain surfaces or withdrawing from touch

- Proprioceptive sensitivities such as seeking deep pressure or invading another's personal space
- Vestibular issues such as spinning or rocking or balance problems
- Olfactory or gustatory sensitivities such as smelling or licking objects or avoiding certain foods
- Auditory issues such as sensitivity to certain noises or making repetitive sounds for stimulation

Educationally Relevant Medical Information

Medical conditions and interventions, such as medications, may affect a child's behavior or development. A thorough review of the student's medical history is critical. Consider if potential behavioral side effects of various medications are affecting the student.

For a quick reference guide, refer to Appendix D for a table outlining ASD criteria discussed in detail throughout this section. The MARSE Rules and DSM-5 criteria are included in Appendix C for your convenience.

See Appendix E for a table highlighting common exclusionary factors when analyzing atypical or intrusive behaviors observed in the student. It is important that you become familiar with this table before determining eligibility for ASD.

Appendix A

Pre-referral Strategies Checklist

Check all that have been attempted when preparing for a meeting

Transitions

- ___ Visual schedule (photos, drawings, symbols, words on wall, velcro strip, card, etc.)
- ___ Pre-teaching of scheduled transitions with practice sessions
- ___ Visual timer to signal start and end times of activities and/or transitions
- ___ Transition notifications (visual, verbal) several minutes prior to transitioning
- ___ Notifications for planned schedule changes (day before & at start of day)
- ___ Adjustments to visual schedule for planned and unplanned schedule changes

Recess

- ___ Restructured recess in place of recess removal when challenging behavior occurs
- ___ Peer or small group assignment to structure partner selection for play
- ___ Preselection of play activity prior to going outside
- ___ Forced choice play selection (visual or written format) using preferred activities
- ___ Collaboration with recess staff to prevent future issues

Emotional Self-Regulation

- ___ Prevention plan using documented times, settings, and situations when behaviors occur
- ___ Calming space for needed or planned breaks (pre-teaching is recommended for proper use)
- ___ Alternative behaviors scheduled away from stimuli (helping with errands, getting a drink, etc.)
- ___ Break cards, script, or visual or verbal prompts for requesting breaks
- ___ Sensory tools or activities (fidgets, weights, puzzles, etc.)

Routines/Following Directions

- ___ Instructions provided one step at a time
- ___ Expectations decreased by size or number requested
- ___ Visual directions (pictures or written words) provided in proximity of activity
- ___ Checklist of steps (pictures or written words) required to complete task
- ___ Pre-teaching of a routine or task with practice sessions

Sensory Issues

- ___ Headphones or earplugs provided during periods of high noise level
- ___ Work area altered to reduce distractions for concentration
- ___ Work area altered to reduce stimulation when agitated
- ___ Visual stimuli decreased (low light, sunglasses, chair facing away from visual noise)

Activity Level Too High/Too Low

- ___ Physical activity breaks (walks, etc.) after sitting too long or when unusually energized
- ___ Space to pace allowed in close proximity to work area or group activities
- ___ Deep pressure or weighted fidgets provided to reduce stress level
- ___ Sensory tools (stress balls, small fidgets, ball seat, wiggle seat, stretch bands, etc.)

Social Engagement

- ___ Peer or small group assignment with scripts or rehearsed behavior and responses
- ___ Pre-teaching of expectations with practice sessions (may use peer model)
- ___ Reminder/cue cards or other visuals reinforcing social rules and etiquette
- ___ Rule recaps before group activities (written rules within activity area recommended)
- ___ Social stories for frequently breached rules (inclusion of real pictures recommended)
- ___ Rule of the day cards (students caught following rule put card in drawing for prize)
- ___ Token economy (tickets, marbles, etc.) for frequency counts of positive rule following

Organization

- ___ Labeled or color-coded binders, folders, boxes, pouches, etc. for visual reference
- ___ Labeled spaces (locker, desk, cubby, etc.) for visual reference of personal space
- ___ Regularly scheduled cleaning sessions to re-organize disorganized areas
- ___ Visual examples of organized spaces posted in proximity to referenced space
- ___ Checklist to prompt systematic visual scanning of space for organization inspection
- ___ Planner (monthly planners can be less overwhelming to disorganized individuals)

Written Expression and Fine Motor Control

- ___ Peer notes or instructor outline for reducing output or supplementing inadequate notes
- ___ Fill-in-the-blank handouts for reducing output while ensuring sustained attention
- ___ Ergonomic writing implement for manual writing
- ___ Computer or other writing device to substitute manual writing
- ___ Assignment of peer or adult scribe for recording oral responses
- ___ Electronic recording device to document thoughts and responses
- ___ Pictures or diagrams allowed in place of written words
- ___ Oral tests and other measures for assessing knowledge acquisition

Other Strategies Implemented:

Appendix B

PARENT INTERVIEW FOR AUTISM – CLINICAL VERSION (PIA-CV) ©2002

Stone, Coonrod, Pozdol, & Turner

INSTRUCTIONS TO PARENTS: "I have some questions for you about _____ 's behavior in different areas. For each behavior I mention, I'd like you to decide how often it occurs, and choose the number from 1 to 5 that fits best. Please describe your child's current behavior."

1 2 3 4 5
Almost Never Once in a While Sometimes Frequently Almost Always

Social Relating

"The first questions are about _____ 's social behavior.

Tell me about how _____ interacts with others:"

- 1 2 3 4 5 1) Does _____ enjoy interacting with familiar adults?
- 1 2 3 4 5 2) Does _____ look at you while you are playing with him/her?
- 1 2 3 4 5 3) Does _____ look at you when you are talking to him/her?
- 1 2 3 4 5 4) Does _____ come to you for comfort when he/she is sick or hurt?
- 1 2 3 4 5 5) Does _____ ignore people who are trying to interact with him/her?
- 1 2 3 4 5 6) Does _____ "look through" people as if they weren't there?
- 1 2 3 4 5 7) Does _____ enjoy being held or cuddled?
- 1 2 3 4 5 8) Does _____ hug you back when you hug him/her?
- 1 2 3 4 5 9) Does _____ become stiff or rigid when you are holding or hugging him/her?
- 1 2 3 4 5 10) Does _____ he/she go limp when you hold or hug him/her?

- 1 2 3 4 5 11) Does _____ come to you for a kiss or a hug on his/her own, without you asking him/her to?
- 1 2 3 4 5 12) Does he/she enjoy being kissed?
- 1 2 3 4 5 13) Does _____ seem to enjoy affection only on his/her own terms? Examples?
- 1 2 3 4 5 14) Does _____ smile back at you when you smile at him/her?
- 1 2 3 4 5 15) Does _____ seem to be "hard to reach", or in his/her own world?
- 1 2 3 4 5 16) Does _____ actively avoid looking at people during interactions?
- 1 2 3 4 5 17) Does _____ look at people more when they are far away than when they are interacting with him/her?

Affective Responses

- 1 2 3 4 5 18) Does _____ seem to understand how others are feeling? Examples?
- 1 2 3 4 5 19) Does he/she understand the expressions on people's faces?
- 1 2 3 4 5 20) Is it difficult to tell what is feeling from his/her facial expression? What makes it hard to tell?
- 1 2 3 4 5 21) Does _____ smile during his/her favorite activities?
- 1 2 3 4 5 22) Does _____ smile, laugh, and cry when you expect him/her to?
- 1 2 3 4 5 23) Do _____'s moods change quickly, without warning? Examples?
- 1 2 3 4 5 24) Does _____ become very frightened of harmless things? Examples?
- 1 2 3 4 5 25) Does _____ laugh for no obvious reason?
- 1 2 3 4 5 26) Does _____ have severe temper tantrums?

Peer Interactions

"The next questions are about _____'s peer relationships.

Tell me about how _____ gets along with other children:."

- 1 2 3 4 5 27) Does _____ prefer to play alone instead of with other children?

- 1 2 3 4 5 28) Will ever join in play with another child?
- 1 2 3 4 5 29) Does _____ enjoy playing with other children?
- 1 2 3 4 5 30) Does _____ seem to be interested in making friends with other children?
- 1 2 3 4 5 31) Does _____ hurt other children by biting, hitting, or kicking?

Motor Imitation

"The next set of questions have to do with _____'s ability to imitate or copy other people's movements or activities."

- 1 2 3 4 5 32) Does _____ imitate simple gestures such as waving goodbye or clapping hands?
- 1 2 3 4 5 33) Does _____ imitate the things you do around the house, such as sweeping or dusting? Examples?
- 1 2 3 4 5 34) Do you have difficulty trying to get to imitate your movements when you want him/her to?
- 1 2 3 4 5 35) Does _____ imitate words or sounds when you want him/her to?

Communication

"The next set of questions have to do with 's language and communication skills. Tell me how communicates:"

Nonverbal Communication

"In addition to talking, there are lots of other ways that children can communicate their needs and wants, such as making sounds, or pointing, or gesturing."

- 1 2 3 4 5 36) How often does communicate to you in ways other than talking?
- 1 2 3 4 5 37) Can you understand what is trying to communicate?
- 1 2 3 4 5 38) Can other people understand ?
- 1 2 3 4 5 39) Does _____ become frustrated when he/she tries to communicate?

"The next questions are about the reasons that _____ communicates. Here's a list of the different reasons for communicating (give card). How often does _____ communicate to:"

- 1 2 3 4 5 40) Let you know he/she wants something, like food or a toy?
- 1 2 3 4 5 41) Get you to do something for him/her? Example?
- 1 2 3 4 5 42) Let you know he/she doesn't want something? How does he/she let you know?
- 1 2 3 4 5 43) Get your attention? Example?
- 1 2 3 4 5 44) Show off? Example?
- 1 2 3 4 5 45) Ask questions about an object or event? Example?
- 1 2 3 4 5 46) Ask your permission to do something? Example?
- 1 2 3 4 5 47) Get you to play with him/her? Example?
- 1 2 3 4 5 48) Get you to look at something he/she's interested in? Example?

Language Understanding

- 1 2 3 4 5 49) Does _____ respond when you call his/her name?
- 1 2 3 4 5 50) Does _____ understand what you say to him/her? How can you tell?
- 1 2 3 4 5 51) When you point at something, does look in the direction you point in?
- 1 2 3 4 5 52) Can follow simple directions such as "Get your coat"?
- 1 2 3 4 5 53) Can follow longer directions that contain more than one idea, such as "Get your coat and bring me your shoes"?
- 1 2 3 4 5 54) Does _____ listen to you when you read him/her short stories?
- 1 2 3 4 5 55) Does _____ seem interested in conversations that other people are having?

Object Play

"The following questions are about _____'s play skills. Tell me how _____ likes to play:"

- 1 2 3 4 5 56) Does he/she play with lots of different toys?
- 1 2 3 4 5 57) Does _____ use his/her toys in appropriate ways, the way they were designed to be

used? (e.g., rolling a toy car, putting Legos together, pushing the buttons on a pop-up toy)

1 2 3 4 5 58) Does _____ use toys in unusual ways, such as spinning them, or lining them up over and over again? Examples?

1 2 3 4 5 59) Does _____ play with toys or other objects in the same exact way each time? Examples?

Imaginative Play

1 2 3 4 5 60) Does _____ use his/her imagination when playing with toys or other objects -- such as pretending that a teacup is a hat or that a comb is an airplane? Examples?

1 2 3 4 5 61) Does _____ play pretend games by him/herself, such as pretending to be a superhero? Examples?

1 2 3 4 5 62) Does _____ play pretend games with other children, like playing "mommy," "daddy," or "teacher"? Examples?

1 2 3 4 5 63) Does _____ play many different pretend games?

Sensory Responses

"The next questions are about the way _____ uses his/her senses, such as hearing and vision."

1 2 3 4 5 64) Does _____ fail to respond to painful events, such as falling down or bumping his/her head? What does he/she do when hurt?

1 2 3 4 5 65) Is overly sensitive to being touched?

1 2 3 4 5 66) Does _____ examine objects by sniffing or smelling them?

1 2 3 4 5 67) Does he/she examine objects by licking or tasting them?

1 2 3 4 5 68) Is overly interested in the way things feel?

1 2 3 4 5 69) Does he/she enjoy touching or rubbing certain surfaces? Examples?

1 2 3 4 5 70) Is overly sensitive to sounds or noises? Examples?

1 2 3 4 5 71) Does _____ cover his/her ears at certain sounds? Examples?

- 1 2 3 4 5 72) Does it seem like does _____ not hear well?
- 1 2 3 4 5 73) Does _____ ever ignore loud noises? Examples?
- 1 2 3 4 5 74) Is overly interested in looking at small details or parts of objects? Examples?
- 1 2 3 4 5 75) Is overly interested in watching the movements of his/her hands or fingers?
- 1 2 3 4 5 76) Is overly interested in watching objects that spin? Examples?
- 1 2 3 4 5 77) Is overly interested in looking at lights or shiny objects? Examples?
- 1 2 3 4 5 78) Does _____ look at things out of the corner of his/her eyes? Examples?
- 1 2 3 4 5 79) Does _____ do things without looking at what he/she is doing? Examples?

Motoric Behaviors

"These questions are about the way _____ moves and uses his/her body."

- 1 2 3 4 5 80) Does _____ spin or whirl him/herself around for long periods of time?
- 1 2 3 4 5 81) Does _____ move his/her hands or fingers in unusual or repetitive ways (e.g., flapping or twisting them)? Example?
- 1 2 3 4 5 82) Does _____ walk in unusual ways (e.g., on his/her toes)? Example?
- 1 2 3 4 5 83) Does _____ hurt him/herself on purpose, such as by banging his/her head, biting his/her hand, or hitting any part of his/her body? Example?

Need for Sameness

"These questions relate to _____'s flexibility in adapting to change. Tell me how _____ responds when something out of the ordinary happens and his/her routines must be changed:"

- 1 2 3 4 5 84) Does _____ insist on certain routines or rituals, such as insisting on wearing a certain jacket when he/she goes outside? Examples?
- 1 2 3 4 5 85) Does _____ become upset if changes are made in his/her daily routines –for example, if a different parent puts him/her to bed? Examples?
- 1 2 3 4 5 86) Does _____ become upset if changes are made in the household-- such as if

furniture is moved? Examples?

- 1 2 3 4 5 87) Does _____ have certain favorite objects or toys that he/she insists on carrying around? What are they?
- 1 2 3 4 5 88) Does _____ become upset when things don't look right--such as if the rug has a spot on it or books in a bookshelf are leaning? Examples?
- 1 2 3 4 5 89) Does _____ become agitated or upset by new people, places, or activities? Example?
- 1 2 3 4 5 90) Does _____ insist on wearing only certain clothes or types of clothes? Example?
- 1 2 3 4 5 91) Does he/she become upset when new clothes are put on?
- 1 2 3 4 5 92) Does _____ have certain mealtime rituals, such as eating from only one specific plate? Example?
- 1 2 3 4 5 93) Does _____ have unusual food preferences, such as only eating foods of certain color or texture? Example?

Thank you for completing this interview.

References

- Stone, W.L., & Hogan, K.L. (1993). A structured parent interview for identifying young children with autism. Journal of Autism and Developmental Disorders, 23, 639-652.
- Stone, W.L., Coonrod, E.E., Pozdol, S.L., & Turner, L.M. (2003). The Parent Interview for Autism-Clinical Version (PIA-CV): A measure of behavioral change for young children with autism. Autism: The International Journal of Research and Practice, 7, 9-30

Data Recording Checklists

Behavior Observation Checklist

Student Name: _____ Grade: _____ School: _____
Teacher: _____ Observer: _____ Date: _____

1. Social Interactions (at least 2):

- Observed ___ Marked Impairment in the use of multiple nonverbal behaviors (eye to eye gaze, facial expression, body posture, etc.).
- Observed ___ Failure to develop peer relationships appropriate to developmental level.
- Observed ___ Marked impairment in spontaneous seeking to share enjoyment, interests, or achievements with others.
- Observed ___ Impairment in the areas of social and emotional reciprocity.

2. Communication (at least 1):

- Observed ___ Delay in or total lack of spoken language.
- Observed ___ Marked impairment in pragmatics or the ability to initiate, sustain or engage in reciprocal conversation with others.
- Observed ___ Stereotyped and repetitive use of language or idiosyncratic language.
- Observed ___ Lack of varied, spontaneous make-believe play, or social imitative play appropriate to developmental level.

3. Restricted, repetitive and stereotyped behavior (at least 1):

- Observed ___ Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.
- Observed ___ Apparently inflexible adherence to specific, nonfunctional routines or rituals.
- Observed ___ Stereotyped and repetitive motor mannerisms, for example, hand or finger flapping or twisting or complex whole-body movements.
- Observed ___ Persistent preoccupation with parts of objects.

Observation Checklist #2

Behavior

- Strongly dislikes changes in routine
- Excessively tidy or precise
- Repetitive gestures
- Repetitive movements
- Becomes upset when his/her things are moved
- Cannot problem solve in active social situation
- Understands only from his/her own viewpoint
- Unable to empathize with others
- Reads for information only
- Difficulty generalizing skills learned
- Does not handle criticism/correction well
- Invades the personal space of others
- Perfectionist
- Difficulty stopping mid-task
- Rigid thinking
- One track mind
- Does not learn from mistakes

During the student's spare/free time he/she:

- Watches television
 - Usually game shows
 - Usually credits
 - Usually preschool shows
 - Usually specific videos
- Plays video games
- Moves about
- Manipulates objects repetitively
- Lines things up
- Holds specific/familiar objects
- Reads
- Plays with building toys
- Plays with infant toys
- Plays alone
- Watches others

Student is fascinated/preoccupied with:

- Television commercials
- Game shows
- Dates of the calendar

Student shows a strong interest in:

- Phone numbers
- Vacuums
- Trains
- Vehicles
- Biology
- Weather
- Science fiction
- Has a special interest area not listed

Student shows exceptional talent in:

- Decoding
- Memorization
- Music
- Knowledge of calendar/dates
- Math
- History

Student reacts to approach from peers by:

- Ignoring
- Moving away
- Directing
- Tantrums
- Yelling
- Increase in repetitive behavior

Student reacts to approach by a familiar adult by:

- Ignoring
- Moving away
- Directing
- Tantrums
- Yelling
- Increase in repetitive behavior

- Clock times
- People's watches
- Numbers
- Reading
- _____

Student reacts to approach from stranger by:

- Ignoring
- Moving away
- Directing
- Tantrums
- Yelling/screaming
- Increase in repetitive behavior
- Is overly friendly

Speech and Language

- Non-verbal
- Minimal speech

Typically makes needs known by:

- a vague distress sound
- a vague gesture
- a well defined gesture
- signing
- other alternative communication system
- words
- phrases or sentences
- Repeats words he/she hears immediately after hearing them
- Repeats commercials almost word for word
- Speech frequently lacks meaning
- Utters words, phrases, or sentences which appear to have no meaningful connection to situation in which they are said
- Talks to self
- Makes non-communicative sounds
- Frequently uses personal pronouns incorrectly
- Communication limited to requesting and/or protesting
- Usually cannot answer 'who, where, what, why' questions

- Speech is repetitive
- Speech lacks spontaneity
- Seems to have many ideas which he/she is unable to express verbally
- Has difficulty initiating conversations
- Conversation is repetitive
- Has a limited number of preferred conversation topics
- Is not able to productively contribute to conversation initiated by another
- Does not use social greetings flexibly
- Has difficulty understanding causality
- Language has little evidence of imagination or symbolism
- Often interprets words literally
- Uses aberrant behavior as a form of communication
- Understands and enjoys slap- stick humor but fails to get the point of verbal humor
- Talks at others rather than engaging in reciprocal conversation
- Has difficulty understanding the "point of view" of others
- Voice is overly loud or soft
- Uses monotonous intonation

Social Skills

- Does not use objects or toys in the same way as other children his/her age do
- Uses objects or toys in unusual ways (peculiar or perseverative)
- Does not typically imitate other children in play
- Does not typically initiate play with other children
- Does not try to engage others in play by bringing them toys, etc.
- Engages in sensuous play rather than using toys symbolically
- Will imitate pretend play when it has been taught to him/her
- Engages in imaginative play but is quite repetitious
- Will respond to game or play session if approached by others
- Seems to enjoy interactions with others, but remains passive
- Has developed some relationships but more with adults than peers
- Relates to adults in more immature fashion than intellectual ability would suggest
- Enjoys rough physical play primarily
- Does not have a 'best friend' in the community
- Lacks the skills for initiating and maintaining long term relationships
- Has difficulty understanding the concept of taking turns
- Often does not look at people when they talk to him/her
- Seems to deliberately refuse to look at people sometimes
- When he/she looks at people he/she often 'looks through' them
- Face often does not show emotion
- Fails to seek comfort when distressed
- Often does not smile back when people smile back at her/him
- Sometimes smiles or laughs 'for no known reason'
- Frequently looks frightened or anxious 'for no known reason'
- Becomes irritable 'for no known reason'
- Prefers working alone
- Prefers being alone
- Difficulty working in cooperative groups
- Is aloof when around other people
- Is indiscriminately friendly
- Is perceived as being odd or peculiar by others
- Lacks awareness of other people's feelings
- Is frequently inadvertently rude
- Seems unaware of normal social conventions
- Frequently does not respond when his/her name is called
- Is very independent, seeking very little help from others
- Often rejects affection
- Accepts affection only when he/she feels like it
- Is preoccupied with non-living things
- Forms attachments to unusual objects

Sensory Responses (Not required for eligibility, but might be useful)

SIGHT

- Scrutinizes visual detail for prolonged periods of time
- Regards own hands for prolonged periods of time
- Regards reflection for prolonged periods of time

TASTE

- Has strong food preferences
- Has strong texture preferences in food
- Likes only a limited number of foods
- Existence of pica

- Stares
- Looks out of peripheral vision
- Attends to changing levels of illumination
- Squints or covers eyes in natural light
- Closely regards spinning objects
- Fails to blink at bright lights
- Is fascinated with shiny objects

HEARING

- Hums or vocalizes to block noise
- Sometimes acts as though deaf
- Closely attends to self-induced sounds
- Closely regards own screaming
- Lacks startle response to loud noise
- Delayed response to verbal directions
- Covers ears
- Places fingers in ears
- Bangs objects repetitively
- Behavioral changes with noise
- Inability to tolerate group noise
- Sensitivity to daily noises (phone ring, cough, dog bark)

BALANCE

- Has poor balance
- Seeks movement
- Avoids activities that challenge balance
- Whirls body
- Walks on toes

TOUCH

- Flinches or gives other exaggerated response when touched
- Does not seem to notice extreme temperature change such as when going outdoors in cold
- Rubs surfaces for prolonged periods of time
- Examines surfaces with fingers
- Removes clothing frequently
- Is very aware of different textures
- Rubs body where touched by another
- Withdraws from possibility of being touched
- Avoids getting messy
- Needs excessive personal space

SMELL

- Smells food items before eating
- Is intensely aware of smells
- Smells many objects
- Smells parts of the body

PAIN

- Delayed response to pain
- Lacks response to injuries
- Does not seem to feel pain normally

BODY

- Makes darting-lunging movements
- Rolls fingers
- Flips hands
- Rocks
- Paces
- Runs in circles
- Jumps repetitively
- Bangs head repetitively
- Hits/bites self
- Has facial grimaces
- Grinds teeth
- Has stiff posture
- Has flaccid body posture
- Has unusual body posture
- Lacks motor coordination

Appendix C

Michigan Administrative Rules for Special Education (MARSE) definition of Autism Spectrum Disorder R 340.1715

Autism spectrum disorder defined; determination. Rule 15. (1) Autism spectrum disorder is considered a lifelong developmental disability that adversely affects a student's educational performance in 1 or more of the following performance areas: (a) Academic. (b) Behavioral. (c) Social. Autism spectrum disorder is typically manifested before 36 months of age. A child who first manifests the characteristics after age 3 may also meet criteria. Autism spectrum disorder is characterized by qualitative impairments in reciprocal social interactions, qualitative impairments in communication, and restricted range of interests/repetitive behavior. (2) Determination for eligibility shall include all of the following:(a) Qualitative impairments in reciprocal social interactions including at least 2 of the following areas: (i) Marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction. (ii) Failure to develop peer relationships appropriate to developmental level. (iii) Marked impairment in spontaneous seeking to share enjoyment, interests, or achievements with other people, for example, by a lack of showing, bringing, or pointing out objects of interest. (iv) Marked impairment in the areas of social or emotional reciprocity. (b) Qualitative impairments in communication including at least 1 of the following: (i) Delay in, or total lack of, the development of spoken language not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime. (ii) Marked impairment in pragmatics or in the ability to initiate, sustain, or engage in reciprocal conversation with others. (iii) Stereotyped and repetitive use of language or idiosyncratic language. (iv) Lack of varied, spontaneous make believe play or social imitative play appropriate to developmental level. (c) Restricted, repetitive, and stereotyped behaviors including at least 1 of the following:(i) Encompassing preoccupation with 1 or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus. (ii) Apparently inflexible adherence to specific, nonfunctional routines or rituals. (iii) Stereotyped and repetitive motor mannerisms, for example, hand or finger flapping or twisting, or complex whole body movements. (iv) Persistent preoccupation with parts of objects. (3) Determination may include unusual or inconsistent response to sensory stimuli, in combination with subdivisions (a), (b), and (c) of subrule 2 of this rule. (4) While autism spectrum disorder may exist concurrently with other diagnoses or areas of disability, to be eligible under this rule, there shall not be a primary diagnosis of schizophrenia or emotional impairment. (5) A determination of impairment shall be based upon a full and individual evaluation by a multidisciplinary evaluation team including, at a minimum, a psychologist or psychiatrist, an authorized provider of speech and language under R 340.1745(d), and a school social worker.

Michigan Administrative Rules for Special Education (MARSE) definition of student with disability
R 340.1702

“Student with a disability” defined. Rule 2. “Student with a disability” means a person who has been evaluated according to the individuals with disabilities education act and these rules, and is determined by an individualized education program team, an individualized family service plan team, or an administrative law judge to have 1 or more of the impairments specified in this part that necessitates special education or related services, or both, who is not more than 25 years of age as of September 1 of the school year of enrollment, and who has not graduated from high school. A student who reaches the age of 26 years after September 1 is a “student with a disability” and entitled to continue a special education program or service until the end of that school year.

Individuals with Disability Education Act (IDEA) definition of a student with a disability § 300.8

(a) Child with a disability. (a) General. (1) Child with a disability means a child evaluated in accordance with §§ 300.304 through 300.311 as having mental retardation, a hearing impairment (including deafness), a speech or language impairment, a visual impairment (including blindness), a serious emotional disturbance (referred to in this part as “emotional disturbance”), an orthopedic impairment, autism, traumatic brain injury, an other health impairment, a specific learning disability, deaf-blindness, or multiple disabilities, and who, by reason thereof, needs special education and related services. (2)(i) Subject to paragraph (a)(2)(ii) of this section, if it is determined, through an appropriate evaluation under §§ 300.304 through 300.311, that a child has one of the disabilities identified in paragraph (a)(1) of this section, but only needs a related service and not special education, the child is not a child with a disability under this part. (ii) If, consistent with § 300.39(a)(2), the related service required by the child is considered special education rather than a related service under State standards, the child would be determined to be a child with a disability under paragraph (a)(1) of this section.

The American Psychiatric Association's Diagnostic and Statistical Manual, Fifth Edition (DSM-5) > Autism Spectrum Disorder - 299.00 (F84.0)

Diagnostic Criteria

- A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are not exhaustive; see text):
 1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation to reduced sharing of interests, emotions, or affect to failure to initiate or respond to social interactions.
 2. Deficits in nonverbal communicative behaviors used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication to abnormalities in eye contact and body language or deficits in

understanding and use of gestures to a total lack of facial expressions and nonverbal communication.

3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behavior to suit various social contexts to difficulties in sharing imaginative play or in making friends to absence of interest in peers.

Specify current severity (Severity is based on social communication impairments and restricted, repetitive patterns of behavior):

1. Restricted, repetitive patterns of behavior, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):
 1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
 2. Insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat same food every day).
 3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or perseverative interests).
 4. Hyper- or hypo-reactivity to sensory input or unusual interest in sensory aspects of the environment (e.g. apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity (Severity is based on social communication impairments and restricted, repetitive patterns of behavior):

1. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).
2. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.
3. These disturbances are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Appendix D

ASD Eligibility Determination	Criteria Met	Show Evidence for this Conclusion
Autism Spectrum Disorder Eligibility Criteria	Y/N	See below
1. Adverse affect in 1 or more of following performance areas: <ul style="list-style-type: none"> a. Academic b. Behavioral c. Social 	a. Y/N b. Y/N c. Y/N	a. b. c.
2. Determination for eligibility shall include all of the following: <ul style="list-style-type: none"> a. Qualitative impairment in reciprocal social interaction as manifested by at least two of the following: <ul style="list-style-type: none"> i. Marked impairment in the use of multiple nonverbal behaviors, such as eye-to-eye gaze, facial expression, body posture, and gestures to regulate social interaction. ii. Failure to develop peer relationships appropriate to developmental level iii. A lack of spontaneous seeking to share enjoyment, interests or achievements with other people (e.g., by a lack of showing, bringing or pointing out objects of interest). iv. Marked impairment in the areas of social or emotional reciprocity. 	i. Y/N ii. Y/N iii. Y/N iv. Y/N	i. ii. iii. iv.
2. <ul style="list-style-type: none"> b. Qualitative impairments in communication including at least 1 of the following: <ul style="list-style-type: none"> i. Delay in, or total lack of, the development of spoken language not accompanied by an attempt to compensate through alternative modes of communication such as gesture or mime. ii. Marked impairment in pragmatics or in the ability to initiate, sustain, or engage in reciprocal conversation with others. iii. Stereotyped and repetitive use of language or idiosyncratic language. iv. Lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level. 	i. Y/N ii. Y/N iii. Y/N iv. Y/N	i. ii. iii. iv.
2. <ul style="list-style-type: none"> c. Restricted, repetitive, and stereotyped behaviors including at least 1 of the following: <ul style="list-style-type: none"> i. Encompassing preoccupation with 1 or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus. 	i. Y/N ii. Y/N iii. Y/N	i. ii. iii.

	<ul style="list-style-type: none"> ii. Apparently inflexible adherence to specific, nonfunctional routines or rituals. iii. Stereotyped and repetitive motor mannerisms, for example, hand or finger flapping or twisting, or complex whole-body movements. iv. Persistent preoccupation with parts of objects. 	iv. Y/N	iv.
3. Is there a primary eligibility of EI or diagnosis of schizophrenia?		Y/N	No history of EI or diagnosis of schizophrenia.
Report Parent Input			
Report Current Levels of Educational Functioning and Educational Needs	See PLAAF report.		

These criteria may change to reflect the most recent findings in research as highlighted in the DSM-5. Please continue to refer to your state’s website to ensure you are using the most current criteria.

Appendix E

Exclusionary Factors in Determining ASD Eligibility

When considering exclusionary factors, the following can be used to assist decision making: teacher observations, classroom observations, rating scales, parent input, outside medical reports and diagnoses, cognitive functioning and discrepancies between cognitive skills and adaptive skills, severity of emotional dysregulation, consideration of other disorders better explaining challenging behaviors and skill deficits.

In order to make a student eligible for special education under the ASD category, the presence of related behaviors must meet the qualifying criteria of 1) having an adverse impact in their educational setting as a result of the disorder (impact may vary across contexts and settings), 2) requiring a need for support at a level such that special education services are necessary for full participation in learning activities (characteristics are pervasive and severe), and 3) not being better explained by another disorder. Other disorders to consider to distinguish ASD criteria from other eligibility determination criteria are as follows:

Other DSM-5/Medical Disorders:	Differential Characteristics	Examples of Manifestation
<u>Attention-Deficit/Hyperactivity Disorder</u>	Social dysfunction in ADHD is often due to peer rejection or teasing as a result of impulsive behavior (not disengagement, isolation, indifference, or lack of social understanding). The predominantly hyperactive/ impulsive type of ADHD includes increased motoric activity that is not stereotypic (fixed and repetitive). Tantrums in ADHD are more likely due to impulsive behavior and poor self-control during transitions or other unstructured situations rather than an intolerance to change. In contrast to rule-following behavior, ADHD is more likely to result to injuries due to impulsivity and forgetting rules.	Inattention includes off-task behavior, lack of persistence, loss of focus, and disorganization (not due to defiance or lack of comprehension). Hyperactivity is manifested as excessive whole-body movement, fidgeting, tapping, or talking out of turn. Impulsivity is manifested as acting in the moment without forethought and may indicate a desire for immediate rewards or inability to delay gratification (interrupting others or another form of social intrusiveness and making hasty decisions that result in major consequences). Symptoms are present prior to age 12, but diagnosis does not occur before 4 years old.

<p><u>Intellectual Disability</u></p> <p>(difficult to differentiate in very young children due to behaviors similar to those seen in ASD - defer decision until later developmental stage if present)</p>	<p>Social-Communicative and Adaptive skills are not significantly discrepant from other intellectual skills.</p> <p>Absence of restricted/repetitive behaviors that are pervasive and severe.</p> <p>Absence of aversive sensitivities to sensory input that are pervasive and severe.</p>	<p><i>Less difficulty</i> with joint attention, shared interests/ emotions/affect, social interaction and awareness, verbal and physical imitation, eye contact, use of communicative gestures, responding to verbal commands or name, developmentally appropriate use of toys, and pretend play exists. Repetitive movements or rituals are related to limited behavioral repertoires, not need for sameness/difficulty with change.</p>
<p><u>Language Disorder</u></p> <p>(consider Social Pragmatic Communication Disorder with absence of other ASD characteristics not related to communication)</p>	<p>Nonverbal communicative skills are typically developing and there is an absence of restricted/repetitive patterns that are pervasive and severe.</p>	<p><i>Less difficulty</i> with reciprocal social interactions, initiation of social interactions, maintaining a topic of conversation, switching topic to others' interests, eye contact, use of communicative gestures, or responding to verbal commands or name exists.</p>
<p><u>Obsessive Compulsive Disorder</u></p>	<p>Stereotypies consist of obsessive thinking and compulsions that cause marked distress rather than provide relief via self stimulation.</p>	<p>Persistent thoughts, impulses, or repetitive behaviors are accompanied by an awareness that they are intrusive, inappropriate, or excessive.</p>
<p><u>Oppositional Defiant Disorder</u></p>	<p>Social difficulties arise from a disturbed interpretation of power and control in human relationships rather than a lack of social understanding. Theory of mind is required to meet criteria for ODD.</p>	<p>Behaviors include deliberate hostile provocation of others and seeking of confrontations. Conflicts are not due to rigid rule following, need for sameness, resistance to change, or difficulty communicating needs or wants.</p>
<p><u>Rhett's Disorder</u></p>	<p>Prevalence rate is much higher in females (as opposed to males with ASD)</p>	<p>Defining characteristics include slow head growth, poor coordination, and poor handwriting. Also look for abnormal hand motion and/or placement.</p>
<p><u>Schizophrenia</u></p>	<p>Development is usually typical and any difficulties with social, academic, or adaptive skills are likely to be due to symptomatology, such as hallucinations and delusions, or medication side-effects.</p>	<p>Social deficits manifest in areas of social isolation, paranoia about others' view of them, rejection due to poor hygiene or absence of/failure to attend to other social norms. Diagnosis often co-occurs with a mood disorder. Onset of symptoms</p>

		occurs after the age of 3 and it usually is not diagnosed until much later.
<u>Selective Mutism</u>	Nonverbal communicative and other skills are typically developing and there is an absence of restricted/repetitive patterns that are pervasive and severe.	Typical use of social reciprocity and joint attention in the absence of verbal language. Verbal communication skills can be intact in specific contexts and settings where comfortable.
<u>Stereotypic Movement Disorder</u>	Consider when <i>full</i> criteria for ASD are not present (i.e. - presence of repetitive movements or other stereotypies that may entail self injurious behaviors in the absence of other ASD characteristics.	Repetitive movements may include head banging, arm waving, hand shaking, rocking and rhythmic movements, self-biting, self-hitting, skin-picking. Other stereotypies can include thumb-sucking, nail biting, hair pulling, teeth grinding, or abnormal running/skipping.
Other Special Education Eligibility Areas:	Differential Characteristics	Examples of Manifestation
<u>Cognitive Impairment</u>	See Intellectual Disability above.	See Intellectual Disability above.
<u>Early Childhood Developmental Delay</u>	ECDD may include characteristics of ASD, as with all other considered eligibilities, but characteristics as presented do not meet the <i>full</i> criteria of another eligibility category or the child is not yet of age for all possible characteristics of a disorder to be present.	ECDD is used to provide needed services while behaviors and symptoms manifest to the level required for a clear differential eligibility determination to be made, considering that most disorders do not fully manifest at initial onset.
<u>Emotional Impairment</u>	EI can co-occur with issues outside the affective domain, but no other domain criteria is required for EI eligibility, whereas an ASD eligibility requires criteria to be met in more than one domain: 1) social communication <i>and</i> 2) restricted, repetitive patterns of behavior, interests, or activities (emotional problems are secondary to these defining characteristics of ASD). Students with EI are more aware of interpersonal	Behavior problems are primarily the product of affective disorders, being accompanied by emotional dysregulation and difficulty problem solving, sometimes during interactions with others, but also in the absence of social interactions. Students with EI must manifest problems for 90 days or more and behaviors may not manifest until

	relationship dynamics (social problems are secondary to problems of affect).	middle school (as opposed to in early childhood as with ASD).
<u>Hearing Impairment</u>	HI usually presents with speech and language deficits, as well as social differences and challenges due to communication difficulties, but without the inability to compensate using other modes of functional communication (nonverbal, gesture, sign) to make wants and needs known.	Be aware of behaviors common to HI, as well as habits that may have formed to facilitate communication and other daily functions that are specific to the individual. There should not be a strong emphasis on lack of eye contact when considering co-occurrence with ASD.
<u>Other Health Impairment</u>	OHI should be considered when there is an existing diagnosed or yet to be diagnosed health problem that adversely affects educational performance and can better account for the presenting problems. Differentiating the source and nature of behaviors is essential, especially when not all criteria for ASD eligibility are met.	It should be noted that a medical diagnosis is a required but <i>not sufficient</i> criterion for an OHI eligibility. It must be determined by a Multidisciplinary Evaluation Team that the existing health problem: 1) has an adverse impact in the educational environment and 2) is chronic or acute in nature. Be aware of all possible traits and behaviors accompanying a specific medical diagnosis before considering other eligibilities.
<u>Physical Impairment</u>	Physical disabilities sometimes include motor anomalies that resemble stereotypical behaviors, but are instead characteristics specific to the medical diagnosis.	Be aware of all possible traits and behaviors accompanying a specific medical diagnosis before considering other eligibilities.
<u>Specific Learning Disability</u>	SLD criteria do not include an inability to interrelate, difficulty integrating sensory input, a need for sameness, or stereotypical behavior in response to environmental stressors. Difficulty with basic psychological processes may include the use of routines, repetition or other learning/memory strategies to aid acquisition and retention of new information, but without the presence of underlying anxiety (except in cases of performance-based or test anxiety).	Typically, overall cognitive functioning is fairly consistent across subdomains, while specific academic skills are much lower than those in other areas of learning (contrary to many ASD IQ profiles that tend to be inconsistent with erratic scores or low scores on a test with higher functioning displayed in context). In the case of a nonverbal learning disability, difficulty reading social cues or hyperlexia may be present, but without the inability to interrelate, inflexibility, or stereotypical behavior.

<p><u>Speech and Language Impairment</u></p> <p>(when ASD and SLI co-exist, ASD precludes an SLI eligibility if the ASD characteristics' impact on education is pervasive and severe).</p>	<p>See Language Disorder above. See Selective Mutism above to differentiate globally nonverbal students from those with emotional issues, such as social anxiety (extreme shyness).</p>	<p>See Language Disorder above. See Selective Mutism above to differentiate globally nonverbal students from those whose characteristics are situation or setting specific.</p>
<p><u>Traumatic Brain Injury</u></p>	<p>TBI may include deficits in executive functioning, mood regulation, speech, language, or social functioning, but the presence of characteristics are a direct result of the TBI. Full criteria for ASD are not met.</p>	<p>TBI behaviors are acquired through a traumatic event to the head with a record of being absent prior to the injury, whereas ASD behaviors manifest in the absence of physical trauma.</p>
<p><u>Visual Impairment</u></p>	<p>Stereotypic behaviors can exist with VI, but communication and socialization criteria for ASD are not present.</p>	<p>Be aware of behaviors common to VI, as well as habits that may have formed to facilitate mobility and other daily functions that are specific to the individual.</p>
<p>Other Relevant Areas:</p>	<p>Differential Characteristics</p>	<p>Examples of Manifestation</p>
<p><u>Intellectually Gifted</u></p>	<p>The presence of preoccupations with high interest areas and/or social difficulties, including a lack of response to social cues, disinterest in others, and/or a tendency to criticize others' imperfections, is unaccompanied by deficits in adaptive behavior and independent functioning, abstract thinking, generalizing learning to unique situations and settings, or deductive reasoning.</p>	<p>Typically, overall cognitive functioning is consistently high across subdomains, with specific academic skills similar to cognitive abilities (contrary to many ASD IQ profiles that tend to be inconsistent with erratic scores or low scores on a test with higher functioning displayed in context, possibly with the presence of isolated savant skills inconsistent with IQ).</p>
<p><u>Sensory Processing Issues</u></p>	<p>Sensory processing differences can exist that result in difficulty regulating sensory input/output without the presence of poor social communication skills.</p>	<p>Behavior varies according to the sensory input or output the individual struggles to process.</p>
<p><u>Mixed Diagnoses</u></p>	<p>See specific diagnostic criteria.</p>	<p>Many diagnoses may coexist that, when combined, can look like ASD</p>

<u>mixed diagnoses</u> <u>continued...</u>		symptomatology. Use caution when determining eligibility for a student with known or yet to be determined medical problems.
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This should not be viewed as an exhaustive list of possible alternatives to explain observed behavior and educational challenges. Also, it should be noted that early childhood trauma and neglect can result in characteristics similar to ASD, as well as other disorders (e.g. - recent research has suggested that up to 60% of children diagnosed with ADHD are actually experiencing long-term effects of trauma. Often, those who are experiencing such environmentally-based difficulties show a faster rate of progress than is typical of someone with a disability when appropriate intensive interventions are implemented. Therefore, one should become familiar with the effects of early trauma and neglect and use caution when determining eligibility if it is discovered that a child has been subjected to trauma or neglect in early childhood.

Diagnostic information is based on the DSM-5, 2013 publication

Note: For preschool age children through age 7, in the absence of other definitive diagnoses, R340.1711, Early Childhood Developmental Delay, may be an appropriate initial consideration.

Appendix F

Table of ASD Assessments

Name of Instrument	Age Range	Areas Assessed
Adolescent & Adult PsychoEducational Profile (AAPEP), 1992	12 and older	Vocational skills, Independent functioning, Leisure skills, Vocational behavior, Functional communication, Interpersonal behavior
Adolescent/Adult Sensory Profile, 2002	11 to 65+	Sensory processing, Modulation, Behavioral and emotional responses
Adolescent Test of Problem Solving (TOPS-2), 2007	12 to 17-11	Evaluating, Fair-mindedness, Analyzing, Thinking independently, Clarifying, Affect
Asperger's Syndrome Diagnostic Scale (ASDS), 2001	5 to 18 years	Language, Social skills, Maladaptive behavior, Sensorimotor, Cognitive
Australian Scale for Asperger's Syndrome Screening Tool, 1998	Higher functioning school-age students	Social/emotional, Communication, Cognitive, Specific interest, Movement, Other characteristics
Autism Diagnostic Interview Revised (ADI-R), 2003	2 to adult	Language and communication, Reciprocal social interactions, Restricted, repetitive, and stereotyped behaviors and interests, Background/early development, Acquisition/ loss of language or other skills, Language and communication functioning, Social development and play, Interests and behaviors, Behaviors of clinical importance
Autism Diagnostic Observation Schedule, 2nd Edition (ADOS-2), 2012	2 to adult	Communication, Reciprocal social interaction, Imagination/ creativity, Stereotyped behaviors and restricted interests

Autism Screening Instrument for Educational Planning-3rd Edition (ASIEP-3), 2008	18 months to adulthood	Behaviors, Vocal behavior, Interaction skills, Classroom skills and Rate of learning
Childhood Autism Rating Scale, 2nd Edition (CARS-2), 2010	No age limits	Relating, Body use, Emotional response, Object use, Verbal and nonverbal communication
Children's Communication Checklist-Second Edition (CCC-2), 2003	4 to 16 years	Speech, Syntax, Semantics, Coherence, Inappropriate initiation, Stereotyped language, Use of context, Nonverbal communication, Social relations, Interests
Communication and Symbolic Behavior Scales Developmental Profile (CSBS DP), 2002	6 months to 6 years	Communicative functions, Gestural communicative means, Verbal communicative means, Reciprocity, Social-affective signaling, Symbolic behavior
Elementary Test of Problem Solving, 3rd Edition (TOPS-3), 2005	6 to 11 years	Problem solving, Determining solutions, Drawing inferences, Empathizing, Predicting outcomes, Using context cues, Vocabulary comprehension
Functional Communication Profile – Revised (FCP-R), 2003	3 to adult	Sensory, Speech, Attentiveness, Voice, Pragmatic/social, Expressive language, Receptive language, Fluency, Oral, Nonverbal communication
Gilliam Asperger's Disorder Scale (GADS), 2003 - may not reflect current DSM-V criteria	3 to 22 years	Social interaction, Restricted patterns of behaviors, Cognitive patterns, Pragmatic communication skills, Developmental disturbances (optional subtest)
Gilliam Autism Rating Scale, 3rd Edition (GARS-3), 2014	3 to 22 years	Stereotyped behaviors, Social interaction, Communication, Developmental disturbances (optional subtest)
Infant/Toddler Sensory Profile, 2002	Birth to 36 months	Sensory processing, Modulation, Behavioral and emotional responses

MacArthur Communicative Development Inventories (CDI), 2005	8 to 30 months	Language and communication skills 5
Parent Interview for Autism, Clinical Version (PIA-CV), 2002 See Appendix B for copy	Preschool level and below	Social relating, Affective responses, Peer interactions, Motor imitation, Communication, Object play, Imaginative play, Sensory responses, Motoric behaviors, Need for sameness
Psychoeducational Profile, 3rd Edition (PEP-3), 2005	6 months to 7 years, 7 to 12 who are below 1st grade	Imitation, Perception, Fine motor, Eye/hand integration, Cognitive performance, Cognitive verbal skills
Sensory Profile, 2nd Edition, 2014	3 to 10 years	Sensory processing, Modulation, Behavioral and emotional responses
Social Communication Questionnaire (SCQ), 2003	Above age 4, mental age above 2	Communication skills, Social functioning
Social Responsiveness Scale, 2nd Edition (SRS-2), 2014	3 to 99 years	Social awareness, Social information processing, Capacity for reciprocal social communication, Social anxiety/ avoidance, Autistic preoccupation and traits
Vineland Adaptive Behavior Scales, 2nd Edition (Vineland-II), 2005	Interview Edition: birth through 90 & low-functioning adults Classroom Edition: 3 through 12-11	Communication (expressive, receptive, written), Daily living skills (personal, domestic, community), Socialization (interpersonal relationships, play and leisure time, coping skills), Motor skills (gross and fine), Maladaptive behavior (included in Interview editions, optional domain)

The assessments listed here are the most current versions as of January 2016. Some of these are currently in revision to reflect the new DSM-5 criteria. Those published after 2012 may already reflect these changes. Check before ordering to make sure you acquire the most recent version.

Appendix G

Centralized Evaluation Team - Documentation Form

Student's Name: _____ Date: _____

Observer's Name: _____

Observation Location: _____

<p style="text-align: center;"><u>Social</u></p>	<p style="text-align: center;"><u>Behavior</u></p>
<p style="text-align: center;"><u>Communication</u></p>	<p style="text-align: center;"><u>Sensory (not a criterion)</u></p>