RULES AND REGULATIONS

Title 55—PUBLIC WELFARE

DEPARTMENT OF PUBLIC WELFARE

[55 PA. CODE CHS. 4225 AND 4226]

Early Intervention Services

The Department of Public Welfare (Department), under the authority of the Early Intervention Services System Act (act) (11 P. S. §§ 875-102—875-503) and section 201(2) of the Public Welfare Code (62 P. S. § 201(2)), adopts amendments to read as set forth in Annex A. Notice of proposed rulemaking was published at 30 Pa.B. 2785 (June 3, 2000).

Purpose

The purpose of this final-form rulemaking is to codify the administrative, financial and eligibility requirements, the standards for personnel and service delivery and the procedural protections that govern the Department's early intervention program.

Need for the Final-Form Rulemaking

In sections 105 and 302(a) of the act (11 P. S. §§ 875-105 and 875-302(a)), the General Assembly directed the Department to develop regulations for a Statewide system of early intervention services. The final-form rulemaking are to address methods for locating and identifying eligible children; criteria for eligible programs; contracting guidelines; personnel qualifications and preservice and in-service training; early intervention services; procedural safeguards; appropriate placement, including the least restrictive environment; quality assurance, including evaluation of the developmental appropriateness, quality and effectiveness of programs, assurance of compliance with program standards and provision of assistance to assure compliance; data collection and confidentiality; interagency cooperation at the State and local level through State and local interagency agreements; development and content of individualized family service plans (IFSP); and other issues as required to comply with the act and Part H of the Individuals with Disabilities Education Act (IDEA), which has since been redesignated as Part C in the IDEA Amendments of 1997 (Pub. L. No. 105-17) (20 U.S.C.A. §§ 1431—1445).

In addition, under the authority of House Resolution 354 of 1996, the Legislative Budget and Finance Committee (LBFC) recommended that the Department promulgate program regulations in accordance with the act. The Department agrees with the LBFC that the early intervention program will benefit from the structure that program regulations provide and that the regulations will promote standardization of practices and procedures among counties. Finally, the regulations are needed to enable the Department to continue to be eligible for Federal funding under Part C of IDEA.

Affected Individuals, Groups and Organizations

County mental health/mental retardation (MH/MR) programs (county MH/MR programs) are directly affected by and must comply with the final-form rulemaking. Public and private service providers and agencies under contract with County MH/MR programs to provide early intervention services are also affected by and must comply with the requirements of this chapter that do not explicitly apply only to County MH/MR programs. Infants and toddlers and their families who are referred for or receive early intervention services are affected by the final-form rulemaking, since they are the consumers of the services that are the subject of the final-form rulemaking.

Summary of Public Comments and the Department's Responses

The Department initially requested that interested parties submit written comments, recommendations or objections regarding the proposed rulemaking within a 60-day comment period. In response to requests from several stakeholders, the Department extended the comment period by 90 days. The Department received a total of 117 written comments and transcribed oral statements within the 150-day comment period. Following receipt and review of public comments, the Department held a meeting with stakeholders on March 22, 2001, to review the revisions to the rulemaking that it was considering. The Department invited the stakeholders to contribute oral comments to the revisions under consideration at the meeting as well as to submit final written comments by March 29, 2001. The Department received and considered these additional comments in developing the final-form rulemaking.

The Department received comments from every sector of the community that will be affected by this final-form rulemaking—consumers, advocates, County MH/MR programs and service providers and agencies—as well as from the Independent Regulatory Review Commission (IRRC) and the Majority and Minority Chairs and the members of the House Health and Human Services Committee. The Department appreciates the many valuable comments and recommendations received from stakeholders in the various venues throughout the public comment period. The Department has carefully reviewed and considered each comment and incorporated many of the recommendations into the final-form rulemaking. The Department values the time and expertise stakeholders contributed to the rulemaking process and their commitment to developing an effective regulatory tool for early intervention services.

Following is a summary of the major comments and the Department's responses, as well as a description of changes made to the proposed rulemaking in response to the public comments received and the Department's own internal review in preparation for final-form rulemaking.

Section 4226.1. Introduction (redesignated as "Policy").

One commentator suggested that the clause "which is focused on the unique needs of the child" did not clearly convey the intent to meet the child's needs.

Response

The Department agrees and has amended this section to address this concern and to set forth the policy of the final-form rulemaking more clearly. In doing so, the Department deleted the sentence "Early intervention services for an infant or toddler are provided in conformity with an IFSP" as redundant because, as explained below in the response to the comments to § 4226.5 (relating to definitions), service provision in conformity with the IFSP has been added to the definition of "early intervention services." The Department also wanted to avoid the connotation that this component of the definition of "early intervention services" is more important than any other by including it in the policy statement while omitting others. In addition, the Department

changed "eligible children" to "infants and toddlers with disabilities and at-risk children" to conform this section to changes made to the definitions of all three terms, also explained in the responses to comments to § 4226.5.

Section 4226.2. Purpose.

The Department amended this section to identify the purpose of the rulemaking more specifically and to clarify that the rulemaking applies only to the Department's early intervention program and does not govern the program administered by the Department of Education.

Section 4226.3. Applicability.

The Department amended this section to clarify that service providers and agencies as well as county MH/MR programs must comply with the final-form rulemaking.

Section 4226.4. Noncompliance (redesignated as "Penalties for noncompliance").

The Department amended this section by incorporating provisions of proposed § 4226.39 (relating to penalties for noncompliance) so that all potential penalties for noncompliance are contained in the same section. To avoid unnecessary repetitiveness, the Department combined the penalties from this section and § 4226.39(a) as proposed into redesignated § 4226.4(a). Because subsection (a) as revised encompasses all potential penalties, whether as a result of action or inaction by either the county MH/MR program or a service provider or agency, the Department deleted the phrase "of a public legal entity." The Department also made technical changes to this subsection to conform to changes made to the definitions of "child," "at-risk child" and "infant or toddler with a disability," explained in the response to comments to § 4226.5.

In redesignated subsection (b), the Department restated the appeal provision from proposed § 4226.39(b), revised to expand the county MH/MR program's right to appeal to apply to any Department action taken in accordance with subsection (a), not merely those actions "related to loss of funding."

Section 4226.5.

Definition of "appropriate professional requirements."

One commentator noted that the phrases "highest requirement" in subparagraph (i) and "suitable qualifications" in subparagraph (ii) were vague and should be clarified. Two other commentators stated that entry-level requirements are based on minimal requirements in a profession or discipline and recommended changing the wording to "lowest requirements." Two commentators suggested that children who are deaf or hard of hearing have special needs and recommended that language be added in the definition specifying that services for these children must be provided by people trained in specific disabilities.

Response

The Department has deleted this definition because additional review confirmed that the term "appropriate professional requirements" does not appear this chapter.

Definition of "assessment."

The Department made two technical changes to this definition by striking "part" and substituting "chapter" to correct an inadvertent error in the proposed rulemaking and by striking the words "identification of" as redundant of the introductory paragraph.

Definition of "assistive technology device."

One commentator asked what is included in the term "assistive technology device" and how it is funded.

Response

The Department did not identify specific assistive technology devices in the final-form rulemaking because scientific and technological advances lead to the development of new devices over time and practitioners in the field are familiar with currently available devices. Assistive technology devices that are currently available for infants and toddlers include augmentative communication systems, auditory equipment and switches and switch-adapted toys. Funding for this service is available through the funding sources that the Department has established for early intervention services and could vary depending on the type and purpose of the device.

The Department made a technical change to the definition to conform to the changes made to the definitions of "child" and "infant or toddler with a disability."

Definition of "assistive technology service."

One commentator suggested that subparagraph (v) of the definition be expanded to state "as in the case of deaf and hard of hearing infants, toddlers, their parents and their families, training may include instruction in visual language, such as American Sign Language."

Response

The definition of "assistive technology service" mirrors 34 CFR 303.12(d)(1) (relating to definition of "early intervention services"). In addition, the Department does not agree that assistive technology services include instruction in American Sign Language, since those services are intended to assist the child "in the selection, acquisition or use of an assistive technology device." Therefore, the Department did not make the suggested change to subparagraph (v). Nonetheless, the Department recognizes that instruction in visual language may be a service determined to be appropriate by the child's IFSP team in accordance with §§ 4226.72 and 4226.74 (relating to procedures for IFSP development, review and evaluation; and content of the IFSP).

After additional internal review, the Department revised the definition to clarify that the services include assistance to the family of an infant or toddler with a disability. The Department also changed "individuals" to "infants and toddlers" in subparagraph (vi) to improve clarity. Finally, the Department changed "child" to "infant or toddler with a disability" to conform the definition to revisions to the definitions of those terms.

Definition of "at-risk infant or toddler."

The Department changed the defined term from "at-risk infant or toddler" to "at-risk child" since the latter term is used in the final-form rulemaking. In addition, to improve clarity and to avoid the need to consult the act for a complete definition of the term, the Department changed the definition by specifying the population categories rather than merely referring to the act.

Definition of "audiology services."

The Department made technical changes to this definition to avoid inconsistency within the definition and with the format of similar definitions in this section.

Definition of "child."

One commentator recommended that the definition of "child" be revised to include "infants and toddlers with

disabilities" to be consistent with the 34 CFR 303.7 (relating to definition of "children").

Response

The Department did not make the recommended change because the definition, if revised as suggested, would exclude children who have not yet been determined eligible for early intervention services as well as at-risk children. In response to the recommendation, the Department instead revised the definition of "child" to distinguish between that term and "infant or toddler with a disability" as used throughout. As revised, "child" as used in this chapter includes children who have been referred for services but not yet determined eligible as well as "at-risk children" and "infants and toddlers with disabilities."

Definition of "county MH/MR program (legal entity)" (redesignated as "county MH/MR program").

One commentator suggested that the acronym "MH/MR" be spelled out in this definition. Several commentators objected to the term "mentally disabled" as used in this definition because it does not include infants and toddlers referred for or receiving early intervention services. They suggested using the term "persons with disabilities" instead.

Response

Rather than spelling the acronym MH/MR as recommended, the Department changed the definition of "county MH/MR program," which was taken from section 201(2) of the Mental Health and Mental Retardation Act of 1966 (50 P. S. § 4201(2)). The proposed alternative of "persons with disabilities" is over inclusive, since it encompasses persons with only physical disabilities who are not served by the county MH/MR programs. Recognizing that the term did not encompass infants and toddlers eligible for early intervention services, the Department revised the definition to tailor it to the final-form rulemaking by replacing "the mentally disabled" with "infants and toddlers with disabilities and at-risk children."

The Department removed the term "legal entity" from the definition and throughout the final-form rulemaking, since the county MH/MR programs are the only entities responsible for administering early intervention services at the local level, and the term is therefore potentially confusing and unnecessary.

Definition of "culturally competent."

Two commentators pointed out that "culturally competent," used in § 4226.33 (relating to traditionally underserved groups), is not defined and suggested adding a definition or providing examples of culturally competent services.

Response

The Department agrees that the term should be defined and has added a definition.

Definition of "developmental delay" (deleted on final-form).

One commentator stated that the definition is unclear. Another commentator noted that the definition is not age specific.

Response

The Department deleted the definition of "developmental delay" because the meaning of the term, including the age group to which it applies, is clearly described in § 4226.22 (relating to eligibility for early intervention services), the only section in which the term appears. Therefore, a free-standing definition of the term is unnecessary.

Definition of "early intervention program" (deleted on final-form).

In reviewing the proposed rulemaking, the Department determined that this term was used inconsistently to refer to both the Statewide and the county early intervention programs and so could be confusing. The term now appears only in § 4226.2 to refer to the Statewide program. Therefore, no definition of the term is needed.

Definition of "early intervention services."

The Department received several comments on the definition of "early intervention services." Some commentators noted that the definition varied from those in 20 U.S.C.A. § 1432(4) and 34 CFR 303.12 by excluding services for the family, references to the IFSP and natural environments and the phrase "but not limited to" in subparagraph (v). These commentators suggested that the definition be revised to mirror the Federal provisions. Other commentators suggested a variety of additional language changes—such as expanding the list of developmental areas in subparagraph (iii) by adding the phrase "but not be limited to these areas"; including all available services and, specifically, hearing sensitivity services, nutrition services and nursing services in subparagraph (v); specifying the qualifications of special educators in subparagraph (vi) by adding the phrase "with specific expertise to address the child's needs, including cognitive, physical and/or sensory (deafness or blindness) related needs"; adding and clarifying the role of teachers of vision and hearing to subparagraph (vi); and adding sign language instructors, doctors of optometry and registered dieticians to subparagraph (vi).

One commentator recommended that because the early interventionist is not a recognized educational entity and does not have defined education standards, the term should be deleted from subparagraph (vi) or the recitation of responsibilities in § 4226.55 (relating to early interventionist qualifications) expanded. One commentator also asked for clarification of the difference between an early interventionist and a special educator and between a mobility specialist and a physical therapist.

Response

The Department made some, but not all, of the suggested changes to the definition, as well as other changes after internal review. The Department inserted "meet the requirements of this chapter," previously in subparagraph (iv), into the introductory paragraph to clarify and to emphasize at the outset of the definition that all early intervention services must be provided in accordance with the final-form rulemaking. The Department added "in conformity with the IFSP" as revised subparagraph (iv) because that is included in the definition of "early intervention services" in section 103(5) of the act (11 P. S. § 875-103(5)).

The Department did not modify the definition to add components of the Federal definition that may be construed to impose substantive requirements. Rather than imposing substantive requirements in a definition, the Department amended § 4226.72(d) to add paragraph (3), to address collaboration with parents and added § 4226.75 (relating to implementation of the IFSP), which addresses natural environments.

The Department added "and the needs of the family related to enhancing the infant or toddler's development"

in subparagraph (iii), which was inadvertently omitted from the proposed rulemaking. The Department also added "including vision and hearing" to subparagraph (iii)(A) because this phrase was also inadvertently omitted from the proposed rulemaking. The Department did not add the phrase "but not limited to these areas" to this subparagraph because the five areas listed are the primary developmental areas for infants and toddlers.

The Department added nursing and nutrition services in subparagraph (v) because these services were inadvertently omitted from the proposed rulemaking. The Department separated audiology services from speech-language pathology services because these are discrete service types. The Department did not add any other services but added the phrase "but not limited to" to clarify that the list of services is not intended to be exhaustive. Therefore, although not included in the listing, hearing sensitivity services may be eligible early intervention services to meet the developmental needs of an infant or toddler with a disability and the infant or toddler's family. The Department deleted "services" from subparagraph (v)(G) to conform the phrasing of the listed service to the term "service coordination" defined later in this section. The Department also deleted the clause "that are necessary to enable an infant or toddler and the infant or toddler's family to receive another service described in this paragraph" from subparagraph (v)(N) because it is redundant of the definition of "transportation and related costs" later in this section.

In subparagraph (vi), the Department separated audiologists from speech-language pathologists because these are discrete specialties. The Department did not otherwise modify the qualified personnel listing because, as with services, the list is not intended to be exhaustive and it is impossible to identify every type of practitioner that could provide early intervention services. With the exception of service coordinator and early interventionist, the enumerated personnel are those specified in the definition of "early intervention services" in section 103(4) of the act, section of IDEA and 34 CFR 303.12(e). The Department included service coordinator and early interventionist in the listing to reflect the Commonwealth early intervention program because these are common provider types in the early intervention program. Because these professionals, unlike the others listed in the definition, are not licensed by another State agency, their specific qualifications and functions are set forth in §§ 4226.52—4226.55. The Department revised and clarified the responsibilities and qualifications of the early interventionist in § 4226.54 (relating to early interventionist responsibilities) and § 4226.55. The changes are explained in more detail in the responses to the comments on those sections.

The Department changed "including, at a minimum" to "including but not limited to" to clarify that other practitioner types may also be "qualified." Therefore, although not included in the listing, teachers of vision and hearing, sign language instructors, doctors of optometry and registered dieticians—among others—may be considered qualified personnel to provide early intervention services that would meet the developmental needs of an infant or toddler with a disability and the infant or toddler's family. Finally, the Department determined that it was unnecessary to add the qualifying phrase to "special educators" because State standards already exist for that profession.

In response to the request for clarification, a special educator is an individual who has been certified by the Department of Education to teach students with disabilities in the school system. An early interventionist is an individual who is not certified as a teacher but has the qualifications in § 4226.55. The early interventionist provides instruction and assistance in designing learning environments and activities in the home and community to promote the acquisition or enhancement of skills, cognitive processes and social integration on the part of an infant or toddler with a disability.

A mobility specialist is an individual who provides support and training to children or adults with visual impairments to enable them to navigate through their environment. The services provided by a mobility specialist are included in the definition of "vision services." A physical therapist is an individual who addresses the promotion of sensorimotor function through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development and effective environmental adaptations.

The Department made some technical changes to the definition to correct grammar and to conform the definition to changes made to other definitions.

Definition of "evaluation."

Two commentators noted that the definition of "evaluation" differs from the definition in 34 CFR 303.322(b)(1) (relating to evaluation and assessment) by omitting the phrase "by appropriate qualified personnel" and 34 CFR 303.322(c)(1) by omitting the clause "be conducted by personnel trained to utilize appropriate procedures." They suggested that the language should be the same.

Response

The Department added the phrase "by qualified personnel" to the revised definition but omitted "appropriate" as redundant of "qualified." Section 303.322(c)(1) of 34 CFR is not a definitional section but imposes a substantive requirement, which is in § 4226.62(b)(1)(i) (redesignated as § 4226.61(b)(1)(i)) (relating to MDE).

The Department revised the definition to include eligibility of at-risk children for tracking services, which was inadvertently omitted from the proposed rulemaking, and to simplify the definition by replacing the cross reference to another definition with the phrase "for tracking or early intervention services." The criteria for "initial and continuing eligibility" for early intervention services in § 4226.22 include a determination of the child's status in the developmental areas. Section 4226.30(a) (redesignated as § 4226.25(a)) (relating to at-risk children) specifies that the child is to be identified through the initial MDE as an at-risk child. As set forth in § 4226.62(b) (redesignated as § 4226.61(b)), the MDE must include a determination of the child's functioning in each developmental area. Therefore, reference to this determination in the definition of "evaluation" was redundant and also deleted.

Definition of "family training, counseling and home visits."

One commentator recommended that this definition be revised to be consistent with 34 CFR 303.12(d)(3). Two other commentators suggested that special educators be included in the definition. They also suggested that the final-form rulemaking more specifically describe the components of training, including resources, available to assist the family in understanding the special needs of the infant or toddler with a disability. Another commentator recommended that the three terms be defined separately because they have different meanings.

Response

The difference between this definition in the proposed rulemaking and the definition in 34 CFR 303.12(d)(3) was

the omission of the phrase "as appropriate." The Department added the phrase but altered its placement in the sentence from that in 34 CFR 303.12(d)(3) based on the Department's interpretation of the definition, to clarify that the type of provider that is appropriate to deliver the specified services will vary depending on the needs of the family. The Department did not define the three terms separately because the services provided-assistance to the family in understanding the needs of and enhancing the development of the infant or toddler—are the same; the specific components of the services delivered will vary depending on the type of provider that delivers the services. The Department did not incorporate special educators or specific training and resources for families. The phrase "other qualified professionals" in the definition includes qualified special educators. The Department determined that it is inappropriate to specify training components and resources in the rulemaking, since those will vary with the needs of each family and over time.

Definition of "health services."

Two commentators stated that subparagraph (i) of the definition of "health services" was inconsistent with 34 CFR 303.13 (relating to definition of "health services") because it limited the availability of health services to the times when an infant or toddler with a disability is receiving medical services. They recommended that the definition be revised to be consistent with 34 CFR 303.13. Another commentator recommended that subparagraph (i)(B) not be limited to "consultation by physicians" but should include other health care practitioners such as optometrists.

Response

The Department agrees with the first comment and made the change as recommended, as well as a corresponding grammatical correction. The Department also changed the organization of subparagraph (i) to conform to subparagraph (ii) and made technical revisions to the definition to conform to changes made to other definitions.

The Department did not amend the list of services in subparagraph (i) because it is not intended to be an exhaustive list of health services. Consultation with health care practitioners other than physicians could appropriately be considered a health service as defined, depending on the needs of the particular infant or toddler with a disability. In addition, consultation by other health care practitioners could appropriately be considered within the scope of another early intervention service (for example, vision services), depending on the reason for the consultation.

Definition of "IFSP—individualized family service plan."

One commentator stated that the definition of "IFSP" varies from the definition in the Federal regulation and suggested that it be revised to be consistent with the Federal regulation or the variation be explained.

Response

The Department did not make the recommended change because the definition is identical to the definition in 34 CFR 303.340(b) (relating to IFSPs—general), which is cross referenced in 34 CFR 303.14 (relating to definition of "IFSP"). Section 303.14 of 34 CFR defines "IFSP" as "the individualized family service plan, as that term is defined in § 303.340(b)." Rather than merely spelling out the acronym in the definition and cross referencing to another definition, the Department combined both definitional sections in 34 CFR 303.340(b) and 303.14 into one definition. The Department made technical changes to the definition to conform the definition to changes made to other definitions.

Definition of "infant and toddler with disabilities" (redesignated as "infant or toddler with a disability").

One commentator stated that the definition of "infant and toddler with disabilities" eliminates language relating to the methods of measuring developmental delays contained in section of IDEA (20 U.S.C.A. § 1432(5)), and suggested it be revised to be consistent with the Federal definition.

Response

After additional review, the Department revised the definition to refer to the eligibility criteria in § 4226.22 to avoid repetitive and therefore potentially confusing references to eligibility criteria. In addition, the revision clarifies that the term as used in the final-form rulemaking means only children who have been determined eligible for early intervention services and does not include children referred for assessment and evaluation or at-risk children (both of which groups are defined elsewhere). The revised definition also resolves the issue raised in the comment because § 4226.22 makes clear that eligibility determinations must be made using appropriate diagnostic instruments and procedures.

The Department retained the phrase "under 3 years of age" rather than revising it to "from birth through age two," the language in 34 CFR 303.16(a) (relating to definition of "infants and toddlers with disabilities"), for clarity and conformity with the *Pennsylvania Code and Bulletin Style Manual (Style Manual)*. The Department also made a technical correction by changing the defined term to the singular form. The Department replaced the terms "child," "eligible child" and "infant or toddler" throughout the final-form rulemaking where the terms were used to refer to a child who has been determined eligible for early intervention services.

Definition of "legal entity" (deleted on final-form).

One commentator requested clarification of the role of the State if the definition of "legal entity" sets forth the role of the county, since the State would appear to be included in the term as defined.

Response

For the reason explained in the response to the definition of "county MH/MR program," the Department deleted the term "legal entity" and the requested clarification is therefore not needed. The Department replaced the term "legal entity" with "county MH/MR program" throughout the final-form rulemaking.

Definition of "location."

The Department made a technical change to the definition of "location" by inserting the phrase "or is" to account for those infants and toddlers with disabilities whose IFSPs are being reviewed and who are therefore already receiving services.

Definition of "MDE" (deleted on final-form).

Two commentators suggested the term "MDE" be defined beyond defining the acronym.

Response

After considering the recommendation of the commentators, the Department decided to delete "MDE" as a defined term. The components of an MDE are in § 4226.62 (redesignated as § 4226.61). As a review of that section shows, the term "MDE" is not easily suscep-

tible to definition. Attempts to define the term would result in either an overly simplistic, incomplete and potentially confusing definition or one that inappropriately includes substantive requirements. Rather than risking either possibility, the Department has chosen the alternative of deleting the term from § 4226.5 and cross referencing to redesignated § 4226.61 when the term "MDE" appears in the final-form rulemaking.

Definition of "medical services only for diagnostic or evaluation purposes."

The Department added a definition of "medical services only for diagnostic or evaluation purposes" because it is listed in the definition of "early intervention services" and was inadvertently omitted from the proposed rulemaking.

Definition of "multidisciplinary."

Two commentators suggested that the definition of "multidisciplinary" be changed to specify that service coordination is not one of the two disciplines or professions that comprise "multidisciplinary." Several other commentators raised the same issue in commenting on § 4226.62 (redesignated as § 4226.61).

Response

The definition of "multidisciplinary" mirrors the definition in 34 CFR 303.17. The Department is unaware of any Federal or State law requirement that two professions or disciplines, in addition to service coordination, participate either in evaluation and assessment activities or in the development of the IFSP. The Department is therefore unwilling to impose this requirement and did not change the definition. Nonetheless, the definition does not preclude more than one professional other than the service coordinator from participating in either the evaluation and assessment of, or development of the IFSP for, a particular infant or toddler with a disability.

The Department made a technical change to the definition to correct a grammatical error.

Definition of "native language."

Two commentators recommended that the definition of "native language" be revised to state "parent's native language or child's native language" to account for those situations in which the parent's and the child's native language is not the same, such as when a deaf child is born to hearing parents.

Response

The sections of the final-form rulemaking in which the term "native language" appears (for example, § 4226.63 (redesignated as § 4226.62) (relating to nondiscriminatory procedures), § 4226.72(d) and § 4226.97 (relating to prior notice, native language) (redesignated as § 4226.95 (relating to prior notice))) address communication with parents, not service delivery to the child. Therefore, the Department determined that it is unnecessary to modify the definition, which is based on 34 CFR 303.401(b) and 303.403(c)(3) (relating to definitions of consent, native language and personally identifiable language; and prior notice, native language). Nonetheless, the Department has highlighted as a training issue the need to communicate with a deaf child in the language used by the child, including sign language.

The Department made three technical corrections to the definition. It changed "an eligible child" to "a child" to clarify that the native language requirements apply not only to children and families that have been determined to be eligible for early intervention services but also to children and families referred for services. The Department also deleted the last sentence, which imposes the same substantive requirements set forth in § 4226.95(d)(1) and was inadvertently included in the definition in the proposed rulemaking. Finally, the Department made a grammatical correction by changing "shall be" to "is," since this is a definitional section and is not intended to impose a substantive requirement, as use of "shall be" connotes.

Definition of "natural environments."

The Department received four comments to the definition of "natural environments." Two commentators noted that some children require services in specialized settings, which may function as a natural environment for those children. They suggested that language be added to the definition to make clear that a natural environment may be a school or other program for the deaf. One commentator suggested that the definition could be more clear. One commentator stated that the language was too limiting and recommended adding the phrase "to the maximum extent appropriate."

Response

The definition of natural environments mirrors the definition in 34 CFR 303.18. The Department recognizes that a child who is deaf or hard of hearing may appropriately receive services in a school or program designed for children who are deaf but does not agree that the setting would be a natural environment. Therefore, the Department did not add the suggested language to the definition.

The phrase "to the maximum extent appropriate" is not definitional and is therefore not included in this paragraph. The substance of the requirement in this phrase is in § 4226.75(a) (relating to implementation of the IFSP).

The Department added the explanatory clause from 34 CFR 303.12(b) to provide additional guidance in interpreting the meaning of the term. The Department also corrected a grammatical error.

Definition of "nutrition services."

One commentator suggested that the terms "feeding skills and feeding problems" be deleted from the definition of "nutrition services" because self-feeding is an activity of daily living appropriately addressed by occupational therapists and swallowing examinations and therapies are provided by speech-language pathologists.

Response

The Department did not make the recommended change. Feeding skills and feeding problems are included as "nutrition services" in 34 CFR 303.12(d)(7)(i)(C) and may therefore not be deleted. Nonetheless, self-feeding as an activity of daily living is also encompassed within the definition of "occupational therapy" in this section and swallowing examinations and therapies are explicitly included in the definition of "speech-language pathology services" in this section.

The Department made technical corrections to the definition to avoid inconsistency with the format of similar definitions in this section and to conform the definition to changes made to other definitions.

Definition of "occupational therapy."

One commentator observed that the definition of "occupational therapy" does not reflect the need to address family concerns, priorities and resources, which are essential for the child's development, and recommended that the definition be revised accordingly.

Response

The need to address family concerns, priorities and resources is a requirement that applies to all services, as set forth in § 4226.62(c)(1) (redesignated as § 4226.61(c)(1)). Therefore, the Department did not revise the definition of "occupational therapy" as recommended. The Department made some technical changes to the definition, to correct grammatical errors and to conform the definition to changes made to other definitions.

Definition of "parent."

One commentator recommended that a foster parent be explicitly identified as a permissible surrogate parent in the definition of "parent." Two commentators suggested that the definition should make clear that no employee of a private as well as a public foster care agency may be considered a parent. Other commentators stated that the definition of "parent" should include foster parents in the circumstances permitted by 34 CFR 303.19(b) (relating to definition of "parent"). Several additional commentators also raised the status of foster parents in addressing § 4226.105 (redesignated as § 4226.96) (relating to surrogate parents).

Response

The Department revised the definition of "parent" to refer explicitly to a foster parent as a permissible surrogate parent. It also included "legal custodian" in the definition, since "guardian" and "legal custodian" are not legally synonymous. This revision also clarifies that a county children and youth agency may not be considered a "parent" when it is the legal custodian of a child, which was the intent of the reference to "county agency" in the proposed rulemaking. Finally, the Department added a parenthetical phrase to explain the meaning of "a person acting as a parent of a child."

The Department gave careful consideration to the many comments that addressed the status of foster parents. The Department acknowledges and values the contribution of foster parents to the lives of children in substitute care and the important role foster parents often play in the delivery of early intervention services to infants and toddlers with disabilities. At the same time, the legal status of foster parents under State law is grounded on the premise that the foster parent/child relationship is by definition temporary and subordinate to the legal relationship between the county agency and the child as well as, more important, the ongoing parental relationship with a child placed in substitute care. The Department is reluctant to inject ambiguity into the legal status of foster parents under State law by conferring on particular foster parents the status of "parent" under even the limited circumstances allowed under the Federal regulation.

Recognizing the invaluable role that foster parents can play in the lives of children referred or eligible for tracking or early intervention services and to encourage that role, the Department has determined that the competing interests are best resolved by loosening the restrictions on allowing a foster parent to serve as a surrogate parent, with the approval of the custodial county children and youth agency. The Department believes that permitting foster parents to serve as surrogate parents will enable them to participate in the decisionmaking process for and pursue procedural protections on behalf of children in their physical care without causing confusion about their legal status under State law. Therefore, the Department did not revise the definition of "parent" to include foster parents, but revised § 4226.105 (redesignated as § 4226.96).

Definition of "personally identifiable information."

One commentator requested clarification of what is included in the definition of "personally identifiable information" and where it is located in the child's file.

Response

As specified in the definition, "personally identifiable information" is information that would make it possible to identify the child or family. The definition includes a nonexhaustive list of examples of this information. The information might be located anywhere in the child's record, depending on the procedures and practices of the county MH/MR program or provider. For example, demographic information on the child and family might be maintained in one section of the record, and evaluation reports and IFSPs, which are also likely to include the name or other identifying characteristics of the child or family members, might be maintained in a different section of the record. The nature of the information, not the location in the child's record, determines whether it is "personally identifiable information."

The Department made two technical corrections to the definition, to correct grammatical and punctuation errors and to avoid inconsistency within the definition.

Definition of "physical therapy."

One commentator recommended that "perceptual . . . development" be deleted from the definition of "physical therapy" because "perception is not a matter of physical functioning" within a physical therapist's scope of practice but is an occupational therapy service. Another commentator suggested including "family support for caregiver-child interaction" in the definition to promote family-centered care and child development.

Response

The Department did not make the recommended changes. The Department does not agree that enhancement of perceptual development, in conjunction with motor development, is inappropriately a physical therapy service. The definition of "physical therapy" in 34 CFR 303.12(d)(9) does not recognize family support and the Department agrees that it should not be included in the definition of "physical therapy."

The Department made some technical changes to the definition to enhance consistency with similar definitions and to conform the definition to changes made to other definitions.

Definition of "referral."

Two commentators suggested that "referral" be defined, with one of these commentators requesting the Department to clarify whether the term means contact with the family or a contact made on behalf of the family.

Response

The Department agrees and added a definition of "referral" as suggested. The definition clarifies that a referral is a contact made on behalf of the child and family.

Definition of "service coordination (case management)."

After additional internal review, the Department made several changes to the definition of "service coordination." First, it added a phrase to clarify that the activities to be carried out by a service coordinator are those specified in § 4226.52 (relating to service coordination activities). Second, it changed "an eligible child" to "a child" because service coordinators are assigned to children and families upon referral, not only after a child has been determined

eligible for tracking or early intervention services. Finally, it made three technical corrections to avoid incorrect or unnecessary wording and inconsistency with other regulations and to correct punctuation.

Definition of "social work."

The Department added a definition of "social work" because it was inadvertently omitted from the proposed rulemaking.

Definition of "special instruction."

Two commentators recommended that the definition of "special instruction" be revised to specify that information conveyed during special instruction may be communicated through sign language or other forms of communication.

Response

The Department did not make the change as recommended. The definition of "special instruction" encompasses the use of language as needed to achieve the outcomes identified on the IFSP, to promote the acquisition of skills by and to enhance the development of all infants and toddlers with disabilities, including those who are deaf or hard of hearing. Special instruction is expected to be tailored to meet the individualized needs of the infant or toddler with a disability, as reflected on the IFSP in accordance with § 4226.74(1), (3) and (4) (relating to content of the IFSP). The Department determined that it is unnecessary to modify the definition to highlight particular disabilities.

The Department made several technical corrections to avoid inconsistency within the definition and with other regulations and to conform the definition to changes made to other definitions.

Definition of "tracking."

Two commentators suggested that a definition of "tracking" be added.

Response

The Department concurs and added a definition of "tracking" as suggested.

Definition of "transportation and related costs."

One commentator asked what is included in the definition of "transportation and related costs." Another commentator asked whether the provision of transportation and related costs is included in service coordination or is the responsibility of the provider.

Response

The definition identifies the types of costs that are included in "transportation and related costs." "Transportation and related costs" is not included in § 4226.52 and so is not a service coordination function. Although providers may bill for this service, it is not expected that the service will need to be provided generally or as a matter of routine, since most early intervention services are provided in the natural environment. The need for transportation and related costs, as with other early intervention services, should be determined by the IFSP team.

The Department made several technical corrections to the definition to avoid redundancy, correct a grammatical error and conform the definition to changes made to other definitions. The Department also changed "early intervention services" to "another early intervention service" to avoid confusion.

Definition of "vision services."

One commentator asked whether "vision services" includes a teacher of the visually impaired who is not certified to provide mobility and orientation services.

Response

The definition of "vision services" does not address the types of providers that may deliver the services. As with all other early intervention services, for an individual to be able to provide vision services, that person must be "qualified" as defined in the final-form rulemaking. The Department made two technical changes to the definition to avoid inconsistency with similar definitions.

Section 4226.5. Definitions—Other comments.

The Department received several additional comments recommending that a number of undefined terms be included in the definitions sections. Two commentators suggested that "communication" be defined to specify that communication may include sign language. These two commentators also suggested that a definition of "sign language instructor" be included, specifying minimum qualifications, because no other State regulations establish credentialing for sign language or sign language instruction.

Some commentators recommended that "early interventionist" be defined. One commentator made the same recommendation for "service coordinator."

Response

The Department did not add the definitions as recommended. The final-form rulemaking as a whole embodies the principle that all services must be directed toward meeting the individualized developmental needs of infants and toddlers with disabilities, including infants and toddlers who are deaf or hard of hearing. The Department believes it is unnecessary to prescribe communication with these infants and toddlers by way of a separate definition of "communication."

Establishing qualifications and scope of practice standards for professions and disciplines that are not limited to the early intervention program but reach across program lines does not lie within the authority of the Department. The Department is unwilling to codify standards for early intervention providers in regulation instead of appropriate, generally applicable requirements from the licensing and credentialing authority. Therefore, it did not add a definition of "sign language instructor."

In response to the comments requesting that a definition of "early interventionist" and "service coordinator" be added, as well as comments expressing general confusion over the two provider types, which are addressed in more detail in the responses to the comments to §§ 4226.52 and 4226.54, the Department revised and clarified the respective roles and responsibilities of these two provider types in those sections of the final-form rulemaking. The Department determined that revising those sections was a better approach to clarifying roles and responsibilities than adding definitions, particularly because none of the other "qualified personnel" listed in the definition of "early intervention services" is included in the definitions.

Section 4226.6. Waiver of regulations.

Many commentators recommended that the Department include a procedure for requesting a waiver of specified regulatory requirements to accommodate situations in which a county MH/MR program is unable to comply with a requirement despite best efforts to do so. The commentators focused particularly on the requirement that the initial multidisciplinary evaluation be conducted by personnel independent of the service provider in § 4226.62(a)(2) (redesignated as § 4226.61(a)(2)).

Response

The Department agrees with the commentators and has determined that special circumstances might justify the waiver of other regulatory requirements as well. Therefore, the Department added this new section, which specifies the circumstances under which it may exercise its discretion to waive a regulatory requirement as well as the information that must be submitted in support of a waiver request. As the language of the regulation makes clear, only county MH/MR programs may submit waiver requests. The Department expects that in the course of its monitoring duties, as specified in § 4226.27 (relating to monitoring responsibilities), a county MH/MR program will assess whether or not special circumstances exist in the county that warrant submission of a waiver request. The Department will not entertain applications under this section from individual provider agencies.

Section 4226.12. Waiver funds (redesignated as "Medicaid waiver funds").

Four commentators stated that counties do not have complete control over whether waiver funds can be expended because use of waiver funds depends on eligible children being identified and their parents agreeing to participate in the waiver. They recommended clarifying the counties' obligation by adding language at the end of the paragraph such as "to the extent that eligible services and eligible children can be identified, and the children's parents consent to participate in the waiver." One commentator suggested that because the waiver is a limited funding source, this section should be deleted.

Response

The Department concurs with the first comment and made the recommended change. The Department agrees that this is a limited funding source. Throughout the development of the waiver program, however, the Department received input recommending that the final-form rulemaking specify the availability of this funding source. In addition, the Department believes that the obligation of the counties to use waiver funds when those funds are available should be set forth in final-form rulemaking so that those funds are used to the maximum possible extent. Therefore, the Department retained this section.

The Department made a technical change by deleting the phrase "allocate and" because the Department, not the county MH/MR programs, allocates funding. The Department also added the word "Medicaid" to the heading of this section to avoid confusion in light of the addition of § 4226.6 (relating to waiver of regulations). The Department made other technical changes to conform this section to other changes made in the final-form rulemaking.

Section 4226.13(a). Nonsubstitution of funds (redesignated as "Payor of last resort").

One commentator stated that the wording of the subsection implies that after private insurance is billed, early intervention funds will be used only in the interim until the insurance payments begin. Two commentators suggested that funding sources be listed in the order in which they can be accessed, since the intent of the subsection was unclear. Two other commentators stated that counties should not be held accountable for not using funds that are not accessible because the family did not consent, with one suggesting the addition of the clause "so long as the use of those funds is without cost to the families, and the families have consented."

Response

The Department revised the heading of the section and the language in subsection (a) to clarify that the intent of this section is to codify the Federal requirement (at 42 U.S.C.A. § 1440(a) and 34 CFR 303.527(a) (relating to payor of last resort)) that the early intervention system be the payor of last resort and that other available public and private funding sources must be used to pay for services before early intervention funds are expended. If parental consent is needed to access a funding source but the family does not consent to the use of that funding source, then the funding source is not available and need not be used before early intervention funds may be used.

The Department is unwilling to impose requirements on the use of other funding sources that are not imposed by Federal law and therefore did not add the recommended language. To underscore that this subsection sets forth the same requirements imposed by Federal law and should be interpreted consistent with Federal law as it currently exists and as it may be modified in the future, the Department added the introductory clause "unless otherwise permitted or mandated by Federal law."

The Department revised the second sentence of this subsection and redesignated it as subsection (c) to clarify the intent of the sentence that services may not be denied or delayed because another funding source, including Medicaid, is unavailable.

Section 4226.13(b).

One commentator stated that parents should not be compelled to use private insurance to pay for services. Another commentator suggested adding the language "after being informed of their rights to refuse consent" to emphasize the voluntary use of private insurance. The same commentator suggested adding the phrase "but are not limited to" to introduce the examples of financial losses and recommended additional examples of losses. Other commentators recommended adding language that clarifies that parents cannot be required to apply for Medicaid to receive early intervention services. One commentator suggested that the Department clarify how families will not suffer financial losses if they volunteer to use private insurance. One commentator suggested that language be added to explain that services may not be delayed while securing funding or adjusted to reflect available funding sources. Three commentators raised the same issue in commenting on § 4226.14 (relating to documentation of other funding sources) or on the financial management sections generally.

Response

As previously noted, Federal law requires that all other available public and private funding sources be exhausted before early intervention funds are expended. Thus, available private and public funding sources, including commercial health insurance, must be used to meet the costs of early intervention services as long as the parent consents and the use does not result in a cost to the family.

Because the comments reflected general confusion about the purpose and intent of this subsection, the Department revised the language of the introductory paragraph to convey the meaning of the subsection more clearly and concisely. The Department added the clause "unless otherwise permitted or mandated by Federal law" to emphasize the intent that this subsection be interpreted consistent with Federal law as it currently exists and as it may be modified in the future. To clarify that parental consent must be obtained to use private health

insurance, the Department used the phrase "with the consent of the family." If the family refuses consent, then private insurance is not available and may not be accessed. As recommended, the Department added the phrase "but are not limited to" to introduce the types of costs, to clarify that the itemized list is not exhaustive but merely illustrative and therefore did not amend the list of examples.

The Department finds that access and use of Medical Assistance (MA) funds in this Commonwealth results in no cost to or potential negative impact on children or families. Therefore, although parents are not required to apply for MA for infants and toddlers to receive early intervention services, they should be informed of and encouraged to use all financial resources available to them. The Department is concerned that county MH/MR programs or service providers or agencies not be dissuaded from informing families of all available funding options, including MA, for fear of a finding of noncompliance. Therefore, the Department did not add the recommended language regarding application for Medicaid. As previously noted, the Department revised the second sentence of subsection (a) and redesignated it as subsection (c), which clarifies that services may not be denied or delayed because another funding source, including Medicaid, is unavailable. This clarification addresses the concern raised by these commentators.

Section 4226.14. Documentation of other funding sources.

Several commentators submitted comments to this section, many of which echoed the comments to § 4226.13 (relating to nonsubstitution of funds (redesignated as payor of last resort)). For example, a few commentators emphasized that other funding sources may not be used unless the parent consents and the use results in no cost to the family and that services should not be delayed because other funding sources are unavailable. They suggested adding language in this section to specify these conditions. One commentator suggested removing "private funding" as a mandatory funding source.

Some commentators questioned the meaning of "all other private and public funding sources" and who is responsible for exhausting the funding. Two commentators expressed concern that this section was intended to require parents to exhaust their personal resources and objected to having to do so. Two commentators recommended that parents should be provided with written details of advantages, disadvantages of and restrictions on or the implications of using the various funding sources. One commentator suggested that the Department prescribe a process to make families aware of various funding sources.

One commentator suggested that the Department specify a time limitation for retaining the permanent file in subsection (a). The same commentator noted that the language in subsection (b) implied that the Department formally approves the county procedures but did not specify the criteria for approval. The commentator recommended that the approval criteria be specified or, if there is no formal approval process, that the phrase "approved by the Department" be deleted.

Response

The Department addressed the comments identified in the first paragraph of the comment summary in its responses to § 4226.13 and will not repeat those responses here. Nonetheless, these comments as well as the others reflect considerable confusion over the purpose and intent of this section. This section is not intended to establish a substantive requirement in addition to those set forth in § 4226.13 but is intended only to require that the county MH/MR programs and service coordination providers maintain documentation of compliance with § 4226.13. The Department has reorganized and amended the language of this section to clarify that intent.

The Department added subsection (a) to replace proposed subsection (b) to specify more clearly that the county MH/MR programs must develop procedures to comply with § 4226.13. The Department expects that these procedures would include the means by which parents are informed of potential funding sources and of the conditions that might apply to each. The Department will review compliance with this subsection in the course of its monitoring review of the county MH/MR programs. Therefore, it omitted any reference to Department approval of the procedures from the subsection.

The Department revised redesignated subsection (b), requiring that the service coordinator maintain documentation that attempts have been made to exhaust other available funding sources, as required in § 4226.13, to clarify that the documentation requirement must be read in conjunction with the substantive requirement set forth in § 4226.13.

As recommended, the Department specified that the documentation must be maintained in accordance with the time periods in § 4226.36(d) and (e) (relating to child records). The Department also changed "child" to "infant or toddler with a disability" to conform the section to the changes made to the definitions of those terms.

Section 4226.15. Interim payments.

One commentator suggested including a specific timeframe rather than the phrase "in a timely fashion" in subsection (a) to improve clarity.

Response

The Department deleted the phrase "in a timely fashion" as redundant of "delay" and therefore unnecessary. "Delay" could vary depending on the needs of the child and the family as reflected on the IFSP. Timelines for service delivery are specified in § 4226.75(b).

After internal review, the Department made additional changes to this section to revise the language to be consistent within the section and with other sections by referring to "funding source" rather than other terms and by using the terms "infant or toddler with a disability" and "county MH/MR program." The Department also changed "shall" to "may" in subsection (a) to clarify that a county MH/MR program is not required to use State early intervention funds to make interim payments but that States funds are available for that purpose. In subsection (b), the Department changed "appropriate" to "responsible" to avoid ambiguity and changed "incurred" to "made" to correct improper usage.

Section 4226.21. Delegation of responsibilities (redesignated as "Nondelegation of responsibilities").

The Department reorganized and made other technical changes to this section to clarify that the county MH/MR program remains responsible for compliance with this chapter if it contracts with another agency. The Department also amended the heading to convey the intent of the section more accurately. Finally, the Department deleted the first sentence of redesignated subsection (a) as redundant and therefore unnecessary.

Section 4226.22(a). Eligibility for early intervention services.

One commentator questioned the basis for establishing 25% developmental delay and 1.5 standard deviations as the criteria for eligibility. Two commentators expressed concern that children who are delayed in only one area of development will not be eligible to receive early intervention services and stated that the eligibility criteria suggest that a child would be eligible for early intervention services only if the child's disability or delay resulted in the need for special education or related services. One commentator recommended that adaptive development be defined. One commentator expressly noted support for the 25% delay criterion.

Response

The eligibility criteria are based on research findings and best practices in early intervention as well as criteria that other State programs have established. The Department finds that the criteria are appropriate for identifying those children whose developmental needs may be met with early intervention services. The criteria do not require that children be delayed in more than one developmental area; nor do they require a determination that a child need special education or related services to be eligible for early intervention services.

The meaning of the term "adaptive development," as well as that of the other areas of development, is known within the professional community. Therefore, it is unnecessary to include a definition of an area of development, including adaptive development.

The Department made some technical changes to this subsection to correct syntax errors and to enhance organizational consistency within the subsection and with other sections in the final-form rulemaking.

Section 4226.22(b).

Four commentators stated that the language on informed clinical opinion was more restrictive than that in 34 CFR 303.300 (relating to State eligibility criteria and procedures) and recommended that the subsection be revised to mirror Federal law. One commentator suggested that examples of circumstances when no standardized measures are available or appropriate, and so would require "informed clinical opinion," would improve clarity. Another commentator expressed support for retaining the use of informed clinical opinion.

Response

The Department did not intend to limit use of informed clinical opinion to cases in which other diagnostic tools are unavailable or inappropriate. As specified in § 4226.62(b)(2) (redesignated as § 4226.61(b)(2)), informed clinical opinion must be a component of every evaluation that determines eligibility for early intervention services. The Department revised the language of the subsection to clarify that informed clinical opinion must guide and may be used in lieu of the use of standardized measures and other diagnostic tools.

After careful consideration of the suggestion to include examples of circumstances that would require informed clinical opinion because other diagnostic tools are unavailable or inappropriate, the Department finds that it would be nearly impossible to list all circumstances. Rather than imply a restriction on the use of informed clinical opinion by citing examples of circumstances in the final-form rulemaking, the Department believes that the determination should be left to the judgment of the professionals who are working with the child. Therefore, it did not revise the subsection as suggested.

Section 4226.23. Waiver eligibility (redesignated as "Eligibility for Medicaid waiver services").

A number of commentators submitted comments to this section. One commentator recommended technical additions or changes to subsection (a), including: spelling out the acronyms ICF/MR and ICF/ORC in the introductory paragraph; clarifying the term "applicant and recipient"; and deleting the term "indefinitely" from paragraph (3)(iii). Another commentator suggested adding the phrase "with the parent's consent" to the introductory paragraph. A third commentator proposed inserting the words "and" and "or" following the paragraphs and subparagraphs to reflect the eligibility criteria more accurately and adding the word "qualified" before "professional" in paragraphs (2) and (3).

Commentators also asked how the waiver eligibility criteria were established and requested clarification of the basis for "more than two standard deviations below the mean" in paragraph (1)(i), "slightly" in paragraph (1)(ii), and "substantial functional limitation" in paragraph (3)(ii); questioned whether the concepts of independent living, economic self-sufficiency and self-direction appropriately apply to infants and toddlers and how they might be evaluated in the infant and toddler population; and suggested that the regulation clarify that only eligible services will be funded.

One commentator recommended that subsection (a)(1) be revised to include a "qualified professional," to reflect the approved waiver eligibility criteria. Another commentator proposed that this section be deleted and that § 4226.14 be renamed and revised to require that parents be informed of all funding options. One commentator stated that the form that parents must complete for the waiver program should be revised to promote clearer understanding of the parents' role in the program.

One commentator questioned use of the term "infant, toddler and family" in subsection (b) rather than "applicant or recipient," as in subsection (a), and recommended that either consistent terms be used in both subsections or the difference in meaning be explained.

Response

The Department concurs with and made the suggested technical changes identified in the first paragraph of the comment summary. Rather than adding a consent provision to this section, the Department included parental consent for enrollment in the Medicaid waiver program in § 4226.95 (redesignated as § 4226.92 (relating to parental consent)).

The Department agrees that the eligibility criteria as set forth in the proposed rulemaking did not accurately reflect the criteria that the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration) approved for the waiver program because the conjunctions between the paragraphs and subparagraphs were omitted. To address this issue and remain in conformance with proper regulatory format as prescribed in the *Style Manual*, the Department reorganized subsection (a) into two subsections and added clauses to introduce each of the subparagraphs in redesignated subsection (b). In reorganizing the section in this manner, the Department did not in any way alter the substance of the eligibility criteria from the proposed rulemaking. As a result of the reorganization, subsection (b) in the proposed rulemaking has been redesignated as subsection (c).

In subsection (a)(2) and (3) (redesignated as subsection (b)(1)(ii) and (2), respectively), the Department clarified that the certifying professional is a "qualified professional" as defined in 42 CFR 483.430(a) (relating to condition of participation: facility staffing). This specification, which was inadvertently omitted from the proposed rulemaking, is necessary to conform to the Federally approved eligibility criteria. The Department did not make a similar change to subsection (a)(1) (redesignated as subsection (b)(1)(i)), as recommended, because the approved waiver requires that a psychologist, certified school psychologist or physician make the certification required in that subparagraph.

In response to the requested clarifications of and suggested changes to the eligibility criteria, the Department is unable to revise the criteria outlined in this subsection. The criteria were developed in negotiations with the CMS for approval of the waiver and were a condition of that approval. The source of the criteria is the ICF/MR or ICF/ORC level of care criteria in this Commonwealth, set forth in §§ 6210.62 and 6210.63 (relating to level of care criteria; and diagnosis of mental retardation); the criteria are the same as for all other waiver programs administered by the Office of Mental Retardation, modified somewhat to apply to the infant and toddler population. The few modifications to the criteria were also approved by CMS. The Department recognizes that the areas of independent living, economic self-sufficiency and self-direction do not apply to infants and toddlers, so that an infant or toddler must have substantial functional limitation in three of the four remaining areas of major life activities to be eligible for the waiver program.

A provision specifying that only eligible services may be funded through the waiver program has been added to § 4226.12. The Department did not delete this section or combine it with § 4226.14 because the purpose of this section is to set forth the eligibility criteria for the waiver program, not prescribe that parents should be informed of the program. The Department revised the section heading to clarify that purpose.

No section of the regulations requires that a particular form be used for waiver enrollment. Therefore, the Department did not address the comment about the form in the final-form rulemaking. In response to the comment, the Department will review the existing form to determine if revision is needed.

The Department made some technical changes to correct grammar and punctuation errors and to conform the section to other changes made in the final-form rulemaking.

Section 4226.24. Comprehensive child find system.

The Department received a number of comments to this section. A few commentators noted that the use of the term "ensure" throughout the section obligates the county MH/MR program to undertake activities and produce outcomes that cannot always be controlled; that the clause "and which children are not receiving services" in subsection (a)(2) is not included in 34 CFR 303.321(b)(2) (relating to comprehensive child find system) and that it is unclear how the county can determine which children should be but are not receiving services; that it would be helpful to specify strategies to structure and improve child find activities in the final-form rulemaking; and that the responsibilities for child find should be performed with the assistance of the State. One commentator asked whether child find is a service coordination function and, if not, who is responsible for child find activities. The same commentator asked whether a specific child find process is recommended. Another commentator suggested that the coordination required in subsection (b) implies that the county MH/MR program is expected to use the identified programs and agencies as county volunteers.

As noted in the response to comments to § 4226.5, two commentators recommended that "referral" be defined. They also suggested that the Department specify criteria for establishing when a referral is "received" in subsection (f) (redesignated as subsection (g)). One commentator suggested that "as soon as possible" in subsection (f)(1) (redesignated as subsection (g)(1)) is vague and recommended including a maximum time frame for assigning a service coordinator after receipt of a referral. Several commentators stated that the 45-day timeline in subsection (f)(2) (redesignated as subsection (g)(2)) is inconsistent with 34 CFR 303.321(e) and suggested that the paragraph be reworded to be consistent with 34 CFR 303.321(e). Some commentators proposed that the requirement for a public awareness program in 34 CFR 303.320 (relating to public awareness program) be included in the final-form rulemaking. Two commentators suggested the State pass legislation that would include the identification of all deaf and hard-of-hearing infants and toddlers in the child find system.

Response

The county MH/MR programs are responsible for developing local child find systems that comply with the requirements of this chapter. Therefore, the term "ensure" is appropriate and the Department did not modify the language as suggested. In assessing county compliance, the Department will take the voluntary nature of parental participation in the program into account.

The Department changed "children" in subsection (a)(2) to "at-risk children and infants and toddlers with disabilities" to conform the language to the revised definitions of those terms. This revision clarifies that the obligation in this paragraph applies to children who have been determined eligible for tracking or early intervention services. The paragraph accurately reflects the Department's intent that county MH/MR programs are responsible for monitoring whether at-risk children are or are not being tracked and whether infants and toddlers with disabilities are or are not receiving needed services. Therefore, the Department retained the second clause of this paragraph, with a minor editorial change.

The child find system is a county-wide initiative, not one directed to a particular child. Therefore, child find is the responsibility of the county MH/MR program, in conjunction with the local interagency coordinating council, not a service coordination function. The Department provides assistance in child find activities by distributing Statewide materials relating to the child find system and providing data to counties to enable them to identify potentially eligible children. Use of the data to identify children is ultimately the responsibility of the county MH/MR programs. Strategies, ideas to improve and specific processes for child find activities are not appropriately included in rulemaking but are addressed on a Statewide basis by Early Intervention Technical Assistance (EITA), the Statewide training and technical assistance system for early intervention, which is another example of the assistance the Department offers to county MH/MR programs in their child find activities.

The Department of course does not expect that the agencies and programs listed in subsection (b) will be-

come the volunteers of the county MH/MR program. Nor does the Department anticipate that the county MH/MR program will meet resistance in its coordination efforts, since each of the identified programs has its own mandate to refer children to appropriate programs, including the county MH/MR program. Nonetheless, recognizing that the county MH/MR program cannot ensure that other programs will cooperate in coordinating efforts, the Department revised the language in this subsection from "shall ensure that the child find system is coordinated" to "shall coordinate the child find system," thereby focusing on the actions of the county MH/MR program rather than on the other agencies. The Department will take the degree of cooperation of the other agencies into account in assessing county compliance.

The Department added a definition of "referral" in § 4226.5. The definition clarifies that referrals may be made orally or in writing. Although each county MH/MR program must adhere to the definition by accepting both oral and written referrals, the mechanism for receiving referrals varies by county. The Department determined that specifying criteria for what constitutes "receipt of a referral" would unnecessarily remove the flexibility the counties need to design their referral systems to meet local needs.

Neither Federal law nor the act requires that a service coordinator be assigned within a specified time period. See 34 CFR 303.321(e)(1). The Department believes that the existing language affords counties flexibility to assign service coordinators consistent with the needs of the referred child.

The Department revised the language on the 45-day timeline in subsection (f)(2) (redesignated as subsection (g)(2)) because it agrees that the language in the proposed rulemaking inadvertently suggested that the IFSP need not be completed within 45 days. As revised, the paragraph clarifies that within the 45-day time period, the county MH/MR program must either complete the MDE and the IFSP for an infant or toddler with a disability or complete the MDE and a tracking plan for an at-risk child.

The Department, not the county MH/MR program, is responsible for implementing a public awareness program. Since the final-form rulemaking applies to the county MH/MR programs and to service providers and agencies, the requirements for a public awareness program are not included in the final-form rulemaking.

The Department does not have the authority to pass legislation. That authority is vested exclusively in the General Assembly. Even without additional legislation, however, children who are deaf or hard of hearing are eligible for early intervention services and are included in the child find system.

The Department added the clause "unless otherwise permitted or mandated by Federal law" to subsection (e)(2) to ensure that the time frame for making a referral reflects Federal law as it currently exists in 34 CFR 303.321(d)(2)(ii) and as it may be modified in the future. The Department redesignated subsection (e)(3) as subsection (f) and made corresponding language changes to correct an error in organization. The Department also made other technical changes to correct grammar, punctuation and citation errors.

Sections 4226.25—4226.29 (deleted on final-form).

Many commentators submitted extensive comments on the screening procedures outlined in the proposed rulemaking. Several commentators requested clarification of various provisions, whereas others recommended that the sections be deleted. Commentators questioned the purpose of the initial screening process; expressed concern that children and families could be determined ineligible for early intervention services without an evaluation; noted that the screening process varies across this Commonwealth; and suggested that parents should be informed in writing of their right to request an evaluation if the child is not referred for an evaluation as a result of the initial screening. One commentator requested clarification of the tracking system and suggested that the term be defined.

Response

After careful consideration, the Department has deleted these five sections in their entirety. The screening process is not a Federal or State law requirement. Screening is also not necessary to assure that eligible children are identified as early as possible, since § 4226.24(f)(2) (redesignated as § 4226.24(g)(2)) (relating to comprehensive child find system) mandates that the evaluation be completed and either the child be referred for tracking or the IFSP meeting be conducted within 45 days of referral. Instead, the screening process was established as a mechanism to identify children who clearly would not meet the eligibility criteria for early intervention services, prior to an extensive evaluation process. The Department did not intend to deprive any referred family of the opportunity to have a child evaluated.

The Department's experience with the screening process confirms the observations of some commentators that screening is conducted inconsistently from county to county. That experience also suggests that continuing the screening process is an inefficient and wasteful use of resources, since in many cases it merely inserts an additional step before the child is evaluated. At the same time, the Department acknowledges the concerns expressed by commentators that children and families might be determined ineligible as a result of the screening process. Although parents may challenge the outcome of the initial screening, any such challenge is likely to delay the evaluation.

After taking all of these considerations into account, the Department finds that, on balance, the risk of a child and family being inappropriately diverted from tracking or early intervention services outweighs the incremental benefits associated with maintaining the initial screening. Therefore, the Department has deleted these sections.

The Department added a definition of "tracking" in § 4226.5 and expanded § 4226.31 (redesignated as § 4226.26) (relating to tracking system) to specify the components of a tracking system.

Section 4226.30 (redesignated as § 4226.25). At-risk children.

One commentator suggested adding language that would permit a child identified as at-risk to be deemed eligible for tracking with parental consent, if the parent declines the initial MDE. One commentator recommended adding another category of at-risk children, those who have a family history of a genetically related condition such as deafness or hearing loss, to assure early detection of hearing loss in infants and toddlers with hearing parents. One commentator noted that citation to the Department of Health regulations that denote dangerous blood lead levels would improve clarity. One commentator suggested that a child identified as an at-risk child as a result of the initial screening process should also be eligible for tracking.

Response

The Department concurs with the recommendation to permit a child to be deemed eligible for tracking and added subsection (b). The Department finds that it is unnecessary to add children with a genetically related condition such as deafness or hearing loss to the categories of at-risk children. Pediatricians and family care practitioners routinely conduct comprehensive evaluations of a child's health, including hearing, and provide follow-up treatment and referrals. For this category of children, tracking is unlikely to provide any benefit beyond that provided by routine evaluation, treatment and referral services.

According to the Department of Health, it has not promulgated regulations establishing dangerous levels of lead poisoning because the lead prevention program is not a mandatory program. Instead, the Department of Health uses the lead levels published by the Centers for Disease Control and Prevention (CDC). The CDC issues publications on a periodic basis as the need arises, rather than according to an established schedule. Revised publications might or might not supersede the existing publication. The most recent CDC publication is *Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials* (November 1997), which was updated by *Managing Elevated Blood Lead Levels Among Young Children: Recommendations from the Advisory Committee on Childhood Lead Poisoning Prevention* (March 2002). Because the Department of Health has issued no regulations and the CDC guidelines are revised periodically, the Department retained the statutory language from the act rather than adding a citation as recommended. The CDC publications are, however, available on the CDC website at www.cdc.gov. The Department also did not amend the section to include the screening process because the initial screening provisions have been deleted from the final-form rulemaking.

As explained in the definitions section, the Department added the population categories of at-risk children to the definition of "at-risk child." Consistent with that revision to the definition, the Department amended and simplified this section by specifying that a child determined to be an at-risk child is eligible for tracking and by deleting the population categories. The Department also added a cross reference to § 4226.26.

Section 4226.31 (redesignated as § 4226.26). Tracking system.

One commentator suggested that "tracking system" be defined. The same commentator observed that the section includes no process for initiating a tracking system or procedures to ensure uniformity and recommended that the section specify processes and procedures for implementing a tracking system.

Response

As previously noted, the Department added a definition of "tracking" to § 4226.5. In addition, the Department revised this section (redesignated as § 4226.26) and deleted § 4226.32 (relating to contacting families) to combine all elements of the tracking system in one section. The revised section specifies the components of the system, including the frequency and method of contact. The revised section also establishes the use of a standardized tool during the contact, as a means of promoting uniformity throughout this Commonwealth. Finally, the revised section requires the county MH/MR program to maintain written documentation of all contacts.

Section 4226.32(a). Contacting families (deleted on final-form).

One commentator questioned how the 4 month frequency of contacts was determined and whether the county MH/MR program is required to make more frequent contact if recommended by the MDE team. The same commentator suggested that the section specify the substance of the contact. Three commentators recommended against prescribing the frequency of contacts because the frequency should be individualized according to family need. Three other commentators suggested adding a requirement for written documentation of all contacts. One commentator stated that e-mail should be added as a contact option or considered to be a written contact. Another commentator observed that the prescribed frequency is greater than current local practice and asked whether additional personnel will be provided.

Response

As noted in the response to comments to § 4226.31 (redesignated as § 4226.26), the Department deleted this section, incorporating the frequency and method of the contact from this section and prescribing the substance of the contact, as well as a requirement that contacts be documented in writing, in redesignated § 4226.26. Given the tender age of these children, delays must be identified as early as possible to maximize opportunities to enhance development and minimize future delays. For this reason, the Department finds that it is necessary to establish the minimum frequency of contact in regulation. The Department revised the frequency from 4 months to 3 months, recognizing that tracking in most counties is conducted by service coordinators, and 3-month contact has been a Department service coordination requirement since 1994. To ease administration and implementation of the tracking system, as well as avoid unnecessary disruption to families caused by repetitive and overlapping contacts, the Department revised the frequency of the tracking contract to coincide with the service coordination contract. Contacts with the child and family may be more frequent if recommended by the MDE team, with the concurrence of the family or less frequent if requested by the family.

Because, as noted, 3-month contact has been a Department service coordination requirement since 1994, the Department would expect that current practice reflects that requirement and therefore does not anticipate a need for additional personnel. The Department agrees that e-mail is an appropriate written contact if the county MH/MR program confirms that the family has e-mail capability and agrees to that method of contact.

Section 4226.33 (redesignated as § 4226.27). Monitoring responsibilities.

One commentator questioned how and why a county MH/MR program would monitor services provided in another state, as required by subsection (a). The same commentator noted that the phrase "complete monitoring of each early intervention service provider at least every 12 months" in subsection (c) is confusing and recommended that the language be revised to reflect that the monitoring is a reporting requirement.

Response

The need to monitor services in another state arises most often when a county MH/MR program contracts with a service provider or agency in a contiguous state to deliver early intervention services to an infant or toddler and family who live in close proximity to the contiguous state. In any case in which the county MH/MR program has contracted with an out-of-State provider, however, the

county MH/MR program is responsible for monitoring services provided by that provider.

After additional internal review, the Department revised subsection (a) to clarify that a county MH/MR program is responsible for monitoring those services that it provides directly as well as the services provided through contract with another service provider or agency. The Department also revised subsection (c) to conform to the revisions to subsection (a); to clarify that the monitoring is expected to be conducted on an ongoing basis but at least annually; and to require that documentation of the monitoring be maintained for at least 4 years. The Department also made technical changes to subsection (b) to conform to the revisions to subsection (a).

Section 4226.34. Community evaluations (redesignated as § 4226.28. Self-assessment reviews).

One commentator questioned how the 3-year cycle was established and noted that the statement "once in every 3 years" is awkward and should be reworded. Another commentator requested clarification on whether the evaluation required in this section is in addition to or instead of the standardized self-assessment process currently being used. The same commentator asked whether the term "legal entity advisory board" is the county MH/MR advisory board.

Response

The Department established the 3-year cycle for conducting the reviews because the families whose infants and toddlers receive tracking or early intervention services change over the course of 3 years because of the age limit of the program and family satisfaction with the program is a critical component of the self-assessment. The Department changed the sentence structure as recommended.

The Department changed the heading and wording of this section to clarify that the reviews required by this section are those currently being conducted. The term "legal entity advisory board" was changed to "county MH/MR advisory board."

After additional internal review, the Department added the phrase "including assessment of family satisfaction," which was inadvertently omitted from the proposed rulemaking, to clarify that this is an element of the self-assessment. The Department also revised the section to remove the requirement that county MH/MR programs have to develop the assessment system, since the Department has developed the tool to be used and procedures to be followed, which are already in place and being used by counties. As revised, the section requires county MH/MR programs to use the tool and procedures that the Department has developed rather than develop their own.

Section 4226.35. Training (deleted on final-form).

One commentator recommended deleting the terms "professional" and "paraprofessional" and the phrase "as approved" as unnecessary. The same commentator suggested that the section be revised to recognize other certification, licensing and registration authorities. Two commentators recommended that the specific number of annual training hours be included in this section. Other commentators asked what job category this section pertains to, what certification is available to paraprofessionals and whether the Department will develop a formal training format.

Response

The Department deleted this section because it was duplicative of the definition of "qualified" in § 4226.5. Section 4226.37(a) (redesignated as § 4226.30(a)) (relating to annual training) specifies the required number of annual hours of training.

Section 4226.36 (redesignated as § 4226.29). Preservice training.

Commentators uniformly commended the Department for adopting both preservice and annual training requirements. One commentator observed that the training requirements seemed to be an attempt to compensate for inadequate qualification requirements elsewhere in the rulemaking. Several commentators submitted suggestions and others expressed some concerns.

Two commentators suggested that the format and time frame for completing preservice training be specified in this section. Other commentators recommended replacing "to encourage family preferences" in paragraph (4) with "will encourage family involvement at all levels" as more appropriate and deleting "(for all staff)" in paragraph (9) as redundant. Some commentators suggested additional training topics, including community resources; family-centered planning and service delivery; typical and atypical development; the nature of disabilities and their impact on families; cultural and social diversity; effective listening; and identifying family strengths and need. One commentator recommended competency-based training as a component or instead of preservice training, including the topics listed in this section in addition to others such as natural environments and IFSP developments and outcomes. One commentator questioned where training in childhood development and health is available to service coordinators.

Several commentators stated that it is inappropriate to require training in cardiopulmonary resuscitation (CPR), fire safety, emergency evacuation and first aid because most children receive services in community-based settings with their families present. Some commentators suggested that this requirement should apply only to direct care staff, and not, for example, to service coordinators, who provide facility-based services. Others noted concerns about issues such as staff liability, "do not resuscitate" orders and fire or evacuation plans in family homes. A few commentators recommended that topics such as family training in use of smoke detectors and evacuation plans might be more appropriate. Other commentators supported this training requirement, with one suggesting only that a reasonable time frame, such as 90 to 120 days, be allowed to complete the training.

A number of commentators who supported preservice training expressed concern that it will result in an additional cost by limiting the availability of staff to provide billable direct service hours. Several of the commentators requested that the Department consider a number of payment proposals, including funding for staff development. Two commentators noted that the preservice training requirement might deter interested persons from a job in the field. One commentator recommended that the final-form rulemaking specify who will pay for training.

Response

The Department concurs with the recommendation to specify a timeframe for completing preservice training, and added a requirement that the training be completed before personnel work alone with infants and toddlers or their families. Personnel may work with infants and toddlers or their families if supervised, before completing the required preservice training. The Department did not specify a training format or a number of training hours

because it expects that both will vary based on the experience of the individuals receiving training. An individual who has experience in early intervention services may receive preservice training through reading materials and videotapes, whereas an individual with less or no experience is likely to need more hands-on training for a longer period of time. Therefore, the Department determined that the specific format for and length of the training should be left to the judgment of the employer.

The Department changed the language in paragraph (4) to "encourage family involvement and consider family preferences" and deleted the parenthetical phrase "(for all staff)" in paragraph (9). The Department did not amend the list of topics for training because those are the topics that the Department believes personnel must be familiar with to be effective. Other topics, although not required, are not prohibited. Training and training materials in child development and health are available from a number of organizations, including EITA and the ECELS program of the American Academy of Pediatrics. The Department believes training in CPR, fire safety, emergency evacuation and first aid is good practice for personnel working in public programs regardless of site and therefore retained those topics. It revised paragraph (9) to allow up to 120 days from the date of hire to complete this training.

The county MH/MR programs are responsible for funding preservice training. They receive an annual training allocation from the Department. In addition, the Department allows the counties to take costs associated with staff training into account when developing rates with early intervention service providers or agencies. The Department has also established an extensive training and technical assistance network through EITA, which provides training at no cost to counties and providers.

The Department revised subsection (a) by striking reference to specific provider types and replacing it with the general term "early intervention personnel." The Department also made some technical changes to subsection (a) to correct improper word usage in the introductory paragraph and paragraph (6), to eliminate redundancy in paragraph (9) and to conform the subsection to other changes made in the final-form rulemaking. The Department added subsection (b) to clarify that all preservice training must be documented, not merely that required by paragraph (9), and to specify a record retention period. The Department deleted the parallel provision regarding documentation from paragraph (9).

Section 4226.37 (redesignated as § 4226.30). Annual training.

As with preservice training, many commentators supported an annual training requirement, although a few viewed annual training as an attempt to compensate for lack of education and experience. Several commentators nonetheless expressed reservations about the requirement, for varying reasons. Some commentators believed that 24 hours of training is excessive and that the requirement was generally vague. Other commentators expressed concern that the requirement will have a negative financial impact, questioning their ability to fund training and to recover income lost because staff are unavailable to deliver billable units.

Commentators also requested that the Department clarify whether the 24 required hours are clock hours, credit hours, continuing education credits or in-service hours; whether the training applies to child care providers; and whether the Department approves training providers or programs and, if so, recommended that the process for approval be included in the final-form rulemaking.

One commentator suggested that subsection (a) be revised to replace "the service coordinator, early interventionist and other early intervention personnel" with the broader "all personnel who work directly with the child." Two commentators recommended that the phrase "at least" be deleted from subsection (a) to avoid the potential for arbitrary variation. One commentator stated that the training topics are too limited and suggested adding the phrase "may include but are not limited to."

Commentators offered a number of other suggestions, including requiring therapists to receive training; allowing existing licenses and certifications to be credited as training; reducing the number of training hours; adjusting current rates to account for the cost of training; collecting data on actual costs; and allowing program funding for staff development activities. Some commentators recommended that fire safety, first aid and CPR should be included in annual training, but others objected to including training for the same reasons set forth in the response to comments to § 4226.36 (redesignated as § 4226.29) (relating to preservice training).

One commentator asked the Department to reconsider applying the requirement to part-time staff and independent contractors, claiming it could alter the status of the agency-contractor relationship. Another commentator observed that requiring 24 hours of training before working with families can cause services to be delayed. One commentator asked the Department to clarify the "annual certification" in subsection (b). Another commentator stated that the recertification is unnecessary because early intervention personnel are never alone with the child and therefore do not have responsibility for emergency situations.

One commentator recommended that the section should specify who pays for training. The same commentator suggested that this section should specify a timeline for maintaining training records.

Response

The Department finds that it is essential for all early intervention personnel, including therapists, part-time personnel and independent contractors, to be knowledgeable about best practices within the early intervention field. A variety of disciplines are involved in the early intervention program in which licensed or certified practitioners receive training in their area of expertise. Training does not displace the vital need for training specific to the early intervention field, community resources and services for children with disabilities. The required number of hours is 24 clock hours, which the Department believes reflects a reasonable and realistic expectation for personnel in the field.

The Department substituted "early intervention personnel" for reference to specific professionals in subsection (a). Because the meaning of the term "hours" as used in this section is consistent with the dictionary definition of the term, the Department did not revise this section to specify the type of hours required. The Department also did not revise this section to expand the list of training topics, which are the topics the Department believes are important for early intervention personnel. Conversely, it did not delete the phrase "at least" because personnel are not prohibited from receiving more training than the prescribed 24 hours.

Training in fire safety, first aid and CPR are included in "universal health procedures," which is one of the listed training topics. For the reasons stated in the response to comments to redesignated § 4226.29, the Department did not delete this training topic. The annual certification required by subsection (b) is issued for training in universal health procedures such as CPR. Because the Department retained this as a topic in subsection (a), the annual certification continues to be required.

Unlike preservice training, the 24 hours of annual training need not be completed before personnel begin to work with children and families. The Department amended subsection (a) to clarify that the 24 hours of annual training is in addition to the preservice training requirements in redesignated § 4226.29. The annual training requirement does not apply to child care providers, although they would not be prohibited from attending training related to early intervention services.

The Department does not approve training providers or programs and therefore did not include a process for approval in this section. The Department revised subsection (b) to specify a record retention period for annual training records, which parallels that in redesignated § 4229.29.

As noted in response to comments to redesignated § 4226.29, the Department has an extensive training and technical assistance network through EITA that provides trainings at no cost to counties and providers. Training is available throughout the year on a Statewide and regional basis and through teleconferencing. Also available are local trainings that can be designed to meet the needs of a particular county. As also previously explained, the county MH/MR programs receive a training allocation each year from the Department that they can utilize to meet the needs in their local area, in addition to being permitted to account for costs associated with training in the service rates they establish for providers.

The Department made technical changes in subsection (b) to make the wording more succinct.

Section 4226.38. Criminal history records check (redesignated as § 4226.31. Child Protective Services Law).

Some commentators pointed out that the requirement for a child abuse clearance was omitted from this section and recommended that the section be revised to require that all staff who have direct contact with children obtain the clearances. One commentator questioned why Commonwealth residents are not required to submit a Federal Bureau of Investigation (FBI) criminal history check. Another commentator asked if current personnel are grandfathered under the Child Protective Services Law (CPSL) (23 Pa.C.S. Chapter 63), as amended by Act 33 (23 Pa.C.S. § 6344) (Act 33). Two commentators complained that the reporting requirements of the Older Adult Protective Services Law (35 P. S. §§ 10225.101—10225.5102) (OAPSL) overlap with those of the CPSL, leading to confusion and delay. They suggested that the Department and the Department of Aging work together to eliminate overlapping rules and procedures.

Response

The requirement for a child abuse clearance was inadvertently omitted from the proposed rulemaking. Rather than restate the substance of Act 33 in this section, the Department revised this section to require that personnel comply with the CPSL and the Department's accompanying regulations in Chapter 3490 (relating to protective services), which mandate both criminal history records checks and child abuse clearances.

Commonwealth residents are not required to obtain an FBI criminal history clearance under State law. The General Assembly created the difference in procedures for criminal history records checks between residents and nonresidents of this Commonwealth (23 Pa.C.S. § 6344(b)(1) and (3)). Because Act 33 has been in effect since 1986, the Department doubts that any current personnel have not obtained the mandated clearances. Act 33 has contained a grandfathering provision since enactment (23 Pa.C.S. § 6344(k)), whereby personnel employed on the effective date of the law were not required to obtain the mandated clearances. If those same personnel change jobs, however, both criminal history and child abuse clearances are necessary. Current personnel who have obtained the necessary clearances do not need to resubmit for the clearances when the final-form rulemaking becomes effective.

The comments addressed to the OAPSL are more appropriately addressed in a different forum. Act 33 unequivocally prescribes that early intervention services are child care services for which personnel must obtain the prescribed clearances. See 23 Pa.C.S. §§ 6303 and 6344(a). The Department of Aging addressed similar comments in the final-form rulemaking amending 6 Pa. Code Chapter 15 (relating to protective services for older adults) published at 32 Pa.B. 2412 (May 18, 2002). Neither Department has the authority to alter the mandates imposed by the General Assembly.

Section 4226.39. Penalties for noncompliance (deleted on final-form).

As explained in the response to comments to § 4226.4, the Department added the substance of this section to § 4226.4 so that all penalties for noncompliance are contained in one section. Accordingly, the Department deleted this section.

Section 4226.40. Reporting (redesignated as § 4226.32. Reporting and record retention).

One commentator objected to the phrase "information as the Department may require" in subsection (a) as vague and recommended that the information be specified. The same commentator observed that it is unclear how often or when the submissions are required and suggested that the time frames covered by the reports and the deadline for submission be identified. The commentator also asked whether the Department provides a form for the reports and suggested that the name of the form and how it may be obtained be included in the rulemaking. Finally, the commentator recommended specifying a time period for record retention in subsection (b).

Response

The Department made several revisions to this section in response to the recommendations. The Department clarified that reports are submitted on a monthly and annual, as well as periodic, basis and specified the subject matter of the reports. The Department did not specify the deadline for submission of the reports, since these vary by report. Instead, the Department added a new subsection (b), which provides that the Department will notify the county MH/MR programs in advance of the submission, both of the content of the report and of the deadline for submission.

This section codifies current practice, whereby the county MH/MR programs submit a number of reports to

the Department. For example, the counties submit monthly electronic reports on demographic information and service delivery. They also submit annual financial reports in hard copy. In addition, the Department occasionally requests ad hoc reports focusing on a particular aspect of the early intervention program. The Department has provided specific instructions to the counties in the *Early Intervention Reporting System Manual* and annual letters to the counties, which include the specific content of each type of report and the deadline for submission. The type of information to be included in a report, as well as the format of the reports, is likely to change over time as the needs of the program change or as technological advances enable the Department to permit additional reports to be submitted electronically.

For these reasons, the Department did not describe the specific content, format or deadline for submission of each type of report but focused on specifying the type of data that must be reported and the frequency of the reports. For the same reasons, the Department did not identify the specific forms to be used or where they can be obtained. This information is, however, included in the instructions to the counties.

The Department concurs with the recommendation that a retention period be specified in subsection (b) and added a time period. The Department made other minor technical corrections to this subsection by striking the word "part" and substituting the word "chapter" to correct an inadvertent error in the proposed rulemaking; and by striking "correctness and verification" and substituting "accuracy," replacing "and" with "or" and substituting "allocated" for "provided" to correct improper word usage.

Section 4226.41 (redesignated as § 4226.33). Traditionally underserved groups.

As noted in the response to comments to § 4226.5, two commentators suggested that the term "culturally competent" services in paragraph (2) be defined.

Response

As stated earlier, the Department concurs with the recommendation and added a definition of "culturally competent" in § 4226.5. The Department also made technical changes to paragraph (1) of this section to avoid repetitiveness and to conform the terminology in this section to that used throughout the final-form rulemaking.

Section 4226.43 (redesignated as § 4226.35). Confidentiality of information.

One commentator recommended that the specific citations to Federal and State law be included. The same commentator asked if "a" in the first line was a typographical error.

Response

The Department concurs with the recommendation and added the specific citations. The Department also corrected the typographical error by replacing "a" with "all."

The Department also revised this section by delineating into two subsections the separate responsibilities of maintaining the confidentiality of personally identifiable information and of informing parents of their rights to notice of and written consent to the exchange of the information. The Department made a corresponding technical change to redesignated subsection (b) by replacing "this" with "personally identifiable."

Section 4226.36. Child records.

One commentator requested the Department to provide guidance on the maintenance and retention of records in the final-form rulemaking.

Response

As requested, the Department added § 4226.36. The section specifies the children for whom a record must be maintained, the type of information that must be included in each record and the retention period.

Section 4226.51. Service coordination (deleted on final form).

After additional internal review, the Department deleted this section because it was repetitive of the definition of "service coordination" in § 4226.5.

Section 4226.52 (redesignated as § 4226.51). Provision of service coordination.

One commentator noted that the phrase "provide the services of a service coordinator" in subsection (a) was wordy and unclear and suggested revision to "assign a service coordinator." The same commentator questioned why this section does not specify a service coordinator-to-family ratio and requested that a maximum caseload ratio be specified or an explanation for why a ratio is unnecessary be given. Several additional commentators raised the caseload ratio issue in addressing § 4226.54 (redesignated as § 4226.53 (relating to service coordinator requirements and qualifications)).

Response

The Department rephrased the wording in subsection (a) as suggested. The Department also revised subsection (a) by substituting "as soon as possible" for "immediately," which mirrors 34 CFR 303.321(e)(1), to make the requirement in this section the same as in § 4226.24(f) (redesignated as § 4226.24(g)). As explained in the response to comments to redesignated § 4226.24(g), "as soon as possible" affords the counties appropriate flexibility to assign a service coordinator consistent with the needs of the referred child. In addition, on review, the Department determined that the standard of "immediately" is impracticable and virtually impossible to monitor for compliance.

The Department changed "referral . . . to early intervention" to "referral . . . to determine eligibility for early intervention services" to clarify the intent that a service coordinator be assigned before the eligibility determination. The Department also made technical changes to this subsection to correct improper word usage and to conform the subsection to other changes made in the final-form rulemaking.

The Department amended subsection (b) by deleting "coordinating all services across agency lines, and" and adding a cross reference to § 4226.52 (redesignated from § 4226.53 (relating to activities)). This amendment, in conjunction with the revision of deleting § 4226.54(b) (redesignated as § 4226.53(b)) avoids inadvertent multiple references in the proposed rulemaking to the responsibilities of a service coordinator in the three sections. The Department also made technical changes to this subsection to avoid inconsistency with other sections.

The rulemaking does not specify a service coordinator caseload ratio because a ratio is not a predictor of quality, effective service coordination and is, in fact, subject to being used as a substitute for quality assurance and monitoring. Conversely, compliance with a caseload ratio does not excuse inadequate service coordination. The Department monitors service coordination activities on an

ongoing basis. Based in part on that review, the Department finds that caseloads may appropriately vary among service coordinators based on the needs of the children and families to whom they are assigned. The Department instructs counties that their annual budget submissions may be based on funding for service coordination up to a 1:35 ratio. This approach, which allows counties to design their programs to reflect local needs, is preferable to establishing an arbitrary caseload ratio in regulation, which ignores the circumstances in individual counties. If a county experiences difficulties in providing appropriate service coordination because of caseload size or for any other reason, the Department addresses the issue with the county during compliance monitoring reviews.

Section 4226.53. Activities (redesignated as § 4226.52. Service coordination activities).

One commentator proposed that the difference in the roles of the service coordinator and the early interventionist should be clarified. Many other commentators presented the same concern in addressing § 4226.55 (redesignated as § 4226.54) and § 4226.56 (redesignated as § 4226.55).

With respect to paragraph (5) (redesignated as paragraph (8)), one commentator asked the Department to identify the recommended advocates. The same commentator requested clarification of the meaning of "coordinating medical services" in paragraph (6) (redesignated as paragraph (9)). Two commentators requested that this section clarify that service coordination activities include assisting families to understand and access systems of financing for early intervention and other health and social services and to facilitate family access to the multiple sources of funding.

Response

The Department acknowledges that the activities of the service coordinator in this section and the responsibilities of the early interventionist in § 4226.55 in the proposed rulemaking overlapped. The Department has revised redesignated § 4226.54 to clarify the distinction between these two professionals. Those revisions are explained in greater detail in the response to the comments to that section.

Although the Department does not "recommend" any particular advocates, "advocacy services" may be provided by professional advocates, other family members or anyone else the parent chooses. The role of the service coordinator is to inform the parent that advocacy services are available.

"Coordinating medical services" does not appear in this section. Rather, redesignated paragraph (9) requires the service coordinator to assist in arranging for the provision of medical and health services, which includes referring the family to appropriate health care professionals and assisting in scheduling appointments. "Coordinating the provision of early intervention services and other services (such as medical services for other than diagnostic and evaluation purposes)" means, for example, assisting the family in assuring that scheduled appointments do not conflict. The listing of services set forth in this section includes several activities (for example, in redesignated paragraphs (4) and (5)) that encompass informing parents about assisting them to access the various sources of funding. Therefore, the section was not revised to specify these functions.

The Department revised the heading of this section to enhance clarity. The Department also amended this section to delineate the specific activities more distinctly. For example, the activities previously set forth in paragraph (1) were separated into paragraph (1) and new paragraphs (2) and (3). Similarly, the activities in paragraph (7) were previously included in paragraph (3) (redesignated as paragraph (5)). The remaining paragraphs have been renumbered to accommodate these changes. The Department also made technical changes to correct improper word usage and to enhance consistency within the section and to conform the section to other changes made in the final-form rulemaking.

Section 4226.54. Requirements and qualifications (redesignated as § 4226.53. Service coordinator requirements and qualifications).

One commentator recommended revising the section heading to "service coordinator requirements and qualifications." Two commentators pointed out that "intervention service" in subsection (a) appeared to be a typographical error and should be deleted. As noted in the response to comments to redesignated § 4226.51 (relating to provision of service coordination), several commentators urged the Department to establish a maximum caseload for service coordinators.

Almost half of the commentators submitted extensive comments to the level of training and qualifications established for the service coordinator in subsection (c). The overwhelming majority of commentators objected to the qualifications as insufficient. Noting the importance of this position to the system, these commentators focused primary concern on not requiring a bachelor's degree in a field at least somewhat related to early intervention; permitting less than a bachelor's degree; and allowing work or volunteer experience—including counseling, management or supervision—unrelated to early intervention or child development. They offered varying recommendations, including requiring at least a bachelor's degree in a field related to early intervention, experience working with young children, other than volunteer experience, training that is "competency based" and more years of experience.

One commentator recommended that the Department explain how the broad degree, course work and work qualifications will ensure consistent, quality service delivery. The same commentator requested that the Department clarify how part-time volunteer experience would be calculated to meet the minimum volunteer experience required.

Some commentators believed that the civil service certification permitted by subsection (c)(3) is inadequate, with one noting that civil service coordination presented an "inherent conflict of interest" and recommended that it be deleted. One commentator suggested that the title of the position be changed from "service coordinator" to "case manager" if the qualifications remained the same. A few commentators recommended specific training and experience for those service coordinators who work with "low incidence" infants and toddlers, such as those who are deaf or hard of hearing.

Some commentators believed that requiring a bachelor's degree is excessive or that a minimum education requirement is not as important as demonstrated experience and expertise in the area. One commentator asked whether the county MH/MR programs had discretion to impose higher qualification requirements than specified in this section.

Response

The Department revised the heading and corrected the typographical error in subsection (a) as recommended. The Department made additional revisions to this subsection by converting it from passive to active voice to avoid ambiguity and by changing "subcontract" to "contract" to correct improper word usage. As noted previously, in the response to comments to redesignated § 4226.51, the Department deleted subsection (b) as redundant of redesignated § 4226.51(b). The Department addressed the maximum caseload ratio in response to comments to redesignated § 4226.51 and will not repeat that response here.

The Department spent a considerable amount of time researching and discussing this issue with advocacy organizations, parents, county MH/MR programs, other stakeholders and the Department's personnel office before issuing the proposed rulemaking, during the public comment period and after the formal public comment period closed. When developing the proposed rulemaking, the Department attempted to establish qualifications that would allow individuals with different degrees as well as varying work experiences, or whose qualifications are consistent with the Civil Service Commission (CSC) requirements, to be service coordinators. Because early intervention services have been provided in this Commonwealth since 1972, the Department believed that many individuals with a wealth of experience but without a particular college degree could be competent and effective service coordinators.

After issuing the proposed rulemaking, the Department had a variety of interactions with the opponents of the proposed rulemaking who strongly believed that individuals who have the first system contact with families should be required to have a bachelor's degree in a related area and work experience with children with disabilities. In their opinion, a person with lesser qualifications would not meet the needs of infants and toddlers and their families.

Discussions with county MH/MR programs revealed that counties have been experiencing difficulty in hiring individuals as service coordinators even with the qualifications outlined in the proposed rulemaking. County MH/MR programs reported that they were using the qualifications from the CSC when recruiting and hiring service coordinators. They emphasized that when hiring, they look for the person best suited for the job based on both education and work qualifications and experience. They expressed concern that if the qualifications were increased as requested, the task of recruiting personnel would become insurmountable.

In an attempt to develop qualifications that would balance these competing interests and needs, the Department discussed the possibility of establishing a separate classification for early intervention caseworkers under the CSC, which would not change degree requirements but would allow the Department to specify the type of degree. After further review, however, it became apparent that this option would not alleviate the problems that county MH/MR programs have had in recruiting personnel.

After careful consideration of the various objections and proposals from all stakeholders, the Department modified the qualifications in the proposed rulemaking in a way that it finds takes the needs of county MH/MR programs into account without compromising the quality and effectiveness of service delivery. The Department revised subsection (c)(1) to require minimum qualifications of a bachelor's degree that includes 12 college credits in specified areas related to early intervention and 1 year of full-time or full-time equivalent experience in related fields. The Department deleted volunteer experience and work in management or supervision. In subsection (c)(2), the Department specified that an associate's degree or 60 credit hours without a degree must be in related areas and revised the work experience requirements as in subsection (c)(1). The Department also made a technical change in both paragraphs by replacing "people" with "individuals." The Department made an additional technical change in subsection(c)(3) by inserting "State" to avoid ambiguity.

In addition to modifying the qualifications, the Department added subsection (b) to this section, which requires that a service coordinator must demonstrate knowledge and understanding about specified subject areas before working with infants and toddlers and their families. The Department, through EITA, has also established a training curriculum for new service coordinators, which is available throughout the year to county MH/MR programs as the need arises. At the same time, the Department has reinstituted a series of service coordinator training sessions, which will be held at designated times throughout the year, to address specific topics and skills that service coordinators need to fulfill their responsibilities. The availability of these training opportunities, the preservice and annual training requirements outlined in redesignated §§ 4226.29 and 4226.30 and the requirement for demonstrated knowledge in subsection (b) of this section, all afford added weight to the revised education and work experience qualifications. These elements combine to ensure that service coordinators are fully equipped to do their jobs effectively.

Section 4226.55. Early interventionist (redesignated as § 4226.54. Early interventionist responsibilities).

Nearly half of the commentators objected to this section as confusing, in main part because the listed responsibilities seemed to duplicate functions of other early intervention personnel such as service coordinators and service providers. They requested the Department to clarify who the early interventionist is and what purpose the position is intended to serve. Several commentators noted, for example, that if the early interventionist is providing special instruction, as suggested in paragraph (3), then that person may not appropriately supervise other early intervention personnel, as specified in paragraph (2) (deleted on final-form), particularly because of the limited qualifications required for this position in § 4226.56 (redesignated as § 4226.55). These commentators uniformly requested that the Department clarify this section or delete it.

One commentator suggested that the term "developmental specialist" be used. Another commentator stated that the interventionist should be an advocate. A third commentator recommended that the "written communication reviews" in paragraph (4) (deleted on final-form) be described.

Response

Recognizing the confusion created by this section, the Department acknowledges duplication and inappropriateness of the activities ascribed to the early interventionist. The Department revised this section to clarify the activities of the early interventionist. As revised, the section specifies that the early interventionist is the person who provides several components of special instruction. The Department deleted proposed paragraphs (1), (2) and (4),

which included service coordination activities and thereby clarified the difference between those professionals. By deleting proposed paragraph (2), the Department also removed any connotation that the early interventionist supervises other service personnel.

The Department retained the term "early interventionist" because that is a term more widely recognized and used by the Federal government and, other states as well as, within this Commonwealth.

Section 4226.56(a). Requirements and qualifications (redesignated as § 4226.55(a). Early interventionist qualifications).

More than half of the comments the Department received addressed the level of training and qualifications for the early interventionist. Commentators criticized the qualifications as too broad, "woefully inadequate" and generally unacceptable. They offered a variety of suggestions: which included that an early interventionist should be a teacher and meet the standards established for special education teachers; an early interventionist should have a bachelor's degree in a related area and some experience working with young children; the scope of practice should be significantly limited if the qualifications remain as proposed; and volunteer experience should be disregarded. Some commentators expressed a different opinion, recommending a competency-based training system instead of formal education qualifications. A small number of commentators stated that a bachelor's degree and 1 year of experience is excessive.

One commentator requested an explanation of how the broad degree and course work requirements will ensure consistent, quality service throughout this Commonwealth. The same commentator requested that the Department clarify how part-time volunteer experience would be calculated to meet the minimum volunteer experience required.

A few commentators recommended that special qualifications for individuals working with children with low incidence disabilities should be included in the regulations. One commentator suggested revising the heading to "early interventionist requirements and qualifications."

Response

As it did with the qualifications of a service coordinator, the Department spent a considerable amount of time researching and discussing this issue with advocacy organizations, county MH/MR programs and other stakeholders. As discussed in the response to comments to § 4226.54 (redesignated as § 4226.53), when developing the proposed rulemaking, the Department attempted to establish qualifications that would allow individuals with varying degrees and experience who are well qualified, to perform the responsibilities of an early interventionist. Those responsibilities, as revised in redesignated § 4226.54, include: designing learning environments and activities that promote the child's acquisition of skills in a variety of different areas; providing families with information, skills and support related to enhancing the skill development of the child; and working with the child and family to enhance the child's development. Particular experience under consideration included early childhood, family studies and other nontraditional teaching degrees.

Stakeholder groups believed very strongly that a bachelor's degree with no instruction in a related field or an associate's degree was insufficient to prepare an individual to adequately provide the services of the early interventionist, regardless of the amount or nature of accompanying work experience. After careful consideration of the objections and proposals from stakeholders, the Department revised the qualifications to strike a balance among competing interests. As revised, paragraph (1) requires at least a bachelor's degree in specified areas related to early intervention and 1 year of either full-time or full-time-equivalent work experience or a student practicum or teaching experience with preschool children with disabilities (infancy through 5 years of age) and their families. The Department deleted volunteer experience and experience with other persons with disabilities as well as counseling. In paragraph (2), the Department has permitted a bachelor's degree with 15 credits hours in areas related to early intervention, 1 year of experience working with preschoolers with disabilities and their families, with demonstrated knowledge, understanding and skills to perform the functions of an early interventionist. These alternative qualifications are directed toward maximizing the potential pool of candidates without compromising the quality of service delivery.

The Department agrees that personnel who work with infants and toddlers with low incidence disabilities should have experience dealing with those populations. As explained in the response to the comments to the definition of "special instruction" in § 4226.5, the Department expects that services to all infants and toddlers with disabilities, including those with low incidence disabilities, will be tailored to meet the individualized needs of the infant or toddler, as reflected on the IFSP in accordance with § 4226.74 (1), (3) and (4). The rulemaking also requires the county MH/MR programs to ensure that services are delivered in conformity with the IFSP. The Department is reluctant to highlight the need for specially trained providers for only certain disabilities because it expects all providers to have the training needed to meet the individualized needs of the infant or toddler. A regulation specifying specially qualified providers for only certain disabilities would dilute the strength of that expectation and message. Therefore, the Department did not include a regulation that emphasizes the need for special training only for certain disabilities.

The Department revised the heading as recommended, with one modification. Because the Department deleted subsection (b), as explained in the response to comments to subsection (b), this section no longer contains "requirements" in addition to "qualifications." Therefore, the section heading was revised to "early interventionist qualifications."

Section 4226.56(b). (redesignated as § 4226.55(b).

A number of commentators questioned the requirement in this subsection for obtaining 6 credit hours annually. Commentators requested clarification on what is meant by "credit hours"; how this requirement relates to the 24 hours of annual training in redesignated § 4226.30; and whether it applies to all personnel, regardless of their degree, other qualifications or experience. Some commentators questioned whether the specified coursework was even available and who was responsible for the costs associated with obtaining the credits. Others complained that the requirement was excessive and unreasonable; would impose an undue financial burden on either providers or staff, or both; and would hinder ability to recruit staff. Some commentators objected that this requirement was redundant of the 24-hour annual training required by redesignated § 4226.30 and recommended that it be included in the annual training or deleted entirely. One commentator criticized the requirement as "another pointless, elitist credentialing exercise."

Response

In response to the objections and recommendations of the commentators, the Department deleted this subsection and reorganized the section accordingly. In light of the revised qualifications for early interventionists required by redesignated § 4226.55, the annual training requirements specified in redesignated § 4226.30 and taking into account concerns expressed by the commentators, the Department determined that an additional 6 credit hours of professional development is unnecessary to assure quality service delivery.

Section 4226.57 (redesignated as § 4226.56). Effective date of personnel qualifications.

Some commentators suggested that the proposed rulemaking wrongly grandfather personnel and recommended that the Department require all staff to meet applicable standards within a specified time period such as 4 years. Three commentators suggested the opposite, that all staff employed on the effective date of the final-form rulemaking be grandfathered. Three commentators proposed adding a provision similar to 34 CFR 303.361(g) (relating to personnel standards), which permits a state to adopt a policy that allows for the recruitment and hiring of appropriately and adequately trained personnel that do not meet established qualifications in geographical areas of the state where there is a shortage of personnel.

Response

The Department finds that it is appropriate to allow current employees to be grandfathered in when the final-form rulemaking becomes effective. The Department determined that it would be unrealistic and unfair to require personnel to, for example, obtain a college degree when they entered the early intervention system and have worked in the system for a number of years with no expectation of having to obtain a degree. The requirement is also unnecessary for existing personnel, since a primary purpose of qualifications is to predict and capture those attributes that are most likely to identify the candidates with little or no experience who are most likely to do the job competently and effectively. In the case of existing personnel, predictors are not needed because on-the-job performance provides actual rather than projected means to evaluate competence and effectiveness. The Department is also concerned that imposing the qualification requirements retroactively will have a dramatically adverse impact on the service delivery system, particularly in light of reports from county MH/MR programs of the difficulty they have historically had in recruiting staff, as noted in the response to comments to redesignated §§ 4226.53 and 4226.55.

The Department did not revise this section to include a provision comparable to 34 CFR 303.361(g). This is an option that the Federal regulation permits the Department to elect and is not appropriately delegated to the county MH/MR programs. If a county MH/MR program is unable to hire sufficient staff, either directly or through contract, who meet the qualifications established by the regulations, it may request a waiver from the qualifications through the procedure established in § 4226.6.

Personnel—Other comments.

Two commentators suggested that two new sections be added that specify the responsibilities and qualifications for therapists and supervisors.

Response

The Department did not make the recommended change. The Department finds that it is unnecessary and misleading to specify this information for therapists and not for other qualified professionals as defined in § 4226.5. As explained in the response to comments to § 4226.5, the Department established the qualifications and responsibilities for a service coordinator and early interventionist because these professionals are not otherwise licensed or certified. For therapists, the Department of State has established both scope of practice and licensing requirements for each discipline. In addition, § 4226.5 contains definitions of the early intervention services, including therapies.

The Department finds that it is likewise unnecessary to prescribe supervisor qualifications or responsibilities. Redesignated § 4226.56 (relating to effective date of personnel qualifications) applies the personnel qualifications established by this chapter to individuals promoted as well as hired after the effective date. The Department is unwilling to interfere in county or provider operations by prescribing supervisory responsibilities in regulation.

Section 4226.61. Parental consent (deleted on final-form).

The Department deleted this section as duplicative of redesignated § 4226.92.

Section 4226.62(a) (redesignated as § 4226.61(a)). MDE.

Many commentators expressed opinions on the requirement in subsection (a)(2) that the initial multidisciplinary evaluation be conducted by personnel independent of the service provider, both supporting and opposing the requirement. Commentators expressed concern that it is less family-friendly and deprives parents of a choice of providers, observed that it complicates the system and is not cost effective. Two commentators recommended that the requirement not be applied to low incidence disabilities. A few commentators noted that the requirement could impose a burden on counties where there are not enough personnel to provide service and conduct evaluations, with some recommending that counties therefore be given the option to implement. Several commentators recommended that the Department consider waiving this requirement when there are no or insufficient providers to conduct evaluations, when the family chooses the same provider for the evaluation and to deliver services, when an evaluator with particular expertise is needed but no independent evaluator is available; and in other similar situations. Some commentators stated that the language is too ambiguous and does not provide clear guidance.

Regarding other general requirements, some commentators requested that the Department require that a written MDE report be provided to the family before the IFSP is developed. One commentator proposed that the MDE report be provided to the family within 60 days, and if a parent disagrees with the report, that a joint meeting with the MDE and IFSP team be convened within 10 days. Two commentators recommended that the final-form rulemaking include a requirement to provide an independent evaluation at no cost to families who have requested a hearing, while other commentators suggested that families be allowed one independent evaluation per year at the county's expense.

Response

The purpose of the requirement that an evaluation be conducted by someone independent of the service provider is to produce an assessment of the child's and family's needs that is not unduly influenced by consideration of services that are available from a particular provider. The Department remains convinced that independent evaluations are the first means of assuring that the needs of at-risk children and infants and toddlers with disabilities

and their families are met. Nonetheless, acknowledging that many of the commentators raised legitimate concerns, particularly concerning availability of evaluators in some counties and family choice, the Department recognizes that flexibility is the key to the success of this initiative. Therefore, as explained in the response to comments to § 4226.6, the Department added a new provision to the final-form rulemaking whereby county MH/MR programs may request a waiver of any regulatory requirement, including this one. After careful consideration of the comments recommending less ambiguous language, the Department determined that the same need for flexibility supports retaining the language as proposed. The very considerations that the commentators emphasized have persuaded the Department that language that is too prescriptive would be counterproductive. The current language allows counties to implement this requirement in a number of different ways, leaving it to the counties in the first instance to tailor the requirement to local needs. Therefore, the Department did not revise this paragraph as recommended.

The Department did revise subsection (a) in other respects. It revised the introductory clause by deleting "the following conditions are met" as unnecessary. It also amended paragraph (1) by simplifying the wording to avoid ambiguity and inconsistency within this section and with other sections of the rulemaking and including reference to the family-directed assessment. The Department deleted paragraph (3) because the county MH/MR programs are generally responsible for assuring that their contracting service providers and agencies comply with those sections of the rulemaking that do not explicitly apply only to county MH/MR programs. This paragraph was therefore redundant.

The Department added paragraph (3), which provides that an MDE be conducted annually. Neither Federal nor State law requires that the family receive a written MDE report before the IFSP is developed, and it would be impracticable to impose this requirement, since the IFSP must be completed within 45 days of referral. However, best practice encourages evaluators to involve parents in the evaluation process and discuss the findings with the family while conducting the evaluation. It is through this means that families are aware of the evaluation findings prior to the IFSP. The Department did add paragraph (4), requiring that a written report be forwarded to the parent within 30 days of the MDE. Finally, the Department accepted the recommendation that an independent evaluation be provided at no cost to a parent who requests a due process hearing and added this requirement as redesignated § 4226.100(b)(1) (relating to parental rights in due process hearings). The Department did not adopt the recommendation to require a joint meeting to be convened if the parent disagrees with the MDE. If the family disagrees with an MDE, the appropriate course is to pursue the available procedural safeguards.

Section 4226.62(b) (redesignated as § 4226.61(b)).

A few commentators suggested the word "qualified" be added to subsection (b)(1)(i) to be consistent with 34 CFR 303.322(c)(1). Several commentators suggested that subsection (b)(2) should be revised to require "at least two" professionals in the MDE. One commentator stated that subsection (b)(2) would be clearer if revised to "MDE team." Two commentators recommended that the Department require that parents be given advance written notice that they may invite anyone they would like to participate in the MDE or the IFSP meeting. A few commentators objected that subsection (b)(1)(iii)(C), which requires an assessment of the needs of the child and identification of services to meet the needs, contradicts the IFSP team process. They suggested providers be directly involved in the planning stages for the IFSP and that providers and therapists should be allowed to inform families of the repercussions of not choosing a particular service as a priority.

Response

The word "qualified" does not appear in 34 CFR 303.322(c)(1) and the Department therefore did not revise subsection (b)(1)(i). The Department revised subsection (b)(2) to clarify that it identifies the participants in the MDE. As explained in the response to comments to the definition of "multidisciplinary" in § 4226.5, a service coordinator is appropriately considered one of the "professionals" that is contemplated in the definition. Therefore, the Department did not revise subsection (b)(2). Although the Department agrees that parents must be notified that they may invite other MDE participants, in the absence of a Federal requirement for written notice, there are likely to be circumstances that make written notice impracticable.

Subsection (b)(1)(iii)(C) is identical to 34 CFR 303.322(c)(3)(iii). Neither Federal nor State law requires providers to be involved in the initial IFSP planning stages; therefore the Department did not impose this requirement in the final-form rulemaking. Although the final-form rulemaking does not prohibit providers and therapists from discussing the importance of various services with the family, it remains the family's decision to establish the priorities for their child and family.

After additional review, the Department added subsection (b)(3). This paragraph is intended to clarify that if existing documentation of medical history is sufficient to render the determinations required in subsection (b), the child need not be subjected to another evaluation to comply with this section. The determination of whether an additional evaluation is needed is left to the judgment of the qualified professionals who are familiar with the child, subject to parental agreement.

The Department made several technical changes to this subsection. In subsection (b)(1), it added the term "referred" to improve clarity in light of the revision to the definition of "child" in § 4226.5. Paragraph (1)(iii)(B) was reformatted to eliminate the enumerations to enhance consistency with similar sections in the final-form rulemaking. In clause (C), the cross reference to "subparagraph (ii)" was corrected to "clause (B)," which relates to the child's developmental areas. In subsection (b)(2), the Department inserted the defined term "qualified" and struck the clause "who meets State approved or recognized certification, licensing or other comparable requirements, if applicable, in which the person is providing services."

Section 4226.62(c) (redesignated as § 4226.61(c)).

One commentator asked whether the family-directed assessment is a formal assessment and who is expected to conduct the assessment.

Response

The service coordinator or MDE team, or both, obtain the information for a family-directed assessment, with agreement by the family, through ongoing discussion to identify resources, concerns and priorities of the family. This is not required to be a formalized assessment.

The Department made some technical changes to subsection (c) to correct improper word choice, avoid redundancy and enhance consistency within the subsection.

Section 4226.62(d) (redesignated as § 4226.61(d)).

Some commentators stated that the timeline established in subsection (d)(1) is inconsistent with the 45-day timeline in 34 CFR 303.321(e)(2) and suggested that this paragraph be revised to clarify that the IFSP must be held within 45 days. Several other commentators raised the same issue in addressing § 4226.24(f) (redesignated as § 4226.24(g)). Commentators questioned how an interim IFSP can be developed if eligibility has not been determined. Other commentators raised this issue in addressing § 4226.75 (redesignated as § 4226.76 (relating to provision of services before MDE is completed)). One commentator asked if the Department intends to issue a form for an interim IFSP and if there will be a way to enter information into the Early Intervention Reporting System. A few commentators expressed concern that changing the reevaluation period from every year to every 2 years is not appropriate.

Response

As already noted, the Department revised § 4226.24(g) to clarify that the IFSP meeting must be conducted within 45 days of referral. Consistent with that revision, the Department revised subsection (d)(1) to clarify that the time frame within which the evaluation must be completed is measured by reference to the IFSP. The evaluation must be completed within the time as needed for the IFSP meeting to be conducted within the 45-day time frame. The Department expects that the timing of the evaluation is likely to vary with the circumstances of each child and family. Subsection (d)(2) was revised accordingly.

An interim IFSP is established in 34 CFR 303.322(e)(2). The purpose of this provision is to prevent delay in service delivery in the exceptional situation where, despite best efforts to do so, the MDE and IFSP cannot be developed within 45 days. The Department does not anticipate creating a separate form for an interim IFSP; the current IFSP form may be utilized for interim IFSPs. The information currently can be input into the Early Intervention Reporting System.

The Department did not propose to change the evaluation period. As clarified in new subsection (a)(4), evaluations must be completed annually.

The Department made some additional revisions to subsection (d). It replaced "evaluation and initial assessment" with "initial MDE, including the family assessment" to avoid inconsistency with other subsections. It also revised paragraph (2)(ii) to clarify that the circumstances are to be documented in the child's record.

Section 4226.63 (redesignated as § 4226.62). Nondiscriminatory procedures.

One commentator recommended that this section provide examples of situations in which communication with parents in their native language, as required by paragraph (1), would be considered "clearly not feasible," to improve clarity. Two commentators suggested that this section clarify that a child should be tested and evaluated in the child's native language or mode of communication, to account for families in which a deaf child is born to hearing parents.

Response

The language in this section mirrors 34 CFR 303.323 (relating to nondiscriminatory procedures). Therefore, the Department did not revise the section to add "child's native language or mode of communication." As explained in the response to comments to the definition of "native language" in § 4226.5, this section is directed toward communication with the parent, which is a critical component of the evaluation, as reflected in redesignated § 4226.61. Nonetheless, to the extent that the child is of an age to communicate and determination of the developmental areas requires communication, the Department expects that communication with the child will be in the child's native language, including sign language. The Department has highlighted this point as a training issue.

The Department likewise expects that there would be few situations in which it is "clearly not feasible" to communicate with a parent in the parent's native language. One example of a situation might be when a family speaks a language that is uncommon, the county MH/MR program has been unable to find an interpreter despite good faith efforts to do so and no family member or friend is available to translate even informally.

After careful consideration of the recommendation to include examples in the final-form rulemaking, the Department determined that it would be unwise and perhaps even misleading to do so. Although, as noted, few situations would present infeasibility, the Department cannot anticipate every scenario that would be justified. More important, whether communication is clearly infeasible will necessarily vary according to the circumstances of each case. For these reasons, the Department did not cite examples as recommended.

The Department made technical changes to this section to eliminate unnecessary wording and redundancy.

Section 4226.71. IFSP—General.

Two commentators noted that since services are by Federal law permitted to be provided in a location other than a natural environment, the final-form rulemaking should specify that the county MH/MR program will honor the placement decisions made by the IFSP team based on the child's needs and the family's preference and not veto locales that reflect the consensus of the IFSP team.

Response

Although these commentators raised the issue of natural environments in comments to this section, several other commentators addressed the same issue in commenting on § 4226.74. Therefore, the Department responded to these comments in the response to § 4226.74.

The Department made a technical correction to this section by deleting the first sentence from subsection (b), since this is the definition of IFSP in § 4226.5. In paragraph (4), the Department struck "option" and inserted "source" to avoid inconsistency with other sections.

Section 4226.72(a). Procedures for IFSP development, review and evaluation.

As did several other commentators in addressing other sections of the rulemaking, three commentators requested clarification on the 45-day timeline for developing the IFSP.

Response

The Department revised § 4226.24(f) (redesignated as § 4226.24(g)) to clarify that the evaluation and IFSP must be completed within 45 days.

Section 4226.72(b).

Some commentators stated that the language "or more often" in subsection (b) was too vague and recommended adding language that makes clear that the review must

be conducted sooner than every 6 months if the family requests such an earlier review. One commentator requested examples of "other means" by which parents and other participants can choose to participate. One commentator observed that problems will occur if the IFSP is not reviewed for 2 years. Other commentators suggested that providers be allowed to use their clinical or professional opinion when providing services to families.

Response

The Department concurs with the first recommendation and revised the introductory paragraph of subsection (b) to mirror 34 CFR 303.342(b)(1) (relating to procedures for IFSP development, review and evaluation). The Department also added conference calls and written reports as examples of the other means that parents and participants can choose. The Department did not include an exhaustive list of "other means" in this subsection because such means are likely to change over time, given technological and other advances and the preferences of team participants.

IFSPs are required to be evaluated once every year, and a review of the plan should take place every 6 months or more frequently if the family requests it, not every 2 years. No provision in the rulemaking prohibits providers from using their clinical or professional opinion when providing services to families.

Section 4226.72(c).

One commentator suggested the evaluation be conducted as part of the 6 month review.

Response

The IFSP and the progress the infant or toddler with a disability is making is reviewed every 6 months so the Department does not believe a formal evaluation of the child is necessary.

Section 4226.72(d).

One commentator suggested that subsection (d)(1) be revised to state "at reasonable times that are convenient to the families and agreed upon by teams members." Another commentator recommended that a minimum amount of time be specified for "early enough" in subsection (d)(3) (redesignated as subsection (e)).

Response

The Department recognizes that all members of the IFSP are important to the process and expects that all participants will be given an opportunity to participate in the development of the IFSP. Primary consideration must, however, be given to the ability of the family to participate in the meeting and the meeting must therefore be scheduled at the family's convenience, within reason. The rulemaking permits other team members to participate by other means if the time established by the family is not convenient for all team members. Therefore, the Department did not make the recommended change.

The Department was reluctant to establish a minimum time frame, because the Department believes that it may be appropriate for the time frame to vary based on the individual circumstances of the child, family and team participants. Because families and early intervention personnel are working within a 45-day timeline to develop an IFSP, families, service coordinators and other team members are in full communication with each other to establish the most convenient times available whenever possible. Notwithstanding these reservations, the Department acknowledges that there is little point to a requirement for written notice if the notice does not arrive on time. Therefore, the Department revised subsection (e) to require that the notice be provided no later than 5 days before the scheduled meeting date.

As noted in the response to comments to the definition of "early intervention services" in § 4226.5, the Department added subsection (d)(3), which requires that the IFSP meeting be conducted in a manner that ensures that services are selected in collaboration with the family. The Department struck "family or other mode of communication used by the family" from subsection (d)(2) because this is part of the definition of "native language" in § 4226.5, and made a technical change by replacing "family" with "parent" to avoid internal inconsistency. The Department redesignated proposed subsection (d)(3) as subsection (e) to correct an organizational error. Finally, the Department deleted proposed subsection (e) from this section and inserted a substantially identical provision as redesignated § 4226.92(c).

Section 4226.73. Participants in IFSP meetings and periodic reviews.

Several commentators expressed various concerns about the participants in the IFSP meeting identified in subsection (a), including that there is a lack of clarity about who is required to participate on the IFSP team and that the final-form rulemaking should state that the IFSP team is to be multidisciplinary and should include two or more disciplines or professions as well as parents; that persons providing services to the child should participate and the words "as appropriate" in subsection (a)(6) be removed or language be added that indicates that families can make a determination on whether the providers should or should not attend and families should be informed of the choice in writing; that parents should be informed in writing that an advocate or person outside the family can participate in the IFSP; and that parents should be informed of those persons who will be attending the meeting prior to the meeting. One commentator asked how child care providers recover costs that will be incurred for attendance at IFSP meetings.

A number of commentators emphasized that the IFSP team, not the county MH/MR program, is responsible for making decisions about the child and suggested that service decisions are not being made at the IFSP meeting. They urged that the service coordinator must have the authority to commit resources or that someone with authority should attend the IFSP meetings. One commentator asked whether a county MH/MR program can deny services agreed upon as part of an IFSP and, if so, what happens regarding the recommendations.

Response

The participants at an IFSP meeting are outlined in this section. As explained earlier, neither Federal nor State law requires that two professionals in addition to the service coordinator participate in the MDE or the IFSP. Nor does it prohibit two or more disciplines from participating in the IFSP meeting. It is the responsibility of the service coordinators to inform the families that advocates and persons outside the family can participate in developing the IFSP. The language "as appropriate" is consistent with federal regulations and therefore was not deleted.

The Department agrees that it is the IFSP team, which includes the family, that has the responsibility to develop a plan of service delivery for the child. As outlined in redesignated in 226.52(3), the service coordinator is responsible for "facilitating and participating in the devel-

opment, implementation, review and evaluation" of the IFSP. The service coordinator is an equal member of the team. The service coordinator or other team members may disagree with the decision being discussed at the IFSP meeting. If consensus cannot be reached on the appropriate services for the child, the parent may pursue any of the procedural safeguards available to challenge the outcome. If the team does reach consensus, then the county MH/MR program must abide by that decision. If it does not, then the parent again should pursue the procedural safeguards available to challenge the county decision.

No mechanism exists for child care providers to receive payment for their attendance at IFSP meetings. If a child is in a child care setting, the child care provider may be an integral member of the team. As do other team members, it has the ability to participate in development of the IFSP through written communications, discussions with the family or conference calls.

The Department made technical changes to subsection (c) to correct improper word usage and typographical errors.

Section 4226.74(1). Content of the IFSP.

Two commentators noted that paragraph (1)(i) was inconsistent with 34 CFR 303.344(a)(1) (relating to content of an IFSP) and recommended that the phrase "based on objective criteria" be deleted.

Response

The Department concurs and made the change as recommended.

Section 4226.74(2).

Two commentators noted that the provision identified in paragraph (2) was inconsistent with 34 CFR 303.344(b) because it did not have the introductory phrase "with the concurrence of the family" and suggested that the paragraph be revised.

Response

The Department concurs and made the change as suggested.

Section 4226.74(4).

A few commentators submitted comments on the listing of qualified personnel in proposed paragraph (4)(ii) that addressed the process for credentialing, the addition of sign language instructors, the addition of language signaling that special educators need to be knowledgeable about the communication needs of the child, and not limiting personnel to those listed in this subparagraph.

One commentator pointed out that location is "defined" in subparagraph (iv) but the section does not require that the location must be listed on the plan. One commentator stated that the terms "frequency" and "intensity" in subparagraph (ii) are defined too restrictively and suggested adding a statement that the maximum number of times per month may not be delivered every month. Another commentator sought direction on how to document "frequency and intensity."

Response

The Department deleted proposed subparagraph (ii) from this section as duplicative of the listing of qualified personnel in the definition of "early intervention services" in § 4226.5. The issues presented by the commentators to this section have been addressed in the response to comments to the definition of "early intervention services" in § 4226.5.

The Department made several revisions to this paragraph. It revised subparagraph (i) to conform to 34 CFR § 303.344(d)(1). It added clause (B) regarding natural environments, requiring that the IFSP include a justification if services are not provided in natural environments. A similar requirement was set forth in proposed paragraph (5) of this section and the many comments received on the issue of natural environments are addressed in the next section. The Department also added clauses (C) and (D), requiring that the IFSP list the payment arrangements and unit costs. It deleted the definition of "method" and "location" since these terms are defined in § 4226.5.

The completion of the IFSP form, including frequency and intensity of service, is an issue to be addressed at training.

Section 4226.74(5).

The Department received a number of comments on the provision related to natural environments. Commentators suggested clarifying that parents have choices and options and that their preferences should be documented and considered; that a school or program for a child that is deaf may be a natural environment; and that the IFSP team must make the decision on the appropriate environment and appropriate justification.

Response

Because the delivery of services in natural environments is integral to the provision of early intervention services, the Department added § 4226.75(a), which requires that to the maximum extent appropriate to meet the needs of the infant or toddler with a disability, as determined by the IFSP team, services are to be provided in natural environments. The basic premise to the provision for natural environments is that services should be provided in communities or locations where the child lives, learns and plays in order to enhance the child's participation in family routines and the activities and routines that occur in a variety of community settings where children and families spend time. Home and community settings provide children the opportunity to learn and practice new skills within a context that provides educational and developmental interventions. The natural environment in which supports and services will be provided should be based on information garnered from the evaluation and assessment as well as the child's present status, family information and desired outcomes, which relate to the outcomes on the IFSP.

It is the responsibility of the IFSP team to determine how early intervention services can be achieved in a natural environment. The parents are clearly an integral part of the team process, but parental preference divorced from the needs of the infant or toddler cannot be used as a justification for providing services in a setting other than a natural environment. The determination for where a service is provided should, again, be based on information from the evaluation and assessment as well as the child's present status, family information and desired outcomes.

It is the responsibility of the IFSP team to make decisions separately for each service. If the team determines that a particular service for the child must be provided in a setting other than a natural environment, the team must include a justification as outlined in § 4226.74(4)(i)(B). It is expected that when developing an IFSP for the child and family, the IFSP team will first determine which services are needed for the child and how they can be delivered in the child's natural environ-

ment. Only if a particular need of the child cannot be met in the natural environment should other settings be considered.

A child who is deaf or hard of hearing may receive services in a setting other than a natural environment based on their individual needs. The Department addressed this same issue in the response to comments to the definition of "natural environments" in § 4226.5 and will not repeat that response here.

Section 4226.74(6) (redesignated as § 4226.74(5)).

One commentator asked if unit costs were no longer required on the IFSP.

Response

The Department added clause (D) to paragraph (4)(i), requiring that unit costs be included on the IFSP.

Section 4226.74(7) (redesignated as § 4226.74(6)).

Almost half of the comments the Department received urged the Department to specify a time period for when services should start after the IFSP is completed. Many commentators suggested that services should start within 14 days. One commentator argued against establishing an arbitrary timeline.

Response

In developing the proposed rulemaking, the Department was hesitant to include a time-line for implementation of the IFSP for a variety of reasons. The Department was concerned that specifying a particular time frame, such as 14 days, could delay the start of service if programs had a "window" of 14 days to comply. It is also possible that there could be an appropriate delay in service based on a team decision or parental request.

After careful consideration, the Department has adopted a requirement that services are to begin within 14 days after the IFSP is completed, subject to exception if the family requests or the needs of the infant or toddler warrant an extension. This requirement is in new § 4226.75(b). The requirement to document the service start date on the IFSP has been modified accordingly in paragraph (7) (redesignated as paragraph (6)).

Section 4226.74(8) (redesignated as § 4226.74(7)).

Two commentators suggested that this paragraph be deleted because the rate structure does not allow for the best team member to coordinate services for the child and family. Two commentators believed that this paragraph contradicts the service coordination model implemented in this Commonwealth.

Response

The Department revised this paragraph by deleting the requirement that the service coordinators be from the profession most immediately relevant to the infant or toddler's needs, since this does not reflect the service coordination system in this Commonwealth. Since the current system is permitted under Federal law, the Department revised this paragraph accordingly.

Section 4226.74(9) (redesignated as § 4226.74(8)).

Many commentators requested that the final-form rulemaking provide guidance to the field on the transition process. Commentators recommended using language that is consistent with Federal regulations; questioning the county's ability to influence the timelines of transition meetings; including specific language to allow more options and defining the ability of the team to authorize or refer a child to services in a center-based program during the transition year, prior to the third birthday; including language on pendency to ensure that services continue when a child turns 3 years of age if a dispute occurs; and the need for more flexibility so that a separate IFSP and IEP are not developed in a short period of time. One commentator believed the local educational entity, not the county, is responsible for coordinating meetings and that a formal conference is not necessary for children not eligible for preschool programs.

Response

After additional internal review, the Department deleted this entire paragraph from this section and restated the substance of the paragraph in new § 4226.77 (relating to transition from early intervention services). Partially in response to the comments received, the Department determined that the provisions of this paragraph impose substantive requirements that are not appropriately set forth in a section that pertains to documentation requirements. The provisions of § 4226.77 are in substance virtually identical to those in paragraph (9) of the proposed rulemaking, with the exception of some technical changes made to improve clarity and reduce unnecessary wordiness. The new section also differs from proposed paragraph (9) in that it includes the specific steps, from 34 CFR § 303.344(h)(2), that the commentators proposed to include. Paragraph (9) of this section (redesignated as paragraph (8)) has been modified accordingly to prescribe what needs to be included on the IFSP.

Turning to the comments, in reference to center-based programming in the transition year, the Department did not offer further clarification because the Department believes there is nothing in the final-form rulemaking to prohibit such programming, but neither is it encouraged for all children. The decision on the location of service, as well as the justification for where the service is provided, is the responsibility of the IFSP team. A team decision that the child needs a particular service in a particular location should be based on evaluation and assessment information. An appropriate justification for providing services in a location other than natural environment is not that the child is turning three.

The Department did not add language regarding pendency to ensure that services continue when a child turns three if there is a dispute. Once the child turns 3 years of age, programmatic and fiscal responsibility transfers to the Department of Education. The Department has no authority to establish regulations that would govern operation of the Department of Education's early intervention program.

It is the responsibility of the county MH/MR program to convene a conference with the local education entity and the family for children who are eligible for Part B services as well as for families of children who are not eligible but may be transitioning to other appropriate services.

Section 4226.75. Provision of services before evaluation and assessment are completed (redesignated as § 4226.76. Provision of services before MDE is completed).

One commentator suggested that this section should identify under what circumstances it would be appropriate for services to begin before an evaluation is completed. Four commentators stated that it is not clear how a child can be determined eligible for services, or what services are needed, in the absence of an evaluation and recommended that the section be deleted.

Response

Unlike § 4226.61(d)(2), which is directed to those situations in which the MDE could not be completed within prescribed timeline despite best efforts to do so, the purpose of this section is to facilitate services if a child has an immediate or apparent need. One example of a child for whom an interim IFSP would be appropriate under this section is a child born with spina bifida whose need for physical therapy is apparent without a full MDE and IFSP. The determination of a need would be based on the very individualized circumstances of the child. It is therefore virtually impossible to attempt to describe even broad categories of examples that would provide meaningful direction. The Department finds it is inappropriate to list any examples in the final-form rulemaking. Outlining specific circumstances might result in service delay for a child with an immediate need because the specific circumstance was not included in the examples.

The Department revised paragraph (3) by adding a cause that clarifies that if an interim IFSP is developed because exceptional circumstances preclude the MDE and IFSP from being developed within 45 days, then the MDE need not be completed within that specified time frame, as this paragraph otherwise requires.

Procedural Safeguards

The sections dealing with procedural safeguards were reorganized to reflect a more cohesive progression from general provisions that apply in any forum to the specific provisions related to each mechanism for resolving a dispute.

Section 4226.91. General responsibility of legal entity for procedural safeguards (redesignated as "General responsibility for procedural safeguards").

Several commentators expressed concern that the rulemaking does not address the complaint management system set forth in 34 CFR 303.510—305.512 (relating to lead agency procedures for resolving complaints), including the requirement that parents receive written notice of procedures to follow to file a complaint. They suggested it be included. One commentator noted that parents do not know how to file a complaint.

Response

The Department revised and redesignated § 4226.97 (redesignated as § 4226.95). As revised, redesignated § 4226.95(b)(3) and (4) requires that the notice issued to parents inform them of their right to conflict resolution, mediation and a due process hearing as well as the right to file a complaint with the Department and the procedures for filing a complaint. The Department did not include the complaint management system in the rulemaking because the Federal regulations impose that requirement on the Department, not the county MH/MR programs. Since the final-form rulemaking applies to county MH/MR programs and service providers and agencies, the complaint management system is appropriately omitted.

The Department made several revisions to this section. It deleted subsection (b) because the county MH/MR programs are generally responsible for assuring that their contracting service providers and agencies comply with those sections of the final-form rulemaking that do not explicitly apply only to the county MH/MR programs. Subsection (b) was therefore redundant.

The Department also amended proposed subsection (a) by inserting "meet the requirements of this chapter, except §§ 4226.101 and 4226.102 (relating to impartial hearing officer; convenience of proceedings, timelines)" in place of "shall include, at a minimum, conflict resolution, mediation and administrative hearing as set forth in." The Department made this change to avoid ambiguity and confusion regarding the responsibilities of the county MH/MR programs under this section. As revised, the section clarifies that the county MH/MR programs must adopt procedural safeguards that comply with all but the two specified sections. Redesignated §§ 4226.101 and 4226.102 address procedures for due process hearings, for which counties have no responsibility. Instead, due process hearings are conducted by a contractor of the Department. For that reason, these sections were excepted from the operation of this section. The Department also reorganized the section to accommodate the deletion of proposed subsection (b).

Section 4226.92. Notice of rights (deleted on final-form).

The Department deleted this section as redundant of redesignated § 4226.75(b).

Section 4226.93 (redesignated as § 4226.97). Conflict resolution.

Some commentators expressed concern that this section, § 4226.94 (redesignated as § 4226.98) (relating to mediation) and § 4226.100 (redesignated as § 4226.99 (relating to due process procedures)) were all very confusing. These commentators noted that the sections did not make clear the difference between county level resolution and mediation; suggested that due process rights are available only after parents use conflict resolution; and lacked clarity on what happens if conflict resolution does not resolve the dispute. One commentator objected that this section did not provide direction to families on how to file a complaint. Another commentator suggested that all of the procedural safeguards sections be combined into one section with the heading "conflict resolution."

Response

The Department made several revisions to this and the other procedural safeguards sections in an attempt to clarify the numerous protections available to families under the final-form rulemaking. The Department revised this section (redesignated as § 4226.97) to clarify the distinction between conflict resolution, which is a meeting with local county staff to resolve an issue, and mediation, which is a meeting conducted by an independent mediator not associated with the county MH/MR program. The Department amended subsection (a) to describe more clearly what conflict resolution is. Subsection (b) was revised by adding paragraph (2) to emphasize that conflict resolution is available independent of a request for mediation or a due process hearing; by amending paragraph (2) (redesignated as paragraph (3)) to clarify that the county MH/MR program must make an offer for conflict resolution when a request for mediation or a due process hearing is filed but that the parent can refuse the offer; by changing the wording in paragraph (3) (redesignated as paragraph (4)) from "if conflict resolution is unsuccessful" to "if no resolution or agreement is reached at the meeting"; and by adding a new paragraph (7) to emphasize that parental participation is voluntary, and that parents do not have to participate in order to exercise other procedural safeguards. The Department also revised § 4226.97 (redesignated as § 4226.95) to specify in redesignated § 4226.95(b)(3) that the notice must include a description of the available procedural safeguards. As noted in the response to comments to § 4226.91 (relating to general responsibility for proce-

dural safeguards), new redesignated § 4226.95(b)(4) requires that the notice also advise of the right to file a complaint with the Department. The comment regarding the complaint management system was otherwise addressed in the response to comments to § 4226.91, and that response will not be repeated here.

The Department acknowledges that an alternative organizational scheme could be to entitle a subchapter or section "conflict resolution" and encompass all remaining sections, but the Department did not choose that scheme. Instead, it clarified the intent of these sections by amending the sections and reorganizing them. Although this commentator offered the proposed reorganization in commenting on every remaining section except § 4226.105, the Department will not repeat this response.

Section 4226.94 (redesignated as § 4226.98). Mediation.

As with the section on conflict resolution, some commentators expressed concern that this section was confusing and requested that it be clarified. One commentator observed that this section implied that mediation is available only if a parent requests a due process hearing and suggested that it be available whenever there is a dispute. Two commentators recommended that this section specify a time frame for conducting the mediation session in subsection (d) rather than retain the phrase "in a timely manner."

Response

The Department revised and redesignated the substance of this section as § 4226.98. The Department revised this section in several respects to dispel confusion and to address other comments submitted. Subsection (a) was revised to delete the clause that began "which, at a minimum" and concluded with "impartial decisionmaker)" in the proposed rulemaking. The reason for this revision is to remove any ambiguity about when mediation must be made available and clarify that a parent does not have to ask for a due process hearing for mediation to be available. Subsection (b) was revised by adding paragraph (2) to clarify that the county MH/MR program must offer mediation to a parent who requests a due process hearing. Subsection (c) in the proposed rulemaking was redesignated as subsection (f) and amended to correct an inadvertent error in the proposed rulemaking by adding the phrase "to encourage the use and explain the benefits of the mediation process" to the introductory paragraph and deleting a similar clause from paragraph (2).

Subsection (d) in the proposed rulemaking was redesignated as subsection (c) and revised to specify that a mediation session must be scheduled within 10 days of a request for either mediation or a due process hearing, rather than "in a timely manner." Subsections (e) and (f) in the proposed rulemaking were redesignated as subsections (d) and (e), respectively, but were otherwise not changed.

The Department has contracted to provide mediation services through the Office of Dispute Resolution (ODR), the same entity that conducts due process hearings. ODR has a staff of trained mediators. A mediator is assigned to conduct the session when a request for mediation is submitted.

Section 4226.95. Consent and native language information (redesignated as § 4226.92. Parental consent).

The Department combined the provisions of this section with those of proposed § 4226.98 (relating to parent consent), as well as consent provisions from other sections of the proposed rulemaking, into one section, redesignated as § 4226.92. The reason for this revision is to consolidate all consent provisions in one section rather than scattering them throughout the final-form rulemaking, for ease of reference.

Redesignated subsection (b) contains the provisions of § 4226.98 in the proposed rulemaking in paragraphs (1) and (4), modified by deleting the reference to a particular form in the introductory clause as unnecessary because of the technical correction to subsection (a)(2); adding the phrase, "or changing"; and deleting reference to § 4226.72(e), since that section was revised and redesignated as subsection (c) of this section. Paragraph (2) was added because it was inadvertently omitted from the proposed rulemaking and paragraph (3) was added at the recommendation of commentators to § 4226.23 (relating to eligibility for Medicaid waiver services). Subsection (c) is redesignated from § 4226.72(e), modified to take into account the need to obtain consent before a service is changed, not just initiated. Subsection (d) is redesignated verbatim from § 4226.98(b) in the proposed rulemaking.

The Department also corrected some technical errors. In subsection (a), it changed "from parents" to "parental" to avoid inconsistency with other regulations. In subsection (a)(1) it struck "or other mode of communication" because this phrase is included in the definition of "native language" in § 4226.5). In subsection (a)(2) it inserted "form" to avoid ambiguity. The Department deleted subsection (b) because this is the definition of "native language" in § 4226.5.

Section 4226.96 (redesignated as § 4226.94). Opportunity to examine records.

Some commentators suggested that the specific applicable Federal procedures should be included in this section. Others recommended that the section be revised to state that families may have access to copies of their records without cost. One commentator expressed concern that the rulemaking is too broadly worded and suggested that the phrase "when appropriate" be added to maintain confidentiality when dealing with situations of abuse or other sensitive issues. Another commentator asked the Department to clarify the meaning of "individual child complaint" in this section and in § 4226.100 (redesignated as § 4226.99. Due process procedures).

Response

The Department finds that it is unnecessary to restate the provisions of the cited regulation in this section. Regarding access to records at no cost, the Federal regulations cited in this section specify in 34 CFR 300.566(a) (relating to fees) that an agency may charge a fee for copies of records "if the fee does not effectively prevent the parents from exercising their right to inspect and review those records." The Department believes that this provision affords parents sufficient protection in exercising their rights.

Regarding the breadth of the language of this section, 34 CFR 300.562(c) (relating to access rights) provides that an "agency may presume that the parent has the authority to inspect and review records relating to his or her child unless the agency has been advised that the parent does not have the authority under applicable State law governing such matters as guardianship, separation, and divorce." The Department does not have the authority to graft any other exceptions onto the exercise of a Federal right.

An individual child complaint is one that relates specifically to one child and is not a complaint against the system of service.

Section 4226.97. Prior notice; native language (redesignated as § 4226.95. Prior notice).

One commentator suggested listing examples of when communication with parents in their native language would be considered "clearly not feasible" to improve clarity. Another commentator recommended that this section should direct that the notice be "written in language understandable to the public."

Response

For the reasons explained in the response to comments to redesignated § 4226.62 (relating to nondiscriminatory procedures), the Department did not add examples of when communication in the parent's language would "clearly not be feasible." The language recommended by the second commentator is in subsection (c)(1).

The Department redesignated this section as § 4226.95. As noted in the response to comments to § 4226.92 (relating to notice of rights) (deleted on final-form), the Department revised subsection (b) by striking paragraph (3) and replacing it with a new paragraph (3) that specifically identifies the procedural safeguards that must be described in the notice. The Department also added a new paragraph (4), requiring that the notice also include a description of how to file a complaint with the Department.

The Department made several technical changes to this section to conform the section to other changes made in the rulemaking. It added "clearly" in subsection (c)(2) because that word was inadvertently omitted from the proposed rulemaking. It deleted "or other mode of communication" from subsections (d) and (e) in its entirety because these provisions are both included in the definition of "native language" in § 4226.5. Because these provisions were deleted, the Department revised the section heading by likewise deleting "native language." Finally, it changed the wording in subsection (d)(3) to clarify where the written evidence should be maintained.

Section 4226.98. Parent consent (deleted on final-form).

As explained in the response to comments to § 4226.95 (redesignated as § 4226.92) the Department deleted this section, having incorporated the substance of the provisions in redesignated § 4226.92.

Section 4226.99. Parental right to decline service.

The Department redesignated the substance of this section as § 4226.93(a) (relating to parental right to decline service). The Department added § 4226.93(b), which is parallel to subsection (a) but applies to at-risk children rather than infants and toddlers with disabilities, and was inadvertently omitted from the proposed rulemaking.

Section 4226.100. Administrative resolution of individual child complaints by an impartial decisionmaker (redesignated as § 4226.99. Due process procedures).

One commentator objected to the word "timely" as unclear and recommended that it be deleted and a maximum time frame substituted.

Response

After additional internal review, the Department revised this section in several respects.

Because the Department's contractor, not the county MH/MR programs, is responsible for the conduct of due process hearings, the county MH/MR programs cannot establish procedures to ensure the timely resolution of these hearings. Therefore, this section was revised to require the county MH/MR programs to implement procedures that ensure that requests for due process hearings are not delayed. The time frame for resolution of a due process hearing has been specified as 30 days in § 4226.103(b) (redesignated as § 4226.102(b) (relating to convenience of proceedings; timelines)). The purpose of this section is to require county MH/MR programs to establish procedures at the local level that do not interfere with resolution of due process hearings within 30 days.

Section 4226.101. Parent rights in administrative proceedings (redesignated as § 4226.100. Parental rights in due process hearings).

Two commentators observed that families often cannot afford to retain an attorney and recommended that subsection (b)(1) (redesignated as subsection (b)(2)) be reworded to clarify that families do not need to have counsel and another person at the hearing.

Response

The language in subsection (b)(2) mirrors 34 CFR 303.423(b)(1). The Department disagrees with the suggestion by the commentators that this paragraph requires that a parent be accompanied both by counsel and by other individuals. Instead, this paragraph affords a parent the right to be accompanied either by counsel or by individuals with special knowledge or training, or both. The Department therefore did not make the requested change.

After additional internal review, the Department made several revisions to this section. It changed references to "administrative proceedings" in both the section heading and the text to "due process hearings" because this is the term commonly used. For the same reasons as set forth in the immediately preceding response, the county MH/MR programs are not in a position to "afford" parents the enumerated rights in a due process hearing. As the opposing party at the hearing, the county MH/MR program would be particularly ill-suited for that role. Therefore, the Department revised this section, consistent with the revisions to redesignated § 4226.99, to require the county MH/MR programs to inform parents of their rights.

The Department also revised subsection (a) by changing "children eligible under this chapter" to "children referred or eligible for tracking or early intervention services" to clarify that parents of children who are referred but determined ineligible also have the right to request a due process hearing to challenge that determination. The Department made additional revisions to this subsection to avoid inconsistency with redesignated § 4226.99 as revised.

The Department amended the introductory clause in subsection (b) to conform the language to the revisions to redesignated § 4226.99 and to clarify that only parents who are parties to a due process hearing, rather than involved in some other capacity such as a witness, have the rights listed in this subsection. In response to a recommendation from commentators, the Department added subsection (b)(1). This paragraph enables a parent who requests a due process hearing to obtain an independent MDE if the hearing officer determines that an MDE is needed to resolve the dispute. The remaining paragraphs in this subsection were renumbered accordingly.

Section 4226.102 (redesignated as § 4226.101). Impartial hearing officer.

Some commentators recommended that this section specify the qualifications and duties of the hearing officer who conducts the due process hearings.

Response

The Department concurs and revised subsection (a) and added subsection (b) to specify qualifications and duties, which are consistent with 34 CFR 303.421 (relating to appointment of an impartial person). The Department also added an introductory clause in subsection (c) (redesignated from proposed subsection (a)) to introduce the definition of "impartial." The Department revised subsection (c)(1) by adding "who is the subject of the hearing" to avoid ambiguity and correcting a grammatical error. Finally, the Department redesignated proposed subsection (b) as subsection (d) and made technical changes to conform to the revisions in redesignated § 4226.99.

Section 4226.103 (redesignated as § 4226.102). Convenience of proceedings; timelines.

Some commentators objected to the absence of a timeline for resolving hearing requests. They recommended that this section specify that hearing requests must be decided within 30 days.

Response

The Department concurs and made the recommended change by adding subsection (b). The Department purposely phrased this subsection in the passive voice, since parents may send requests for due process hearings either to the county MH/MR program or directly to the ODR. The 30-day time period begins from the date of receipt by either entity.

Section 4226.104 (redesignated as § 4226.103). Status of a child during proceedings.

One commentator urged the Department to consider addressing the issue of pendency at transition in this section, in addition to having raised the issue in commenting on § 4226.74(9) (redesignated in part as §§ 4226.74(8) and 4226.77).

Response

For the reasons explained in the response to the comments to § 4226.74(8), the Department does not agree that pendency of services at transition to preschool services are appropriately encompassed within these regulations.

The Department revised subsection (a) to clarify that this section applies regardless of the procedural avenue the parent pursues. The Department deleted subsection (c) as duplicative of redesignated § 4226.93. The Department also made technical changes to conform the section to other changes made in the final-form rulemaking.

Section 4226.105 (redesignated as § 4226.96). Surrogate parents.

Several commentators stated that the language of this section unnecessarily limits a foster parent's ability to serve as a surrogate parent for a child in substitute care and suggested that foster parents should be eligible to serve as a surrogate if all requirements in this section are met. One commentator requested clarification of the period of time that qualifies as a long-term relationship in subsection (f)(3) and what constitutes a conflict of interest in subsection (f)(5). Some commentators asked why the provisions that authorize the county MH/MR programs to appoint a surrogate at the request of the parent under certain circumstances and that protects surrogate parents from liability were omitted. One commentator observed that the responsibilities in subsections (b)(2) and (c) were the same. The same commentator suggested that this section emphasize that surrogacy is not needed only for children in substitute care.

Response

For the reasons explained in the response to comments to the definition of "parent" in § 4226.5, the Department revised subsection (f) (redesignated as § 4226.96(e)) to permit a foster parent to serve as a surrogate if all other requirements of this section are met and the custodial county children and youth agency approves the appointment.

According to advice received from the Office of Special Education Programs of the United States Department of Education, the type of long-term relationship contemplated in proposed subsection (f)(3) is one in which the foster parent has pursued an interest in adoption but is unable to adopt because, for example, the family would lose medical coverage for the child. An example of a disqualifying conflict of interest under subsection (f)(5) is a former member of the Board of an agency providing services to the child who had a dispute with the agency or a current Board member of an agency providing services to the child.

In redesignating this section as § 4226.96, the Department made several revisions. In response to language proposed by commentators and after additional internal review, the Department revised subsection (a) to delineate more clearly the types of situations for which appointment of a surrogate is not only appropriate but necessary. The Department revised subsection (b) by deleting the enumeration to eliminate redundancy. The Department combined subsections (c) and (d) into redesignated subsection (c) for the same reason. The Department added a new subsection (c)(3) to ensure that only persons who are willing to serve as surrogates are appointed. The Department revised subsection (d)(3) (redesignated as § 4226.96(c)(4)) and added subsection (c)(5) to ensure that any State public agency or private agency serving the child or a family member is not selected as a surrogate parent.

The provisions that authorize the county MH/MR programs to appoint a surrogate at the request of the parent under certain circumstances and that protect surrogate parents from liability were omitted from this section because 34 CFR 303.406 (relating to surrogate parents) does not authorize those provisions, and the Department is unwilling to extend surrogacy beyond what is explicitly authorized by Federal law. Because the language of this section itself makes clear that surrogacy is not needed only for children in substitute care, the Department did not revise the section to address that issue.

Other Issues

Some commentators raised global issues not related to a specific section of the final-form rulemaking. These commentators both commended and criticized the Department for adopting much of the language in 34 CFR Chapter 303; urged the Department to consider the proposed rulemaking for Part C that has been withdrawn and questioned how the Department could expect to comply with Federal regulations that have yet to be promulgated; advocated that the Department use the regulations as a means to adopt creative approaches to

service delivery and funding. As with the other comments previously summarized, the Department considered each of these comments in adopting this final-form rulemaking.

The Department corrected typographical or grammatical errors or made other minor technical changes to the definitions of "method," "nursing services," "psychological services" and "speech-language pathology services" in § 4226.5. In addition, the Department redesignated § 4226.42 as § 4226.34 (relating to local interagency coordinating council).

Fiscal Impact

Public Sector—Commonwealth and Local Government

The final-form rulemaking incorporates requirements already imposed under the act, Part C of IDEA and accompanying Federal regulations and the infants, toddlers and families Medicaid waiver approved by the CMS, all of which are currently in place. Therefore, no additional costs or savings are anticipated for the Commonwealth or for local government entities.

Private Sector

In drafting the final-form rulemaking, the Department gave careful consideration to the concerns of some commentators that the proposed rulemaking would have a significant cost impact, particularly on providers of service, because of the preservice and annual staff training requirements. The training requirements received wide support from commentators, including families, advocacy groups and providers.

The Department has an extensive training and technical assistance network through EITA, which provides training at no cost to counties and service providers and agencies. Training sessions are available throughout the year on a Statewide and a regional basis, both in person and through teleconferencing. Also available are local training opportunities that can be designed to meet the needs of a particular county. In addition, the county MH/MR programs receive an annual training allocation from the Department that they may utilize to meet the local needs of their area, including provider staff training. Therefore, the Department anticipates that provider cost increases associated with the training requirements will be minimal and will not impose an undue burden on providers. Cost increases are outweighed by the benefits that well-trained staff will bring to children and families who receive early intervention services.

General Public

There is no anticipated fiscal impact on the general public.

Paperwork Requirements

The final-form rulemaking imposes some additional reporting and paperwork requirements associated with documentation of efforts to exhaust other available resources and recordkeeping of staff training hours. The county MH/MR programs and service coordination providers will be required to maintain and make available records that they have attempted to exhaust other available public and private resources before early intervention funds are expended. The county MH/MR programs and service providers and agencies will also be required to maintain and make available records to confirm that all early intervention personnel have received both preservice and annual training.

Effective Date

The final-form rulemaking will take effect July 1, 2003.

Sunset Date

No sunset date has been set. The regulations will be revised as necessary to remain in compliance with State and Federal law.

Regulatory Review Act

Under section 5(a) of the Regulatory Review Act (71 P. S. § 745.5(a)), on October 24, 2002, the Department submitted a copy of these final-form regulations to IRRC and to the Chairpersons of the House Committee on Health and Human Services and the Senate Committee on Public Health and Welfare for review and comment.

Under section 5(c) of the Regulatory Review Act, IRRC and the Committees were provided with copies of the comments received during the public comment period, as well as other documents when requested. In preparing this final-form rulemaking, the Department has considered the comments received from IRRC, the Committees and the public.

Under section 5.1(d) of the Regulatory Review Act (71 P. S. § 745.5a(d)), on November 13, 2002, this final-form rulemaking was deemed approved by the House and Senate Committees. Under section 5.1(e) of the Regulatory Review Act, IRRC met on November 21, 2002, and approved the final-form rulemaking.

Findings

The Department finds that:

(1) Public notice of proposed rulemaking was given under sections 201 and 202 of the act of July 31, 1968 (P. L. 769, No. 240) (45 P. S. §§ 1201 and 1202) and the regulations thereunder in 1 Pa. Code §§ 7.1 and 7.2.

(2) A public comment period was provided as required by law, and all comments were considered.

(3) The final-form rulemaking is necessary and appropriate for the administration of the act and the Public Welfare Code.

Order

Acting under the authority of section 201(2) of the Public Welfare Code and sections 105 and 302(a) of the act, the Department orders that:

(a) The regulations of the Department, 55 Pa. Code, are amended by adding §§ 4226.1—4226.6, 4226.11—4226.15, 4226.21—4226.36, 4226.51—4226.56, 4226.61, 4226.62, 4226.71—4226.77 and 4226.91—4226.103 and by deleting §§ 4225.1—4225.4, 4225.11—4225.15, 4225.21—4225.50, 4225.61—4225.64, 4225.71—4225.82, 4225.91—4225.99 and 4225.101—4225.106 to read as set forth in Annex A.

(b) The Secretary of the Department has submitted this order and Annex A to the Office of General Counsel and the Office of the Attorney General for review and approval as to legality and form as required by law. The Office of General Counsel and the Office of Attorney General have approved this order and Annex A as to legality and form.

(c) The Secretary of the Department shall certify this order and Annex A and deposit them with the Legislative Reference Bureau as required by law.

(d) This order takes effect on July, 1, 2003.

ESTELLE B. RICHMAN,
Acting Secretary

(*Editor's Note*: For the text of the order of the Independent Regulatory Review Commission, relating to this document, see 32 Pa.B. 6016 (December 7, 2002).)

Fiscal Note: Fiscal Note 14-452 remains valid for the final adoption of the subject regulations.

Annex A

TITLE 55. PUBLIC WELFARE

PART VI. MENTAL HEALTH/MENTAL RETARDATION MANUAL

Subpart C. ADMINISTRATION AND FISCAL MANAGEMENT

CHAPTER 4225. (Reserved)

§§ 4225.1—4225.4. (Reserved).

§§ 4225.11—4225.15. (Reserved).

§§ 4225.21—4225.50. (Reserved).

§§ 4225.61—4225.64. (Reserved).

§§ 4225.71—4225.82. (Reserved).

§§ 4225.91—4225.99. (Reserved).

§§ 4225.101—4225.106. (Reserved).

CHAPTER 4226. EARLY INTERVENTION SERVICES

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GENERAL PROVISIONS

§ 4226.1. Policy.

Early intervention services and supports are provided to families and infants and toddlers with disabilities and at-risk children to maximize the child's developmental potential. Service planning and delivery are founded on a partnership between families and early intervention personnel which is focused on meeting the unique needs of the child, addressing the concerns and priorities of each family and building on family and community resources.

§ 4226.2. Purpose.

This chapter establishes administrative, financial and eligibility requirements, standards for personnel and service delivery, and procedural protections for the Department's early intervention program.

§ 4226.3. Applicability.

This chapter applies to county MH/MR programs that provide early intervention services and to public and private service providers and agencies that contract with a county MH/MR program to provide early intervention services.

§ 4226.4. Penalties for noncompliance.

(a) The failure to comply with this chapter so that needs of at-risk children and infants and toddlers with disabilities are not being adequately met, shall subject the county MH/MR program to penalties consistent with section 512 of the Mental Health and Mental Retardation Act of 1966 (50 P. S. § 4512), including loss or delay of early intervention funding to the county MH/MR program.

(b) Appeals from Department action taken in accordance with subsection (a) shall be made by the county MH/MR program in accordance with 2 Pa.C.S. §§ 501—508 and 701—704 (relating to the Administrative Agency Law).

§ 4226.5. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Assessment—The ongoing procedures used throughout the period of a child's eligibility under this chapter to identify the following:

(i) The child's unique strengths and needs and the services appropriate to meet those needs.

(ii) The resources, priorities and concerns of the family and the supports and services necessary to enhance the family's capacity to meet the developmental needs of its child.

Assistive technology device—An item, piece of equipment or product system, whether acquired commercially off the shelf, modified or customized, that is used to

increase, maintain or improve the functional capabilities of infants and toddlers with disabilities.

Assistive technology service—A service that directly assists an infant or toddler with a disability or the infant or toddler's family in the selection, acquisition or use of an assistive technology device. The term includes:

(i) The evaluation of the needs of an infant or toddler with a disability, including a functional evaluation in the infant or toddler's customary environment.

(ii) Purchasing, leasing or otherwise providing for the acquisition of assistive technology devices by infants and toddlers with disabilities.

(iii) Selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing or replacing assistive technology devices.

(iv) Coordinating and using other therapies, interventions or services with assistive technology devices, such as those associated with existing education and rehabilitation plans and programs.

(v) Training or technical assistance for an infant or toddler with a disability or, if appropriate, that infant or toddler's family.

(vi) Training or technical assistance for professionals, including individuals providing early intervention services, or other individuals who provide services to or are otherwise substantially involved in the major life functions of infants and toddlers with disabilities.

At-risk child—An individual under 3 years of age:

(i) Whose birth weight is under 1,500 grams.

(ii) Who was cared for in a neonatal intensive care unit.

(iii) Who was born to a chemically dependent mother and referred by a physician, health care provider or parent.

(iv) Who is seriously abused or neglected, as substantiated and referred by the county children and youth agency under 23 Pa.C.S. Chapter 63 (relating to the Child Protective Services Law).

(v) Who has confirmed dangerous levels of lead poisoning as set by the Department of Health.

Audiology services—Includes the following:

(i) Identification of hearing loss, using audiological screening techniques.

(ii) Determination of the range, nature and degree of hearing loss and communication functions, by use of audiological evaluation procedures.

(iii) Referral for medical and other services necessary for the habilitation or rehabilitation of hearing loss.

(iv) Provision of auditory training, aural rehabilitation, speech reading and listening device orientation and training, and other services to address hearing loss.

(v) Provision of services for prevention of hearing loss.

(vi) Determination of the need for individual amplification, including selecting, fitting and dispensing appropriate listening and vibrotactile devices, and evaluating the effectiveness of those devices.

Child—An individual under 3 years of age.

County MH/MR program—An MH/MR program established by a county or two or more counties acting in concert which includes a complex array of services providing a continuum of care in the community for infants and toddlers with disabilities and at-risk children.

Culturally competent—Conducted or provided in a manner that shows awareness of and is responsive to the beliefs, interpersonal styles, attitudes, language and behavior of children and families who are referred for or receiving services.

Department—The Department of Public Welfare of the Commonwealth.

Early intervention services—Developmental services that meet the requirements of this chapter and:

(i) Are provided under public supervision.

(ii) Are provided at no cost to families.

(iii) Are designed to meet the developmental needs of an infant or toddler with a disability and the needs of the family related to enhancing the infant or toddler's development in one or more of the following areas:

(A) Physical development, including vision and hearing.

(B) Cognitive development.

(C) Communication development.

(D) Social or emotional development.

(E) Adaptive development.

(iv) Are provided in conformity with an IFSP.

(v) Include, but are not limited to, the following:

(A) Family training, counseling and home visits.

(B) Special instruction.

(C) Speech-language pathology services.

(D) Occupational therapy.

(E) Physical therapy.

(F) Psychological services.

(G) Service coordination.

(H) Medical services only for diagnostic or evaluation purposes.

(I) Early identification and assessment services.

(J) Health services necessary to enable an infant or toddler with a disability to benefit from other early intervention services.

(K) Social work services.

(L) Vision services.

(M) Assistive technology devices and assistive technology services.

(N) Transportation and related costs.

(O) Audiology services.

(P) Nursing services.

(Q) Nutrition services.

(vi) Are provided by qualified personnel, including, but not limited to, the following:

(A) Special educators.

(B) Speech-language pathologists.

(C) Occupational therapists.

(D) Physical therapists.

(E) Psychologists.

(F) Social workers.

(G) Nurses.

(H) Nutritionists.

(I) Family therapists.

(J) Orientation and mobility specialists.

(K) Pediatricians and other physicians.

(L) Early interventionists.

(M) Service coordinators.

(N) Audiologists.

Evaluation—Procedures used by qualified personnel to determine a child's initial and continuing eligibility for tracking or early intervention services.

Family training, counseling and home visits—Services provided by social workers, psychologists or other qualified personnel, as appropriate, to assist the family of an infant or toddler with a disability in understanding the special needs of and enhancing the development of the infant or toddler.

Health services—Services necessary to enable an infant or toddler with a disability to benefit from other early intervention services, while an infant or toddler is receiving another early intervention service.

(i) The term includes the following:

(A) Clean intermittent catheterization, tracheostomy care, tube feeding, the changing of dressings or colostomy collection bags.

(B) Consultation by physicians with other service providers concerning the special health care needs of an infant or toddler with a disability that will need to be addressed in the course of providing other early intervention services.

(ii) The term does not include the following:

(A) Services that are surgical in nature (such as cleft palate surgery, surgery for club foot or the shunting of hydrocephalus).

(B) Services that are purely medical in nature (such as hospitalization for management of congenital heart ailments, or the prescribing of medicine or drugs for any purpose).

(C) Devices necessary to control or treat a medical condition.

(D) Medical-health services (such as immunizations and regular "well-baby" care) that are routinely recommended for all children.

IFSP—Individualized family service plan—A written plan for providing early intervention services to an infant or toddler with a disability and the infant or toddler's family.

Infant or toddler with a disability—An individual under 3 years of age who needs early intervention services because the individual meets one or more of the eligibility criteria specified in § 4226.22(a) (relating to eligibility for early intervention services).

Location—The actual place or places where a service is or will be provided.

MH/MR—Mental health/mental retardation.

Medical services only for diagnostic or evaluation purposes—Services provided by a licensed physician to determine a child's developmental status and need for early intervention services.

Method—How a service is provided, including whether the service is given directly to the infant or toddler with a disability, with family or child care participation or without family or child care participation, or whether the service is provided as instruction to the family or caregiver.

Multidisciplinary—Involving two or more disciplines or professions in the provision of integrated and coordinated services, including evaluation and assessment activities and development of the IFSP.

Native language—The language or mode of communication normally used by the parent of a child. If the parent is deaf or blind, or has no written language, the mode of communication is that normally used by the parent (such as sign language, Braille or oral communication).

Natural environments—Settings that are natural or normal for a child's age peers who have no disabilities, including the home and community settings in which children without disabilities participate.

Nursing services—Includes the following:

(i) Assessing health status for the purpose of providing nursing care, including the identification of patterns of human response to actual or potential health problems.

(ii) Providing nursing care to prevent health problems, restore or improve functioning, and promote optimal health and development.

(iii) Administering medications, treatments and regimens prescribed by a licensed physician.

Nutrition services—Includes the following:

(i) Conducting individual assessments in the following:

(A) Nutritional history and dietary intake.

(B) Anthropometrical, biochemical and clinical variables.

(C) Feeding skills and feeding problems.

(D) Food habits and food preferences.

(ii) Developing and monitoring appropriate plans to address the nutritional needs of infants and toddlers with disabilities, based on the findings of the assessments in subparagraph (i).

(iii) Making referrals to appropriate community resources to carry out nutrition goals.

Occupational therapy—Services to address the functional needs of an infant or toddler with a disability related to adaptive development, adaptive behavior and play, and sensory, motor and postural development, which are designed to improve the functional ability of the infant or toddler to perform tasks in home, school and community settings, and include the following:

(i) Identification, assessment and intervention.

(ii) Adaptation of the environment, and selection, design, and fabrication of assistive and orthotic devices to facilitate development and promote the acquisition of functional skills.

(iii) Prevention or minimization of the impact of initial or future impairment, delay in development or loss of functional ability.

Parent—A natural or adoptive parent; a guardian; a legal custodian, excluding a county children and youth agency; a person acting as a parent of a child (such as a grandparent or stepparent with whom the child lives); or a surrogate parent, including a foster parent, appointed under § 4226.96 (relating to surrogate parents).

Personally identifiable information—Information that would make it possible to identify a particular child or family, including the following:

(i) The name of the child, the child's parent or other family member.

(ii) The address of the child or family.

(iii) A personal identifier, such as the child's or parent's Social Security number.

(iv) A list of personal characteristics or other information that would make it possible to identify the child or family with reasonable certainty.

Physical therapy—Services to address the promotion of sensorimotor function of an infant or toddler with a disability through enhancement of musculoskeletal status, neurobehavioral organization, perceptual and motor development, cardiopulmonary status and effective environmental adaptation, which include the following:

(i) Screening, evaluation and assessment to identify movement dysfunction.

(ii) Obtaining, interpreting and integrating information appropriate to program planning to prevent, alleviate or compensate for movement dysfunction and related functional problems.

(iii) Providing individual and group services or treatment to prevent, alleviate or compensate for movement dysfunction and related functional problems.

Psychological services—Includes the following:

(i) Administering psychological and developmental tests and other assessment procedures.

(ii) Interpreting assessment results.

(iii) Obtaining, integrating and interpreting information about child behavior, and child and family conditions related to learning, mental health and development.

(iv) Planning and managing a program of psychological services, including psychological counseling for infants and toddlers with disabilities and their parents, family counseling, consultation on child development, parent training and education programs.

Qualified—Meeting State-approved or State-recognized certification, licensing, registration or other comparable requirements that apply to the area in which the person is providing early intervention services.

Referral—Oral or written action by an individual to direct information about a child or the child's family to another individual or entity, requesting that the receiving individual or entity take action on behalf of the child and family.

Service coordination—Activities carried out by a service coordinator in accordance with § 4226.52 (relating to service coordination activities) to assist and enable a child and the child's family to benefit from the rights and procedural safeguards and to receive the services that are authorized under this chapter.

Social work—Includes the following:

(i) Making home visits to evaluate the living conditions of an infant or toddler with a disability and patterns of parent-child interaction.

(ii) Preparing a social or emotional developmental assessment of an infant or toddler with a disability within the family context.

(iii) Providing individual and family or group counseling to the parent and other family members of an infant or toddler with a disability, and appropriate social skill-building activities to the infant or toddler and the infant or toddler's parent.

(iv) Working to address those problems in the living situation of an infant or toddler with a disability and the infant or toddler's family (home, community, and any center where early intervention services are provided) that impede the maximum use of early intervention services.

(v) Identifying, mobilizing and coordinating community resources and services to enable an infant or toddler with a disability and the infant or toddler's family to receive maximum benefit from early intervention services.

Special instruction—Includes the following:

(i) Designing the learning environments and activities that promote the acquisition of skills by an infant or toddler with a disability in a variety of developmental areas, including cognitive processes and social interaction.

(ii) Curriculum planning, including the planned interaction of personnel, materials and time and space, that leads to achieving the outcomes on the IFSP.

(iii) Providing the family with information, skills and support related to enhancing the skill development of the infant or toddler with a disability.

(iv) Working with the infant or toddler with a disability and family to enhance the infant or toddler's development.

Speech-language pathology services—Includes the following:

(i) Identification of communicative or swallowing disorders and delays in development of communication skills, including the diagnosis and appraisal of specific disorders and delays in those skills.

(ii) Referral for medical or other professional services necessary for the habilitation or rehabilitation of communicative or swallowing disorders and delays in development of communication skills.

(iii) Provision of services for the habilitation, rehabilitation or prevention of communicative or swallowing disorders and delays in development of communication skills.

Tracking—A systematic process to monitor the development of at-risk children to determine whether they have become eligible for early intervention services under this chapter.

Transportation and related costs—Includes the expenses incurred in travel (such as mileage or travel by taxi, common carrier or other means or tolls and parking expenses) that are necessary to enable an infant or toddler with a disability and the infant or toddler's family to receive another early intervention service.

Vision services—Includes the following:

(i) Evaluation and assessment of visual functioning, including the diagnosis and appraisal of specific visual disorders, delays and abilities.

(ii) Referral for medical or other professional services necessary for the habilitation or rehabilitation of visual functioning disorders.

(iii) Communication skills training, orientation and mobility training for all environments, visual training, independent living skills training and additional training necessary to activate visual motor abilities.

§ 4226.6. Waiver of regulations.

(a) The Department may, upon application by a county MH/MR program and a showing of good cause as specified in subsection (b), waive specific requirements contained in this chapter if the waiver will not result in violation of another provision of Federal or State law and will not jeopardize receipt of Federal funding. A waiver may be granted only when the health, safety and well-being of infants and toddlers with disabilities and other children and their families and the quality of services is not adversely affected.

(b) The Department may waive one or more requirements of this chapter upon written request for a waiver from a county MH/MR program on a form prescribed by the Department, which includes:

(1) The specific regulatory sections for which a waiver is requested.

(2) A detailed description of the unusual or special circumstances that justify the waiver for the county MH/MR program.

(3) An explanation of how the county MH/MR program will ensure that the health, safety and well-being of infants and toddlers with disabilities and other children and their families will be protected if the waiver is granted.

(4) A description of how the county MH/MR program will meet the objective of the requirement in another way if the waiver is granted.

(c) A waiver granted under this section will be effective for a specified time period and may be revoked if the Department determines that the county MH/MR program has failed to comply with the conditions of the waiver.

(d) The purpose, applicability and definitions sections of this chapter may not be waived.

FINANCIAL MANAGEMENT

§ 4226.11. Financial administration.

Chapter 4300 (relating to county mental health and mental retardation fiscal manual) applies to the county MH/MR program for purposes of identifying allowable costs and for the general financial administration of early intervention services.

§ 4226.12. Medicaid waiver funds.

The county MH/MR program shall expend supplemental grant funds for the provision of early intervention services to infants and toddlers with disabilities and their families under the home and community waiver known as the Infant, Toddlers and Families Medicaid Waiver approved by the Department of Health and Human Services under section 1915(c) of the Social Security Act (42 U.S.C.A. § 1396n(c)) to the extent that eligible services and eligible infants and toddlers can be identified and the infants' and toddlers' parents consent to participate in the waiver.

§ 4226.13. Payor of last resort.

(a) Unless otherwise permitted or mandated by Federal law, State early intervention funds may not be used to satisfy a financial commitment for early intervention services if another public or private funding source is available to pay for the services.

(b) Unless otherwise permitted or mandated by Federal law, private insurance may be used with the consent of the parent to pay for early intervention services as long as such use will not result in a cost to the family, including but not limited to the following:

(1) A decrease in available lifetime coverage or any other benefit under an insurance policy.

(2) An increase in premiums or the discontinuation of the policy.

(3) An out-of-pocket expense such as the payment of a deductible amount in filing a claim.

(c) Services on the IFSP may not be denied or delayed because another public or private funding source, including Medicaid, is unavailable.

§ 4226.14. Documentation of other funding sources.

(a) The county MH/MR program shall develop and maintain a written policy that sets forth the procedures used to identify and exhaust all other public and private sources of funding for early intervention services, as required in § 4226.13 (relating to payor of last resort).

(b) The service coordinator shall maintain written documentation that attempts have been made to exhaust all other private and public funding sources available to an infant or toddler with a disability and the infant or toddler's family, as required by § 4226.13, in the infant or toddler's record, in accordance with § 4226.36(d) and (e) (relating to child records).

§ 4226.15. Interim payments.

(a) When necessary to prevent a delay in the receipt of early intervention services by an infant or toddler with a disability or the infant or toddler's family, State early intervention funds may be used to pay the provider of services pending reimbursement from the funding source that has ultimate responsibility for the payment.

(b) The county MH/MR program shall seek reimbursement from the responsible funding source to cover the interim payments made for early intervention services.

GENERAL REQUIREMENTS

§ 4226.21. Nondelegation of responsibilities.

(a) The county MH/MR program may contract with another agency for delivery of early intervention services under this chapter.

(b) If the county MH/MR program contracts with another agency as permitted in subsection (a), the county MH/MR program retains responsibility for compliance with the requirements of this chapter and shall ensure compliance by all agencies under contract to provide early intervention services.

§ 4226.22. Eligibility for early intervention services.

(a) The county MH/MR program shall ensure that early intervention services are provided to all children who meet one or more of the following eligibility criteria:

(1) A developmental delay, as measured by appropriate diagnostic instruments and procedures, of 25% of the child's chronological age in one or more of the developmental areas of cognitive development; physical development, including vision and hearing; communication development; social or emotional development; and adaptive development.

(2) A developmental delay in one or more of the developmental areas of cognitive development; physical development, including vision and hearing; communication development; social or emotional development; and adaptive development, as documented by test perfor-

mance of 1.5 standard deviations below the mean on accepted or recognized standard tests for infants and toddlers.

(3) A diagnosed physical or mental condition which has a high probability of resulting in a developmental delay as specified in paragraphs (1) and (2), including a physical or mental condition identified through an MDE, conducted in accordance with § 4226.61 (relating to MDE), that is not accompanied by delays in a developmental area at the time of diagnosis.

(b) In addition to the diagnostic tools and standard tests specified in subsection (a)(1) and (2), informed clinical opinion shall be used to establish eligibility, especially when there are no standardized measures or the standardized measures are not appropriate for a child's chronological age or developmental area. Informed clinical opinion makes use of qualitative and quantitative information to assist in forming a determination regarding difficult-to-measure aspects of current developmental status and the potential need for early intervention.

§ 4226.23. Eligibility for Medicaid waiver services.

(a) *Enrollment.* The county MH/MR program shall ensure that infants and toddlers with disabilities enrolled in the Infant, Toddlers and Families Medicaid Waiver meet the level of care criteria for an intermediate care facility/mental retardation (ICF/MR) or intermediate care facility/other related conditions (ICF/ORC) as set forth in subsection (b).

(b) Eligibility criteria for ICF/MR or ICF/ORC level of care.

(1) Minimum eligibility for ICF/MR or ICF/ORC level of care is established by one of the following:

(i) A licensed psychologist, certified school psychologist or licensed physician shall certify that the infant or toddler has significantly subaverage intellectual functioning which is documented by one of the following:

(A) Performance that is more than two standard deviations below the mean as measured on a standardized general intelligence test.

(B) Performance that is slightly higher than two standard deviations below the mean as measured on a standardized general intelligence test during a period when the infant or toddler manifests serious impairments of adaptive behavior.

(ii) A qualified professional who meets the criteria in 42 CFR 483.430(a) (relating to condition of participation: facility staffing), shall certify that the infant or toddler has other related conditions, which may include cerebral palsy and epilepsy as well as other conditions except mental illness, such as autism, that result in impairments of general intellectual functioning or adaptive behavior and require early intervention services.

(2) In addition to the certification required in paragraph (1), a qualified professional who meets the criteria in 42 CFR 483.430(a) shall certify that the infant or toddler has impairments in adaptive behavior, which are likely to continue for at least 12 months, as documented by an assessment of adaptive functioning which shows one of the following:

(i) Significant limitations in meeting the standards of maturation, learning, personal independence or social responsibility of the infant's or toddler's age and cultural group, as evidenced by a minimum of a 50% delay in one or a 33% delay in two of the following developmental areas:

(A) Cognitive development.

(B) Physical development, including vision and hearing.

(C) Communication development.

(D) Social and emotional development.

(E) Adaptive development.

(ii) Substantial functional limitation in three or more of the following areas of major life activities:

(A) Self-care.

(B) Receptive and expressive language.

(C) Learning.

(D) Mobility.

(E) Self-direction.

(F) Capacity for independent living.

(G) Economic self-sufficiency.

(c) *Financial eligibility.* The county MH/MR program shall cooperate with the county assistance office in determining the initial and continuing financial eligibility of an infant or toddler with a disability and the infant or toddler's family for waiver services.

§ 4226.24. Comprehensive child find system.

(a) The county MH/MR program shall develop a child find system that will ensure that:

(1) All at-risk children and infants and toddlers with disabilities in the geographical area of the county MH/MR program are identified, located and evaluated.

(2) An effective method is developed and implemented to determine which at-risk children and infants and toddlers with disabilities are receiving needed early intervention services, and which are not receiving those services.

(b) The county MH/MR program, with the assistance of the local interagency coordinating council, shall coordinate the child find system with all other major efforts to locate and identify at-risk children and infants and toddlers with disabilities, which include the following:

(1) The local preschool program authorized under Part B of the Individuals with Disabilities Education Act (IDEA) (20 U.S.C.A. §§ 1411—1419).

(2) Maternal and Child Health Programs authorized under Title V of the Social Security Act (42 U.S.C.A. §§ 701—709).

(3) The Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program under Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396—1396v).

(4) Programs authorized under the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C.A. §§ 15001—15083).

(5) Head Start Programs authorized under the Head Start Act (42 U.S.C.A. §§ 9831—9852).

(6) The Supplemental Security Income Program under Title XVI of the Social Security Act (42 U.S.C.A. §§ 1381—1383f).

(c) The county MH/MR program, with the assistance of the local interagency coordinating council, shall take steps to ensure that:

(1) There is not unnecessary duplication of effort by the various agencies involved in the local child find system.

(2) It coordinates and makes use of resources available through the local public agencies to implement the child find system in an effective manner.

(d) The child find system shall include procedures for use by primary referral sources for referring a child to the county MH/MR program for the following:

(1) Evaluation and assessment, in accordance with §§ 4226.61 and 4226.62 (relating to MDE; and nondiscriminatory procedures).

(2) As appropriate, the provision of services, in accordance with § 4226.72(a) or § 4226.76 (relating to procedures for IFSP development, review and evaluation; and provision of services before MDE is completed).

(e) The procedures required in subsection (a)(1) shall:

(1) Provide for an effective method of making referrals by primary referral sources.

(2) Ensure that referrals are made no more than 2 working days after a child has been identified, unless otherwise permitted or mandated by Federal law.

(f) The term "primary referral sources" in subsection (d) includes the following:

(1) Hospitals, including prenatal and postnatal care facilities.

(2) Physicians.

(3) Parents.

(4) Day care programs.

(5) Local educational agencies.

(6) Public health facilities.

(7) Other social service agencies.

(8) Other health care providers.

(g) Timelines to act on referrals are as follows:

(1) Once the county MH/MR program receives a referral, it shall appoint a service coordinator as soon as possible.

(2) Within 45 days after it receives a referral, the county MH/MR program shall do one of the following:

(i) Complete the evaluation activities in § 4226.61 and hold an IFSP meeting, in accordance with § 4226.72.

(ii) Complete the evaluation activities in § 4226.61 and develop a plan for further assessment and tracking.

§ 4226.25. At-risk children.

(a) A child identified as an at-risk child through the initial MDE conducted in accordance with § 4226.61 (relating to MDE) is eligible for tracking as specified in § 4226.26 (relating to tracking system).

(b) If a child is referred for an MDE to determine whether the child is an at-risk child and the family declines the MDE, with parental consent the child may be deemed eligible for tracking as specified in § 4226.26.

§ 4226.26. Tracking system.

(a) The county MH/MR program shall develop a system for tracking at-risk children.

(b) The tracking system shall include the following:

(1) Procedures for contacting the at-risk child and family by telephone, in writing or through a face-to-face meeting at least once every 3 months after the child is referred to the tracking system, unless an MDE conducted in accordance with § 4226.61 (relating to MDE) recommends and the parent agrees to more frequent contact. The parent may also request less frequent contact and may request no further contact.

(2) The use of a standardized developmental checklist as approved by the Department to review the child's development to determine the need for one of the following:

(i) Further tracking.

(ii) Further evaluation or reevaluation for eligibility for early intervention services.

(c) The county MH/MR program shall maintain written documentation of all contacts made through the tracking system in the child's record.

§ 4226.27. Monitoring responsibilities.

(a) The county MH/MR program shall be responsible for monitoring early intervention services, including service coordination, which the county MH/MR program provides directly or through contract, including services provided in another county or state.

(b) Monitoring shall include the measurement and assurance of compliance with this chapter and of the quality of services provided.

(c) The county MH/MR program shall conduct the monitoring required by this section on an ongoing basis but at least once every 12 months and maintain written documentation of the results of the monitoring for 4 years or until any audit or litigation is resolved.

§ 4226.28. Self-assessment reviews.

The county MH/MR program, in consultation with the local interagency coordinating council and the county MH/MR program advisory board, shall conduct an early intervention self-assessment review at least once every 3 years, including assessment of family satisfaction, using the tool provided by and adhering to the procedures established by the Department.

§ 4226.29. Preservice training.

(a) Early intervention personnel who work directly with at-risk children or infants and toddlers with disabilities, including personnel hired through contract, shall receive training before working alone with at-risk children or infants and toddlers with disabilities or their families in the following areas:

(1) Orientation to the early intervention service system of the Department, including the purpose and operation of the State and local interagency coordinating councils.

(2) The requirements of this chapter.

(3) The duties and responsibilities of their position.

(4) Methods for working with families utilizing family-centered approaches to encourage family involvement and consider family preferences.

(5) The interrelated social, emotional, health, developmental and educational needs of children.

(6) The availability and use of available local and State community resources.

(7) The principles and methods applied in the provision of services in the natural environment.

(8) The fiscal operations of the early intervention service system and the specific funding sources.

(9) Within 120 days of the date of hire, fire safety, emergency evacuation, first aid techniques and child cardiopulmonary resuscitation.

(b) Records of preservice training for all personnel shall be kept in the county MH/MR program's or provider's personnel files for as long as the individual is employed or under contract or for 4 years, whichever is longer, or until any audit or litigation is resolved.

§ 4226.30. Annual training.

(a) Early intervention personnel who work directly with at-risk children and infants and toddlers with disabilities, including personnel hired through contract, shall have at least 24 hours of training annually, in addition to any preservice training, relevant to early intervention services, child development, community resources or services for children with disabilities. Specific areas shall include cultural competence, mediation, procedural safeguards and universal health procedures.

(b) The training specified in § 4226.29(a)(9) (relating to preservice training) shall be renewed annually, unless there is a formal certification for first aid or cardiopulmonary resuscitation by a recognized health source that is valid for more than 1 year, in which case the time period specified on the certification applies.

(c) Records of all annual training shall be kept in the county MH/MR program's or provider's personnel files for as long as the person is employed or under contract or for 4 years, whichever is longer, or until any audit or litigation is resolved.

§ 4226.31. Child Protective Services Law.

County MH/MR programs and service providers and agencies that contract with county MH/MR programs to deliver early intervention services shall comply with the provisions of 23 Pa.C.S. Chapter 63 (relating to Child Protective Services Law) and regulations in Chapter 3490 (relating to protective services), regarding background clearances for all employees who will have direct contact with children.

§ 4226.32. Reporting and record retention.

(a) The county MH/MR program shall submit reports to the Department on a monthly, annual and periodic basis related to program operations, financial expenditures and disbursements, service delivery and demographic information, in the format and within the timelines as the Department may require.

(b) The Department will provide advance notice to the county MH/MR program of the specific reports to be submitted and the deadlines for submission.

(c) The county MH/MR program is responsible for keeping records and affording access to those records as the Department may find necessary to assure compliance with this chapter, the accuracy of reports or the proper disbursement of funds allocated under this chapter. Unless otherwise specified in this chapter for specific records, records shall be kept for 4 years or until any audit or litigation is resolved.

§ 4226.33. Traditionally underserved groups.

The county MH/MR program shall ensure that:

(1) Traditionally underserved groups, including minority, low-income and rural families, are provided the opportunity to be active participants in the local interagency coordinating councils and parent advisory groups and to participate in the development and implementation of the IFSPs for their infants and toddlers with disabilities.

(2) Families have access to culturally competent services within their local geographical areas.

§ 4226.34. Local interagency coordinating council.

The county MH/MR program shall ensure that:

(1) A local interagency coordinating council is established and maintained, which shall include parents and service providers and agencies.

(2) The local interagency coordinating council is authorized to advise and comment on the development of local interagency agreements.

(3) The local interagency coordinating council is authorized to communicate directly with the Department of Education, the Department of Health, the Department of Public Welfare and the State Interagency Coordinating Council regarding the local interagency agreement and any other matters pertaining to this chapter.

§ 4226.35. Confidentiality of information.

(a) The county MH/MR program shall ensure the protection of all personally identifiable information collected, used or maintained under this chapter.

(b) The county MH/MR program shall ensure that parents are informed of their rights to written notice of and written consent to the exchange of personally identifiable information among agencies in accordance with 34 CFR 300.560—300.576 (relating to confidentiality of information); 34 CFR Part 99 (relating to the family educational rights and privacy); and section 305(d) of the Early Intervention Services System Act (11 P. S. § 875-305(d)).

§ 4226.36. Child records.

(a) The county MH/MR program and every provider that contracts with a county MH/MR program to deliver early intervention services shall maintain a separate file for each child referred or accepted for tracking or early intervention services.

(b) Entries in a child's record shall be legible, dated and signed by the person making the entry.

(c) Each child's record shall contain, as applicable:

(1) Personally identifiable information.

(2) Intake information.

(3) Child evaluation and assessment information.

(4) IFSPs.

(5) Service support plans specifying the therapy services to be provided.

(6) Letters of medical necessity.

(7) Service coordination and service delivery activity logs.

(8) Health records.

(9) Notices issued under § 4226.95 (relating to prior notice).

(10) Other information, as specified in this chapter.

(d) Information in the child's record shall be kept for at least 4 four years or until any audit or litigation is resolved.

(e) A child's record shall be kept for a least 4 years following the child's discharge from service or until any audit or litigation is resolved.

PERSONNEL

§ 4226.51. Provision of service coordination.

(a) As soon as possible after the referral of a child and family to determine eligibility for early intervention services, the county MH/MR program, either directly or through contract, shall assign a service coordinator to the family.

(b) Each child and the child's family shall be provided with one service coordinator who is responsible for serving as the single point of contact in helping the parent to obtain the services and assistance needed and for the activities specified in § 4226.52 (relating to service coordination activities).

§ 4226.52. Service coordination activities.

Service coordination is an active, ongoing process that includes the following activities:

(1) Coordinating the performance of initial and ongoing evaluations and assessments.

(2) Referring at-risk children to the tracking system and tracking at-risk children.

(3) Facilitating and participating in the development, implementation, review and evaluation of IFSPs.

(4) Assisting the family of an infant or toddler with a disability in gaining access to the early intervention services and other services identified on the IFSP.

(5) Facilitating the timely delivery of early intervention services.

(6) Assisting the family in identifying available service providers and facilitating communication with and between the family and the service provider.

(7) Coordinating and monitoring the delivery of early intervention services.

(8) Informing the family of the availability of advocacy services.

(9) Assisting the family in arranging for the infant or toddler with a disability to receive medical and health services, if the services are necessary, and coordinating the provision of early intervention services and other services (such as medical services for other than diagnostic and evaluation purposes) that the infant or toddler needs or is being provided.

(10) Offering the family opportunities and support for the infant or toddler with a disability to participate in community activities with other children.

(11) Informing the family of appropriate community resources.

(12) Facilitating the development of a transition plan as part of the IFSP.

§ 4226.53. Service coordinator requirements and qualifications.

(a) A county MH/MR program shall employ a minimum of one service coordinator directly or through contract.

(b) Before performing service coordination activities, a service coordinator shall demonstrate knowledge and understanding about the following:

(1) At-risk children and infants and toddlers with disabilities.

(2) Part C of IDEA (20 U.S.C.A. §§ 1431—1445) and accompanying regulations (currently codified at 34 CFR Chapter 303 (relating to early intervention program for infants and toddlers with disabilities)), and the Early Intervention Services System Act (11 P. S. §§ 875-101—875-503).

(3) The nature and scope of services available under this chapter and the funding sources available.

(c) A service coordinator shall have one of the following groups of minimum qualifications:

(1) A bachelor's degree from an accredited college or university which includes 12 college credits in early intervention, early childhood special education, early childhood education, child development, special education, family counseling, family studies, social welfare, psychology or other comparable social sciences, and 1 year of full-time or full-time-equivalent experience working with or providing counseling to children, families or individuals with disabilities.

(2) An associate's degree, or 60 credit hours, from an accredited college or university in early intervention, early childhood special education, early childhood education, child development, special education, family counseling, family studies, social welfare, psychology, or other comparable social sciences, and 3 years of full-time or full-time-equivalent experience working with or providing counseling to children, families or individuals with disabilities.

(3) Certification by the Pennsylvania Civil Service Commission as meeting the qualifications of a Caseworker 2 or 3 classification.

§ 4226.54. Early interventionist responsibilities.

An early interventionist is responsible for the following:

(1) Designing the learning environments and activities that promote the acquisition of skills by an infant or toddler with a disability in a variety of developmental areas, including cognitive processes and social interaction.

(2) Providing the family with information, skills and support related to enhancing the skill development of the infant or toddler with a disability.

(3) Working with the infant or toddler with a disability and family to enhance the infant or toddler's development.

§ 4226.55. Early interventionist qualifications.

An early interventionist shall have one of the following groups of minimum qualifications:

(1) A bachelor's degree from an accredited college or university in early intervention, early childhood special education, early childhood education, child development, special education or family studies, and 1 year of full-time or full-time-equivalent experience working directly with preschool children with disabilities and their families or a university-supervised or college-supervised student practicum or teaching experience with young children with disabilities and their families.

(2) A bachelor's degree from an accredited college or university which includes 15 credit hours in early intervention, early childhood special education, early childhood education, child development, special education or family studies; and 1 year of full-time or full-time-equivalent experience working directly with preschool children with disabilities and their families; and demonstrated knowledge, understanding and skills needed to perform the functions specified in § 4226.54 (relating to early interventionist responsibilities).

§ 4226.56. Effective date of personnel qualifications.

Sections 4226.53 and 4226.55 (relating to service coordinator requirements and qualifications; and early interventionist qualifications) apply to service coordinators and early interventionists hired or promoted on and after July 1, 2003.

EVALUATION AND ASSESSMENT

§ 4226.61. MDE.

(a) *Requirements for MDE.* The county MH/MR program shall ensure that:

(1) Each child referred for evaluation receives a timely, comprehensive MDE and a family-directed assessment of the needs of the child's family to assist in the development of the child.

(2) The initial MDE is conducted by personnel independent of service provision.

(3) An MDE is conducted for each infant or toddler with a disability at least annually.

(4) A written MDE report is provided to the parent within 30 calendar days of the MDE.

(b) *Evaluation and assessment of the child.*

(1) The evaluation and assessment of each referred child shall:

(i) Be conducted by personnel trained to utilize evaluation and assessment methods and procedures.

(ii) Be based on informed clinical opinion.

(iii) Include the following:

(A) A review of pertinent records related to the child's current health status and medical history.

(B) An evaluation of the child's level of functioning in each of the developmental areas of cognitive development; physical development, including vision and hearing; communication development; social and emotional development; and adaptive development.

(C) An assessment of the unique needs of the child in terms of each of the developmental areas in clause (B), including the identification of services appropriate to meet those needs.

(2) The annual MDE will include the participation of the family, the service coordinator, anyone whom the parent would like to invite and at least one other qualified professional.

(3) The MDE required by this subsection may be based on review and analysis of existing documentation of medical history, if the parent agrees and the qualified professionals in exercising their judgment conclude that the elements specified in paragraph (1) can be determined through such review and analysis.

(c) *Family assessment.*

(1) The family assessment shall be family directed and designed to determine the resources, priorities and concerns of the family and to identify the supports and services necessary to enhance the family's capacity to meet the developmental needs of the child.

(2) A family assessment shall be voluntary on the part of the family.

(3) If a family assessment is carried out, the assessment shall:

(i) Be conducted by personnel trained to utilize assessment methods and procedures.

(ii) Be based on information provided by the family through a personal interview.

(iii) Incorporate the family's description of its resources, priorities and concerns related to enhancing the child's development.

(d) *Timelines.*

(1) Except as provided in paragraph (2), the initial MDE of each child (including the family assessment) shall be completed within sufficient time to enable an IFSP to be developed within the 45-day time period in § 4226.24(g) (relating to comprehensive child find system).

(2) The county MH/MR program shall develop procedures to ensure that if exceptional circumstances make it impossible to complete the initial MDE, including the family assessment, within the timeline specified in paragraph (1) (for example, if a child is ill), the county MH/MR program will do the following:

(i) Document those circumstances in the child's record.

(ii) Develop and implement an interim IFSP consistent with § 4226.76 (relating to provision of services before MDE is completed).

§ 4226.62. Nondiscriminatory procedures.

Each county MH/MR program shall adopt nondiscriminatory procedures for the evaluation and assessment of children and families that ensure, at a minimum, that:

(1) Tests and other evaluation materials and procedures are administered in the native language of the parent, unless it is clearly not feasible to do so.

(2) Assessment and evaluation procedures and materials are selected and administered so as not to be racially or culturally discriminatory.

(3) No single procedure is used as the sole criterion for determining a child's eligibility under this chapter.

(4) Evaluations and assessments are conducted by qualified personnel.

IFSPs

§ 4226.71. General.

(a) Each county MH/MR program shall adopt policies and procedures regarding IFSPs.

(b) The IFSP shall:

(1) Be developed in accordance with §§ 4226.72 and 4226.73 (relating to procedures for IFSP development, review and evaluation; and participants in IFSP meetings and periodic reviews).

(2) Be based on the evaluation and assessment described in § 4226.61 (relating to MDE).

(3) Include the matters specified in § 4226.74 (relating to content of the IFSP).

(4) Be developed prior to funding source decisions.

(c) The county MH/MR program shall ensure that an IFSP is developed and implemented for each infant or toddler with a disability.

§ 4226.72. Procedures for IFSP development, review and evaluation.

(a) For a child who has been evaluated for the first time and determined to be eligible for early intervention services, a meeting to develop the initial IFSP shall be conducted within the 45-day time period in § 4226.24(g) (relating to comprehensive child find system).

(b) A review of the IFSP for an infant or toddler with a disability and the infant or toddler's family shall be conducted every 6 months, or more frequently if conditions warrant or if the family requests such a review. The review may be conducted by a meeting or by another means, such as conference call or written reports, that is

acceptable to the parent and other participants. The purpose of the review is to determine:

(1) The degree to which progress toward achieving the outcomes is being made.

(2) Whether modification or revision of the outcomes or services is necessary.

(c) A meeting shall be conducted at least annually to evaluate the IFSP for an infant or toddler with a disability and the infant or toddler's family and, as appropriate, to revise its provisions. The results of current evaluations conducted under § 4226.61 (relating to MDE), and other information available from the ongoing assessment of the infant or toddler and family, shall be used in determining what services are needed and will be provided.

(d) IFSP meetings shall be conducted as follows:

(1) In settings and at times that are convenient to the family.

(2) In the native language of the parent, unless it is clearly not feasible to do so.

(3) In a manner that ensures that the early intervention services to be provided to an infant or toddler with a disability are selected in collaboration with the parent.

(e) IFSP meeting arrangements shall be made with and written notice provided to, the family and other participants early enough before the meeting date to ensure that they will be able to attend, but no later than 5 days before the scheduled meeting date.

§ 4226.73. Participants in IFSP meetings and periodic reviews.

(a) Each initial meeting and each annual meeting to evaluate the IFSP shall include the following participants:

(1) The parent of the infant or toddler with a disability.

(2) Other family members, as requested by the parent, if feasible to do so.

(3) An advocate or person outside of the family, if the parent requests that the person participate.

(4) The service coordinator who has been working with the family since the initial referral for evaluation, or who has been designated by the county MH/MR program to be responsible for implementation of the IFSP.

(5) A person directly involved in conducting the evaluations and assessments in § 4226.61 (relating to MDE).

(6) Persons who will be providing services to the infant or toddler with a disability or family, as appropriate.

(b) If a person listed in subsection (a)(5) is unable to attend a meeting, arrangements shall be made for the person's involvement through another means, including one or more of the following:

(1) Participating in a telephone conference call.

(2) Having a knowledgeable authorized representative attend the meeting.

(3) Making pertinent records available at the meeting.

(c) Each periodic review shall include the participation of persons listed in subsection (a)(1)—(4). If conditions warrant, provisions shall be made for the participation of other representatives identified in subsection (a).

§ 4226.74. Content of the IFSP.

The IFSP shall be in writing and the standardized format will contain:

(1) *Information about the status of the infant or toddler with a disability.*

(i) A statement of the present levels of physical development (including vision, hearing and health status), cognitive development, communication development, social or emotional development, and adaptive development of the infant or toddler with a disability.

(ii) The statement in subparagraph (i) shall be based on professionally acceptable objective criteria.

(2) *Family information.* With the concurrence of the family, a statement of the family's resources, priorities and concerns related to enhancing the development of the infant or toddler with a disability.

(3) *Outcomes.* A statement of the major outcomes expected to be achieved for the infant or toddler with a disability and the family, and the criteria, procedures and timelines used to determine:

(i) The degree to which progress toward achieving the outcomes is being made.

(ii) Whether modification or revision of the outcomes or services is necessary.

(4) *Early intervention services.*

(i) A statement of the specific early intervention services necessary to meet the unique needs of the infant or toddler with a disability and the family to achieve the outcomes required in paragraph (3), including:

(A) The frequency, intensity and method of delivering the services.

(B) The natural environments in which early intervention services will be provided and, if a service will be provided in a location other than a natural environment, a justification of the extent to which each service will not be provided in a natural environment and the location in which it will be provided.

(C) The payment arrangements, if any.

(D) The unit cost for each service.

(ii) As used in this section, "frequency" and "intensity" are the number of days or sessions that a service will be provided, the length of time the service is provided during each session, and whether the service is provided on an individual or a group basis.

(5) *Other services.*

(i) A statement of medical and other services that the infant or toddler with a disability needs but that are not required under this chapter and of the funding sources to be used to pay for those services, or the steps that will be taken to secure those services through public or private sources.

(ii) The requirement in subparagraph (i) does not apply to routine medical services (for example, immunizations and "well-baby" care), unless the infant or toddler with a disability needs those services and the services are not otherwise available or being provided.

(6) *Dates; duration of services.*

(i) The projected dates for initiation of early intervention services in paragraph (4), which shall be as specified in § 4226.75(b) (relating to implementation of the IFSP).

(ii) If an early intervention service is projected to start later than 14 days after the IFSP is completed as permitted by § 4226.75(b), the date and the reasons for the later date.

(iii) The anticipated duration of early intervention services.

(7) *Service coordinator.* The identity of the service coordinator who will be responsible for the implementation of the IFSP and coordination with other agencies and persons.

(8) *Transition from early intervention services.* A statement of the steps to be taken to support the transition of the toddler with a disability to preschool services under Part B of IDEA (20 U.S.C.A. §§ 1411—1419) or other appropriate services, which shall include at least the activities specified in § 4226.77 (relating to transition from early intervention services).

§ 4226.75. Implementation of the IFSP.

(a) To the maximum extent appropriate to meet the needs of the infant or toddler with a disability, as determined by the IFSP team, early intervention services shall be provided in the infant or toddler's natural environments.

(b) Early intervention services shall be initiated as soon as possible after the IFSP is completed at the meeting described in § 4226.72 (relating to procedures for IFSP development, review and evaluation) but no later than 14 calendar days from the date the IFSP is completed, unless a later date is recommended by the team, including the family, based on the needs of the infant or toddler with a disability, or if requested by the family.

§ 4226.76. Provision of services before MDE is completed.

Early intervention services for an infant or toddler with a disability and the infant or toddler's family may commence before the completion of the evaluation and assessment in § 4226.61 (relating to MDE), if the following conditions are met:

(1) Parental consent is obtained.

(2) An interim IFSP is developed that includes the following:

(i) The name of the service coordinator who will be responsible for implementation of the interim IFSP and coordination with other agencies and persons.

(ii) The early intervention services that have been determined to be needed immediately by the infant or toddler with a disability and the infant or toddler's family.

(3) The evaluation and assessment are completed within the time period specified in § 4226.61(d)(1), unless exceptional circumstances exist as set forth in § 4226.61(d)(2).

§ 4226.77. Transition from early intervention services.

(a) The county MH/MR program shall adopt policies and procedures to ensure a smooth transition for toddlers receiving early intervention services to preschool or other appropriate services, which meet the requirements of this section.

(b) For every toddler with a disability, the county MH/MR program shall:

(1) Notify the local educational agency for the area in which the toddler resides that the toddler will shortly reach 3 years of age.

(2) In the case of a toddler who may be eligible for preschool services under Part B of IDEA (20 U.S.C.A. §§ 1411—1419), with the approval of the toddler's family, convene a conference among the county MH/MR program, the family and the local educational agency at least 90 days (and if all parties agree, up to 6 months) before the toddler's third birthday, to discuss services that the toddler may receive.

(3) In the case of a toddler who may not be eligible for preschool services under Part B of IDEA, with the approval of the toddler's family, make reasonable efforts to convene a conference among the county MH/MR program, the family and providers of other appropriate services for toddlers who are not eligible for preschool services under Part B of IDEA, to discuss appropriate services the toddler may receive.

(4) If a toddler's third birthday occurs during the school year, review the program options available to the toddler for the period from the third birthday through the remainder of the school year.

(5) Establish a transition plan in consultation with the toddler's family.

(c) The IFSP team of every toddler with a disability shall take steps to ensure the toddler's smooth transition from early intervention services, which shall include at least the following:

(1) Discussions with, and training of, the toddler's parent regarding future placements and other matters related to the toddler's transition.

(2) Preparation of the toddler for changes in service delivery, including activities to help the toddler adjust to, and function in, a new setting.

(3) With parental consent, transmission of information about the toddler, including evaluation and assessment information and copies of the toddler's IFSPs, to the local educational agency, to ensure continuity of services.

(d) The county MH/MR program shall develop interagency agreements with the local educational agency responsible for providing preschool programs under Part B of IDEA, to ensure coordination on transition matters.

PROCEDURAL SAFEGUARDS

§ 4226.91. General responsibility for procedural safeguards.

A county MH/MR program is responsible for adopting procedural safeguards that meet the requirements of this chapter, except §§ 4226.101 and 4226.102 (relating to impartial hearing officer; and convenience of proceedings; timelines).

§ 4226.92. Parental consent.

(a) The following requirements apply for parental consent:

(1) The parent shall be fully informed of all information relevant to the activity for which consent is sought, in the parent's native language.

(2) The parent shall be informed and agree in writing to the carrying out of the activity for which consent is sought, and the consent form shall describe that activity and list the records (if any) that will be released and to whom.

(3) The parent shall be informed that the granting of consent is voluntary on the part of the parent and may be revoked at any time.

(b) Written parental consent shall be obtained before:

(1) Conducting the initial evaluation and assessment under § 4226.61 (relating to MDE).

(2) Referring an at-risk child to the tracking system under § 4226.26 (relating to tracking system).

(3) Determining eligibility for Medicaid waiver services in accordance with § 4226.23 (relating to eligibility for Medicaid waiver services).

(4) Initiating or changing early intervention services.

(c) Before an early intervention service is provided or changed, the contents of the IFSP shall be fully explained to the parent. If the parent does not consent to the delivery of a particular early intervention service or withdraws consent after first providing it, that service may not be provided. Those early intervention services to which the parent consented shall be provided. If the parent does not consent to a proposed change that reduces or terminates early intervention services, the requirements of § 4226.103 (relating to status of a child during proceedings) apply.

(d) If the parent does not consent, the county MH/MR program shall make reasonable efforts to ensure that the parent:

(1) Is fully aware of the nature of the evaluation and assessment or the services that would be available.

(2) Understands that the child will not be able to receive the evaluation and assessment or services unless consent is given.

§ 4226.93. Parental right to decline service.

(a) The parent of an infant or toddler with a disability may determine whether to accept or decline any early intervention service offered to the infant or toddler or the family and may decline a service after first accepting it, without jeopardizing the provision of other early intervention services.

(b) The parent of an at-risk child may accept or decline referral of the child to the tracking system under § 4226.26 (relating to tracking system) without jeopardizing the referral at a later time.

§ 4226.94. Opportunity to examine records.

In accordance with the confidentiality procedures in Federal regulations in 34 CFR 300.560—300.576 (relating to confidentiality of information), the parent of a child referred or eligible for tracking or early intervention services shall be afforded the opportunity to inspect and review records relating to evaluations and assessments, eligibility determinations, development and implementation of IFSPs, individual complaints dealing with the child and any other records about the child and the family.

§ 4226.95. Prior notice.

(a) Written prior notice shall be given to the parent of a child referred or eligible for tracking or early intervention services before a county MH/MR program proposes, or refuses, to initiate or change the identification, evaluation or placement of the child, or the provision of early intervention services to the child and the family.

(b) The notice shall be in sufficient detail to inform the parent about the following:

(1) The action that is being proposed or refused.

(2) The reasons for taking the action.

(3) The right to request one or all of the following, including a description of the procedures and rights that apply to each:

(i) Conflict resolution, as described in § 4226.97 (relating to conflict resolution).

(ii) Mediation, as described in § 4226.98 (relating to mediation).

(iii) A due process hearing, as described in § 4226.99 (relating to due process procedures).

(4) The right to file a complaint with the Department, including a description of how to file a complaint and timelines for filing the complaint.

(c) The notice shall be:

(1) Written in language understandable to the general public.

(2) Provided in the native language of the parent, unless it is clearly not feasible to do so.

(d) If the native language of the parent is not a written language, the county MH/MR program shall take steps to ensure that:

(1) The notice is translated orally or by other means to the parent in the parent's native language.

(2) The parent understands the notice.

(3) Written evidence that the requirements of this subsection have been met is maintained in the child's record.

§ 4226.96. Surrogate parents.

(a) Each county MH/MR program shall ensure that the rights of a child referred or eligible for tracking or early intervention services are protected by the appointment of a surrogate parent if one of the following applies:

(1) A parent cannot be identified.

(2) The whereabouts of an identified parent, after reasonable efforts, cannot be discovered.

(3) The child is in the legal custody of a county children and youth agency and one of the following applies:

(i) The birth parents cannot be identified.

(ii) The whereabouts of the birth parents, after reasonable efforts, cannot be discovered.

(iii) The birth parents are deceased and the child has no other parent.

(iv) The parental rights of the birth parents have been terminated and the child has no other parent.

(b) The duty of the county MH/MR program under subsection (a) includes establishing procedures for determining whether the child needs a surrogate parent and assigning a surrogate parent to the child.

(c) In complying with subsection (b), the county MH/MR program shall select a surrogate parent who:

(1) Has no interest that conflicts with the interests of the child the surrogate represents.

(2) Has knowledge and skills that ensure adequate representation of the child.

(3) Is willing to assume the responsibilities of being a surrogate parent.

(4) Is not an employee of an agency or persons providing early intervention services or other services to the child or to any family members of the child.

(5) Is not an employee of any State agency.

(d) A person who otherwise qualifies to be a surrogate parent under subsection (c) is not an employee solely because the surrogate is paid by a public agency to serve as a surrogate parent.

(e) The foster parent of a child in substitute care, who meets the criteria in subsection (c), may serve as a surrogate parent for the child with the approval of the county children and youth agency that has legal custody of the child.

(f) A surrogate parent may represent a child in all matters related to the following:

(1) The evaluation and assessment of the child.

(2) The development and implementation of the child's IFSPs, including annual evaluation and periodic review meetings.

(3) The ongoing provision of early intervention services to the child.

(4) Other rights established under this chapter.

§ 4226.97. Conflict resolution.

(a) The county MH/MR program shall establish a system of conflict resolution whereby parents, providers, as appropriate, or other parties may request a meeting with the county administrative staff to discuss and resolve issues relating to the provision of early intervention services to an infant or toddler with a disability and the infant or toddler's family.

(b) The county MH/MR program shall establish conflict resolution procedures to ensure that:

(1) Requests for conflict resolution may be made either orally or in writing.

(2) A conflict resolution meeting shall be held within 7 calendar days of the request.

(3) When a parent requests mediation under § 4226.98 (relating to mediation) or a due process hearing under § 4226.99 (relating to due process procedures), the county MH/MR program shall offer the parent a conflict resolution meeting with the county MH/MR administrator or a designee, and the meeting shall be held within 7 calendar days of receipt of the request, unless the parent declines the offer of conflict resolution. If the parent agrees to participate, the meeting may not delay the processing of the request for mediation or for a due process hearing.

(4) When a resolution or agreement is reached at the meeting, the IFSP or other documents shall be revised accordingly.

(5) If no resolution or agreement is reached at the meeting, all other procedural safeguards continue to be available.

(6) The conflict resolution process does not impede or deny other rights under this chapter.

(7) The conflict resolution process is voluntary on the part of the parents, and parents do not have to participate in the process before exercising other procedural rights.

§ 4226.98. Mediation.

(a) The county MH/MR program shall adopt procedures that afford a party who presents a complaint about any matter relating to the identification, evaluation or placement of the child, or the provision of appropriate early intervention services, the opportunity to resolve the dispute through a mediation process.

(b) The procedures shall ensure that the mediation process is:

(1) Voluntary on the part of the parents.

(2) Offered to a parent who requests a due process hearing under § 4226.99 (relating to due process procedures).

(3) Not used to deny or delay a parent's right to a due process hearing under § 4226.99, or to deny or impede other rights afforded under this chapter.

(4) Conducted by a qualified and impartial mediator who is trained in effective mediation techniques.

(c) The mediation session shall be scheduled within 10 calendar days of the request for mediation or a due process hearing and shall be held in a location that is convenient to the parties to the dispute.

(d) An agreement reached by the parties to the dispute in the mediation session shall be set forth in a written mediation agreement.

(e) Discussions that occur during the mediation session shall be confidential and may not be used as evidence in any subsequent due process hearings or civil proceedings, and the parties to the mediation may be required to sign a confidentiality pledge before the session begins.

(f) The county MH/MR program shall establish procedures to encourage the use and explain the benefits of the mediation process, whereby a parent who chooses not to use the mediation process may request a meeting, at a time and location convenient to the parent, with a disinterested party or one of the following:

(1) A parent training and information center or community parent resource center.

(2) An alternative dispute resolution entity.

§ 4226.99. Due process procedures.

Each county MH/MR program shall implement procedures to ensure that the resolution of requests for due process hearings by parents concerning any of the matters in § 4226.95(a) (relating to prior notice) on behalf of an individual child is not delayed.

§ 4226.100. Parental rights in due process hearings.

(a) Each county MH/MR program shall ensure that the parents of children referred or eligible for tracking or early intervention services are informed of the rights in subsection (b) in each due process hearing requested to resolve any of the matters in § 4226.95(a) (relating to prior notice) on behalf of an individual child.

(b) A parent who is a party to a due process hearing has the following rights:

(1) To obtain an independent MDE conducted in accordance with § 4226.61 (relating to MDE) at no cost if the parent disagrees with the results of the MDE obtained through the county MH/MR program and the hearing officer determines that the MDE is needed to assist in the resolution of the dispute.

(2) To be accompanied and advised by counsel and by individuals with special knowledge or training with respect to early intervention services.

(3) To present evidence and confront, cross-examine and compel the attendance of witnesses.

(4) To prohibit the introduction of any evidence at the proceeding that has not been disclosed to the parent at least 5 days before the proceeding.

(5) To obtain a written or electronic verbatim transcription of the proceeding.

(6) To obtain written findings of fact and decisions.

§ 4226.101. Impartial hearing officer.

(a) The impartial hearing officer appointed to conduct the due process hearing shall have knowledge of the requirements of this chapter, the Early Intervention Services System Act (11 P. S. §§ 875-101—875-503) and Part C of IDEA (42 U.S.C.A. §§ 1431—1445) and accompanying regulations (currently codified in 34 CFR Part 303 (relating to early intervention program for infants and toddlers with disabilities)), as well as the needs of, and services available for, at-risk children and infants and toddlers with disabilities and their families.

(b) The duties of the impartial hearing officer include:

(1) To preside over the presentation of evidence and each party's position, examine all presented evidence and render a timely decision.

(2) To make available a record of the proceedings.

(3) To forward a written decision to all parties to the proceedings.

(c) As used in this section, "impartial" means that the appointed hearing officer:

(1) Is not an employee of an agency or other entity involved in the provision of early intervention services to or care of the child who is the subject of the hearing.

(2) Does not have a personal or professional interest that would conflict with the hearing officer's objectivity in conducting the hearing and rendering a decision.

(d) A person who otherwise qualifies under this section is not an employee of an agency solely because the person is paid to conduct the due process hearing.

§ 4226.102. Convenience of proceedings; timelines.

(a) The due process hearing shall be carried out at a time and place that is reasonably convenient to the parent.

(b) The due process hearing shall be conducted and a written decision mailed to each party no later than 30 days after the parent's request for a hearing is received by the county MH/MR program.

§ 4226.103. Status of a child during proceedings.

(a) During the pendency of a conflict resolution, mediation or due process proceeding, unless the county MH/MR program and parent of the infant or toddler with a disability otherwise agree, the infant or toddler shall continue to receive the early intervention services currently being provided.

(b) If the complaint involves an application for initial services under this chapter, the infant or toddler with a disability shall receive those services that are not in dispute.

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