Presented is the Illinois Regional Resource Center’s Manual for Diagnostic Teachers which is designed to provide a model for assessment, individualized educational planning, optimal placement, and short and long range follow-up of children (3-21 years old) with unexplained learning problems. Section 1 provides an introduction to the Illinois Regional Resource Center Diagnostic Teaching Model (IRDTM) with sections on the model’s purpose, target population, and 11 features of the IRDTM (such as the emphasis on diagnosis rather than remediation; the delivery of both on-site and in-classroom services; and a holistic approach which covers the motor, sensory-perceptual, academic, speech/language, social-emotional, and self-help domains). Section 2 makes up the bulk of the document with flow charts on the five phases of the model--initial information gathering, on-site or in-classroom diagnosis, program development and testing, transition, and follow-up. Among the exhibits presented in section 3 are samples of a referral form; follow-up form; case contact records; formal and informal test score worksheets; teacher, parent, and child follow-up records; informal and formal evaluation data summaries, and federal reporting form. A hypothetical case study for the IRDTM is given in section 4 which provides examples of the written materials produced by the diagnostic team during the diagnostic, program development, and testing phases. Among appended materials in a final section are regional resource center job descriptions; suggested qualifications for diagnostic teachers; a list of consultants available to the regional resource center team; and bibliographies of diagnostic tests, instructional materials and equipment, and behavioral checklists. (SBH)
The Illinois Regional Resource Center

MANUAL FOR DIAGNOSTIC TEACHERS

Prepared in cooperation with the
Regional Resource Center #7
School District 150, Peoria, Illinois

by

Validated Instruction Associates, Inc.

with

technical assistance from
Illinois State University

Primary Author: Kirsten Preston-Hinsdale, VIA, Inc.
Co-authors: James W. Cook, VIA, Inc.
Lanny Morreau, ISU
Paula Smith, ISU
J. Zink, VIA, Inc.

Director, Regional Resource Center #7: Harold Berjohn
Assistant Director, Regional Resource Center #7: Dea Baker

August, 1976
PREFACE TO DIAGNOSTIC TEACHERS

In recent years, state and federal legislation has reflected the increasing public concern for providing handicapped children with high-quality, comprehensive services. Local agencies and institutions, too, have addressed the problems of exceptional children, often developing cooperative efforts at the district and regional levels to provide classroom support services and to serve comprehensively children with unusual educational needs.

While these programs have proved highly successful in helping many children, they also have drawn the focus of attention to a group of children whose needs heretofore have been met inadequately. These are children with rare or unexplained learning disabilities—children for whom learning diagnosis and prescription at local and regional facilities, if available at all, has proved ineffective and who thus continue to display a bewildering and frustrating variety of physical, psychological, behavioral, emotional, and educational handicaps.

THE ILLINOIS REGIONAL RESOURCE CENTER'S DIAGNOSTIC TEACHING MODEL AND ITS REPPLICATION

To assist such children, the Bureau of Education for the Handicapped established and funded 13 Regional Resource Centers, of which RRC #7 in Peoria is one.

The mandate of RRC #7 provides for establishing and field testing a prototypical diagnostic and prescriptive program for children with rare and unexplained learning problems and for installing that program throughout the State of Illinois in a replication effort.

This replication effort is now in complete operation.

From each of your districts the regional directors or their representatives already have been involved in the process. They have attended a series of workshops which have acquainted them in general with the procedures you will learn here in detail, and have been provided the information necessary to enlist the support of their regional boards and other constituencies.

You were chosen to represent your region at this workshop because of your level of professional expertise and your commitment to special education.

WORKSHOP OBJECTIVES

Upon completion of this workshop, participants, in concert with other members of a diagnostic team, will be able to:

1) systematically gather and record all relevant data collected from sending teacher interviews, parent and child interviews, as well as other data sources, with implications for an accurate and comprehensive diagnosis of a child with unexplained learning disabilities.
systematically formulate specific written diagnostic team objectives and an individual behavioral change plan based on data gathered during Phase I of the IRDTM; further, to conceptualize a comprehensive diagnostic summary based on the systematic use of formal and informal tests, classroom observation, and medical and other relevant consultants.

3) systematically conceptualize and articulate for a given child with learning disabilities a written individualized educational plan which results from the formulation of long and short range program objectives, a written task analysis, and initial and finalized program prescriptions which consist of existing or teacher-made instructional materials and strategies, a schedule of reinforcement strategies, a detailed description of optimal learning environments and teaching strategies, and a time-referenced individualized behavioral ladder.

4) systematically assess a given child’s readiness for re-entry into his or her receiving system as well as prepare the receiving teacher by adapting the child’s individual educational plan to the constraints of the receiving system and by training the receiving teacher and other implementers of the child’s individual educational plan.

5) systematically providing follow-up services to assure the success of the child’s individual education plan, and systematically collect follow-up data to self-correct and validate the Illinois Regional Resource Center Diagnostic Teaching Model.

PHILOSOPHY AND LAW

The replication process that we undertake here is deeply rooted both in American educational philosophy and in the law that has been devised to turn that philosophy into action.

The federal and state governments recognize in principle their obligation to provide every American child free appropriate public education. In making this right available and in providing access to that education, government at the state and the federal levels has recognized that many local school systems are fiscally unable to provide for the needs of extraordinary children. Accordingly, government has provided mechanisms for paying the excess cost for the special education of such children over and above the costs associated with the education of children in regular programs.

In November of 1975, the President signed the Education for All Handicapped Children Act (Public Law 94-142), which expanded the existing Education of the Handicapped Act and added some new dimensions.

Under the new law, the State Education Agency (SEA) must assure a free appropriate public education and assume responsibility for supervision of all handicapped children.
The law also provides for extensive child identification, due process, confidentiality and placement in the least restrictive environment. An individual educational plan for each handicapped child is also a provision of PL 94-142.

For those of you with special interest, copies of these laws or of excerpts from them can be made available upon request for examination.

BEST WISHES

Much rests upon your commitment to the task. The members of the workshop staff will do everything in their power to assist you in mastering and applying this system in your regions. Nor will the help stop when you leave here. Field assistance will be available when you return to your situations in the fall. Best wishes for a rewarding workshop and a successful year’s teaching.

James W. Cook, Ph.D.
Chairman, Board of Directors
VALIDATED INSTRUCTION ASSOCIATES, INC.

J. Zink, Ph.D.
President
VALIDATED INSTRUCTION ASSOCIATES, INC.
Dr. Harold Berjahn is director of Regional Programs for Peoria District 150. These programs include the Mid Central Association, Title VI and Title I programs and the Regional Resource Center. Prior to this position, Dr. Berjahn worked for two years as director of Title III ESEA Project PRIDE in Georgia. This project used a differentiated staffing pattern to provide on-the-job training and support to regular classroom teachers. The training and support was designed to enable target teachers to serve moderately and mildly exceptional children in the regular classroom.

Dr. Berjahn received his B.A. from Loyola University of Chicago, his M.A. from Catholic University and his Ph.D. from Illinois State University. He has served as administrative assistant to the I.O.E., Title III Consultant and Research Assistant on the School District Survey report to the Illinois legislature. Dr. Berjahn has also served on the faculty of Illinois State University.

Dr. Berjahn has several years teaching experience in high school English. He also has taught elementary and high school special education classes. His publications include the Project PRIDE Planning and Training Manual and many video tape packages.

Dr. Berjahn was awarded ADMINISTRATOR OF THE YEAR for a seven county area in Georgia.
Ms Baker joined the Regional Resource Center for Illinois as Assistant Director in February, 1976. She was previously employed by Tazewell - Mason Counties joint agreement as a program coordinator. She served in this capacity for five years at which time she also supervised student teachers for Illinois State University.

Prior to living in the Central Illinois area, Ms Baker was employed as a teacher for high school mentally handicapped in Skokie, Illinois where she began the class at Niles East High School. She also taught special education, elementary and high school in Littleton, Colorado for several years.

Ms Baker received her B.A. in psychology from the University of Nebraska and her M.A. from the University of Denver. She is currently enrolled in the doctoral program at Illinois State University.
JAMES W. COOK

Chairperson of the Board of Directors of Validated Instruction Associates, Inc.,

Dr. Cook has in recent years acted as Principal Investigator for the U.S. Navy Leadership and Management Education and Training Project, the U.S. Navy Human Resources Management Instructor Training Task Analysis, the Michigan Department of Social Services Competency-Based Supervisory Training Project, and the Formative Evaluation System for the U.S. Navy Human Goals Program.

In addition, Dr. Cook has since 1964 been involved in faculty development efforts including the Great Lakes Colleges Association's Programmed Instruction Project and the Kellogg Foundation-Association of Independent Colleges and Universities of Michigan's faculty development project. Among the many companies and agencies whose training departments have sought Dr. Cook's counsel are Xerox Corporation, Western Electric, the Michigan Department of Social Services, Steelcase Inc., the U.S. Army Command and General Staff College, and the Chief of Naval Education and Training.

Among his publications Dr. Cook numbers Poetry: Method and Meaning, several articles on Chaucer, several on applications of instructional technology to the humanities, numerous video scripts, and several monographs.

He has also acted as a curriculum consultant for St. Anselm's College, for the American University in Cairo, Egypt, and for Walden University.
LANNY E. MORREAU

Dr. Morreau, Assistant Professor of Special Education at Illinois State University, has extensive experience in planning for handicapped persons. For six years, he taught educable mentally retarded children at the elementary and secondary levels, and his most recent experience involved the coordination and design of a de-institutionalization plan for the State of Minnesota.

While serving as program coordinator for the Upper Midwest Regional Educational Laboratory, Dr. Morreau created a classroom model which responds to individual learner needs—a model which has subsequently been described in Behavioral Management in the Classroom. In addition he has designed and produced a programmed television sequence for instructing parents in techniques for modifying children's behavior using positive reinforcement procedures.

Dr. Morreau has authored several texts as well as nearly forty articles in the areas of instructional design and motivation. He has also served as consultant to numerous programs for handicapped persons, medical organizations, and business.
KIRSTEN PRESTON HINSDALE

Vice President for Research and Development for Validated Instruction Associates, Inc.,

Ms. Prestan possesses a wide range of experience in the systems approach to training task analysis, work measurement and work simplification, job design, program development and evaluation, and curriculum design, validation, and evaluation. She has served as Project Director for the Illinois Regional Resource Center Diagnostic Teaching Project; Manager of Data Analysis for the U.S. Navy Leadership and Management Education and Training Project; Co-Manager of the U.S. Navy Human Resource Management School Curriculum Development and Evaluation Project; and Coordinator for the Michigan Department of Social Services Public Service Careers Training Program and Assistance Payments Staffing Standards Study.

Additionally, Ms. Preston served as a staff member during the VIA designed and implemented programs for the faculties of William Paterson College of Wayne, New Jersey, and the Michigan Association of Independent Colleges and Universities.

Among her publications are:


PAULA SMITH

Ms. Smith is an instructor of Special Education at Illinois State University where she coordinates and supervises graduate students in the Educational Evaluation Unit. She is also employed as a technical consultant to the Illinois Regional Resource Center, a statewide project for children with unexplained handicaps. Through this association she has acted as a consultant to Validated Instruction Associates, Inc. in the development of the Illinois RRC Diagnostic Teaching Model and in the design and presentation of in-service training for Diagnostic Teachers throughout Illinois. As a result of this effort, Ms. Smith coauthored the Illinois RRC Diagnostic Teaching Model: A Systems Approach to Assessment and Programming for Children with Unexplained Handicaps.

Upon graduation from Illinois State University with a B.S. in Ed. (1969) and an M.S. in Ed. (1971), Ms. Smith has accumulated a wide range of experiences. In addition to teaching in regular elementary classrooms and classrooms for learning disabled children, she has supervised a multi-county Learning Disabilities Program in which she managed human and financial resources, coordinated program policies, and performed numerous public relations functions. Among her accomplishments in this connection were the design and implementation of selection criteria for L.D. teachers, placement criteria for handicapped children, and in-service workshops.
Dr. J. Zink is the President of Validated Instruction Associates, Inc. Prior to coming full-time to VIA, where he is a member of the Board of Directors, Dr. Zink was Associate Professor of Humanities and Coordinator of The Institute For Innovation and Continuing Education at The William Paterson College of New Jersey.

A Doctor of Philosophy in Medieval Languages and Literatures from the University of Detroit, Dr. Zink completed a year of Post-Doctoral work at the University of Michigan in the Graduate School of Business at the Center for Programmed Learning, where he later became a Senior Editor and Staff Member.

Dr. Zink is the author of dozens of mediated instructional sequences including Pronouncing Chaucer's Language, which has become a standard text for students of Chaucer at many prestigious colleges and universities in this country and Canada. In 1975 Dr. Zink produced Opera One, a thirteen one-hour, criterion-referenced color television series broadcast over fifteen cablevision stations in the North Jersey-Metropolitan New York area to an audience of two hundred thousand viewers. In April of 1975 Opera One was awarded a national Exceptional Achievement Award by the Council for the Advancement and Support of Education.

During his professional career Dr. Zink has served as an educational consultant to the United States Navy, the Association of Independent Colleges and Universities in Michigan, the State of Michigan, the State of Illinois, the State of New Jersey, the University of Richmond, the University of Michigan, the State Prison of Southern Michigan, and Walden University, as well as TITLE IV B projects in the State of New Jersey and TITLE VI B projects in the State of Illinois.
WORKSHOP FOR DIAGNOSTIC TEACHERS

August 9-20, 1976

Monday, August 9

8:30 Coffee and Danish

9:00 Welcome and Greetings by
   Dr. Harold Berjohn
   Director, RRC #7
   Dr. James W. Cook, Chairman
   Validated Instruction Associates, Inc.

Introductions:
   Staff and Participants

9:15 Presentation
   "IRDTM: An Overview"
   Dr. J. Zink, Workshop Director,
   President, Validated Instruction Associates, Inc.

12:00 Lunch

1:00 Phase I: IRDTM/Initial Information Gathering

Presentation: "An Introduction To Flowcharting"
   Ms. Kirsten Preston-Hinsdale, Workshop Coordinator,
   Vice President for Research and Development
   Validated Instruction Associates, Inc.

Flowcharts 1.1-1.5 Walkthrough

2:00 Role Play/Demonstration (1.5.1)
   "The Sending Teacher Conference"
   Sending Teacher: Ms. Millie Moser
   Diagnostic Teacher
   RRC #7
August 9, Continued

Diagnostic Teacher: Ms. Colleen Matthews
Deaf Educator
RRC #7

Feedback and Discussion

4:00 Closure

5:00 Cocktails at the home of
Ms. Dea Baker
Assistant Director, RRC #7
Tuesday, August 10

8:30  Coffee and Danish

9:00  Presentation (1.5.3)  
"What to Look for During the Child Interview"  
Ms. Colleen Matthews  
Deaf Educator  
RRC #7

Feedback and Discussion  
Discussion Leader: Ms. Paula Jean Smith  
Instructor, Special Education  
Illinois State University

10:00  Presentation (1.6)  
"What the Social Worker looks for during the Home Visit"  
Mr. Michael Wasson  
Social Worker  
RRC #7

Flowcharts 1.7-1.9 Walkthrough  
Ms. Preston-Hinsdale

12:00  Lunch

1:00  Phase II: IRDTM/Diagnosis  
Dr. Zink:  
Introduction of Team Alpha, Beta, Delta, Gamma  
Team Concept Explained  
Raw Data for Workshop Case Study Distributed

Flowchart 2.1 Walkthrough  
Diagnostic Team Objectives: Ms. Preston-Hinsdale  
Team Activity: Write Diagnostic Team Objectives for Workshop Case Study

Discussion and Feedback

Flowchart 2.2 Walkthrough  
Change Plan: Ms. Preston-Hinsdale

3:30  Viewing: Classroom Management of Disruptive Behavior  
(Videotape/34 minutes)

4:00  Closure
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<td>9:00</td>
<td>Presentation (2.2)</td>
<td>&quot;Writing Behavioral Objectives&quot;</td>
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<td>Dr. Lanny Morreau</td>
<td>Assistant Professor of Special Education</td>
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<td>Illinois State University</td>
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<td><strong>Team Activity:</strong> Write Behavioral Objectives</td>
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<td>Discussion and Feedback</td>
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<td>12:00</td>
<td>Lunch</td>
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<tr>
<td>1:00</td>
<td>Presentation (2.2)</td>
<td>&quot;Using Reinforcers and Reinforcement Strategies&quot;</td>
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<td>Dr. Lanny Morreau</td>
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<td>2:00</td>
<td><strong>Team Activity:</strong> Write a Change Plan for the Workshop Case Study</td>
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<td>Discussion and Feedback</td>
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<td>3:30</td>
<td>Presentation (2.2)</td>
<td>&quot;Behavioral Charting&quot;</td>
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<td>Ms. Paula Jean Smith</td>
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<td>4:00</td>
<td>Closure</td>
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Thursday, August 12

8:30   Coffee and Danish

9:00   Flowcharts 2.3–2.4 Walkthrough  
       Ms. Preston-Hinsdale

9:30   Presentation (2.5)  
       "Selecting and Administering Formal Diagnostic Tests"  
       Ms. Paula Jean Smith

11:30  Discussion and Feedback  
       Participant Examination of a Display of Formal Diagnostic Testing Materials

12:00  Lunch

1:00   Team Activity: Interpret Formal Diagnostic Test Results of the  
       Workshop Case Study (including item analysis)  
       Discussion and Feedback  
       Discussion Leader: Ms. Paula Jean Smith

4:00   Closure

5:00   Cookout/Grand View Drive
Friday, August 13

8:30  Coffee and Donish

9:00  Presentation (2.6)

"Selecting and Administering Informal Diagnostic Tests"

Ms. Millie Moser
Ms. Sherry LaCasse, (Diagnostic Teacher, ISU)
Ms. Colleen Matthews, Deaf Educator, RRC #7

10:30  Discussion and Feedback

Discussion Leaders: Dr. Morreau and Ms. Smith

12:00  Lunch

1:00  Team Activity: Based on Formal Test Results and Item Analysis,

Suggest Informal Tests and Procedures for Workshop

Case Study

2:00  Discussion and Feedback

With critique by Dr. Morreau, Ms. Smith, Ms. Moser, Ms. LaCasse,
and Ms. Matthews

3:00  Closure
Monday, August 16

8:30 Coffee and Danish

9:00 Flowchart 2.7 Walkthrough
  Formal/Informal Consultative Staffing
  Ms. Preston-Hinsdale

9:20 Team Activity: (2.8) Complete A, Diagnostic Summary
  for the Workshop Case Study

11:00 General Group Discussion and Feedback
  "Problems and Solutions"

12:00 Lunch

1:00 Phase III: IRDTM/Program Development and Testing

  Flowcharts 3.1-3.2 Walkthrough

  Long Range/Short Range Program Objectives
  Ms. Preston-Hinsdale

2:00 Group Discussion and Feedback

3:00 Team Activity: (3.3) Brainstorm
  A Task Analysis based on Provided and Accumulated
  Data on the Workshop Case Study

  Group Discussion and Feedback

4:00 Closure
Tuesday, August 17

8:30  Coffee and Danish

9:00  Team Activity: (3.4) Devise An Initial Program Prescription for the Workshop Case Study by

   a) Identifying, Selecting, and/or Devising Instructional Strategies (3.4.1) from a list provided;

   b) Select and Devising Reinforcement Strategies (3.4.2); and

   c) Determine Optimal Learning Environment and Teaching Strategies (3.4.3).

10:00 Group Discussion and Feedback

10:30 Flowchart 3.5-3.7 Walkthrough
       Based on Data Supplied by Team Activity for 3.4 Testing, Revising, and Finalizing Program Prescriptions, Including Placement and Implementation Plans
       Ms. Preston-Hinsdale

12:00 Lunch

1:00  Team Activity: (3.8) Construct an Individual Behavioral Ladder for Three Behavioral Objectives from the Workshop Case Study

2:00 Group Discussion and Feedback

2:30 Flowchart 3.9 Walkthrough
       Follow-Up Services, and Post Placement Data Collection
       Ms. Preston-Hinsdale

3:00  Team Activity: (3.10) Write Placement and Follow-Up Activities for the Individual Educational Plan for the Workshop Case Study

3:30 Group Discussion and Feedback

4:00 Closure

22
Wednesday, August 18

8:30  Coffee and Danish

9:00  Phase IV: IRDTM/Transition
      Flowchart 4.1 Walkthrough
      Assessing the Child’s Readiness for Exit
      Ms. Colleen Matthews

10:00 Role Play/Demonstration (4.2)
      “The Receiving Teacher Conference - Adapting the IEP to his/her
      Constraints”
      Diagnostic Teacher: Ms. Millie Moser
      Receiving Teacher: Dr. Charles Alcorn
      School Psychologist: Ms. Millie Moser
      RRC #7

11:00 Group Discussion and Feedback
      Discussion Leader: Dr. Alcorn

12:00 Lunch

1:00  Video Taped Role Plays (4.3)
      “Training the Program Implementers, or Co-opting the Receiving Teacher”
      Receiving Teachers: Mr. Michael Wasson
                          Dr. Charles Alcorn
                          Ms. Millie Moser
                          Ms. Sherry LaCasse
                          Ms. Deo Baker
                          Ms. Colleen Matthews
      Diagnostic Teachers: Workshop Participants

3:00  Videotape Viewing
      Group Discussion and Feedback

4:00  Closure

Evening Assignment:
Walkthrough Flowcharts 4.4-4.7

23
Thursday, August 19

8:30  Coffee and Danish

9:00  Questions and Answers 4.4-4.7

9:15  Phase V: IRDTM/Follow-Up

Flowchart 5.1 Walkthrough
Program Implementation Follow-Up
Mr. Thomas Borkowski

Flowchart 5.2 Walkthrough
Social Work Services Follow-Up
Mr. Michael Wasson

11:00 Group Discussion and Feedback

12:00 Lunch

1:00  Flowcharts 5.3-5.11 Walkthrough
Including Information on the Follow-Up of the Workshop Case Study which is based on the Actual Case from the RRC #7 Files
Ms. Preston-Hinsdale

3:00  Closure

5:00  Cocktail Party at Jumer's Castle Lodge sponsored by
Validated Instruction Associates, Inc.

6:30  Group Dinner at Jumer's (optional)
Friday, August 20

30  Coffee and Danish

Summary and Evaluation
  Dr. J. Zink

Workshop Evaluation
Staff Evaluation
Suggestions for Follow-Up Activities
General Group Discussion

12:00  Lunch and Closure
ACKNOWLEDGEMENTS

The authors of this text would like to thank the following persons for their generous cooperation and assistance in providing consultation, guidance, and clerical aid. Without each of their valuable contributions, this book would not have been possible.

Mr. Harry Whitaker   Superintendent, Peoria Public Schools
Dr. Aaron G. Gray    Assistant Superintendent, Peoria Public Schools
Dr. Charles Alcorn   Regional Resource Center #7
Dr. Nelson Ashline   Illinois Office of Education
Dr. Harold Berjohn   Regional Resource Center #7
Dr. Larry Betterman  Educational Regional Association
Ms. Dione Blackwell  Regional Resource Center #7
Mr. Elwood Bland     Bureau of Education for the Handicapped
Mr. Thomas Borkowski Regional Resource Center #7
Dr. Robert Bowen     Western Illinois Association
Dr. Mary Voss Budzik  Lake-McHenry
Ms. Gloria Calovini   Illinois Office of Education
Ms. Rosalie Carter   Regional Resource Center #7
Dr. Reuben Chapman   Validated Instructions
Ms. Barbara Cook     Validated Instructions
Mr. Howard Falk      Area Services Project
Mr. Joe Fisher       Illinois Office of Education
Mr. Lorry Goldsmith  Southern Illinois Association for Low-Incidence Handicapped
Dr. Dean Hage       Illinois State University
Dr. Norm Howe
Ms. Paula Jacko
Dr. Wayne Johnson
Mr. Wendell Jones
Ms. Sherry LaCasse
Mr. Lloyd Lehman
Ms. Nora Loukides
Mr. Paul Loukides
Mr. Jerry Maring
Ms. Colleen Matthews
Dr. J. H. McGrath
Ms. Millie Moser
Mr. Stan Nelson
Dr. Sam Price
Ms. Elberta Pruitt
Mr. Paul Reinert
Ms. Marie Roane
Ms. Gwen Ross
Ms. Nan Spalding
Mr. Burdette Thurman
Dr. Bill Tilley
Dr. Richard Urbano
Mr. Robert Van Dyke
Mr. Michael Wasson
Bureau of Education for the Handicapped
Regional Resource Center #7
CORRC
West Suburban Association
Regional Resource Center #7
Regional Service-Association
Validated Instructions
Validated Instructions
Northwestern Illinois Association
Regional Resource Center #7
Illinois State University
Regional Resource Center #7
West Central
Illinois State University
Chicago Board of Education
East Central Regional Program
Bureau of Education for the Handicapped
Chicago PL 89-313 Non-Public SESR
Illinois Office of Education
South Western Illinois Regional Special Education Association
Illinois Office of Education
VIA, Inc.
South Metropolitan Association
Regional Resource Center #7
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THE ILLINOIS REGIONAL RESOURCE CENTER

DIAGNOSTIC TEACHING MODEL:
A Systems Approach to Assessment
and Programming for Children with
Unexplained Handicaps
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Section 1.

INTRODUCTION TO THE ILLINOIS REGIONAL RESOURCE CENTER DIAGNOSTIC TEACHING MODEL.
INTRODUCTION TO THE ILLINOIS RRC DIAGNOSTIC TEACHING MODEL

Purpose

The Illinois-RRC Diagnostic Teaching Model (IRDTM) was developed to incorporate both the best practices of master performer diagnostic teachers and current state-of-the-art techniques in the field of Special Education. The purpose of the model is to provide a means through which a specific subset of the handicapped population—children with unexplained handicaps—may be helped to realize their full potential through complete and accurate assessment, individualized educational planning, optimal placement, and short and long range follow-up. As such, the model fully addresses a number of current legislative concerns, including the treatment of the child in the "least restrictive environment," the use of the Individual Educational Plan, and the decentralization of high quality, specialized services to the handicapped.

Target Population

The target population of the IRDTM is the population of children, age 3 to 21, with "unexplained" learning problems. These are children for whom all local and regional avenues of diagnosis have been exhausted and who remain problematic in their current placements in terms of diagnosis or educational programming. The severity of the handicap (e.g., profound retardation, blind/deaf, etc.) is not the criterion for acceptance into the program. It is rather the presence of an unusual combination of physical, psychological, sensory, or educational handicaps in need of further diagnosis or alternative programming which indicate the suitability of a referred child for program acceptance. Figure 1, "Origination of Diagnostic Classroom Referrals," shows the process through
TEACHER REFERS PROBLEM CHILD TO SCHOOL PRINCIPAL

AS INDICATED, PRINCIPAL REFERS CHILD TO PPS TEAM

AS INDICATED, PPS TEAM REFERS CHILD TO LOCAL SPECIAL EDUCATION DISTRICT

AS INDICATED, SPECIAL EDUCATION DISTRICT REFERS CHILD TO REGIONAL LOW INCIDENCE PROGRAM

REGION DETERMINES THAT SPECIAL EDUCATION AND LOW INCIDENCE DIAGNOSTIC RESOURCES HAVE BEEN EXHAUSTED

REGION MAKES REFERRAL TO DIAGNOSTIC CLASSROOM PROGRAM COORDINATOR

Referral Form (see page 532)
which children are referred to the Diagnostic Classroom. Charts 1.1 - 1.9, pp. 28.

Further depict the process through which the decision to provide services to a referred child is made.

Features of the IRTDM

While many of the principles and procedures included in the IRTDM are widely used in special education in general and in diagnostic classrooms in particular, they are combined in the IRTDM to produce a unique and thorough system for maximizing services delivery to children with unexplained handicaps. The remainder of this chapter presents an overview of the major features of the IRTDM.

1. The model emphasizes diagnosis rather than remediation. An overriding goal of the IRTDM is to facilitate the academic, physical, and social functioning of its target population of exceptional children. Since this is not best accomplished through removal of the child from his or her normal environment for lengthy remediation, the model stresses a brief period of in-depth diagnosis and trial programming which usually lasts no longer than six weeks. During this time, the referred child is fully diagnosed and an Individual Education Plan is developed and tested. After the plan is finalized, the child is returned to his or her original placement (or as indicated, a more appropriate placement) and program implementation becomes the responsibility of the child's receiving teacher supported by follow along consultation from the Diagnostic Teacher.

2. The model employs a team approach to services delivery. The team concept is widely used across various services delivery systems and has been well-substantiated both as a cost-effective use of manpower and an effective
mean of services delivery. The IRDM, when fully staffed, uses a Diagnostic Team consisting of one or more diagnostic teachers, a consulting diagnostic teacher, a team social worker, a team psychologist, and two or more team specialists, such as a speech therapist, vision educator, media specialist, and/or deaf educator. The roles of these team members, as well as those of supportive staff, are implicit in the flowcharts in Section 2, and are fully described in Appendix A, "Regional Resource Center Job Descriptions," and Appendix B, "Suggested Qualifications for Diagnostic Teacher." Appendix C, "Alternative Replication Staffing Models," further presents eight options for the composition of the Diagnostic Team, which varies according to the size and resources of the replicating region.

3. The model provides for the delivery of both on-site and in-classroom services.

In its comprehensive approach to services delivery—and unlike most other models—the IRDM accommodates two major branches of services delivery: "on-site" and "in-classroom" services. In on-site services delivery, the Diagnostic Team works primarily with the child's teachers, other sending school staff, and the child's parents in the development and implementation of an Individual Educational Plan for the child in his or her current placement. In-classroom services, on the other hand, involve the acceptance of the child into the Diagnostic Classroom for in-depth diagnosis and trial programming.

Approximately 10% of the children who receive team services are found to need the extensive services of the Diagnostic Classroom. A referred child is placed in the Diagnostic Classroom when, after initial on-site observation and conferences with the sending school staff, it is determined that further medical diagnosis and/or continued on-site services will not fully suffice to diagnose
the child's handicapping conditions.

The same general procedures are employed for the delivery of both on-site and in-classroom services. On-site services, however, usually involve less intense team involvement and more specialized concentration on specific handicaps. Also, it is often the case with on-site services that while diagnosis has been adequate, the child's teacher has skill deficiencies which prevent him or her from effectively dealing with the child. In these cases, the team concentrates on training the child's teacher in appropriate methods, techniques, and materials usage, thereby promoting effective programming for the child in his or her current classroom placement. Thus, by offering an alternative to placement in the Diagnostic Classroom, the IRDTM further facilitates the child's development in the least restrictive environment.

4. The model is procedural. The IRDTM specifies in detail the procedures and decision-making guidelines to be used from the time the child is first referred to the Diagnostic Team through annual follow-up of the child as he or she progresses through the educational system. The model organizes these procedures and decision-making guidelines into five discrete phases, including:

Phase I: Initial Information-Gathering, which specifies procedures for

a) the collection of historical and current information on the child (medical, academic, psychological, and social), b) the preliminary assessment of the need for team services, c) on-site conferences with sending school staff, and d) on-site observation of the child;
Phase 2: Diagnosis, which provides guidelines for a) informal and formal testing and observation by the Diagnostic Team, b) the use of medical testing by "consultants," c) the evaluation of diagnostic data, and d) the formulation of diagnostic conclusions;

Phase 3: Program Development and Testing, which provides procedures for a) setting objectives, b) testing instructional materials and strategies, and c) writing the child's Individual Educational Plan;

Phase 4: Transition, which presents procedures for a) the adaptation of the Individual Educational Plan to the reality constraints of the receiving school, b) training the child's parents and receiving teacher in program implementation, and c) preparing the child for exit; and

Phase 5: Follow-up, which specifies the procedures for a) ongoing consultation to the child's parents and receiving teacher, b) the collection of formal and informal follow-up data, and c) the evaluation of the Individual Educational Plan and total services delivery system.

The procedures and decision-making guidelines for each of the above phases of the IRDTM are presented in full in the ensuing section, "Flowcharts for the IRDTM."

5. The model uses a wide range of human resources to ensure that diagnosis is comprehensive. Critical to the successful implementation of the IRDTM are the services and inputs of a wide range of human resources. Thus, the model leans heavily on the use of a number of professional and paraprofessional "consultants" and involves the child's family in each of the five model phases.

The rationale for the involvement of the child's parents and siblings in the IRDTM is apparent: the model takes a holistic approach to both diagnosis
and programming, and family life represents fully two-thirds of the child's time. In the model the family therefore serves as a primary source of diagnostic information, a touchstone for establishing the directions that diagnosis and programming should take, and a means of program implementation. In addition, the model further encourages the full use of this valuable human resource by specifying in detail the procedures for the initial home visit, ongoing social work services, parent training, and parent follow-up.

As mentioned, also highly necessary to model implementation is access by the Diagnostic Team to the services of a variety of medical and other consultants. Among these consultants are family doctors, pediatricians, neurologists, psychologists, family counselors, physical therapists, etc. Without access to the services of these and other expert diagnostic personnel, complete, accurate diagnosis cannot occur, and the impact of the IRDTM is seriously undermined. For a complete listing of medical and other consultants, see Appendix D, "Consultants Available to the RRC Team."

6. The model stresses a holistic approach to the individual child. To ensure that all aspects of the child's functioning are fully considered by the Diagnostic Team, the IRDTM incorporates a comprehensive set of diagnostic categories for use as an organizational framework for diagnostic information and program prescriptions. These diagnostic categories, or "diagnostic domains," are:

1) Motor Domain, including:
   a. Gross Motor
   b. Fine Motor
2) Sensory-Perceptual Domain, including:
   a) Visual Reception
   b) Visual Perception or Acuity
   c) Visual Association
   d) Auditory Reception
   e) Auditory Perception
   f) Auditory Association
   g) Sensory-Motor Skills

3) Academic Domain, including:
   a) Reading Skills
   b) Math Skills
   c) Writing

4) Speech/Language Domain, including:
   a) Concept Information
   b) Receptive Language
   c) Expressive Language
   d) Language Usage

5) Social-Emotional Domain, including:
   a) Peer Relationships
   b) Adult Relationships
   c) Family Relationships
   d) Self-concept
   e) Behaviors

6) Self-Help Domain, including:
   a) Feeding
   b) Dressing
c) Toileting

d) Hygiene

The emphasis given to each of the above diagnostic domains depends upon the extent to which a given child's diagnostic and programming needs are concentrated in that domain. In this manner, the individual child's strengths and weaknesses become the frame of reference for both diagnosis and programming.

7. The model is eclectic in its use of theory, diagnostic tests, and educational materials. The IRDTM is not based on any particular child development or psychological theory; nor does it recommend the use of any particular materials or testing devices. Instead, the model assumes that the Diagnostic Team members possess the skill, knowledge, and experience to select and employ various theories, tests, and materials as appropriate to the handicaps and strengths of the individual child.

Lending some structure to this eclectic method of diagnosis and programming are 1) the diagnostic categories described in §6 above, and 2) the decision-making guidelines contained throughout the IRDTM. These guidelines, by directing the Diagnostic Team through a comprehensive series of strategies for diagnosis and programming, provide the parameters within which the composite team skills, knowledge, and experience may be eclectically brought to bear on the needs of the individual child.

8. The model is comprehensive in its approach to diagnosis and programming. Many diagnostic teaching models subscribe to either a traditional, assessment-oriented approach to diagnosis and programming or to the exclusive use of behavior modification. The former approach depends largely on the use of
standardized tests and instructional materials; the latter employs strictly behavioral testing, measurement, and remediation. However, to accommodate treatment of the "whole child," the IRDTM incorporates both. During Phase 1, Initial Information-Gathering, both assessment-oriented and behavioral data on the child are gathered. In Phase 2, Diagnosis, both standardized testing and behavioral testing and observation are used as the need is indicated for the individual child. And in Phase 3, Program Development and Testing, both behavioral and traditional academic means of educational planning and programming are employed, once again, as dictated by the needs of the individual child.

9. The model is self-correcting. The IRDTM contains both formal and informal mechanisms for the evaluation of the Individual Educational Plan and the evaluation and revision of the total services delivery system. The formal mechanism, also called the "Child Tracking System," consists of the collection and analysis of three types of data on children who have received in-classroom services. These are a) Child Follow-Up Data, b) Longitudinal Follow-Up Data, and c) Pre-and-Post-Placement Data, and are described below.

a) Child Follow-Up Data is collected at 3, 6, 9, and 12 month intervals after the child's exit from the Diagnostic Classroom and measures the extent to which the child has achieved the behavioral objectives established by the Diagnostic Team. Child Follow-Up Data is initially analyzed for each child and used in the revision of the child's behavioral objectives. Because by implication a child's failure is also the Diagnostic Team's failure, this data also provides information useful to the team.
members in identifying their strengths and weaknesses and in modifying
t heir approaches to diagnosis, programming, and services delivery.
Later in time, as the data base accumulates, analyses may be performed
to determine the extent to which the total child population, or children
with a certain handicap, or children of different ages, etc., achieve
the behavioral objectives set for them. This long range evaluation
mechanism has numerous implications for the validation and revision
of the total services delivery system.

b) **Longitudinal Follow-Up Data** is collected on the child annually and
relates to the child's progression through the educational system and
movement toward or away from the goals set for the child. It is
used in long range program validation and revision.

c) **Pre-and-Post-Placement Data** consists of data gathered on the child during
Phase 1, Initial Information-Gathering, and later compared to similar
data collected during Phase 5, Follow-Up. Included in this category
are pre-and post-placement grades, psychological test scores, achievement
test scores, and observational, behavioral, and other data on the child.
Because it is not possible to establish uniformity in the types of pre-and
post-placement data collected on each child who has received in-classroom
services, this component of the Child Tracking System is less formalized
than the two components previously mentioned. However, its usefulness
should not be underestimated. Particularly important in this connection
is the use of pre-placement and post-placement behavioral and observational
data. It is often the case that the child's behavioral disorders at the time of
referral are not evident in the diagnostic classroom setting, where the child
is exposed to a completely different set of environmental variables.

The one-to-one student-teacher ratio, for example, tends to eliminate many behaviors displayed by the child in a normal classroom setting. By comparing the child's pre-and post-placement behaviors a true measure of the child's progress or regression which is not otherwise available may be obtained.

The informal evaluation mechanism included in the IRDTM consists of two feedback loops. While these feedback loops provide less precise data than does the Child Tracking System, they do have the advantage of providing immediate, and immediately useful, information on the quality of the Individual Educational Plan and the effectiveness of the total services delivery system. Also, unlike the Child Tracking System, the informal evaluation data is gathered on children who have received either on-site or in-classroom services. The informal feedback loops are:

a) Parent Follow-Up, which is conducted one month after program implementation and examines 1) the degree to which the child's parents are satisfied with the scope and quality of on-site or in-classroom services, and 2) the parents' observations of improvement and regression in the child; and

b) Teacher Follow-Up, which is also conducted one month after program implementation and investigates 1) the child's general adjustment to his or her placement and programming, 2) areas of improvement and regression observed in the child, 3) the usefulness of the Individual Educational Plan, and 4) overall receiving teacher satisfaction with the quality and scope of team services.
The information obtained from Parent and Teacher Follow-Up provides immediate feedback on the effectiveness of team services, the value of the Individual Educational Plan, and the child's initial adjustment, improvement, or regression. Like the Child Follow-Up Data, this information may be used by the Diagnostic Team to isolate the domains in which the team is particularly weak or needs additional training, and to adjust their approaches to diagnosis and programming accordingly. It may also be used to provide more immediate feedback on the total services delivery system than does the Child Tracking System, and to serve as a basis for interim program revision. Then, as the data from the Tracking System accumulates, the Parent and Teacher Follow-Up data may be used as corroborative information to substantiate the outcomes of the Child Follow-Up and Longitudinal data analyses.

10. The model uses child adjustment, achievement, and movement toward the established educational goals as the major criteria for system success. As can be surmised from the previous section, data from the child (e.g., behavioral objectives achievement) and data about the child, (e.g., subsequent placements, adjustments, movement toward normalization) comprise the heart of the informal and formal evaluation systems. Since the model is based on a holistic approach to the individual child, it follows that the true success of the model, the team, the program, and each Individual Educational Plan should be measured in terms of the outcomes of the system for the children served. Thus, as with the emphasis on individualization and eclecticism in diagnosis and prescription, the child becomes the pivotal point for system evaluation.
11. The model is responsive to the needs, strengths, and constraints of those for program implementation. Built into the IRDTM are procedures designed to maximize the probability that each child's Individual Educational Plan will be implemented — i.e., will meet the needs of those who must use it as well as the child's needs. These procedures include:

during Phase 1:
a) a determination of the questions that both the child's sending school staff and parents would like to have answered as a result of diagnosis of the child, and
b) conferences with sending school staff to ascertain their reality constraints for program implementation in terms of time, materials, etc.;
during Phases 2 and 3:
c) the ongoing use of the sending/receiving school staff and the child’s parents as "reality checks" to ensure that the course of diagnosis and programming is consistent with their needs and objectives for the child;
during Phase 4:
d) the adjustment of the Individual Educational Plan to reflect the strengths and constraints of the child’s parents and receiving school staff, and
e) the training of parents, teachers, and other resource persons in program implementation; and
during Phase 5:
f) assistance in program implementation,
g) the provision of follow-up services to all program implementers, and
h) the revision of program prescriptions based on the actual success of the Individual Educational Plan as reported by parents and teachers at the
time of the one month follow-up.

Summary

As is apparent from the above narrative, the IRDTM incorporates the best practices and principles used in special education, with special emphasis on children with unexplained handicaps. The full use of this model, and faithful attention to the details on the following flowcharts, will ensure the maximization of services delivery to children with unexplained learning problems. In addition, it will address a number of legislative concerns such as treatment of the child in the least restrictive environment, the use of the Individual Educational Plan, and the ultimate goal of normalization and improved services to the handicapped.
SECTION 2
FLOWCHARTS FOR THE ILLINOIS RRC DIAGNOSTIC TEACHING MODEL
Phase 1: INITIAL INFORMATION-GATHERING

Objectives of Phase 1: Initial Information-Gathering

Overview of Phase 1: Initial Information-Gathering

Chart 1.1 Receive Referral

Chart 1.2 Process Request for Direct Service Funds

Chart 1.3 Conduct Preliminary Assessment of Need for Team Services

Chart 1.4 Conduct/Participate in Weekly Intake Staffing

Chart 1.5 Plan/Conduct Initial On-Site Visit

1.5.1 Confer with Sending Teacher

1.5.2 Conduct On-Site Observation

1.5.3 Interview Child

1.5.4 Collect Existing Records

Chart 1.6 Make Home Visit

Chart 1.7 Contact Resource Persons

Chart 1.8 Review Information Gathered; Decide on Need for Continued Team Services

Chart 1.9 Plan/Conduct/Participate in Placement Staffing

Phase 2: ON-SITE OR IN-CLASSROOM DIAGNOSIS

Objectives of Phase 2: On-Site or In-Classroom Diagnosis

Overview of Phase 2: On-Site or In-Classroom Diagnosis

Chart 2.1 Devise/Prioritize/Sequence Diagnostic Team

Objectives
Chart 2.2 Devise/Implement Change Plan

Chart 2.3 Arrange for Use of Medical and Other Consultants

Chart 2.4 Arrange for Use of Resource Persons in Diagnosis

Chart 2.5 Select/Administer/Interpret Formal Diagnostic Tests

Chart 2.6 Select/Administer/Interpret Informal Diagnostic Tests

Chart 2.7 Plan/Conduct/Participate in Formal or Informal Consultative Staffing

Chart 2.8 Complete Diagnostic Summary

Phase 3: PROGRAM DEVELOPMENT AND TESTING

Objectives of Phase 3: Program Development and Testing

Overview of Phase 3: Program Development and Testing

Chart 3.1 Devise Long-Range Program Objectives

Chart 3.2 Devise Short-Range Program Objectives

Chart 3.3 Conduct Task Analysis

Chart 3.4 Devise Initial Program Prescriptions

3.4.1 Identify/Select/Devise Instructional Materials and Equipment

3.4.2 Select/Devise Reinforcement Strategies

3.4.3 Determine Optimal Learning Environment and Teaching Strategies

Chart 3.5 Test Initial Program Prescriptions

3.5.1 Test Instructional Materials and Equipment

3.5.2 Test Reinforcement Strategies

3.5.3 Test Learning Environment and Teaching Strategies

Chart 3.6 Revise/Retest Program Prescriptions

Chart 3.7 Finalize Program Prescriptions, Placement Recommendations, and Implementation Plans
Phase 4: TRANSITION

Objectives of Phase 4: Transition

Overview of Phase 4: Transition

Chart 4.1 Assess Child’s Readiness for Exit

Chart 4.2 Adapt Individual Educational Plan to Needs of Program Implementers

Chart 4.3 Train Program Implementers

Chart 4.4 Plan/Conduct/Attend On-Site or In-Classroom Demonstration

Chart 4.5 Plan/Conduct/Participate in Exit Staffing

Chart 4.6 Plan/Supervise Integration of Child into New Placement

Chart 4.7 Prepare Child for Exit

Phase 5: FOLLOW-UP

Objectives of Phase 5: Follow-Up

Overview of Phase 5: Follow-Up

Chart 5.1 Assist in Program Implementation

Chart 5.2 Provide Follow-up Social Work Services

Chart 5.3 Conduct One-Month Teacher Follow-Up

Chart 5.4 Conduct One-Month Parent Follow-Up

Chart 5.5 Conduct Post-Placement Observation, Testing, and Records Collection

Chart 5.6 Conduct 3, 6, 9, and 12 Month Child Follow-Up

Chart 5.7 Conduct Longitudinal Follow-Up
Chart 5.8  Plan/Conduct/Participate in Quarterly Staff Meeting

Chart 5.9  Conduct Annual Analysis of Informal Evaluation Data

Chart 5.10 Conduct Annual Analysis of Formal Evaluation Data

Chart 5.11 Conduct Annual Collection and Analysis of Data of Federal Reporting
FLOWCHART SYMBOLS

The purpose of the following flowcharts is to outline in a visually understandable format the flow of the Illinois RRC Diagnostic Teaching Model. The charts are organized into five major sections including, Phase 1: Initial Information-Gathering, Phase 2: Diagnosis, Phase 3: Program Development and Testing, Phase 4: Transition, and Phase 5: Follow-Up.

The charts should be read from left to right and top to bottom. The symbols are as follows:

- **Arrows:** Used to indicate the direction of the flow.

- **Process:** Used to indicate a task.

- **Bracket:** Used to indicate cross-references to a task.

- **Decision:** Used to indicate a decision point in the process.

- **Input/Output:** Used to indicate the input or output of information.

- **Connector:** Used to indicate the beginning of a chart and to connect process.

- **Terminal:** Used to indicate the beginning or end of a process.
Horizontal or Vertical Branching: Used to indicate sequential sub-tasks.

Parallel Branching: Used to indicate tasks performed simultaneously.
OVERVIEW OF THE ILLINOIS NBC DIAGNOSTIC TEACHING MODEL, PHASES I - V

BEGIN

PHASE I

INITIAL INFORMATION GATHERING

1. To determine the child's technical eligibility for team services.
2. To gather, through conferences, classroom observation, and a review of existing medical, academic, and social information on the referred child.
3. To determine the child's need for on-site services or Diagnostic Classroom placement.

PHASE II

ON-SITE OR IN-CLASSROOM DIAGNOSIS

1. To conduct, through the use of formal and informal tests, classroom observation, and medical and other consultants, a complete diagnosis of the child's handicaps across all diagnostic domains.
2. To devise and implement Diagnostic Team Objectives.
3. To devise and implement a Change Plan.
4. To organize and evaluate all diagnostic information.
5. To form diagnostic conclusions.

PHASE III

PROGRAM DEVELOPMENT AND TESTING

1. To establish long and short range program objectives.
2. To devise, test, modify, retest, and finalize program prescriptions.
3. To devise placement recommendations and follow-up plans.

PHASE IV

TRANSITION

1. To prepare the child for exit.
2. To adopt the Individual Educational Plan to the resources and constraints of the receiving school.
3. To train the child's parents and current or receiving teacher in program implementation.

PHASE V

FOLLOW-UP

1. To assist in initial program implementation.
2. To provide post-placement consultation and assistance to the child's parents, teachers, and other program implementers.
3. To gather and analyze informal evaluation data for use in program evaluation and revision.
4. To gather and analyze formal evaluation data for use in the revision of the Individual Behavioral Ladder and in program evaluation and revision.

END

Objectives

1. To determine the child's technical eligibility for team services.
2. To gather, through conferences, classroom observation, and a review of existing records, all historical and current medical, academic, and social information on the referred child.
3. To determine the child's need for on-site services or Diagnostic Classroom placement.

PHASE II

ON-SITE OR IN-CLASSROOM DIAGNOSIS

1. To conduct, through the use of formal and informal tests, classroom observation, and medical and other consultants, a complete diagnosis of the child's handicaps across all diagnostic domains.
2. To devise and implement Diagnostic Team Objectives.
3. To devise and implement a Change Plan.
4. To organize and evaluate all diagnostic information.
5. To form diagnostic conclusions.

PHASE III

PROGRAM DEVELOPMENT AND TESTING

1. To establish long and short range program objectives.
2. To devise, test, modify, retest, and finalize program prescriptions.
3. To devise placement recommendations and follow-up plans.

PHASE IV

TRANSITION

1. To prepare the child for exit.
2. To adopt the Individual Educational Plan to the resources and constraints of the receiving school.
3. To train the child's parents and current or receiving teacher in program implementation.

PHASE V

FOLLOW-UP

1. To assist in initial program implementation.
2. To provide post-placement consultation and assistance to the child's parents, teachers, and other program implementers.
3. To gather and analyze informal evaluation data for use in program evaluation and revision.
4. To gather and analyze formal evaluation data for use in the revision of the Individual Behavioral Ladder and in program evaluation and revision.
Phase I: INITIAL INFORMATION-GATHERING

Objectives:

1. To determine the child's technical eligibility for team services.

2. To gather, through conferences, classroom observation, and a review of existing records, all historical and current medical, academic, psychological, and social information on the referred child.

3. To determine the child’s need for on-site services or Diagnostic Classroom placement.

Initiating Event: Receipt of referral

Terminating Event: Intake/Placement Staffing
OVERVIEW OF PHASE 1: INITIAL INFORMATION-GATHERING

Cf:

BEGIN

Chart 1.1
RECEIVE REFERRAL

Chart 1.2
AS INDICATED, PROCESS REQUEST FOR DIRECT SERVICE FUNDS

Chart 1.3
CONDUCT PRELIMINARY ASSESSMENT OF NEED FOR TEAM SERVICES

Chart 1.4
CONDUCT/PARTicipate in WEEKLY INTAKE STAFFING

Staff:
Program Coordinator
Diagnostic Team

Continued on next page
Phase 1 Overview Chart, Continued

Chart 1.5

PLAN/CONDUCT
INITIAL ON-SITE VISIT

Case Leader
Diagnostic Team as needed

Chart 1.5.1

CONFER WITH SENDING TEACHER

Case Leader
Diagnostic Team

Chart 1.5.2

CONDUCT ON-SITE OBSERVATION

Case Leader
Diagnostic Team

Chart 1.5.3

INTERVIEW CHILD

Case Leader or Social Worker

Chart 1.5.4

COLLECT EXISTING RECORDS

Case Leader

Chart 1.6

MAKE HOME VISIT

Social Worker

Chart 1.7

CONTACT RESOURCE PERSONS

Case Leader

Chart 1.8

REVIEW INFORMATION GATHERED; DECIDE ON NEED FOR CONTINUED TEAM SERVICES

Case Leader
Diagnostic Team

Chart 1.9

PLAN/CONDUCT/ PARTICIPATE IN PLACEMENT STAFFING

Case Leader
Diagnostic Team

END
1.1

BEGIN

RECEIVE REFERRAL

Referral Form (see p. 158)

ENTER APPROPRIATE DATA ON MASTER CLIENT REGISTRY; ASSIGN CASE NUMBER

Master Client Registry (see p. 158)

IS REFERRAL FORM CLEAR AND COMPLETE?

CONTACT SENDING SPECIAL ED DISTRICT FOR CLARIFICATION/ADDITIONAL INFORMATION

IS PARENTAL CONSENT SIGNED?

RETURN REFERRAL TO SENDING SPECIAL ED DISTRICT WITH NOTE OF EXPLANATION

IS REFERRAL FOR CONTRACTUAL MEDICAL SERVICES ONLY?

PROCESS REQUEST FOR DIRECT SERVICE FUNDS

CONDUCT PRELIMINARY ASSESSMENT OF NEED FOR TEAM SERVICES

END
Chart 1.2 PROCESS REQUEST FOR DIRECT SERVICE FUNDS

1.2 BEGIN

RECEIVE REQUEST FOR CONTRACTUAL MEDICAL SERVICES

CONTACT SPECIAL ED DISTRICT OR CASE LEADER

ARE LOCAL SOURCES OF FUNDING EXHAUSTED?

No

DENY REQUEST

Yes

GATHER INFORMATION FOR LETTER OF REQUEST TO REGIONAL RESOURCE CENTER #7

COMPOSE/FORWARD LETTER OF REQUEST TO REGIONAL RESOURCE CENTER #7

END

From sending Special Ed District or Case Leader

MEMO RE: USE OF DIRECT SERVICE FUNDS (see P. 161)

NOTE: Direct Service Funds will not be available after January 31, 1977.

Continued on next page

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Chart 1.2 Continued

1. RECEIVE RESPONSE

2. WAS REQUEST APPROVED?
   - No: CONTACT CASE LEADER AND/OR SENDING SPECIAL DISTRICT; EXPLAIN REASONS FOR DENIAL
   - Yes: ENTER APPROVAL OF DIRECT SERVICE FUNDS ON MASTER CLIENT REGISTRY

3. Time Lapse
   - RECEIVE NOTIFICATION OF SERVICES DELIVERED FROM CASE LEADER

4. ENTER SERVICES PURCHASED/DELIVERED ON MASTER CLIENT REGISTRY

5. Master Client Registry (see p. 161)

END

MEMO RE: USE OF DIRECT SERVICE FUNDS (see p. 163)

ENTER DISPOSITION ON MASTER CLIENT REGISTRY

END
Chart 1.3 CONDUCT PRELIMINARY ASSESSMENT OF NEED FOR TEAM SERVICES

Program Coordinator
Diagnostic Team

BEGIN

AS NECESSARY, CONFER WITH DIAGNOSTIC TEAM AND STAFF FROM SENDING SCHOOL

HAS PLACEMENT IN SPECIAL ED PROGRAMS BEEN INVESTIGATED?

Yes

NO

HAS PLACEMENT IN LOW INCIDENCE PROGRAMS BEEN INVESTIGATED?

Yes

NO

IS FURTHER MEDICAL SCREENING REQUIRED BEFORE PLACEMENT DECISION CAN BE MADE?

Yes

NO

DOES FAMILY QUALIFY FOR PUBLIC ASSISTANCE?

Yes

NO

IS FAMILY WILLING TO OBTAIN PUBLIC ASSISTANCE?

Yes

NO

ARRANGE FOR FAMILY TO SEEK PUBLIC ASSISTANCE; FOLLOW-UP AS NECESSARY

END

COUNSEL FAMILY RE: ACCEPTING PUBLIC ASSISTANCE

ENTER DISPOSITION ON MASTER CLIENT REGISTRY

Master Client Registry (see P. 161)

ENTER DISPOSITION ON MASTER CLIENT REGISTRY

Master Client Registry (see P. 161)

ARRANGE FOR REFERRAL OF CHILD TO LOCAL SPECIAL ED DISTRICT

END

ARRANGE FOR REFERRAL OF CHILD TO REGIONAL LOW INCIDENCE PROGRAMS

END

ENTER DISPOSITION ON MASTER CLIENT REGISTRY

Master Client Registry (see P. 161)

ARRANGE FOR REFERRAL OF CHILD TO LOCAL SPECIAL ED DISTRICT

END

CONTINUED ON NEXT PAGE
Chart 1.3 Continued

- CAN FUNDING BE ARRANGED THROUGH LOCAL SERVICE CLUBS OR CHILD AND FAMILY SERVICES? Yes → ARRANGE FOR FUNDING; FOLLOW UP AS NECESSARY
  No → CAN FUNDING BE ARRANGED THROUGH LOCAL CHAPTERS OF STATE ORGANIZATIONS?
    Yes → ARRANGE FOR FUNDING; FOLLOW UP AS NECESSARY
    No → PROCESS REQUEST FOR DIRECT SERVICE FUNDS

- IS FURTHER OBSERVATION OR TESTING REQUIRED FOR COMPLETE, ACCURATE DIAGNOSIS? No → ARE PRESCRIPTIVE SERVICES OF DIAGNOSTIC TEAM REQUIRED?
  Yes → DISCUSS REFERRAL AT WEEKLY INTAKE STAFFING
  No → END

- INAPPROPRIATE REFERRAL: INFORM SENDING SPECIAL ED DISTRICT; ENTER ON MASTER CLIENT REGISTRY (see p.161)
- Master Client Registry

END
Chart 1.4 CONDUCT/PARTICIPATE IN WEEKLY INTAKE STAFFING

1.4

BEGIN

OPEN MEETING

DISCUSS INFORMATION AVAILABLE ON NEW REFERRALS

From Referral Form
From Preliminary Assessment of Need for Team Services (Chart 1.3)

ASSIGN REFERRALS TO CASE LEADERS

Give Referral Form to Case Leader for Case Record

DISCUSS/DETERMINE NEED FOR ON-SITE OR IN-CLASSROOM SERVICES FOR EACH CHILD REFERRED

See

1.5 Initial On-Site Visit
1.6 Home Visit
1.7 Resource Persons

AS INDICATED, DISCUSS REQUIRED INITIAL INFORMATION-GATHERING ACTIVITIES FOR EACH CHILD

Continued on next page

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Page one of two
Chart 1.4 Continued

CLOSE MEETING

WERE TEAM SERVICES APPROVED?

Yes

CONTACT SENDING SPECIAL ED DISTRICT; EXPLAIN REASONS FOR DENIAL

ENTER DISPOSITION ON MASTER CLIENT REGISTRY

Master Client Registry (see p. 161)

AS NECESSARY, ENTER DATES FOR INITIAL INFORMATION-GATHERING ACTIVITIES ON TICKLER FILE

Follow-Up Form (see p. 165)

END
Chart 1.5 PLAN/CONDUCT INITIAL ON-SITE VISIT

1.5 BEGIN

MAKE CASE RECORD; FILE REFERRAL FORM

ESTABLISH OBJECTIVES FOR INITIAL ON-SITE VISIT

CONTACT SENDING TEACHER

EXPLAIN OBJECTIVES OF INITIAL ON-SITE VISIT

SET DATE FOR INITIAL ON-SITE VISIT

ASK SENDING TEACHER TO IDENTIFY AND NOTIFY OTHER APPROPRIATE PARTICIPANTS

Case Leader
Diagnostic Team as needed

Referral Form (see p.158)

Conferences with sending school staff
Observation of child
Interview with child
Records collection

Continued on next page
Chart 1.5 Continued

1.5A

ENTER CONTACT WITH SENDING TEACHER ON CASE CONTACT RECORD

Case Contact Record (see p. 166)

Confer with Sending Teacher

Conduct On-Site Observation

Interview Child

Collect Existing Records

AS NECESSARY, CONFER WITH SENDING TEACHER TO PLAN NEXT ON-SITE VISIT

RETURN TO OFFICE

FILE FORMS AND NOTES IN CASE RECORD

Initial Information-Gathering Checklist
Child Observation Record
Child Interview Record

Continued on next page
Chart 1.5 Continued

UPDATE CASE CONTACT RECORD

Case Contact Record (see p. 163)

AS NECESSARY, ENTER DATES FOR ADDITIONAL CONTACTS IN TICKLER FILE

Follow-Up Form (see p. 165)

END
Chart 1.5.1  CONFER WITH SENDING TEACHER

BEGIN

MAKE ON-SITE VISIT

MEET SENDING TEACHER AND OTHER SENDING SCHOOL STAFF; STATE OBJECTIVES OF VISIT

USING INITIAL INFORMATION-GATHERING CHECKLIST, DISCUSS/DETERMINE CHILD'S STRENGTHS AND WEAKNESSES

DISCUSS/DETERMINE/MAKE NOTE OF RECORDS AVAILABLE ON CHILD

ARRANGE FOR ACCESS TO CHILD'S RECORDS

Case Leader
Sending Teacher
Diagnostic Team as needed
Other Sending School Staff as needed

Initial Information-Gathering Checklist (see P. 167)

Medical
Academic
Psychological
Social

Continued on next page
DISCUSS/MAKE NOTE
OF OTHER PROFESSIONAL AND PARAPROFESSIONAL QUALIFICATIONS INVOLVED

DISCUSS/MAKE NOTE
OF CHILD'S PRIORITIES AND PROGRAMMING

EVIDENCE MADE

DISCUSS/MAKE NOTE
OF CHILD'S PRIORITIES

RESOURCES AND
CONSTRAINTS IF
SENDING TEACHER

PUBLIC WELFARE AGENCIES, PUBLIC HEALTH AGENCIES, MENTAL HEALTH AGENCIES, HOSPITALS, VOLUNTEER PROGRAMS, ETC.

Which placements were most successful? Least successful?

Which teaching strategies, materials, equipment, etc., have been most and least successful?

From: Public Welfare Agencies, Public Health Agencies, Mental Health Agencies, Hospitals, Volunteer Programs, etc.

END
Chart 1.5.2 CONDUCT ON-SITE OBSERVATION

1.5.2 → BEGIN

CONFER WITH 
SENDING TEACHER 
RE: OBJECTIVES 
OF OBSERVATION

IF POSSIBLE, 
ARRANGE FOR 
UNOBTRUSIVE 
OBSERVATION

USING CHILD 
OBSERVATION 
RECORD, CONDUCT 
OBSERVATION OF 
CHILD

IDENTIFY/MAKE 
NOTE OF POSITIVE 
AND NEGATIVE 
BEHAVIORS

IDENTIFY/MAKE 
NOTE OF INITIATING 
CIRCUMSTANCES

**Case Leader**

Diagnostic Classroom Teacher 
(after placement decision— see Chart 1.9)

...e.g., to see child in 
current classroom 
setting; to gather baseline 
observational data for 
comparison to post-placement 
observational data, etc.

Child 
Observation 
Record (see 
p.173)

Continued on next page
IDENTIFY/MAKE NOTE OF CONDITION UNDER WHICH BEHAVIORS ARE EXHIBITED

IDENTIFY/MAKE NOTE OF PEER AND ADULT RESPONSES TO CHILD'S BEHAVIOR

RECORD OTHER NOTEWORTHY OBSERVATIONS

TERMINATE PERIOD OF OBSERVATION.

COMPLETE OBSERVATION RECORD; DISCUSS WITH TEACHER

CONDUCT CHILD INTERVIEW

END

---

e.g., concerning learning environment, teacher attitude or activity, materials and equipment, etc.

Child Observation Record (see p.173)

See 1-5-3
Chart 1.5.3 INTERVIEW CHILD

Case Leader or Social Worker

1. INTRODUCE SELF TO CHILD; EXPLAIN HELPING ROLE

2. ASK INTRODUCTORY QUESTIONS
   - e.g., age, interests, favorite play activities, what he or she wants to be, number of brothers and sisters, etc.

3. EXPLORE WHAT CHILD LIKES/DISLIKES ABOUT HIS OR HER FAMILY
   - Information useful in isolating child’s motivational patterns (Chart 3.4.2)

4. EXPLORE WHAT CHILD LIKES/DISLIKES ABOUT HIS OR HER FRIENDS AND PEERS
   - Information useful in isolating child’s motivational patterns (Chart 3.4.2)

5. EXPLORE WHAT CHILD LIKES/DISLIKES ABOUT SCHOOL (favorite books, materials, activities, equipment, etc.)
   - Information useful in choice of instructional materials (Chart 3.4.1)

Continued on next page
Chart 1.5.3 Continued

1. Ask child what he or she would like to learn

Information useful in establishing Program Objectives (Chart 3.2)

2. As appropriate, explore child's fears

3. As appropriate, explore child's feelings during observation period

4. Terminate child interview

5. Complete child interview record

6. Collect existing records on child

---

Child Interview Record (see p.176)

---

END

See p. 54

---

Page two of two
Chart 1.5.4 COLLECT EXISTING RECORDS

1.5.4

BEGIN

REVIEW SCHOOL RECORDS ON CHILD

IDENTIFY USEFUL, RELEVANT DIAGNOSTIC INFORMATION

IDENTIFY POSSIBLE PRE-PLACEMENT MEASURES OF CHILD PERFORMANCE LEVELS (for comparison to similar post-placement data)

AS PERMITTED*, HAVE PERTINENT RECORDS COPIED OR COMPLETE STATEMENT OF RECORD EXAMINED

TERMINATE ON-SITE VISIT; RETURN TO OFFICE

END

Case Leader

Grades
Psychological Work-Ups
Teacher Remarks
Social Summaries

Grades
Psychological Test Scores
Academic Test Scores
Normative Test Scores

See Statement of Record Examined, p.172)

*Signed Parental Consent Form is required for release of records. See Parental Consent Form, p. ...
Chart 1.6 MAKE HOME VISIT

Social Worker

1.6 → BEGIN

CONTACT CHILD'S PARENTS; ARRANGE DATE AND TIME FOR HOME VISIT

MAKE HOME VISIT; INTRODUCE SELF; STATE OBJECTIVES OF VISIT; CONDUCT INTERVIEW USING HOME CALL CHECKLIST

DISCUSS/TAKE NOTES ON CHILD'S FAMILY HISTORY

DISCUSS/TAKE NOTES ON CHILD'S MEDICAL HISTORY; COMPLETE HEALTH HISTORY FORM

DISCUSS/DETERMINE/MAKE NOTE OF FAMILY'S ATTITUDE TOWARD CHILD'S HANDICAP(S)

Continued on next page
### Chart 1.6 Continued

#### DISCUSS/MAKE NOTE OF SCHOOL PLACEMENTS AND OTHER SITUATIONS IN WHICH CHILD PROGRESSED OR INDICATED INTEREST

- Information useful in planning child's optimal learning environment (see Chart 3.4.3)

#### DISCUSS/MAKE NOTE OF CHILD'S FAVORITE GAMES, TOYS, BOOKS, ACTIVITIES, ETC.

- Information useful in selection/development of instructional materials, equipment, and activities (see Chart 3.4.1)

#### DISCUSS/MAKE NOTE OF CHILD'S SOCIAL FUNCTIONING

- Child-Adult Relationships
- Child-Peer Relationships
- Play Activities
- Self-Concept

#### DISCUSS/MAKE NOTE OF PROFESSIONAL AND PARAPROFESSIONAL PERSONS INVOLVED WITH CHILD

- Family Doctor
- Hospital Personnel
- Mental Health Professionals
- Public Health Professionals
- Public Welfare Agency Staff
- Volunteers, etc.

#### DISCUSS/MAKE NOTE OF REWARDS AND PUNISHMENTS USED BY PARENTS AND THEIR EFFECTIVENESS

- Information useful in selection of reinforcement strategies (see Chart 3.4.2)

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<td><strong>DIAGNOSTIC TEAM;</strong></td>
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<td><strong>LIST QUESTIONS</strong></td>
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<td><strong>IMPLEMENTATION</strong></td>
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| **AS INDICATED,** |
| **MAKE APPOINTMENT** |
| **FOR NEXT HOME VISIT** |

| **AS INDICATED,** |
| **MAKE APPOINTMENT** |
| **FOR PARENTS TO** |
| **VISIT DIAGNOSTIC** |
| **CLASSROOM** |

| **TERMINATE HOME** |
| **VISIT; RETURN** |
| **TO OFFICE** |

---

*Continued on next page*
See 1.7A

**COMPLETE HOME CALL CHECKLIST; FORWARD TO CASE LEADER FOR CASE RECORD**

**Update Case Contact Record**

**As Necessary, Enter Dates for Future Parental Contact in Tickler File**

**Home Call Checklist (see p. 180)**

**Case Contact Record (see p. 166)**

**Follow-Up Form (see p. 165)**

**END**
Chart 1.7 CONTACT RESOURCE PERSONS

1.7 BEGIN

1.7A USING INFORMATION FROM ON-SITE VISIT AND HOME VISIT MAKE LIST OF RESOURCE PERSONS

- Home Call Checklist
- Initial Information-Gathering Checklist

CONTACT RESOURCE PERSONS

- Letter
- Phone Call

DISCUSS/MAKE NOTE OF RESOURCE PERSONS' INVOLVEMENT WITH CHILD

- Investigate nature of involvement, services provided, successes and failures with child, etc.

DISCUSS/MAKE NOTE OF WILLINGNESS AND AVAILABILITY OF RESOURCE PERSONS TO ASSIST IN PROGRAM IMPLEMENTATION

AS NECESSARY, ARRANGE FOR FUTURE CONTACT WITH RESOURCE PERSONS

- To observe methods/techniques
- To demonstrate methods/techniques
- To share information, etc.

Continued on next page

Page one of two
As necessary, enter dates for future contacts in tickler file.

Update case contact record.

Follow-up form (see p.165).

Case contact record (see p.166).
Chart 1.8 REVIEW INFORMATION GATHERED; DECIDE ON NEED FOR CONTINUED SERVICES

Case Leader
Diagnostic Team

READ/REVIEW CASE RECORD MATERIALS

AS NEEDED, CONFER WITH TEAM MEMBERS/PROGRAM COORDINATOR

IS CHILD IN NEED OF INTENSIVE EVALUATION WHICH CAN BEST BE ACCOMPLISHED IN DIAGNOSTIC CLASSROOM?

Yes

INFORM PROGRAM COORDINATOR THAT PLACEMENT STAFFING IS REQUIRED; PROVIDE LIST OF PARTICIPANTS

Participate in Placement Staffing

END

No

IS ON-SITE DIAGNOSIS OR PROGRAMMING REQUIRED?

Yes

INITIATE/CONTINUE ON-SITE DIAGNOSTIC SERVICES

End

No

INFORM PROGRAM COORDINATOR THAT EXIT STAFFING IS REQUIRED; PROVIDE LIST OF PARTICIPANTS

Participate in Exit Staffing

END

ENTER CASE DISPOSITION ON MASTER CLIENT REGISTRY

Master Client Registry (see p.161)
Chart 1.9  PLAN/CONDUCT/PARTICIPATE IN PLACEMENT STAFFING

1.9  BEGIN

1.9A  RECEIVE NOTICE FROM CASE LEADER THAT PLACEMENT STAFFING IS REQUIRED; OBTAIN LIST OF PARTICIPANTS

CONFERENCE WITH TEAM TO SET TIME, DATE, AND LOCATION FOR STAFFING

 AS NECESSARY, ARRANGE FOR MEETING FACILITY

CALL/CONTACT MEETING PARTICIPANTS; INFORM OF MEETING

Time lapse

OPEN MEETING; INTRODUCE PARTICIPANTS

DISCUSS INFORMATION AVAILABLE ON CHILD FROM INITIAL INFORMATION-GATHERING ACTIVITIES

Placement staffings may be held during the time set aside for weekly intake staffings

As applicable, discuss the following diagnostic domains:
1. Motor
2. Sensory/Perceptual
3. Speech and Language
4. Academic
5. Social/Emotional
6. Self-Help

Program Coordinator
Diagnostic Team
Sending School Staff
Parents
Resource Persons/Consultants

Continued on next page

Page one of three
Chart 1.9 Continued

DISCUSS/DETERMINE/MAKE NOTE OF WHAT FURTHER INFORMATION IS REQUIRED RE: CHILD FOR COMPLETE DIAGNOSIS

DISCUSS/DETERMINE/MAKE NOTE OF NEED FOR CLASS-ROOM PLACEMENT OR CONTINUED ON-SITE SERVICES

DISCUSS/DETERMINE/MAKE NOTE OF EXPECTATIONS PARTICIPANTS HAVE FOR DIAGNOSIS, PROGRAMMING, AND CHILD PERFORMANCE

ATTEMPT TO ESTABLISH SOME CONCURRENCE AMONG PARTICIPANTS RE: EXPECTATIONS

DISCUSS/DETERMINE/MAKE NOTE OF ROLES OF TEAM MEMBERS AND MEETING PARTICIPANTS IN DIAGNOSIS, PROGRAMMING, AND PROGRAM IMPLEMENTATION

DISCUSS/DETERMINE/MAKE NOTE OF OBJECTIVES FOR DIAGNOSIS AND PROGRAMMING

i.e., What questions are as yet unanswered?

Include strategies for ongoing involvement of parents, sending school staff, resource persons, and consultants

Continued on next page
Chart 1.9 Continued

DISCUSS/DETERMINE/MAKE NOTE OF DATE
AND TIME FOR DIAGNOSTIC CLASSROOM
TEACHER TO CONDUCT OBSERVATION OF CHILD

DISCUSS/DETERMINE/MAKE NOTE OF DATE
OF CLASSROOM
PLACEMENT AND ANTICIPATED LENGTH OF
STAY

SUMMARIZE/CLOSE
MEETING

Time lapse

ENTER CASE DISPOSITION ON MASTER
CLIENT REGISTRY

AS NECESSARY, ENTER DATES DISCUSSED DURING
MEETING IN TICKLER FILE

MASTER CLIENT
REGISTRY (see p.161)

FOLLOW-UP FORM
(see p.165)

END

INITIATE IN CLASSROOM DIAGNOSIS

WAS CHILD ACCEPTED FOR PLACEMENT IN
DIAGNOSTIC CLASSROOM?

INITIATE/CONTINUE ON-SITE
DIAGNOSIS

END

56

83
Phase 2: ON-SITE OR IN-CLASSROOM DIAGNOSIS

Objectives:

1. To conduct, through the use of formal and informal tests, classroom observation, and medical and other consultants, a complete diagnosis of the child's handicaps across all diagnostic domains.

2. To devise and implement Diagnostic Team Objectives.

3. To devise and implement a Change Plan for the child.

4. To organize and evaluate all diagnostic information.

5. To form diagnostic conclusions.

Initiating Event: Decision to initiate delivery of on-site or in-classroom services

Terminating Event: Completion of Diagnostic Summary
OVERVIEW OF PHASE 2: ON-SITE OR IN-CLASSROOM DIAGNOSIS

Chart 2.1
DEVISE/
PRIORITIZE/
SEQUENCE
DIAGNOSTIC TEAM
OBJECTIVES

Chart 2.2
DEVISE/
IMPLEMENT
CHANGE PLAN

Chart 2.3
ARRANGE FOR USE
OF MEDICAL AND
OTHER
CONSULTANTS

Chart 2.4
ARRANGE FOR USE
OF RESOURCE
PERSONS IN
DIAGNOSIS

Chart 2.5
SELECT/
ADMINISTER/
INTERPRET
FORMAL DIAG-
NOSTIC TESTS

Staff:
Case Leader
Diagnostic Team

Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)

Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)

Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)

Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)

Continued on next page
Phase 2 Overview Chart, Continued

Chart 2.6
SELECT/
ADMINISTER/
INTERPRET
INFORMAL
DIAGNOSTIC TESTS

Case Leader (On-Site)
Diagnostic Classroom Teacher
(In-Classroom)

Chart 2.7
PLAN/CONDUCT/
PARTICIPATE IN
FORMAL OR
INFORMAL
CONSULTATIVE
STAFFING

Case Leader (On-Site)
Diagnostic Classroom Teacher
(In-Classroom)
Diagnostic Team

Chart 2.8
COMPLETE
DIAGNOSTIC
SUMMARY

Case Leader

END
Devise Diagnostic Team Objectives:

1. **READ/REVIEW CASE RECORD MATERIALS**

2. **CONFERENCE WITH DIAGNOSTIC TEAM**

3. **REVIEW CHILD'S STRENGTHS AND WEAKNESSES IN EACH "DIAGNOSTIC DOMAIN"

4. **REVIEW QUESTIONS AS YET UNANSWERED RE: CHILD**

5. **REVIEW INFORMATION AVAILABLE ON CHILD'S MOTIVATIONAL PATTERNS; ISOLATE FURTHER INFORMATIONAL NEEDS**

6. **REVIEW INFORMATION AVAILABLE ON SUCCESSFUL AND UNSUCCESSFUL LEARNING ENVIRONMENTS AND TEACHING STRATEGIES**

As applicable, review the following diagnostic domains:

1. Motor
2. Sensory/Perceptual
3. Speech and Language
4. Academic
5. Social/Emotional
6. Self-Help

As necessary, refer to notes from Placement Staffing, Home Call Checklist, and Initial Information-Gathering Checklist

As necessary, refer to Initial Information-Gathering Checklist, Observation Record, Child Interview Record, and Home Call Checklist

As necessary, refer to Initial Information-Gathering Checklist, Home Call Checklist, Child Interview Record
Chart 2.1 Continued

Prioritize Diagnostic Team Objectives:

1. Objectives should address:
   1. Information required on child in each diagnostic domain
   2. Information required on child's motivational patterns
   3. Information required on optimal learning environments and teaching strategies for the child

Objectives should address:

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2. Information required on child's motivational patterns
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Prioritize Diagnostic Team Objectives:

1. Objectives should address:
   1. Information required on child in each diagnostic domain
   2. Information required on child's motivational patterns
   3. Information required on optimal learning environments and teaching strategies for the child
Sequence Diagnostic Team Objectives:

1. Prioritize Diagnostic Team Objectives
2. Sequence Diagnostic Team Objectives
3. Establish Time Frames for Achievement of Diagnostic Team Objectives
4. Assign Diagnostic Team Objectives to Appropriate Team Members
5. Write Diagnostic Team Objectives

To address:
1. Obstacles to learning
2. Integration needs
3. Teacher Questions
4. Parent Questions
5. Learning Facilitation (i.e., use of reinforcers, learning environments, and teaching strategies)

To address:
1. Priorities
2. Staff availability and time constraints
3. Logical flow in process of diagnosis

See Sample Diagnostic Team Objectives, p. 739

Continued on next page
Chart 2.1 Continued

As appropriate, distribute diagnostic team objectives to program coordinator, sending teacher, parents, and other resource persons.

As necessary, enter dates for objectives achievement in tickler file.

File diagnostic team objectives in case record.

Follow-up form (see p. 165)

Case record

End
Chart 2.2 DEVI CE/IMPLEMENT CHANGE PLAN

**Case Leader (On-Site)**
**Diagnostic Classroom Teacher (In-Classroom)**
**Diagnostic Team**

READ/REVIEW CASE MATERIALS RELEVANT TO CHANGE PLAN

AS NECESSARY, CONSULT WITH DIAGNOSTIC TEAM

DISCUSS/DETERMINE SKILLS AND BEHAVIORS WHICH CHILD CAN BE REALISTICALLY EXPECTED TO ACQUIRE, INCREASE, OR MAINTAIN DURING DIAGNOSIS AND PROGRAMMING

DISCUSS/DETERMINE BEHAVIORS WHICH CHILD CAN BE REALISTICALLY EXPECTED TO DECREASE OR EXTINGUISH DURING DIAGNOSIS AND PROGRAMMING

ESTABLISH/SEQUENCE CHANGE PLAN, BEHAVIORAL OBJECTIVES FOR CHILD

Continued on next page
Chart 2.2 Continued

AS APPROPRIATE, DISCUSS CHANGE PLAN BEHAVIORAL OBJECTIVES WITH CHILD

AS APPROPRIATE, DISTRIBUTE CHANGE PLAN BEHAVIORAL OBJECTIVES TO DIAGNOSTIC TEAM, SENDING TEACHER, AND PARENTS

DETERMINE BEHAVIORS FOR WHICH ADEQUATE BASELINE DATA IS AVAILABLE (i.e., on frequency of behavior)

See Observation Record Initial Information-Gathering Checklist

COLLECT BASELINE DATA ON BEHAVIORS FOR WHICH NONE IS AVAILABLE

Rate of daily/weekly/monthly performance or Always/Often/Sometimes/Seldom/Never

LIST BEHAVIORS AND BASELINE FREQUENCY ON BEHAVIORAL CHARTS

See Sample Change Plan, p. 241)

Continued on next page
Chart 2.2 Continued

CONDUCT ONGOING OBSERVATION AND BEHAVIORAL CHARTING DURING DIAGNOSIS AND PROGRAM DEVELOPMENT AND TESTING

FIELD TEST REINFORCEMENT STRATEGIES BY NOTING USE OF REINFORCERS ON BEHAVIORAL CHARTS

EVALUATE SUCCESS OF CHANGE PLAN

END

See 5.5.2

See 4.1
Chart 2.3  ARRANGE FOR USE OF MEDICAL AND OTHER CONSULTANTS

2.3

BEGIN

Case Leader
Diagnostic Team

READ/REVIEW
DIAGNOSTIC TEAM
OBJECTIVES

AS NECESSARY,
CONSULT WITH
DIAGNOSTIC TEAM

DISCUSS/DETERMINE
CHILD'S NEED FOR
MEDICAL AND OTHER
PURCHASED DIAGNOSTIC
TESTING

DISCUSS/DETERMINE
MEDICAL OR OTHER
CONSULTANT BEST
SUITED TO PROVIDE
SERVICE

SUBMIT REQUEST
FOR CONTRACTUAL
MEDICAL SERVICES
TO PROGRAM
COORDINATOR *

Time lapse

Continued on next page

*Direct Service Funds for Contractual Medical Services are not available from the RRC after January 31, 1977.
Chart 2.3 Continued

RECEIVE RESPONSE FROM PROGRAM COORDINATOR

WAS USE OF DIRECT SERVICE FUNDS APPROVED? No

CONTACT CONSULTANT; MAKE APPOINTMENT; EXPLAIN INVOICING PROCEDURES; REQUEST REPORT

SEND LETTER OF CONFIRMATION TO CONSULTANT

ARRANGE FOR USE OF ALTERNATIVE FUNDING SOURCES

ARRANGE FOR USE OF RESOURCE PERSON(S) (non-purchased)

END

To include:
- Confirmation of appointment
- Copy of parental consent (from Referral Form)
- Invoicing procedures
- Request for report

Continued on next page
ENTER REMINDFR IN TICKLER FILE

CONTACT CHILD'S PARENTS RE: TIME AND DATE OF APPOINTMENT

AS NECESSARY, ARRANGE TRANSPORTATION

RECEIVE/REVIEW REPORT FROM CONSULTANT-

FILE IN CASE RECORD

Follow-Up Form (see p. 165)

PAGE THREE OF FOUR
Chart 2.3 Continued

AS NECESSARY, CONTACT CONSULTANT FOR CLARIFICATION/ADDITIONAL INFORMATION

AS NECESSARY, ARRANGE FOR CONFERENCE WITH (or demonstration by) CONSULTANT

INFORM PROGRAM COORDINATOR OF SERVICES DELIVERY

See 1.2E

END
Chart 2.4 ARRANGE FOR USE OF RESOURCE PERSONS IN DIAGNOSIS

BEGIN

READ/REVIEW DIAGNOSTIC TEAM OBJECTIVES AND LIST OF RESOURCE PERSONS

AS NECESSARY, CONFER WITH DIAGNOSTIC TEAM

DISCUSS/DETERMINE NEED FOR USE OF RESOURCE PERSONS IN DIAGNOSIS

DISCUSS/DETERMINE RESOURCE PERSONS BEST ABLE TO PROVIDE DIAGNOSTIC SERVICE

CONTACT RESOURCE PERSON(S); MAKE NECESSARY APPOINTMENT(S) FOR CHILD AND/OR SELF

See 2.7

Case Leader
Diagnostic Team

0.B._ Hospital personnel, mental health professionals, public health professionals, public welfare agency staff, volunteers, public and private school personnel, etc.

Continued on next page
Chart 2.4 Continued

AS APPROPRIATE, REQUEST WRITTEN REPORT FROM RESOURCE PERSON(S)

AS NECESSARY, CONTACT CHILD'S PARENTS RE: APPOINTMENT; ARRANGE TRANSPORTATION

ENTER REMEMBER IN TICKLER FILE

Time lapse

AS INDICATED, CONFER WITH RESOURCE PERSON RE: CHILD AND/OR OBSERVE RESOURCE PERSON WORKING WITH CHILD

AS NECESSARY, PLAN FUTURE CONTACTS WITH RESOURCE PERSON

Follow-Up Form (see p. 165)

Continued on next page
Chart 2.4 Continued

1. **ENTER REMINDER IN TICKLER FILE**
2. **UPDATE CASE CONTACT RECORD**
3. **AS PLANNED, RECEIVE/READ REPORT FROM RESOURCE PERSON**
4. **FILE IN CASE RECORD**

END

Follow-Up Form (see p.165)

Case Contact Record (see p.166)

Case Record
Chart 2.5 SELECT/ADMINISTER/INTERPRET FORMAL DIAGNOSTIC TESTS

BEGIN

REVIEW DIAGNOSTIC TEAM OBJECTIVES FOR EACH DIAGNOSTIC DOMAIN

ISOLATE THOSE OBJECTIVES BEST ADDRESSED THROUGH FORMAL TESTING

IDENTIFY/OBTAIN FORMAL TEST(S) TO ADDRESS OBJECTIVES

READ/REVIEW/EVALUATE FORMAL TEST(S)

IS TEST APPROPRIATE TO CHILD'S LEVEL OF DEVELOPMENT?

SELECT A DIFFERENT TEST

Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)
Diagnostic Team

See Appendix, "Formal Diagnostic Tests," pp. 193
See also CORRC Publication

Continued on next page
Chart 2.5 Continued

Is child capable of response required on test? No, test be adapted to child's response capabilities? No.

Select a different test

Is appropriate staff available for administration of test? No.

Select a different test.

See 2.5A

Is length of test appropriate to child attention span and staff availability? No, portions be shortened or omitted? No.

Select a different test.

See 2.5A

Is length of test appropriate to child attention span and staff availability? Yes.

Condense test as necessary.

Continued on next page
Chart 2.5 Continued

Are all portions of the test relevant to diagnostic team objectives? [Yes/No]
If No, omit irrelevant portions of test.

Is type of scoring (mental age, IQ, grade level, etc.) appropriate to diagnostic team objectives? [Yes/No]
If No, select a different test (See 2.5A).

Administer test according to published guidelines and/or modifications made.

Score test; enter results on formal test score worksheet.

Interpret test according to published guidelines and/or modifications made.

Compare/crosscheck formal test results against informal test results.

End.
Chart 2.6 SELECT/ADMINISTER/INTERPRET INFORMAL DIAGNOSTIC TESTS

2.6 BEGİN

READ/REVIEW DIAGNOSTIC TEAM OBJECTIVES; ISOLATE THOSE BEST ADDRESSED BY INFORMAL TESTING

REVIEW FORMAL TESTS PLANNED OR ADMINISTERED; DETERMINE WHICH NEED CORROBORATION THROUGH INFORMAL TESTING

IDENTIFY/OBTAIN CHECKLISTS, DEVELOPMENTAL SCALES, AND TASK INVENTORIES APPROPRIATE TO CHILD'S SKILL LEVEL IN EACH DIAGNOSTIC DOMAIN

READ/REVIEW/ EVALUATE EACH CHECKLIST/SCALE/ INVENTORY

IS IT APPROPRIATE TO CHILD'S RESPONSE CAPABILITIES?

No  MODIFY AS NECESSARY OR SELECT A DIFFERENT CHECKLIST, SCALE, OR INVENTORY

Yes  See Appendix B Bibliography of Behavioral Checklists, pp. 313)

Continued on next page

Page one of four
Chart 2.6 Continued

IS ITS SEQUENCING CONSISTENT WITH CHILD'S DEVELOPMENTAL SEQUENCE?

Yes

RES SEQUENCE ITEMS ON CHECKLIST, SCALE, OR INVENTORY

No

DOES IT CONTAIN AN APPROPRIATE NUMBER OF DEVELOPMENTAL STEPS?

Yes

AS NECESSARY, ADD OR DELETE ITEMS TO DEVISE FLOW OF GRADUATED STEPS APPROPRIATE TO CHILD'S NEEDS

No

CONSOLIDATE TWO OR MORE CHECKLISTS, SCALES OR INVENTORIES OR ADD TASKS AS NECESSARY

IS IT COMPLETE?

Yes

DETERMINE MATERIALS REQUIRED FOR INFORMAL TESTING

No

SEE APPENDIX, "BIBLIOGRAPHY OF INSTRUCTIONAL MATERIALS AND EQUIPMENT," PP. 305

SELECT/OBTAIN REQUIRED OFF-THE-SHELF MATERIALS

Continued on next page
Chart 2.6 Continued

SELECT/OBTAIN REQUIRED EQUIPMENT

AS NECESSARY, DEVISE TEACHER-MADE MATERIALS, EQUIPMENT, ACTIVITIES, AND TASKS

CONDUCT INFORMAL TESTING

BEGIN WITH TASKS OR ACTIVITIES THAT CHILD IS CAPABLE OF PERFORMING

PROGRESS UP CHECKLIST, SCALE, OR INVENTORY UNTIL CHILD IS UNABLE TO GO ANY FARTHER

TRY TWO OR THREE ADDITIONAL STEPS TO MAKE CERTAIN THAT CHILD (or checklist) IS NOT OUT OF SEQUENCE

Continued on next page

See Appendix, "Bibliography of Instructional Materials and Equipment," pp. 305

106 Page three of four
Chart 2.6 Continued

ENTER CHILD'S INFORMAL TEST RESULTS ON INFORMAL TEST SCORE WORKSHEET

Informal Test Score Worksheet (see p. 194)

AS APPLICABLE, CROSSCHECK RESULTS AGAINST FORMAL TEST SCORES

See 2.5

END
Chart 2.7 PLAN/CONDUCT/PARTICIPATE IN FORMAL OR INFORMAL CONSULTATIVE STAFFING

BEGIN

DETERMINE NEED/SET OBJECTIVES FOR CONSULTATIVE STAFFING

AS NECESSARY, CONFER WITH TEAM TO ESTABLISH DATE, TIME, AND LOCATION FOR STAFFING

AS NECESSARY, ARRANGE FOR MEETING FACILITY

CONTACT DESIRED PARTICIPANTS; INFORM OF TIME, DATE, AND LOCATION OF MEETING

e.g., Information-sharing
Problem-solving
Goal-setting

Parents, sending school staff, other resource persons

Time lapse

OPEN MEETING; INTRODUCE PARTICIPANTS

Continued on next page
Chart 2.7 Continued

- Discuss meeting objectives and issues

- Obtain input from participants on topics of discussion

- As appropriate, discuss placements, persons, strategies, materials, etc. that have been successful with the child

- As appropriate, discuss placements, persons, strategies, materials, etc. that have not been successful with the child

- As appropriate, discuss/determine alternate or supplemental approaches to diagnosis and/or program development and testing

- As appropriate, discuss/determine alternate approaches to services delivery and/or program implementation

Continued on next page
Chart 2.7 Continued

ATTEMPT TO ESTABLISH CONCURRENCE AMONG MEETING PARTICIPANTS ON ISSUES/TOPICS OF DISCUSSION

AS NECESSARY, REDEFINE TEAM MEMBER ROLES OR TASKS

AS NECESSARY, REDEFINE DIAGNOSTIC TEAM OBJECTIVES, CHANGE PLAN, AND/OR PROGRAM OBJECTIVES

SUMMARIZE/CLOSE MEETING

UPDATE CASE RECORD AS NECESSARY

ENTER OUTCOME(S) OF STAFFING ON MASTER CLIENT REGISTRY

Master Client Registry (see p. 161)

END
Chart 2.8 COMPLETE DIAGNOSTIC SUMMARY

[Diagram with steps]

1. **BEGIN**

2. **READ/REVIEW CASE RECORD MATERIALS**

3. **CONSOLIDATE/SUMMARIZE DIAGNOSTIC INFORMATION; FORM DIAGNOSTIC CONCLUSIONS**

   - Case Leader (On-Site)
   - Diagnostic Classroom Teacher (In-Classroom)

4. **COMPLETE DIAGNOSTIC SUMMARY**

5. **ATTACH RECORDS AND FORMS USEFUL TO RECEIVING TEACHER**

6. **FORWARD COPIES TO SENDING/RECEIVING SCHOOL, TEAM MEMBERS, PROGRAM COORDINATOR, AND PARENTS**

7. **AS NECESSARY, ARRANGE TO DISCUSS DIAGNOSTIC SUMMARY WITH SENDING/RECEIVING SCHOOL, PARENTS, ETC.**

   - Referral Format, Initial Information-Gathering Checklist, Observation Record, Home Call Checklist, Child Interview Record, Case Contact Record, Diagnostic Objectives, Change Plan, Formal and Informal Test Score Worksheets, Behavioral Charts, School Records, Doctor Reports, etc.

   - To include:
     - Reasons for Referral
     - Diagnostic Objectives
     - Summary of General Diagnostic Information
     - Summary of Diagnostic Information by Domain

8. **END**
Phase 3: PROGRAM DEVELOPMENT AND TESTING

Objectives:

1. To establish long and short range program objectives.
2. To devise, test, modify, retest, and finalize program prescriptions.
3. To devise placement recommendations and follow-up plans.

Initiating Event: Formation of Program Objectives

Terminating Event: Completion of Individual Educational Plan
OVERVIEW OF PHASE 3: PROGRAM DEVELOPMENT AND TESTING

BEGIN

Chart 3.1
DEVISE LONG RANGE PROGRAM OBJECTIVES
Case Leader
Diagnostic Team

Chart 3.2
DEVISE SHORT RANGE PROGRAM OBJECTIVES
Case Leader
Diagnostic Team

Chart 3.3
CONDUCT TASK ANALYSIS
Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)

Chart 3.4
DEVISE INITIAL PROGRAM PRESCRIPTIONS
Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)

Chart 3.4.1
IDENTIFY/SELECT/DEVISE INSTRUCTIONAL MATERIALS AND EQUIPMENT
Case Leader (On-Site)
Diagnostic Teacher (In-Classroom)

Chart 3.4.2
SELECT/DEVISE REINFORCEMENT STRATEGIES
Case Leader (On-Site)
Diagnostic Teacher (In-Classroom)

Chart 3.4.3
DETERMINE OPTIMAL LEARNING ENVIRONMENT AND TEACHING STRATEGIES
Case Leader (On-Site)
Diagnostic Teacher (In-Classroom)

Continued on next page
Phase 3 Overview Chart, Continued

Chart 3.9

DEVISE PLANS FOR FOLLOW-UP SERVICES AND POST-PLACEMENT DATA COLLECTION

Chart 3.10

WRITE INDIVIDUAL EDUCATIONAL PLAN

Case Leader
Diagnostic Team

Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)

END
Chart 3.1 DEVISE LONG-RANGE PROGRAM OBJECTIVES

3.1 BEGIN

READ REVIEW DIAGNOSTIC SUMMARY AND OTHER RELEVANT CASE MATERIALS

AS NECESSARY, CONFER WITH TEAM MEMBERS

FOR EACH DIAGNOSTIC DOMAIN, DISCUSS/DETERMINE/MAKE NOTE OF FUTURE GOALS FOR CHILD

FOR EACH DIAGNOSTIC DOMAIN, WRITE LONG-RANGE PROGRAM OBJECTIVES

END

Case Leader
Diagnostic Team

see sample
long-range program objectives, p. 251)

i.e., given the best possible placements and programming, what levels of proficiency/functioning could the child ultimately attain?

See Sample Long-Range Program Objectives, p. 251

Diagnostic Summary
Child Interview Record
Etc.

See 2.7
Chart 3.2 DEVISE/PRIORITIZE/SEQUENCE SHORT RANGE PROGRAM OBJECTIVES

3.2 → BEGIN

READ/REVIEW DIAGNOSTIC SUMMARY

Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)

READ/REVIEW LONG RANGE PROGRAM OBJECTIVES; ISOLATE SKILLS AND SUBSKILLS THE CHILD MUST ACQUIRE TO ACHIEVE THEM

SEE SAMPLE Diagnostic Summary, p.

SEE Long-Range Program Objectives

AS NECESSARY, CONFER WITH DIAGNOSTIC TEAM

FOR EACH DIAGNOSTIC DOMAIN, DISCUSS/DETERMINE/MAKE NOTE OF CHILD'S OBSTACLES TO LEARNING

FOR EACH DIAGNOSTIC DOMAIN, DISCUSS/DETERMINE/MAKE NOTE OF CHILD'S NORMALIZATION NEEDS

i.e., those behavioral, psychological, and physical blocks that prevent learning

i.e., what does the child need in terms of academics, behavioral change, self-help skills, social skills, etc. to be successfully integrated into his or her anticipated placement and to move toward achievement of the Long Range Program Objectives?

Continued on next page
Chart 3.2 Continued

READ/REVIEW/DISCUSS PARENT AND Sending Teacher EXPECTATIONS FOR CHILD PERFORMANCE

See Initial Information-Gathering Checklist

Home Call Checklist

DISCUSS/DETERMINE/MAKE NOTE OF WHAT CHILD IS MOTIVATED TO DO AND LEARN

Refer to Child Interview Record

FOR EACH DIAGNOSTIC DOMAIN, DISCUSS/DETERMINE/MAKE NOTE OF CHILD'S CURRENT PERFORMANCE CAPABILITIES

See Formal and Informal Test Score Worksheets

Diagnostic Summary

ESTABLISH/MAKE NOTE OF SHORT-RANGE OBJECTIVES

To reflect:
1. Removal of obstacles to learning
2. Normalization needs
3. Teacher and parent performance expectations
4. Child's learning preferences

PRIORITIZE SHORT-RANGE OBJECTIVES

Continued on next page
Chart 3.2 Continued

SEQUENCE SHORT-RANGE OBJECTIVES

To reflect (for each diagnostic domain):
1. Priorities
2. Logical developmental flow
3. Availability of human and material resources

WRITE SHORT-RANGE PROGRAM OBJECTIVES

See Sample Short-Range Program Objectives, p.253

ATTACH LONG-RANGE OBJECTIVES AND DISTRIBUTE TO SENDING/RECEIVING TEACHER(S), PARENTS, AND OTHER PROGRAM IMPLEMENTERS

RETAIN COPY FOR CASE RECORD

COMMUNICATE SHORT-RANGE PROGRAM OBJECTIVES TO CHILD

END

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Chart 3.3 CONDUCT TASK ANALYSIS

3.3 BEGIN

READ/REVIEW SHORT-RANGE PROGRAM OBJECTIVES

ISOLATE CHILD'S CURRENT LEVEL OF FUNCTIONING IN RELATION TO EACH SHORT-RANGE PROGRAM OBJECTIVE

AS APPROPRIATE, ISOLATE CHILD'S RESPONSE CAPABILITIES IN RELATION TO EACH SHORT-RANGE PROGRAM OBJECTIVE

IDENTIFY/DETERMINE ALL TASKS AND ACTIVITIES CHILD MUST MASTER TO ACHIEVE SHORT-RANGE PROGRAM OBJECTIVES

SEQUENCE TASKS AND ACTIVITIES BY INCREASING DIFFICULTY

Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)

Refer to Formal and Informal Test Score Worksheets and Behavioral Charts

As necessary, employ behavioral checklists, developmental scales, activity guides, task inventories, etc. (See Appendix, "Bibliography of Behavioral Checklists", pp. 313)

Continued on next page
LIST SEQUENTIAL TASKS AND ACTIVITIES FOR EACH SHORT-RANGE OBJECTIVE BY DIAGNOSTIC DOMAIN

AS NECESSARY, DISTRIBUTE COMPLETED TASK ANALYSIS TO DIAGNOSTIC TEAM AND PROGRAM COORDINATOR

See Sample Task Analysis, P.

Retain copy for Case Record

END
Chart 3.4  DEVISE INITIAL PROGRAM PRESCRIPTIONS

Case Leader (On-Site)
Diagnostic Classroom
Teacher (in-Classroom)

READ/REVIEW CASE MATERIALS

Diagnosis Summary
Long-Range Program Objectives
Short-Range Program Objectives
Task Analysis

SELECT/DEVISE REINFORCEMENT STRATEGIES

SELECT/DEVISE INSTRUCTIONAL MATERIALS EQUIPMENT

END
Chart 3.4.1 IDENTIFY/SELECT/DEVISE INSTRUCTIONAL MATERIALS AND EQUIPMENT

BEGIN

READ/REVIEW SHORT-RANGE PROGRAM OBJECTIVES AND TASK ANALYSIS

READ/REVIEW INFORMATION ON BOOKS, GAMES, MATERIALS, AND EQUIPMENT THE CHILD LIKES

AS NECESSARY, REFER TO ACTIVITY CURRICULUM GUIDES

AS NECESSARY, IDENTIFY MATERIALS CORRELATED TO SCORES ON FORMAL TESTS THE CHILD HAS BEEN GIVEN

SELECT INSTRUCTIONAL MATERIALS AND EQUIPMENT REQUIRED TO TRAIN CHILD IN TASKS AND ACTIVITIES FROM TASK ANALYSIS

See: Initial Information-Gathering Checklist
Home Call Checklist
Child Interview Record

See also Appendix, "Bibliography of Instructional Materials and Equipment," pp. 303

Continued on next page
Chart 3.4.1 Continued

- **IS MATERIAL/EQUIPMENT AVAILABLE?**
  - Yes
    - DEVISE TEACHER-MADE MATERIALS/EQUIPMENT
  - No
    - EVALUATE MATERIALS/EQUIPMENT

- **CAN SIMILAR TEACHER-MADE MATERIALS/EQUIPMENT BE DEvised?**
  - Yes
    - SELECT DIFFERENT MATERIALS/EQUIPMENT
  - No
    - MODIFY EXISTING MATERIALS/EQUIPMENT

- **DOES IT FIT THE AGE, SIZE, LEVEL, AND RESPONSE CAPABILITIES OF THE CHILD?**
  - Yes
    - MODIFY MATERIALS/EQUIPMENT AS APPROPRIATE
  - No
    - SELECT DIFFERENT MATERIALS/EQUIPMENT

*Continued on next page*
Chart 3.4.1 Continued

DOES IT FIT THE TASKS REQUIRED BY THE SHORT RANGE PROGRAM OBJECTIVES?

Yes

CAN IT BE MODIFIED TO DO SO?

Yes

MODIFY MATERIALS/ EQUIPMENT AS APPROPRIATE

No

CHOOSE DIFFERENT MATERIALS/ EQUIPMENT

CAN IT BE USED TO MEET MORE THAN ONE SHORT-RANGE PROGRAM OBJECTIVE OR TASK?

Yes

CAN IT BE MODIFIED TO DO SO?

Yes

MODIFY MATERIALS/ EQUIPMENT AS APPROPRIATE

No

CHOOSE DIFFERENT MATERIALS/ EQUIPMENT

IS THERE ANYTHING ELSE WHICH COVERS AS MANY OBJECTIVES AND HAS OTHER ADVANTAGES?

Yes

CHOOSE DIFFERENT MATERIALS/ EQUIPMENT

See 3.4.1A

No

IS IT FLEXIBLE ENOUGH TO BE ADAPTED TO THE INDIVIDUAL CHILD?

Yes

See 3.4.1A

No

CHOOSE DIFFERENT MATERIALS/ EQUIPMENT

Continued on next page
Chart 3.4.1 Continued

IS IT REAL IN THE CONTEXT OF THE CHILD'S NATURAL ENVIRONMENT? No

CAN IT BE MODIFIED TO BE MORE REALISTIC? No

MODIFY MATERIALS/EQUIPMENT AS APPROPRIATE

Yes

CAN IT BE EASILY USED BY CHILDREN AND/OR ADULTS? No

MODIFY AS APPROPRIATE OR CHOOSE DIFFERENT MATERIALS/EQUIPMENT

See 3.4.1A

Yes

IS IT CONSISTENT WITH THE CHILD'S PREFERENCES? No

MODIFY AS APPROPRIATE OR CHOOSE DIFFERENT MATERIALS/EQUIPMENT

See 3.4.1A

Yes

IT ALLOW ADEQUATE PRACTICE FOR THE CHILD? No

MODIFY AS APPROPRIATE OR CHOOSE DIFFERENT MATERIALS/EQUIPMENT

See 3.4.1A

Continued on next page
Chart 3.4.1 Continued

IS IT DURABLE AND SAFE? 

Yes

NO

CHOOSE DIFFERENT MATERIALS/EQUIPMENT

See 3.4.1A

CAN IT BE EASILY MOVED AND STORED?

YES

NO

MODIFY AS APPROPRIATE OR CHOOSE DIFFERENT MATERIALS/EQUIPMENT

See 3.4.1A

IS AVAILABLE OTHER THAN THROUGH PROGRAM FUNDS?

YES

ARRANGE TO OBTAIN MATERIALS/EQUIPMENT OTHER THAN THROUGH PROGRAM FUNDS

e.g., through shop class, volunteer service, direct from publisher, etc.

NO

ARRANGE FOR PURCHASE OF MATERIALS/EQUIPMENT THROUGH PROGRAM FUNDS

TEST MATERIALS AND EQUIPMENT

See 3.5.

END
Chart 3.4.2 SELECT/DEVISE REINFORCEMENT STRATEGIES

BEGIN

READ/REVIEW INFORMATION AVAILABLE ON CHILD'S MOTIVATIONAL PATTERNS

DETERMINE WHICH REWARDS HAVE BEEN SUCCESSFULLY USED WITH THE CHILD AND BY WHOM

GENERATE A LIST OF SUCCESSFUL REWARDS AND SIMILAR ALTERNATIVES

DETERMINE WHICH PUNISHMENTS HAVE BEEN SUCCESSFULLY USED AND BY WHOM

DECIDE ON/SEQUENCE/LIST REINFORCERS TO BE TESTED

END

Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)

From:
- Initial Information-Gathering Checklist
- Observation Record
- Child Interview Record
- Home Call Checklist
- Behavioral Charts

e.g., gold stars, m&m's, cereal, praise, free time, grades, field trips, physical affection, use of record player or other special equipment, participation in games or other group activities, etc.

e.g., shouting, stern talking to, red pencil, threats, poor grades, removal from group, cutting back recess or other privileges, etc.

See

Sequence as follows:
1. Positive reinforcers with greatest likelihood of success
2. Withdrawal of positive reinforcers
3. Negative reinforcers
Chart 3.5  TEST INITIAL PROGRAM PRESCRIPTIONS

BEGIN

ISOLATE PROGRAM PRESCRIPTIONS IN NEED OF TESTING; DECIDE ON SEQUENCING OF TESTING

USING FIELD TEST WORKSHEET, TEST INITIAL PROGRAM PRESCRIPTIONS

Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)

Some prescriptions may have been adequately field-tested during the administration of informal tests during Phase 2, Diagnosis

Field Test Worksheet (see p.198)

TEST INSTRUCTIONAL MATERIALS AND EQUIPMENT

See 3.5.1

TEST REINFORCEMENT STRATEGIES

See 3.5.2

TEST LEARNING ENVIRONMENT VARIABLES AND TEACHING STRATEGIES

See 3.5.3

AS INDICATED, MODIFY, REVISE, ADD, AND/OR DELETE PROGRAM PRESCRIPTIONS

END
Chart 3.4.3 DETERMINE OPTIMAL LEARNING ENVIRONMENT AND TEACHING STRATEGIES

3.4  BEGIN

READ/REVIEW RELEVANT CASE MATERIALS

DETERMINE WHICH LEARNING ENVIRONMENTS AND TEACHING STRATEGIES HAVE WORKED BEST WITH THE CHILD

DETERMINE WHICH LEARNING ENVIRONMENTS AND TEACHING STRATEGIES HAVE NOT WORKED WITH THE CHILD

ISOLATE LEARNING ENVIRONMENT VARIABLES AND TEACHING STRATEGIES WHICH MAY BE MANIPULATED DURING PROGRAM DEVELOPMENT AND TESTING

GENERATE LIST OF LEARNING ENVIRONMENT VARIABLES AND TEACHING STRATEGIES TO BE TESTED

TEST LEARNING ENVIRONMENT VARIABLES AND TEACHING STRATEGIES

END

Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)

Initial Information-Gathering Checklist
Observation Record
Child Interview Record
Home Call Checklist

E.g., class size, student-teacher ratio, noise level, child positioning, type of desk, child mobility, degree of group involvement, degree of supervision, time of day, length and complexity of child activity, diversity of assignments, teacher attitude, mode of presentation of instructional materials (e.g., lecture, games, self-instructional, peer-teaching) concentration on strong vs. weak learning channels, meeting multiple objectives through one activity, etc.
Chart 3.5.1  TEST INSTRUCTIONAL MATERIALS AND EQUIPMENT

BEGIN

AS APPROPRIATE, PICK REINFORCEMENT STRATEGY TO TEST SIMULTANEOUSLY

AS APPROPRIATE, ARRANGE LEARNING ENVIRONMENT; CHOOSE TEACHING STRATEGY TO TEST SIMULTANEOUSLY

TEST INSTRUCTIONAL MATERIALS AND EQUIPMENT USING FIELD TEST WORKSHEET

AS NECESSARY, INSTRUCT CHILD IN USE OF MATERIAL/EQUIPMENT

AS NECESSARY, PROVIDE ONGOING SUPERVISION/DIRECTIONS

Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)

Field Test Worksheet (see p.198)

Continued on next page
Chart 3.5.1 Continued

OBSERVE CHILD'S RESPONSE TO MATERIALS/EQUIPMENT

RESPOND TO CHILD, USING CHOSEN REINFORCERS AS APPROPRIATE

IS CHILD CAPABLE OF AN ADEQUATE AND APPROPRIATE RESPONSE?

Yes

No

CAN MATERIALS/EQUIPMENT BE MODIFIED (length, difficulty, type of response, etc.)?

Yes

No

ELIMINATE MATERIALS/EQUIPMENT; CHOOSE DIFFERENT MATERIALS/EQUIPMENT

NOTE REQUIRED REVISIONS ON FIELD TEST WORKSHEET

REVISE/RETEST INSTRUCTIONAL MATERIALS/EQUIPMENT

See 3.6

See 3.5.2

Field Test Worksheet (see p. 198)

Continued on next page

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Page two of three

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Chart 3.5.1 Continued

1. NOTE TEST OUTCOMES ON FIELD TEST WORKSHEET (see p. 198)
2. REVISIT/RETEST INSTRUCTIONAL MATERIALS/EQUIPMENT
3. NOTE REQUIRED REVISIONS ON FIELD TEST WORKSHEET (see p. 198)
4. Field Test, see Field Test Worksheet (see p. 198)
5. MATERIAL OR EQUIPMENT TO BE MODIFIED? NO
6. ELIMINATE MATERIAL/EQUIPMENT; CHOOSE DIFFERENT
7. Can MATERIAL OR EQUIPMENT BE MODIFIED? NO
8. GENERATE EXPERIENCE?
   - Yes
   - No
9. REVISE/RETEST INSTRUCTIONAL MATERIALS/EQUIPMENT

See p. 3.6

END
Chart 3.5.2 TEST REINFORCEMENT STRATEGIES

BEGIN

IDENTIFY TASKS, ACTIVITIES, MATERIALS, AND EQUIPMENT TO BE USED DURING TEST OF REINFORCEMENT STRATEGIES

DETERMINE CHILD'S BASELINE TASK PERFORMANCE; NOTE ON FIELD TEST WORKSHEET OR BEHAVIORAL CHART

DETERMINE POSSIBLE AVERSIVE CONSEQUENCES TO TASK PERFORMANCE; ATTEMPT TO ELIMINATE THEM

SYSTEMATICALLY ADMINISTER SELECTED REINFORCERS IMMEDIATELY AFTER TASK PERFORMANCE

OBSERVE CHILD'S RESPONSE; NOTE ON FIELD TEST WORKSHEET OR BEHAVIORAL CHART

Refer to Change Plan, Task Analysis, and Chart 3.5.1

Field Test Worksheet (see p.198)
Behavioral Chart (see p.257)

i.e., through engineering of the learning environment and/or choice of teaching strategies (see Chart 3.5.3)

i.e., during Change Plan implementation (see Chart 2.2) or testing of instructional materials and equipment (see Chart 3.5.1)

Field Test Worksheet (see p.198)
Behavioral Chart (see p.257)

Continued on next page
**NOTE: In testing reinforcers, always begin with positive reinforcers with greatest likelihood of success. For extreme cases, positive reinforcers may be withheld, however, if a reinforcer is truly positive in the first place, negative ones should not be necessary.**
BEGIN

WHILE TESTING MATERIALS/EQUIPMENT AND REINFORCERS, SYSTEMATICALLY VARY LEARNING ENVIRONMENT VARIABLES AND TEACHING STRATEGIES

DETERMINE IF AND HOW LEARNING ENVIRONMENT AND TEACHING STRATEGIES AFFECT CHILD LEARNING OR TASK PERFORMANCE

ENTER OUTCOMES ON FIELD TEST WORKSHEET

Field Test Worksheet (see p. 198)

END

For a listing of learning environment variables and teaching strategies, see Chart 3.4.3
Chart 3.6 REVERSE/RETEST PROGRAM PRESCRIPTIONS

BEGIN

READ/REVIEW FIELD TEST WORKSHEETS

FIELD TEST WORKSHEETS

IDENTIFY LEAST SUCCESSFUL PROGRAM PRESCRIPTIONS

INSTRUCTIONAL MATERIALS/EQUIPMENT

REINFORCERS

LEARNING ENVIRONMENT VARIABLES

TEACHING STRATEGIES

CAN PROGRAM PRESCRIPTION BE MODIFIED?

Yes

MODIFY PROGRAM PRESCRIPTION; RETEST AS NECESSARY (See Charts 3.5.1, 3.5.2, and 3.5.3)

FIELD TEST WORKSHEET

No

WAS MODIFIED PROGRAM PRESCRIPTION MORE SUCCESSFUL?

Yes

NOTE ON FIELD TEST WORKSHEET

No

AS NECESSARY, OMIT OR REPLACE RETEST PROGRAM PRESCRIPTION

END

Continued on next page 137

Page one of two

Page 110
Chart 3.6 Continued

WAS PROGRAM PRESCRIPTION CRITICAL TO ACHIEVEMENT OF PROGRAM OBJECTIVES?  
Yes

ELIMINATE PROGRAM PRESCRIPTION

NOTE ON FIELD TEST WORKSHEET

Field Test Worksheet

END

See 3.4.

REPLACE/RETEST PROGRAM PRESCRIPTION

WAS MODIFIED PROGRAM PRESCRIPTION MORE SUCCESSFUL?  
Yes

NOTE ON FIELD TEST WORKSHEET

Field Test Worksheet

END
Chart 3.7 FINALIZE PROGRAM PRESCRIPTIONS, PLACEMENT RECOMMENDATIONS, AND IMPLEMENTATION PLANS

3.7 BEGIN

Case Leader
Diagnostic Team

READ/REVIEW FIELD TEST WORKSHEETS

Field Test Worksheets

AS NECESSARY, CONSULT WITH DIAGNOSTIC TEAM

See 2.7

DISCUSS RESULTS OF TESTING OF PROGRAM PRESCRIPTIONS

See Charts 3.5.1, 3.5.2, 3.5.3, and 3.6

DISCUSS/DETERMINE/MAKE NOTE OF PROGRAM PRESCRIPTIONS WHICH BEST FACILITATE ACHIEVEMENT OF PROGRAM OBJECTIVES

ESTABLISH CONCURRENCE ON PROGRAM PRESCRIPTIONS

Continued on next page
Chart 3.7 Continued

DISCUSS/DEVISE PLANS FOR PROGRAM IMPLEMENTATION

DISCUSS/DETERMINE OPTIMAL PLACEMENT FOR CHILD

CONTACT RECEIVING SPECIAL ED DISTRICT AND CHILD'S PARENTS TO ASCERTAIN THEIR CONSTRAINTS FOR PROGRAM IMPLEMENTATION

REVISE PROGRAM PRESCRIPTIONS, PLACEMENT RECOMMENDATIONS, AND IMPLEMENTATION PLANS AS INDICATED

INCORPORATE INTO INDIVIDUAL EDUCATIONAL PLAN

[i.e., for parental involvement, for use of resource persons, for receiving teacher activities, etc.]

END

See 3.10
Chart 3.8 CONSTRUCT INDIVIDUAL BEHAVIORAL LADDER

Case Leader (On-Site)
Diagnostic Classroom Teacher (In-Classroom)

READ/REVIEW RELEVANT CASE MATERIALS

CONSTRUCT INDIVIDUAL LADDER OF BEHAVIORAL OBJECTIVES

BY DIAGNOSTIC DOMAIN AND FOR EACH SHORT-RANGE PROGRAM OBJECTIVE, LIST THE SKILLS AND BEHAVIORS THE CHILD MUST ACQUIRE, INCREASE, MAINTAIN, DECREASE, AND EXTINGUISH

DETERMINE/LIST THE TIME FRAME FOR EACH SKILL AND BEHAVIOR

i.e., how will you know when the child achieves the behavioral objective? A test score? a behavioral count? a measure of the quality, accuracy, or speed with which the child performs the behavior?

DETERMINE/LIST THE CRITERION MEASURE OR STANDARD OF ACHIEVEMENT FOR EACH SKILL AND BEHAVIOR

See Task Analysis, Behavioral Charts, and Formal and Informal Test Score Worksheets

See Sample Individual Behavioral Ladder, p. 257

3, 6, 9, or 12 months

Continued on next page
Chart 3.8 Continued

DETERMINE/LIST CONDITIONS UNDER WHICH EACH SKILL AND BEHAVIOR MUST BE PERFORMED

See Field Test Worksheets for Learning Environment and Teaching Strategies

DETERMINE/LIST THE INSTRUCTIONAL MATERIALS AND EQUIPMENT REQUIRED TO TRAIN TO EACH SKILL AND BEHAVIOR

See Field Test Worksheets for Instructional Materials/Equipment

IDENTIFY/LIST BASELINE PERFORMANCE DATA FOR EACH SKILL AND BEHAVIOR

See Behavioral Charts Formal and Informal Test Score Worksheets

AS NECESSARY, CONFER WITH TEAM RE: INDIVIDUAL BEHAVIORAL LADDER

See 2.7

COMPLETE INDIVIDUAL BEHAVIORAL LADDER; DISTRIBUTE COPIES TO PARENTS, TEAM, AND RECEIVING TEACHER

Retain copy for Case Record

END
Chart 3.9  DEVISE PLANS FOR FOLLOW-UP SERVICES AND DATA COLLECTION

- Case Leader
- Diagnostic Team

1. **Begin**

   **Consult with Diagnostic Team as Necessary**

2. **Discuss/Determine/Make Note of Need for Follow-Up Consultation and Assistance by Diagnostic Team**

3. **Discuss/Determine/Make Note of Post-Placement Data Collection Required**
   - i.e., observation, formal and informal testing, grades, psychological work-ups, and medical testing; etc. for comparison to pre-placement data (see Chart 5.5)

4. **Discuss/Determine/Make Note of Required Follow-Up Social Services**

5. **Make Note of Dates for Informal and Formal Evaluation**
   - i.e., 1, 3, 6, 9, and 12 months after child's exit. See charts 5.3, 5.4, and 5.6

6. **Enter Dates for Follow-Up Services, Data Collection, and Formal and Informal Evaluation in Tickler File**

7. **See Follow-Up Form, p. 165**

**End**
Chart 3.10 WRITE INDIVIDUAL EDUCATIONAL PLAN

See format for Individual Educational Plan, p.259, and Sample Individual Educational Plan, pp.

READ/REVIEW RELEVANT CASE MATERIALS

WRITE INDIVIDUAL EDUCATIONAL PLAN

ATTACH DIAGNOSTIC SUMMARY AND INDIVIDUAL BEHAVIORAL LADDER TO PLAN

ATTACH SUPPORTIVE RECORDS AND DOCUMENTS TO PLAN

FORWARD COPIES OF PLAN TO DIAGNOSTIC TEAM, PROGRAM COORDINATOR, RECEIVING TEACHER, AND CHILD'S PARENTS

Case Leader

Individual Behavioral Ladder
Long- and Short-Range Program Objectives
Diagnostic Summary
Field Test Worksheets

To include:
1. Summary of Long-Range Program Objectives
2. Summary of Short-Range Program Objectives
3. Summary of Behavioral Objectives
4. Teaching Strategies
5. Learning Environment Strategies
6. Reinforcement Strategies
7. Recommended Materials, Activities, and Equipment
8. Placement Recommendations
9. Recommendations for Program Implementation
10. Recommended Follow-Up

Retain copy for Case Record

END
Phase 4: TRANSITION

Objectives:

1. To prepare the child for exit.

2. To adapt the Individual Educational Plan to the resources and constraints of the receiving school.

3. To train the child's parents and current or receiving teacher in program implementation.

4. To supervise the child's integration into his or her new placement.

Initiating Event: Program finalization and placement decision.

Terminating Event: Exit of child from Diagnostic Classroom or termination of on-site services.
OVERVIEW OF PHASE 4: TRANSITION

BEGIN

Chart 4.1
ASSESS CHILD'S READINESS FOR EXIT

Chart 4.2
ADAPT INDIVIDUAL EDUCATIONAL PLAN TO NEEDS OF PROGRAM IMPLEMENTERS

Chart 4.3
TRAIN PROGRAM IMPLEMENTERS

Chart 4.4
PLAN/CONDUCT/ ATTEND ON-SITE OR IN-CLASSROOM DEMONSTRATION

Chart 4.5
PLAN/CONDUCT/ PARTICIPATE IN EXIT STAFFING

Chart 4.6
PLAN/SUPERVISE INTEGRATION OF CHILD INTO NEW PLACEMENT

Chart 4.7
PREPARE CHILD FOR EXIT

END

Staff:
Diagnostic Classroom Teacher

Chart 4.4
Case Leader
Diagnostic Team

Chart 4.5
Case Leader
Program Coordinator
Diagnostic Team

Chart 4.6
Case Leader

Chart 4.7
Case Leader
Chart 4.1 ASSESS CHILD'S READINESS FOR EXIT (In-Classroom Only)

Diagnostic Classroom Teacher

4.1

BEGIN

READ/REVIEW DIAGNOSTIC TEAM OBJECTIVES

See Sample Diagnostic Team Objectives, p.238

WERE DIAGNOSTIC TEAM OBJECTIVES ACHIEVED?

Yes

WERE UNACHIEVED OBJECTIVES NECESSARY AND APPROPRIATE?

No

Yes

OMIT OBJECTIVES; NOTE IN CASE RECORD

READ/REVIEW CHANGE PLAN AND BEHAVIORAL CHARTS

See Sample Change Plan and Behavioral Charts, p.240

No

DURING FOLLOW-UP PHASE, CONDUCT ADDITIONAL DIAGNOSIS AND PROGRAM DEVELOPMENT AND TESTING AS REQUIRED

See 5.5

CAN UNACHIEVED OBJECTIVES BE ACCOMPLISHED IN CHILD'S NEW PLACEMENT?

Yes

CONDUCT ADDITIONAL IN-CLASSROOM DIAGNOSIS AND PROGRAM DEVELOPMENT AND TESTING AS NECESSARY

See 2.1

No

Continued on next page
Chart 4.1 Continued

i.e., have behavioral obstacles to learning been removed?

WERE OBJECTIVES ACHIEVED?

Yes

WERE OBJECTIVES NECESSARY AND APPROPRIATE?

No

Yes

OMIT OBJECTIVES; NOTE IN CASE RECORD

No

INTEGRATE UNACHIEVED OBJECTIVES INTO INDIVIDUAL BEHAVIORAL LADDER

H ave ALL PROGRAM PRESCRIPTIONS BEEN TESTED AND FINALIZED?

No

TEST/FINALIZE REMAINING PROGRAM PRESCRIPTIONS

Yes

DETERMINE WHAT ADDITIONAL INFORMATION IS NEEDED; ATTACH TO OR INCLUDE IN INDIVIDUAL EDUCATIONAL PLAN

See Diagnostic Summary, Individual Behavioral Ladder, and Individual Educational Plan?

Yes

Continued on next page

Page two of three
Chart 4.1 Continued

DEVISE STRATEGY FOR GRADUAL INTEGRATION OF CHILD INTO NEW PLACEMENT.

- No
- Yes
  - REVISE PLACEMENT RECOMMENDATIONS AND INDIVIDUAL EDUCATIONAL PLAN AS NECESSARY.
  - PREPARE CHILD FOR EXIT.
  - CHILDO EMOTIONALLY PREPARED FOR NEW PLACEMENT?
  - Yes
  - NO MORE SUITABLE AVAILABLE?
  - Yes
  - NO FOR GRADUAL INTEGRATION OF CHILD INTO NEW PLACEMENT.
  - END
  - See 4.6
  - See 4.10
  - See 4.2

Page three of three
See 2.7

PLAN/CONDUCT CONSULTATIVE STAFFING OR INDIVIDUAL CONFERENCES WITH PROGRAM IMPLEMENTERS

EXPLAIN OBJECTIVES OF STAFFING OR CONFERENCE

DISCUSS PROGRAM OBJECTIVES, PRESCRIPTIONS, PLACEMENT RECOMMENDATIONS, IMPLEMENTATION PLANS, AND FOLLOW-UP PLANS

DISCUSS/DETERMINE/MAKE NOTE OF RESOURCES AND CONSTRAINTS OF PROGRAM IMPLEMENTERS

MAKE REQUIRED CHANGES, ADDITIONS, AND DELETIONS IN INDIVIDUAL EDUCATIONAL PLAN

DISCUSS/DETERMINE/MAKE NOTE OF TEACHER TRAINING AND DEMONSTRATIONS REQUIRED FOR PROGRAM IMPLEMENTATION

END

To include receiving school staff, child's parents, resource persons, and/or other program implementers

i.e., to ensure that the Individual Educational Plan meets the needs of program implementers; to adjust the Plan as necessary; and to determine implementers' needs for training, demonstrations, and technical assistance

i.e., in use of parents and receiving school staff, materials, program objectives, time frames, follow-up plans, etc.
AS NECESSARY, PLAN CONDUCT INDIVIDUAL CONFERENCES WITH PROGRAM IMPLEMENTERS

EXPLAIN/DISCUSS DIAGNOSTIC EVALUATION, INDIVIDUAL EDUCATIONAL PLAN, AND INDIVIDUAL BEHAVIORAL LADDER

ANSWER QUESTIONS POSED BY PROGRAM IMPLEMENTER

ASK QUESTIONS TO CHECK COMPREHENSION OF PROGRAM IMPLEMENTER

DISCUSS/DETERMINE MAKE NOTE OF DEMONSTRATIONS REQUIRED BY PROGRAM IMPLEMENTER; SET DATE(S)

Continued on next page
Chart 4.3 Continued

DISCUSS/DETERMINE/
MAKE NOTE OF
CONSULTATION AND
ASSISTANCE REQUIRED
BY PROGRAM IMPLEMENTER
DURING FOLLOW-UP

CLOSE
CONFERENCE

ENTER DATES FOR
DEMONSTRATIONS
AND FOLLOW-UP
CONSULTATION AND
ASSISTANCE ON
TICKLER FILE

See Follow-Up
Form, p. 165

UPDATE CASE
CONTACT RECORD

Case Contact
Record (see p.
166)

END
Chart 4.4 PLAN/CONDUCT/ATTEND ON-SITE OR IN-CLASSROOM DEMONSTRATION

BEGIN

DETERMINE NEED FOR DEMONSTRATION OF METHODS/MATERIALS/EQUIPMENT TO PROGRAM IMPLEMENTER

AS NECESSARY, CONTACT DEMONSTRATOR TO ARRANGE DATE, TIME, AND LOCATION FOR DEMONSTRATION

As necessary, arrange for availability of materials/equipment/facility for demonstration

CONTACT PROGRAM IMPLEMENTER TO INFORM OF DATE, TIME, AND LOCATION OF DEMONSTRATION

AS NECESSARY, ARRANGE FOR PRESENCE OF CHILD AT DEMONSTRATION

Case Leader

During 4.2 and/or 4.3

Demonstrator might be another team member, a medical consultant, or a resource person such as a physical therapist, media specialist, speech therapist, etc.

Continued on next page

153 Page one of three
Chart 4.4 Continued

- Conduct/Attend Demonstration
- Assist Implementer in trying methods/materials/equipment
- Answer questions posed by Program Implementer
- Ask questions to check Implementer's understanding
- Discuss required follow-up consultation and assistance

Continued on next page
Chart 4.4 Continued

TERMINATE DEMONSTRATION

AS NECESSARY, ENTER DATES FOR FOLLOW-UP CONSULTATION AND ASSISTANCE IN TICKLER FILE

UPDATE CASE CONTACT RECORD

See Follow-Up Form, p. 165

Case Contact Record (see p. 166)

END
Chart 4.5 PLAN/CONDUCT/PARTICIPATE IN EXIT STAFFING

**CASE LEADER**
**PROGRAM COORDINATOR**
**DIAGNOSTIC TEAM**

1. **BEGIN**
   - **DETERMINE NEED FOR EXIT STAFFING**
   - **CONFER WITH TEAM TO SET TIME, DATE, AND LOCATION FOR STAFFING**
   - **AS NECESSARY, ARRANGE FOR AVAILABILITY OF FACILITY**
   - **CONTACT MEETING PARTICIPANTS TO INFORM THEM OF DATE, TIME, AND LOCATION FOR STAFFING**

   *Time lapse*

   - **OPEN MEETING; INTRODUCE PARTICIPANTS**

   *As appropriate, include receiving school administrators, receiving teacher, child's parents, and resource persons*

   *Continued on next page*
Refer to Initial Information-Gathering Checklist

Referral Form
Home Call Checklist

See Diagnostic Summary

To include:
- Program Objectives
- Program Prescriptions
- Plans for Program Implementation
- Placement Recommendations
- Follow-Up Plans

AS APPROPRIATE, DISCUSS CONTENTS OF INDIVIDUAL EDUCATIONAL PLAN

AS APPROPRIATE, DISCUSS REALITY CONSTRAINTS OF PROGRAM IMPLEMENTERS AND ALTERNATIVES FOR PROGRAM IMPLEMENTATION

AS APPROPRIATE, DISCUSS CHILD’S NEED FOR GRADUAL INTEGRATION INTO NEW PLACEMENT

Continued on next page
Chart 4.5 Continued

1. Close Meeting

2. As necessary, update tickler file
   - See Follow-Up Form, p. 165

3. Update master client registry
   - Master Client Registry (see p. 161)

4. Update case contact record
   - Case Contact Record (see p. 166)

5. End
Case Leader

**Chart 4.6 PLAN/SUPERVISE INTEGRATION OF CHILD INTO NEW PLACEMENT**

1. **BEGIN**

2. **DETERMINE CHILD'S INTEGRATION NEEDS**

3. **AS NECESSARY, CONDUCT CONSULTATIVE STAFFING WITH RECEIVING SCHOOL STAFF**

   - Discuss/determine/make note of:
     1. Child's integration needs
     2. Objectives of integration
     3. Time frames for increasing exposure of child to new placement
     4. Plans for receiving school/Diagnostic Classroom liaison (daily phone contact, weekly reports, etc.)

4. **AS NECESSARY, ARRANGE FOR TRANSPORTATION OF CHILD BETWEEN DIAGNOSTIC CLASSROOM, NEW PLACEMENT, AND HOME**

5. **SUPERVISE INTEGRATION OF CHILD**

6. **MAINTAIN ONGOING CONTACT WITH RECEIVING TEACHER**

Continued on next page
Maintain ongoing contact with child.

I.e., interview child at least once per week re: likes and dislikes in new placement.

As problems arise, conduct consultative staffings with diagnostic team and/or receiving school staff.

Are plans for integration succeeding?

Yes

No

Can they be modified?

Yes

No

Reconsider/modify integration strategies as indicated.

Devise alternative integration strategies.

No

Yes

Continue with integration as planned until child's placement is complete.

Update case contact record.

See Case Contact Record, P. 166.

See page two of two.
Chart 4.7 PREPARE CHILD FOR EXIT

1. BEGIN

2. DESCRIBE NEW PLACEMENT TO CHILD

3. DESCRIBE/EXPLAIN EXPECTATIONS FOR CHILD IN NEW PLACEMENT

4. DESCRIBE/EXPLAIN PLANNED POST-PLACEMENT INVOLVEMENT OF DIAGNOSTIC TEAM WITH CHILD

5. VISIT CHILD'S NEW PLACEMENT; INTRODUCE CHILD TO NEW TEACHER(S) AND PEERS

6. UPDATE CASE CONTACT RECORD

7. END

Case Leader

Case Contact Record (see p. 166)
Phase 5: FOLLOW-UP

Objectives:

1. To assist in initial program implementation.

2. To provide post-placement consultation and assistance to the child's parents, teachers, and other program implementers.

3. To gather and analyze informal evaluation data for use in program evaluation and revision.

4. To gather and analyze formal evaluation data for use in the revision of the Individual Behavioral Ladder and in program evaluation and revision.


Terminating Event: Exit of the child from the educational system.
OVERVIEW OF PHASE 5: FOLLOW-UP

BEGIN

Staff:

Chart 5.1 ASSIST IN PROGRAM IMPLEMENTATION

Case Leader

Diagnostic Team

Chart 5.2 PROVIDE FOLLOW-UP SOCIAL WORK SERVICES

Social Worker

Chart 5.3 CONDUCT ONE-MONTH TEACHER FOLLOW-UP

Case Leader

Chart 5.4 CONDUCT ONE-MONTH PARENT FOLLOW-UP

Case Leader or Social Worker

Chart 5.5 CONDUCT POST-PLACEMENT OBSERVATION, TESTING, AND RECORDS COLLECTION

Case Leader

Chart 5.6 CONDUCT 3, 6, 9, AND 12 MONTH CHILD FOLLOW-UP

Case Leader

Continued on next page
Phase 5 Overview Chart, Continued

Chart 5.7
CONDUCT LONGITUDINAL FOLLOW-UP

Case Leader

Chart 5.8
PLAN/CONDUCT/PARTICIPATE IN QUARTERLY STAFF MEETING

Program Coordinator
Diagnostic Team

Chart 5.9
CONDUCT ANNUAL ANALYSIS OF INFORMAL EVALUATION DATA

Program Coordinator

Chart 5.10
CONDUCT ANNUAL ANALYSIS OF FORMAL EVALUATION DATA

Program Coordinator

Chart 5.11
CONDUCT ANNUAL COLLECTION AND ANALYSIS OF DATA FOR FEDERAL REPORTING

Program Coordinator

END
Chart 5.1 ASSIST IN INITIAL PROGRAM IMPLEMENTATION

5.1 BEGIN

PHONE RECEIVING TEACHER TO INVESTIGATE PROBLEMS, CHECK USE OF PROGRAM, AND OFFER SUPPORT AND SUGGESTIONS

AS INDICATED IN INDIVIDUAL EDUCATION PLAN, PROVIDE CONSULTATION AND ASSISTANCE TO PROGRAM IMPLEMENTERS

RESPOND TO ONGOING REQUESTS FROM PROGRAM IMPLEMENTERS FOR CONSULTATION AND ASSISTANCE

AS NECESSARY, PROVIDE TRAINING OR DEMONSTRATIONS TO PROGRAM IMPLEMENTERS

ENTER CONTACTS WITH PROGRAM IMPLEMENTERS ON CASE CONTACT RECORD

END

Case Leader
Diagnostic Team

At least once per week for first month after termination of in-classroom or active on-site services

See Individual Educational Plan, p. 259

See Individual Educational Plan, p. 259

Case Contact Record (see p. 166)
Chart 5.2 PROVIDE POST-PLACEMENT SOCIAL WORK SERVICES

Social Worker

5.2 → BEGIN

PHONE CHILD'S PARENTS TO CHECK ON CHILD'S ADJUSTMENT, PARENT SATISFACTION, AND USE OF PROGRAM; OFFER SUPPORT AND SUGGESTIONS

At least once per month for first six months after termination of in-classroom or on-site services

See Individual Educational Plan, p.259

AS INDICATED IN INDIVIDUAL EDUCATIONAL PLAN, PROVIDE FOLLOW-UP SOCIAL WORK SERVICES TO CHILD AND CHILD'S FAMILY

Home visit
Visits to child
Phone consultation

RESPOND TO ONGOING REQUESTS FOR SOCIAL WORK SERVICES FROM PARENTS AND RECEIVING TEACHER

REPORT TO/CONFERENCE WITH CASE LEADER AS NECESSARY

ENTER CONTACTS ON CASE CONTACT RECORD

END

Case Contact Record (see p.166)
5.3 CONDUCT ONE MONTH TEACHER FOLLOW-UP (Informal Evaluation)

BEGIN

**Case Leader**

CONTACT RECEIVING TEACHER; ARRANGE TIME, DATE, AND LOCATION FOR ONE MONTH FOLLOW-UP CONFERENCE

USING TEACHER FOLLOW-UP RECORD, CONDUCT CONFERENCE - Teacher Follow-Up Record (see p.165)

DISCUSS/DETERMINE/MAKE NOTE OF TEACHER SATISFACTION WITH ON-SITE OR IN-CLASSROOM SERVICES

DISCUSS/DETERMINE/MAKE NOTE OF TEACHER'S USE OF AND SATISFACTION WITH DIAGNOSTIC SUMMARY, INDIVIDUAL EDUCATIONAL PLAN, AND INDIVIDUAL BEHAVIORAL LADDER

DISCUSS/DETERMINE/MAKE NOTE OF CHILD'S GENERAL ADJUSTMENT AND INTEGRATION

Continued on next page

See Diagnostic Summary, Individual Educational Plan, and Individual Behavioral Ladder

Page one of three
Chart 5.3 Continued

DISCUSS/DETERMINE/MAKE NOTE OF CHILD'S PROGRESS, REGRESSION, AND CHANGE IN EACH DIAGNOSTIC DOMAIN

DISCUSS/DETERMINE/MAKE NOTE OF CHILD'S CHARACTERISTIC NEGATIVE AND POSITIVE BEHAVIORS

AS INDICATED, PLAN FOR ADDITIONAL CONSULTATION, ASSISTANCE, AND POST-PLACEMENT SERVICES

TERMINATE CONFERENCE

COMPLETE TEACHER-FOLLOW-UP RECORD

Teacher Follow-Up Record (see p. 205)

AS NECESSARY, ENTER DATES FOR FOLLOW-UP CONSULTATION, ASSISTANCE, AND OTHER SERVICES ON TICKLER FILE

See Follow-Up Form, p. 165

Page two of three

Continued on next page
Chart 5.3 Continued

See

FORWARD COPY OF TEACHER FOLLOW-UP RECORD TO PROGRAM COORDINATOR FOR INFORMAL EVALUATION

File original in Case Record

UPDATE CASE CONTACT RECORD

Case Contact Record (see p. 166)

END
Chart 5.4  CONDUCT ONE MONTH PARENT FOLLOW-UP (Informal Evaluation)

5.4  BEGIN

CONTACT PARENTS; ARRANGE TIME AND DATE FOR HOME CALL

USING PARENT FOLLOW-UP RECORD, CONDUCT ONE MONTH PARENT FOLLOW-UP

DISCUSS/DETERMINE/MAKE NOTE OF CHILD'S GENERAL ADJUSTMENT AND BEHAVIORAL CHANGE

DISCUSS/DETERMINE/MAKE NOTE OF PARENT SATISFACTION WITH ON-SITE OR IN-CLASSROOM SERVICES AND CHILD'S EDUCATIONAL PROGRAM AND NEW PLACEMENT (if applicable)

AS APPLICABLE, DISCUSS PARENTS' ROLES IN PROGRAM IMPLEMENTATION

Parent Follow-Up Record (see p. 213)

Continued on next page
AS INDICATED, PLAN FOR ADDITIONAL CONSULTATION, ASSISTANCE, AND FOLLOW-UP SERVICES

TERMINATE CONFERENCE

COMPLETE PARENT FOLLOW-UP RECORD

AS NECESSARY, ENTER DATES FOR FOLLOW-UP CONSULTATION, ASSISTANCE, AND OTHER SERVICES ON TICKLER FILE

FORWARD COPY OF PARENT FOLLOW-UP RECORD TO PROGRAM COORDINATOR FOR INFORMAL EVALUATION

UPDATE CASE CONTACT RECORD

Parent Follow-Up Record (see p. 213)

See Follow-Up Form (p. 165)

Parent Follow-Up Form (see p. 213)

Case Contact Record (see p. 166)

END
Chart 5.5 CONDUCT POST PLACEMENT OBSERVATION, TESTING, AND RECORDS COLLECTION
(Formal Evaluation)

5.5 BEGIN

Case Leader

AS PLANNED IN INDIVIDUAL EDUCATIONAL PLAN, ARRANGE FOR POST PLACEMENT
OBSERVATION, TESTING, AND RECORDS COLLECTION

See 1.5

CONDUCT POST-PLACEMENT OBSERVATION, USING OBSERVATION RECORD

Observation Record (see p. 173)

See 2.5

CONDUCT POST-PLACEMENT TESTING USING FORMAL AND INFORMAL TEST
SCORE WORKSHEETS

Formal Test Score Worksheet (see p. 193)
Informal Test Score Worksheet (see p. 194)

See 2.6

REVIEW/COPY RECORDS ON POST-PLACEMENT PSYCHOLOGICAL TESTING,
ACADEMIC TESTING, NORMATIVE TESTING, GRADES, ETC.

As applicable, complete Statement of Records Examined

See 5.4

COMPARE POST-PLACEMENT DATA AND RECORDS TO SIMILAR PRE-PLACEMENT
DATA AND RECORDS TO GAUGE CHILD'S PROGRESS

See Initial Information-Gathering Checklist
Observation Record
Pre-placement School Records
Test Score Worksheets

See 5.10

FORWARD COPIES OF PRE- AND POST-PLACEMENT DATA AND RECORDS TO
PROGRAM COORDINATOR FOR FORMAL EVALUATION

Retain copy for Case Record

END
Chart 5.6  CONDUCT 3, 6, 9, AND 12 MONTH CHILD FOLLOW-UP
(Formal Evaluation)

5.6  BEGIN

ARRANGE FOR CONFERENCE WITH CHILD’S RECEIVING TEACHER

CONDUCT CONFERENCE, USING CHILD FOLLOW-UP RECORD

DISCUSS/DETERMINE/MAKE NOTE OF CHILD’S ACHIEVEMENT OF BEHAVIORAL OBJECTIVES IN INDIVIDUAL BEHAVIORAL LADDER

DISCUSS/DETERMINE/MAKE NOTE OF NECESSARY REVISIONS IN INDIVIDUAL BEHAVIORAL LADDER

CLOSE CONFERENCE

ANALYZE/SUMMARIZE DATA ON BEHAVIORAL OBJECTIVES ACHIEVEMENT

Child Follow-Up Record (see p.216)

See Individual Behavioral Ladder, p. 257

1. Across domains
2. By domain
3. By direction (acquire, increase, maintain, decrease, extinguish)
4. By Short Range Program Objective

Continued on next page
Chart 5.6 Continued

COMPLETE CHILD FOLLOW-UP RECORD

Child Follow-Up Record (see p.216)

FORWARD COPY TO PROGRAM COORDINATOR FOR FORMAL EVALUATION

Retain copy for Case Record

REVISE INDIVIDUAL BEHAVIORAL LADDER

FORWARD COPY OF REVISED INDIVIDUAL BEHAVIORAL LADDER TO CHILD'S TEACHER

Retain copy for Case Record

UPDATE CASE CONTACT RECORD

Case Contact Record (see p.166)

END
Chart 5.7 CONDUCT LONGITUDINAL FOLLOW-UP (Formal Evaluation)

BEGIN

Longitudinal Follow-Up is to be conducted at the end of each school year

READ/REVIEW PROGRAM OBJECTIVES

PHONE CHILD'S TEACHER; CONDUCT INTERVIEW USING LONGITUDINAL FOLLOW-UP RECORD

DETERMINE/MAKE NOTE OF CHILD'S CURRENT PLACEMENT

DISCUSS/DETERMINE/MAKE NOTE OF CHILD'S GENERAL ADJUSTMENT AND INTEGRATION INTO CURRENT PLACEMENT

DISCUSS/DETERMINE/MAKE NOTE OF CHILD'S PROGRESS, REGRESSION, AND CHANGE FOR EACH DIAGNOSTIC DOMAIN

OBTAIN ANY NORMATIVE TEST SCORES ON CHILD FOR CLOSING SCHOOL YEAR

Refer to Program Objectives in Individual Educational Plan (see p. 259)

Longitudinal Follow-Up Record (see p. 219)

Continued on next page
Chart 5.7 Continued

CLOSE CONFERENCE

COMPARE CHILD'S SCORES ON NORM-REFERENCED TESTS TO SIMILAR DATA FROM PREVIOUS YEARS

COMPLETE LONGITUDINAL FOLLOW-UP RECORD

LONGITUDINAL FOLLOW-UP RECORD (see p.219)

FORWARD COPY TO PROGRAM COORDINATOR FOR USE IN FORMAL EVALUATION

RETAIN COPY FOR CASE RECORD

UPDATE CASE CONTACT RECORD

CASE CONTACT RECORD (see P-166)

END
Chart 5.8 PLAN/CONDUCT/PARTICIPATE IN QUARTERLY STAFF MEETING

BEGIN

**Program Coordinator**

**Diagnostic Team**

**CONFER WITH**
**DIAGNOSTIC**
**TEAM TO SET**
**DATE, TIME AND**
**LOCATION FOR**
**MEETING**

**READ/REVIEW**
**FORMAL AND INFORMAL**
**EVALUATION DATA**
**GATHERED OR**
**ANALYZED DURING**
**PREVIOUS QUARTER**

**i.e., what criti-**
**cisms do parents**
**and teachers have**
**of the program?**
**of the team?**

**AS NECESSARY,**
**SUMMARIZE INFORMAL**
**DATA IN TERMS OF**
**PROGRAM/TEAM**
**STRENGTHS AND**
**WEAKNESSES**

**i.e., in which**
**domains are chil-**
**dren failing to**
**achieve behavioral**
**objectives?**

**AS NECESSARY,**
**SUMMARIZE FORMAL**
**DATA IN TERMS OF**
**PROGRAM/TEAM**
**STRENGTHS AND**
**WEAKNESSES**

**AS NECESSARY,**
**CIRCULATE FORMAL**
**AND INFORMAL**
**EVALUATION DATA**
**AMONG DIAGNOSTIC**
**TEAM**

Continued on next page

**Including:**
Teacher Follow-Up Records
Parent Follow-Up Records
Child Follow-Up Records
Longitudinal Follow-Up Record
Pre- and Post Placement Data
Informal Evaluation Data Summary
Sheet (see Chart 5.9)
Formal Evaluation Data Summary
Sheet (see Chart 5.10)
Federal Reporting Form (see Chart 5.11)
Also useful in this connection
is data on the achievement of
Change Plan Objectives and
Diagnostic Team Objectives

Page one of two
Chart 5.8 Continued:

CONDUCT MEETING; DISCUSS/DETERMINE/ MAKE NOTE OF PROGRAM AND TEAM STRENGTHS AND WEAKNESSES

DISCUSS/DETERMINE/ MAKE NOTE OF NECESSARY PROGRAM REVISIONS

DISCUSS/DETERMINE/ MAKE NOTE OF IN-SERVICE TRAINING NEEDS OF DIAGNOSTIC TEAM

CLOSE MEETING

MAKE NECESSARY PROGRAM REVISIONS

PLAN/ARRANGE NECESSARY IN-SERVICE TRAINING

END
Chart 5.9 CONDUCT ANNUAL ANALYSIS OF INFORMAL EVALUATION DATA

BEGIN

READ/REVIEW PARENT FOLLOW-UP AND TEACHER FOLLOW-UP RECORDS COMPLETED TO DATE

USING INFORMAL EVALUATION DATA SUMMARY SHEET, CONDUCT INFORMAL EVALUATION

COMPILE/ANALYZE/SUMMARIZE TEACHER FOLLOW-UP DATA

COMPILE/ANALYZE/SUMMARIZE PARENT FOLLOW-UP DATA

DISTRIBUTE ANALYZED DATA TO TEAM; USE AS DISCUSSION GUIDE DURING QUARTERLY STAFF MEETINGS

AS DESIRED, ATTACH INFORMAL EVALUATION DATA SUMMARY SHEET TO FEDERAL REPORTING FORM FOR DISTRIBUTION TO FUNDING SOURCES

END
Chart 5.10  CONDUCT ANNUAL ANALYSIS OF FORMAL EVALUATION DATA

Program Coordinator

BEGIN

READ/REVIEW FOR "AL EVALUATION DATA

Pre- and Post-Placement Data (See Chart 5.5)
Child Follow-Up Data (See Chart 5.6)
Longitudinal Follow-Up Data (See Chart 5.7)

USING FORMAL EVALUATION DATA SUMMARY SHEET, CONDUCT FORMAL EVALUATION

Formal Evaluation Data Summary Sheet (see p.227)

COMPILE/ANALYZE SUMMARIZE PRE- AND POST-PLACEMENT DATA

COMPILE/ANALYZE/ SUMMARIZE CHILD FOLLOW-UP DATA

COMPILE/ANALYZE/ SUMMARIZE LONGITUDINAL DATA

Federal Reporting Form (see p.231)

DISTRIBUTE ANALYZED DATA TO DIAGNOSTIC TEAM; USE AS DISCUSSION GUIDE DURING QUARTERLY STAFF MEETING

AS DESIRED, ATTACH INFORMAL EVALUATION DATA SUMMARY SHEET TO FEDERAL REPORTING FORM FOR DISTRIBUTION TO FUNDING SOURCES

See 5.8

END

180 See 5.1
BEGIN

USING FEDERAL REPORTING FORM, COMPILe DATA FOR FEDERAL REPORTING

Federal Reporting Form (see p. 231)

# Children served
Handicaps
Services Provided
# Staffings
Etc.

COMPILE/SUMMARIZE DATA FROM MASTER CLIENT REGISTRY

Master Client Registry (see p. 161)

# and Types of Contacts

OBTAIN SUMMARIZED CASE CONTACT DATA FROM TEAM CAPTAIN

Case Contact Record (see p. 166)

See 6.9

ATTACH FORMAL AND INFORMAL EVALUATION DATA SUMMARY SHEETS TO FEDERAL REPORTING FORM

Federal Reporting Form (see p. 23)

See 6.10

DISTRIBUTE REPORT TO DIAGNOSTIC TEAM AND FUNDING SOURCES

END
Section 3.

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</tr>
<tr>
<td>M.</td>
<td>Formal Test Score Worksheet</td>
<td>193</td>
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<td>O.</td>
<td>Format For Diagnostic Summary</td>
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<td>P.</td>
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<tr>
<td>Q.</td>
<td>Individual Behavioral Ladder</td>
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<td>R.</td>
<td>Format For Individual Education Plan</td>
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<td>S.</td>
<td>Teacher Follow - Up Record</td>
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<td>T.</td>
<td>Parent Follow - Up Record</td>
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<td>U.</td>
<td>Child Follow - Up Record</td>
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<tr>
<td>V.</td>
<td>Longitudinal Follow - Up Record</td>
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"Eric"
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<th>Exhibit</th>
<th>Title</th>
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<td>X.</td>
<td>Formal Evaluation Data Summary</td>
<td>227</td>
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<tr>
<td>Y.</td>
<td>Federal Reporting Form</td>
<td>231</td>
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</tbody>
</table>
EXHIBIT A

REFERRAL FOR SERVICES

NAME: ____________________________ SEX: ___________________ BIRTHDATE: ______________________

PHONE: ___________________ PARENTS' NAME: ________________________________

HOME ADDRESS: ____________________________ CITY: __________________ ZIP CODE: ________

RESIDENT DISTRICT: ___________ COUNTY: ___________ CITY: ___________

SCHOOL ATTENDING: ___________ COUNTY: ___________ GRADE: ___________

TEACHER: ________________________

Child's major problems (check all that apply):

1. _____ No handicaps
2. _____ Retarded
3. _____ Orthopedic
4. _____ Speech Impaired
5. _____ Hearing Impaired
6. _____ Deaf
7. _____ Visually Impaired
8. _____ Blind
9. _____ Emotionally disturbed
10. _____ Learning Disabilities
11. _____ Other (Specify)

Services Requested (Check all that apply)

1. _____ Diagnostic Classroom Placement
2. _____ Consultation (Check all that apply)
   a. _____ Psychologist
   b. _____ Social Worker
   c. _____ Consulting Diagnostic Teacher
   d. _____ Deaf Educator
   e. _____ Vision Educator
   f. _____ Other (Please specify)
3. _____ Contractual Medical (Please specify)
4. _____ Other (Please specify)

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158
Please list the questions you want answered about the child:

Pertinent Comments:

Family Physician: ____________________________ Address: ____________________________

Specialists: ____________________________ Address: ____________________________

Signature and Title of Person Referring the Child

______________________________
Date

______________________________
Telephone

Approved by: Region: Program Director

Please contact:

______________________________
Telephone:

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PARENTAL CONSENT FORM

DATE: ____________________

To Whom It May Concern:

We hereby give permission and consent for __________________________________________

__________________________________________________________

to release the following confidential information regarding our child, (child's name) _________

Achievement Test Scores
Psychological Report
Social Development Reports
Medical Reports
Speech and Language Report
Audiological Report
Annual School Progress Report
Other ____________________

We have read this consent form and understand its implications, and therefore, we affix our signatures.

Father: ____________________________

Mother: ____________________________

Please address all correspondence to: 187
### MASTER CLIENT REGISTRY

<p>| | | |</p>
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<thead>
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<tbody>
<tr>
<td>1. Client Name</td>
<td>2. ID #</td>
<td>3. Zip Code</td>
</tr>
<tr>
<td>7. Date of Referral</td>
<td>8. Case Leader</td>
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#### Services Requested (check all that apply)

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<th>Services Provided (check all that apply)</th>
<th>Dates</th>
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<td>1. Diagnostic Classroom Placement</td>
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<td>2. Consultation</td>
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<tr>
<td>a. Psychologist</td>
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<tr>
<td>b. Social Worker</td>
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<tr>
<td>c. Consulting Diagnostic Teacher</td>
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<td>d. Deaf Educator</td>
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<td>e. Vision Educator</td>
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<tr>
<td>f. Other (Specify)</td>
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<tr>
<td>3. Contractual Medical (Specify)</td>
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<td>4. Other (Specify)</td>
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# Master Client Registry Codes

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<tr>
<th>Federal Handicap Code</th>
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<tr>
<td>A. No Handicap</td>
<td>A. No Handicap</td>
<td>A. Under 5</td>
</tr>
<tr>
<td>B. Retarded</td>
<td>B. Mild</td>
<td>B. 5 - 15</td>
</tr>
<tr>
<td>C. Hard of Hearing</td>
<td>C. Moderate</td>
<td>C. Over 15</td>
</tr>
<tr>
<td>D. Deaf</td>
<td>D. Severe</td>
<td></td>
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<tr>
<td>E. Speech Impaired</td>
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<td></td>
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<tr>
<td>F. Visually Handicapped</td>
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<td></td>
</tr>
<tr>
<td>G. Seriously Emotionally Disturbed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Crippled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Other Health Impairments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. Hearing Disabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K. Multiple (Specify J - K above)</td>
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<td></td>
</tr>
</tbody>
</table>
RE: Use of Direct Service Funds

Dear

The Regional Resource Center has available direct flow-through money from the federal government which can be used to assist handicapped children through diagnosis. This money may purchase medical diagnosis, speech and language diagnosis, hearing evaluations, or any other type of diagnostic work which is deemed necessary for a child with unexplained handicapping conditions.

In order to request the use of this money for a specific child, we need a letter from the Special Education Director or Diagnostic Classroom Program Coordinator which includes the following information:

1. Name and birthdate of Child
2. Address including Zip Code
3. Specific nature of problem
4. Type of evaluation desired
5. Approximate cost
6. Specific doctor or clinic to be used
7. A statement verifying that the local special education district has exhausted all possibilities for assistance to this child

When this information is received, we will consider the request and, in almost every case, grant it. We will write a letter giving our approval and you may then make direct appointment necessary for completion of the diagnostics approved. If there is travel expense for the parents to take the child to the diagnostician, this will also be paid by the RRC when the parents submit their mileage to us. You may request the diagnostician to send their bill directly to me at the RRC, 3202 N. Wisconsin, Peoria, Illinois 61603

After the diagnosis is completed, we request that you write us an additional letter commenting on the value of the service rendered. This is necessary for our files.
and we would appreciate your help with it.

We hope that you will avail yourself of this fund in cases of need. If you have any questions concerning a child or the use of the funds, please feel free to call. My number is (309) 672-6725. We hope we will be able to serve the handicapped in your area. This service is available through January 31, 1977.

Sincerely,

Dea Baker
Assistant Director
Regional Resource Center
EXHIBIT D

FOLLOW-UP FORM

DATE INITIATED ____________________________

TEAM MEMBER RESPONSIBLE ____________________________

CASE NAME: ____________________________

1st Control Date ________________ 2nd Control Date ________________ 3rd Control Date ________________

Notes:

Action Completed ____ (Return to Control Clerk) ____ (Remove Control for other reasons)

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EXHIBIT E.

CASE CONTACT RECORD

<table>
<thead>
<tr>
<th>Date of Child:</th>
<th>Birthdate:</th>
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<table>
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<th>DATE OF CONTACT:</th>
<th>TYPE OF CONTACT:</th>
<th>CONTACT PERSONS:</th>
<th>PURPOSE OF CONTACT:</th>
<th>COMMENTS:</th>
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<td>Staffing</td>
<td>Provide Information</td>
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<td>Home Call</td>
<td>Provide Training</td>
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<td>Other</td>
<td>Receive Technical Assistance</td>
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<td>Support Staff (Specify Type)</td>
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<td>Other Resource Person (Specify Type)</td>
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<td>Medical Consultant (Specify)</td>
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<td></td>
<td></td>
<td>Administrator</td>
<td>Teach送/Receiving Teacher</td>
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</tbody>
</table>

Follow-Up
EXHIBIT F

INITIAL INFORMATION GATHERING CHECKLIST

INSTRUCTIONS: This form is to be completed by the Case Leader within two weeks of receipt of the Referral Form. It is to be used during the initial conference with the child's sending teacher and/or other representatives of the referring agency or school and may be employed as a) a record of previous diagnostic work, b) the basis for the development of Diagnostic Team objectives, c) the basis for the development of initial program prescriptions, d) a baseline against which post-placement performance and behavioral data may be compared, e) and a tool for the tailoring of program prescriptions to receiving school constraints.

Name of Child: 
Date: 

Referring Agency: 
I.D. #: 

Child's Current Placement Program: 

Case Leader: 
Title: 

Conference Participants: 

A. General Information: 

1. What, in the opinion of the sending school staff, are the child's strengths?

2. What are the child's weaknesses?
3. How does the child relate to:
   a. other children.
   b. adults.
   c. his or her assigned tasks?
4. What general observations have been made in each of the following areas?
   a. Motor Skills?
   b. Sensory - Perceptual Skills?
   c. Speech and Language?
   d. Academics (school - age only)?
   e. Social - Emotional:
   f. Self - help?
C. Characteristic Negative Behaviors

1. List below the child's characteristic negative behaviors and their frequencies:

2. What factors precipitate negative behaviors in the child?

D. Prior Programming and Placements

1. What rewards and punishments have been used with the child? Which have worked? Which have not worked?

2. What instructional methods, materials, and equipment and teaching strategies have been tried with the child? What have been the outcomes?

3. What have been the child's previous placements? Have any worked out better than others? If yes, which ones and why?
4. What human and material resources will the sending school be able to allocate to implementation of the child's educational program?

5. What are the constraints of the sending school staff (especially the sending teacher) which may affect the nature of the child's program? (e.g., time, equipment, and materials limitations, etc.)?
Any request to inspect a student's record must state specifically the legitimate educational or other interest of such persons and their right to such information.
EXHIBIT H

CHILD OBSERVATION RECORD

Initial On-Site Observation
Follow-Up Observation

Instructions: This form is for use by the Consulting Diagnostic Teacher and the Diagnostic Classroom Teacher in a) Initial on-site observation of the child and b) On-site follow-up observation of the child. As such, it serves as a record of the child’s pre-placement and post-placement behaviors in a normal classroom setting, and can be used to track the child’s behavioral progress, regression, and change. The information from the Child Observation Record is also useful in the initial selection of all program prescriptions, including instructional materials, teaching strategies, learning environment strategies, and motivational strategies.

A. General Information

Date: __________________________ Name of Observer: __________________________

Name of Child: __________________________

Child’s Current Placement or Program: __________________________

Observation Setting:
   a) Name of facility of classroom: __________________________
   b) Physical setting: __________________________
   c) Time of observation: __________________________
   d) Number and roles of adults present during observation: __________________________
   e) Number of child’s peers present: __________________________
   f) Was child aware of observer’s presence? Yes ____ No ____
   g) Is this setting part of the child’s day-to-day environment? Yes ____ No ____

B. Summary and Conclusions

1. Observer Summary. (Include a statement of any patterns observed in columns I-IV of the Child Observation Record. Be certain to note the rewards and punishments which were particularly effective or ineffective.)

2. If applicable, how does this Child Observation Record compare to previous Observation Records?

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3. Observer Conclusions and Recommendations:

C. Child Observation Record

Use the following format to list all positive and negative behaviors observed in the child during the period of observation. Even if the child does nothing particularly noteworthy, list what he does do. For example, the child may simply sit quietly for ten minutes—a seemingly unimportant behavior. However, in the event that a future date the child becomes disruptive, this baseline data will provide a most useful standard of comparison.

For each behavior listed in column I, complete the following:

Column II: Circumstances Initiating the Behavior. This may be any stimulus—physical, verbal, or non-verbal—which appeared to elicit the behavior, such as, "Teacher aide frowned at child." "Teacher instructed the group to ______." "Child in next desk threw spitball." "School bell rang." If there were no apparent initiating circumstances, write "none."

Column III: Conditions. This section should include remarks on any noteworthy task-related or environmental factors operant at the time of the observed behavior, such as the child's assignment, materials, equipment, furniture, degree of independence or group involvement, positioning in the classroom, etc.

Column IV: Teacher/Peer Response. In this column enter the reaction to the child's behavior displayed by the teacher and/or students.

Column V: Comments. Note any additional remarks on the child's behavior, its causes, and its outcomes.
CHILD OBSERVATION RECORD

Date: ____________________  Name of Observer: ____________________

Name of Child: ____________________

<table>
<thead>
<tr>
<th>I. CHILD BEHAVIOR OR PERFORMANCE</th>
<th>II. INITIATING CIRCUMSTANCES</th>
<th>III. CONDITIONS</th>
<th>IV. TEACHER/PEER RESPONSE</th>
<th>V. COMMENTS</th>
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</table>
EXHIBIT I

CHILD INTERVIEW RECORD

INSTRUCTIONS: The Child Interview Record is to be completed by the Case Leader or Social Worker during the initial on-site visit to the child's sending school. If possible, the interview should be conducted privately within two weeks of receipt of the Referral Form. The information from the Child Interview is to be used in the development of Diagnostic Team Objectives, Program Objectives, initial program prescriptions, and placement recommendations.

A. GENERAL INFORMATION

Name of Child

I.D. #: Date:

Child's Current Placement or Program:

Interviewer:

Interview setting. (Facility and persons present).

B. INTERVIEW AREAS

I. General

a. Do you have brothers and sisters?

b. How old are you?

c. What do you like to do?

d. What are your favorite play activities?

e. What are your favorite toys?

f. What is your favorite music?

g. What are your favorite sports?

h. What are your favorite T.V. Shows?

i. What do you want to be?
2. Family relationships
   a. What do you like best about your family (siblings)?
   b. What do you like least?

3. Peer Relationships
   a. What are your friends like?
   b. What do you like about your friends?
   c. Why do you think they like you?
   d. Do you ever fight or argue with them?
   e. Why?
4. Schooling
   a. What do you like most about school?
   
   b. What do you like least?
   
   c. Who has been your favorite teacher? Why?
   
   d. Have you ever had a teacher you didn't like? Why?
   
   e. What are your favorite:
      (1) books?
      (2) playground or classroom equipment?
      (3) games?
   
   f. What is your favorite class period or activity?
   
   g. If you could learn anything you wanted to in school, what would you want to learn?
5. Other
EXHIBIT J
HOME CALL CHECKLIST

INSTRUCTIONS: The Home call Checklist must be completed by the Team Social Worker within two weeks of receipt of the Referral Form. The information gathered during the home visit is to be used in the development of the Diagnostic Team Objectives, the Diagnostic Summary, and the Long and Short Range Program Objectives.

A. GENERAL INFORMATION:

Name of Child: Date:

Interviewer:

Name of Parent or Guardian: I.D. #:

Address:

Phone:

B. MEMBERS OF HOUSEHOLD

1. Sex and age:
   a. Siblings:
   b. Relatives (specify relationship):
   c. Other household members:

2. Parent Occupation:
   a. Mother (specify if other than mother):
   b. Father (specify if other than father):

3. Parental Employment History:

4. Parental Marital History:

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5. Child's Relationship with Parents:

6. Child's Relationship with Siblings:

7. Family Attitude Toward Child and Child's Handicap:

8. Child's Peer Relationships:
9. Child's Prior Programming and Placements and Their Outcomes:

10. Child's Special Interests:

11. Child's Favorite Play Activities, Toys, Games, Books, etc.:

12. Child's In-Home Positive and Negative Behaviors:
13. Rewards and Punishments Used by Parents and Their Effectiveness:

14. Parental Concerns (i.e., questions parents would like to have answered re: child):

15. Parental Expectations for Child (i.e., long and short range; at home and in school):

16. Parents' Willingness to Assist in Program Implementation:
17. Suggested Resource Persons (Names and Telephone Numbers):

1. Family Doctor:

2. Hospital Personnel:

3. Mental Health Professionals:

4. Public Health Professionals:

5. Public Welfare Agency Staff:

6. Other:

18. Other Comments
This information is confidential and will be used only for the benefit of your child.

Please complete all portions of this form that apply to your child. If some sections do not apply please disregard.

**HEALTH HISTORY**

### A. Identifying Information:

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<th>Birthdate:</th>
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<td>School:</td>
<td>Teacher:</td>
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<td>Father:</td>
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<table>
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<th>Other Children: Name:</th>
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**Service Agency Contacts (Please List):**

1. **Has child had a recent physical examination?**
   - Date: __________

2. **Name and address of family physician and/or pediatrician.**

3. Is there any history of a handicapping condition in the child's family? (eye, emotional, speech, hearing, or physical problem(s), etc.)

Describe:

4. Describe your major concern(s) about your child.

5. What questions would you like to have answered?

6. Has the child been seen by a Neurologist? _______ Psychologist? _______ Had an EEG? _______ Has his Speech or Hearing been tested? _______ Has child had training in a speech, hearing, language, or developmental center? _______ If "YES" to any of the above, please explain and give dates.

7. Is this child presently on any type of medication? _______ For what? _______

8. Has your child been screened for vision, hearing and/or speech? If so, what were the findings?

B. Prenatal and Birth History:

1. Was pregnancy normal? _______ If not, explain

2. What illnesses did mother have during pregnancy? (measles, mumps, flu, etc.)

3. Any falls or accidents during pregnancy?

4. Was pregnancy full term? _______ If not, explain

5. Was delivery normal?

6. Length of labor?

7. What drugs were used during pregnancy and/or at delivery?
8. Instruments used?

9. What was the child's condition at birth?  
   color good? ___________ breathe easily? ___________ birth weight? ___________

10. Name and address of attending physician ________________________________________

11. Was there Rh incompatibility? ________________________________________________

12. Was infant placed in an incubator following birth? ___________ Describe ___________

13. Was any special medical attention or hospitalization required for this child during the first three months?

14. Mother's age at this pregnancy? _________ What numbered pregnancy? _________

15. How did this delivery compare with others? ______________________________________

C. Developmental History:
   At what age did this child:
   Sit alone ________________ Stand alone ________________
   Walk ________________

   Toilet Trained: Begin ___________ Completed ___________
   Bowl ________________
   Bladder ________________
   Has child returned to wetting at any time? ___________ Explain ___________
   Has child returned to soiling at any time? ________________

D. Early Illnesses:
   Childhood Illnesses or Diseases Age Complications or Problems
   High Fevers ________________ Ear Infections Mild ( ) Severe ( )
   How High? ________________ How Long? ________________
   Ear Infections Mild ( ) Severe ( )
   Allergies or sinus condition ___________ if so, explain

Comments: ____________________________________________
E. **Child's Communication:** (Tell how child understands and uses speech)

1. Does the child usually ask for things? __________ or point? __________
2. Does the child attempt to use speech? __________
3. Can the entire family understand the child? __________
4. Can friends and casual acquaintances understand the child? __________
5. When did your child say his first word? __________ What was it? __________
6. Approximately how many words does your child usually combine to make a sentence? __________
7. Write down a typical phrase or sentence your child says __________
8. At any time, has your child's communication drastically changed? __________
   If yes, describe __________
   To what do you attribute this change? __________
   Gestures? __________

F. **Ear History:**

1. Has your child ever had an ear examination in an ear doctor's office? Yes __________
   No __________
   If so, when? __________ By Whom? __________
2. Have you noticed signs which may indicate ear problems? Yes __________
   No __________
   If yes, what are they? __________
   Does any type of fluid ever come from your child's ear? __________
   Does your child have a heavy amount of ear wax? __________
3. Do any of the immediate members of the family have any of the ear problems mentioned in question #2? __________
4. Has there been surgery or medication for ear problems? _____ Describe: _____

5. Has your child ever received any medication such as Aureomycin _____ Streptomycin _____ or Sulfon? _____

6. Family History:

List relatives having hearing problems: ______________________________________________________

Causes: Otosclerosis _____ Genetic _____ Infection _____

G. Hearing Loss:

1. How long have you been aware of some hearing problems? ________________

2. Do you know what may have caused the hearing loss? _______________________

3. Does your child complain of any "ringing" or noise in his ears? _________

4. Does your child complain of any "dizziness"? _______________

Describe: ________________________________________________________________

If "yes" to above, how often, for how long, and at any particular time? ______

5. Does your child wear a hearing aid? _____ If "yes" for how long? ______

6. Does your child respond to sounds in his environment? _______________

7. Which ear appears to be the better ear? ______________________________

8. Does the hearing vary from one day to the next? ____________________

9. Is the hearing better at any season of the year? ____________________

10. Has your child's hearing been tested previously? ______ Dates: ______

   By Whom: ______________________ Address: ______________________

H. Eye History:

1. Has your child ever been examined by an eye doctor? _____ If so, when? ______

   Doctor's name: ________________ Address: ______________________

   Ophthalmologist: ________________ Address: ______________________

   Optometrist: ________________ Address: ______________________

2. Does your child wear glasses? ______________________

3. Has your child ever worn an eye patch or had a course of visual training? ______

   If "yes" please describe: __________________________________________

4. Has your child had eye surgery? _____ If "yes" please describe: ______

5. Do the eyes look crossed or does one eye wander away from the object at which the child is looking especially when ill or tired? ______
6. Do any members of your family have crossed eyes or one eye which is weaker than the other?
7. Does your child take medication for eye infections or allergies?
8. Does your child have eye-hand coordination problems?

I. Physical

Orthopedic History:
1. Describe child’s physical problem:
2. Are you aware of the child’s exact medical diagnosis? If so, please state:
3. What may have caused the condition?
4. How long has the condition existed?
5. Medical Specialist(s) involved in diagnosis and/or treatment of the child:
   - Pediatrician: __________________________ Address: __________________________
   - Orthopedist: __________________________ Address: __________________________
   - Physiatrist: __________________________ Address: __________________________
   - Other: __________________________ Address: __________________________
6. Treatment recommendations:
7. Are there any special devices needed for treatment and/or daily living (e.g., braces, catheter, aspirator, etc.)?

J. Check any of the below which you have observed in your child
   - Restless or overactive
   - Excitable
   - Inattentive
   - Overly sensitive, feelings easily hurt
   - Daydreams
   - Temper tantrums or outbursts
   - Irritable, prone and bickering
   - Destructive of his things or others
   - Overly bold, rude, or ill-mannered

Describe: __________________________

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K. List or describe the things you like about your child's behavior:


Signature
Relationship
Date

Please contact:
**EXHIBIT I**

**DATE:**

**SUMMARY OF**

- **INTAKE PLACEMENT STAFFING**
- **CONSULTATIVE STAFFING**
- **EDUCATIONAL STAFFING**

**Name** ___________________________ **Teacher** ___________________________

**Birthdate** ___________________________ **Level or Grade** ___________________________

**Parents** ___________________________ **Program** ___________________________

**Participants** ___________________________

**Specific Concerns:**

**Pertinent Information:**

**Recommendations:**
**EXHIBIT M**

Name of Child: ______________________

I.D. #: ______________________

**FORMAL TEST SCORE WORKSHEET**

**INSTRUCTIONS:** This form is to be maintained during diagnosis as an ongoing record of formal test results. In addition to providing information for the Diagnostic Summary, Formal Test Scores may be used as baseline measures in the Individual Behavioral Ladder and later compared to comparable post-placement data.

<table>
<thead>
<tr>
<th>Name of Test</th>
<th>Date Tested</th>
<th>Scores</th>
<th>Comments/Interpretation</th>
</tr>
</thead>
<tbody>
<tr>
<td>193 220</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
INFORMAL TEST SCORE WORKSHEET

INSTRUCTIONS: This form is to be maintained during diagnosis as an ongoing record of informal test results. In addition to providing information for the Diagnostic Summary, informal test results may be used as baseline measures in the Individual Behavioral Ladder and later compared to comparable post-placement data.

<table>
<thead>
<tr>
<th>Test, Checklist, Scale</th>
<th>Date tested</th>
<th>Task/Activity</th>
<th>Materials/Equipment</th>
<th>Results/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test 221</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Test 222</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
A. **Identifying Information**

Child's Name: ____________________ Sex: ___________ Birthdate: ___________

Parents' Name: ____________________

Home Address: ____________________

Referring Agency or School: ___________

Address of Agency or School: ___________

Child's Current Program or Placement:

Name of Sending Teacher: ___________

Name of Case Leader: ___________ Title: ___________

B. **Reasons for Referral** In essay or outline form, briefly state the reasons the child was referred to the Diagnostic Team. List the specific questions posed by the referring person (s) and the child's parents concerning the child's diagnosis and program.

C. **Statement of Major Handicapping Condition (s)**

1. **Developmental History** This section should include any pertinent or noteworthy information concerning the child's birth and early development. Facts to include may be the mother's age at the time of birth and any unusual factors which may have complicated the delivery. Developmental stages to note may be the child's age of walking, talking, and toilet training.

2. **Medical Summary** This section should summarize the child's past and present medical status. Information such as diseases, accidents, and hospitalizations should be mentioned here. Included should be the names of physicians and therapists who have worked with the child prior to or during the Team diagnosis.

3. **Social Summary** This section should include pertinent facts relating to the child's family background, rank in the family, number of siblings, parents marital status, relationship to family, peers, and adults, socialization difficulties at home and school, and interests or hobbies.
Diagnostic Team Objectives

List in priority sequence the objectives which the diagnostic team identified at the outset of Phase 2, Diagnosis, as guidelines for the diagnostic process.

Tests Administered

List the formal tests that were given to the child along with the dates the tests were administered and the scores obtained.

Summary of Diagnostic Information by Domain

This section should include a summary, by category or domain, of 1) the Diagnostic Teacher's observations of the child's strengths and weaknesses, 2) an interpretation of formal and informal tests administered to the child, and 3) observations of the child during testing. It is of particular importance that brief and concise interpretations of test scores and test performance data be given to the receiving agency or teacher.

As appropriate to the individual child, the "domains" should be inclusive of the following:

1. Motor Skills, including:
   a. Gross motor
   b. Fine motor

2. Sensory/Perceptual Skills, including:
   a. Visual reception
   b. Visual association
   c. Visual perception
   d. Visual motor
   e. Auditory reception
   f. Auditory association
   g. Auditory perception

3. Speech and Language, including:
   a. Articulation
   b. Receptive language
   c. Expressive language
   d. Language usage

4. Academic Skills, including:
   a. Reading skills
      1. Reading readiness
      2. Oral reading: rate and comprehension, fluency
      3. Silent reading: rate and comprehension
      4. Phonetic/word attack skills
      5. Spelling
   b. Math Skills, including:
      1. Number identification, numeration, counting
      2. Basic operations: addition, subtraction, multiplication, division
      3. Money: coin identification, making change

2 2 3

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4. Telling time
5. Fractions, decimals, percentages, etc.

c. Writing Skills, including:
   1. Handwriting/penmanship/letter formation
   2. Written expression/creative writing

5. Social-Emotional Skills, including:
   a. Peer relationships
   b. Adult relationships
   c. Family relationships
   d. Self concept
   e. Behavior

6. Self-help Skills, including:
   a. Feeding
   b. Dressing
   c. Toileting
   d. Personal hygiene
   e. Mobility

H. Attachments. Any reports, records, or documents which might be useful to the receiving agency or teacher should be attached. These may include medical reports, psychological evaluations, or school records.
**EXHIBIT P**

Name of Child: ________________________

I.D. #: ________________________

**FIELD TEST WORKSHEET**

**INSTRUCTIONS:** This form is to be used while field-testing initial program prescriptions. Enter comments and required revisions for each prescription in the appropriate column.

<table>
<thead>
<tr>
<th>Instructional Materials</th>
<th>Equipment</th>
<th>Reinforcers</th>
<th>Learning Environment</th>
<th>Teaching Strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

[2258]
INDIVIDUAL BEHAVIORAL LADDER

INSTRUCTIONS: The Individual Behavioral Ladder consists of a series of graduated behavioral objectives established for the child at the completion of Phase 3, Program Development and Testing. It must contain, for each diagnostic domain and short range program objective, the skills and behaviors the child is to acquire, increase, maintain, decrease, and extinguish during the twelve month follow-up period. These skills and behaviors are to be obtained from the Task Analysis and Behavioral Change Plan.

The Individual Behavioral Ladder initially forms a tool for the receiving teacher to assess the effectiveness of his or her efforts in terms of the objectives set for the child. It is later used by the Case Leader, along with the Individual Behavioral Ladder Follow-Up Sheet to measure the extent to which the child has achieved the behavioral objectives and the program has proven successful. Finally, based on the information on the Follow-Up Sheet, the Individual Behavioral Ladder is revised and redistributed at 3, 6, 9, and 12 month follow-up intervals.

The Individual Behavioral Ladder should be filled in as follows:

Column I, Behavioral Objective: In this column list the behavioral objectives for the diagnostic domain and Short Range Program Objective under consideration (see upper left hand corner.) The behavioral objectives are to be listed in order of increasing difficulty, and should correspond to increasing time frames in Column II. Each of the behavioral objectives must include:

a) an action verb,
b) the conditions under which the behavior is to be performed, and
c) the standard to which the behavior is to be performed.

For further information on writing behavioral objectives, see Appendix, "Behavioral Objectives."

Column II, Time Frame: In Column II simply check the 3 month post-placement time frame in which the child is expected to achieve the behavioral objective.

Column III, Direction: In this column check the "direction" of the behavioral objective according to whether it represents a behavior the child is to acquire, increase, decrease, maintain, or extinguish.

Column IV, Baseline Performance: In Column IV enter data describing the child's level of functioning in relation to the behavioral objective at the time on-site or in-classroom services are terminated. This data may consist of a behavioral count, a formal test score, an informal test score, or any other concrete measure of the speed, accuracy, quality, quantity, or frequency of the child's performance. It may be obtained from the child's behavioral charts and the Formal and Informal Test Score Worksheets completed during Phase 2, Diagnosis.
Column V, Program Prescriptions

This column must contain a description of the instructional materials, equipment, and activities required to train the child to achieve the behavioral objective. Also included in this column may be recommendations for teaching and motivational strategies, the child's learning environment, or any other instructions, remarks, or comments useful to the receiving teacher.

The completed Individual Behavioral Ladder is to be forwarded to the child's receiving teacher, parents, and other program implementers along with the Diagnostic Summary and Individual Educational Plan.
### Individual Behavioral Ladder

**Diagnostic Domain:**

**Short Range Objective:**

<table>
<thead>
<tr>
<th>Name of Child:</th>
<th>Date:</th>
<th>ID#:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Case Leader:**

**Original**

**First Revision**

**Second Revision**

**Third Revision**

### Behavioral Objective

<table>
<thead>
<tr>
<th>II. Time Frame (in months)</th>
<th>III. Direction</th>
<th>IV. Baseline Performance</th>
<th>V. Program Prescriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td></td>
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<tr>
<td>6</td>
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<tr>
<td>12</td>
<td></td>
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</tr>
</tbody>
</table>

**Acquire**

**Increase**

**Maintain**

**Decrease**

**Extinguish**

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**ERIC**

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EXHIBIT R

SAMPLE FORMAT FOR INDIVIDUAL EDUCATIONAL PLAN

A. General Information

Child's Name: I.D. #: 
Diagnostic Teacher: Date: 
Case Leader: 

B. Objectives

1. Summary of Long Range Program Objectives. This section should include a summary of the long range program objectives developed for the child. It should describe the skills and competencies the child should be able to acquire by adulthood in each diagnostic domain.

2. Summary of Short Range Program Objectives. This section should include a summary of the short range program objectives which have been developed for the child. It should describe the subskills the child must attain in order to meet the long range program objectives which have been previously set.

3. Summary of Behavioral Objectives. This section, based on the "individualized Behavioral Ladder," should summarize, by domain, the behavioral objectives that have been set for the child for the 3, 6, 9 and 12 month follow-up periods. Included for each domain addressed in this section should be a statement of the rationale for the corresponding behavioral objectives.

C. Summary of Recommended Strategies. This section, which is heavily based on the "Field Test Worksheets," should include specific instructions for strategies which have been found to be particularly effective in implementing programs for the child. As necessary, the rationale for each strategy should be indicated. Included in this section should be:

1. Teaching Strategies. This section may include specific procedures, priorities, and sequencing recommended for use by the receiving teacher or agency. It may also include general teaching guidelines for the receiving teacher such as "concentrate on remediation of the child's weak sensory channel (e.g., auditory). Use the child's strong channel (e.g., visual) to teach subject matter." Concrete examples should be given.

Also included here should be any comments on the optimal length, complexity, and variation of assignments given to the child. Include comments regarding the degree to which the child requires independence or group or teacher in-
volvement in completing tasks, the degree of specificity required in giving instructions to the child, etc.

2. Motivational Strategies. Included here should be:
   a. a statement of rewards and punishments which were found to particularly effective or ineffective in working with the child.
   b. a description of token systems and/or reinforcement schedules recommended for use with the child.

The importance of this section cannot be overestimated, as this information will prevent the receiving teacher or agency from having to rediscover what "makes the child tick."

3. Environmental Strategies. Included in this section should be any comments relating to the optimal learning environment for the child. For example, the child's positioning in the classroom, the type of desk or other equipment required by the child, the degree to which the child should be given mobility within the classroom, the optimal student-teacher ratio and the time of day the child functions best, may be noted.

D. Recommended Materials, Equipment, Activities. Any materials, special equipment, or activities recommended for use with the child should be listed in this section by diagnostic domain.

E. Placement Recommendations. This section should simply state the type of program and/or the name of a particular facility in the child's local district which is best suited to implement strategies and attain program objectives mentioned in the previous sections. As necessary, the rationale for the placement decision should be fully explained.

F. Recommendations for Program Implementation. This section should contain the names, titles, location, and phone numbers of resource persons, parents, and other program implementers, as well as their roles and responsibilities in program implementation.

G. Recommended Follow-Up. Included in this section should be:

1. A list of the names, titles, specialties, and phone numbers of resource persons whom the receiving agency or teacher may wish to contact for further information or clarification of existing information. The list may include appropriate local professional persons and Diagnostic Team members, as well as persons who have served the child on a contractual medical basis.

2. Recommendations for the continued involvement of Diagnostic Team members in services delivery and post-placement data collection. Time frames for future involvement, as well as the nature of the involvement (e.g., to conduct re-testing of the child, to observe the child, to work directly with the teacher and/or child, etc.) should be specified.
3. Other recommendations, such as suggestions for follow-up services provided by persons other than the Diagnostic Team, for medical re-evaluations, for additional psychological evaluations, and for follow-up social services.

H. Attachments. Any materials that might be useful to the receiving agency or teacher should be attached to the main body of the report. These might include:

1. Forms and documents compiled by the Diagnostic Team, including the Diagnostic Summary, Individual Behavioral Ladder, and other materials as necessary.

2. Social, medical, psychological, and academic reports, records, and documents.

3. A list of the questions initially posed by the referring agency and/or the child’s parents and the answers to these questions.

4. Samples of materials recommended for use with the child, particularly those that are teacher-made or those that are not widely distributed.
EXHIBIT S

TEACHER FOLLOW-UP RECORD

INSTRUCTIONS: The Teacher Follow-up Record is to be completed by the Case Leader one month after the termination of Team services during a personal interview with the child's receiving teacher. The completed form must be forwarded to the Program Coordinator for use in informal program evaluation. Items 9 and 10 may also be used by the Case Leader as a comparison to identical information in the Initial Information Gathering Checklist to behavioral changes in the child since program acceptance.

A. GENERAL INFORMATION

1. Name of child:
2. Case Leader:
3. Placement:
4. Receiving Teacher:
5. Child's handicaps:
6. Services Provided (check all that apply):
   a. Contractual Medical
   b. In-classroom:
      1. Diagnosis
      2. Programming
   c. On-site:
      1. Diagnosis
      2. Programming
      3. Consultation

B. Feedback

1a. To what extent have you been satisfied with the services rendered by the Diagnostic Team?
   1. Not at all

   232
2. To a very little extent _____
3. To some extent _____
4. To a great extent _____
5. To a very great extent _____
6. Receiving Teacher Comments:

2a. To what extent did the Diagnostic Summary increase your understanding of the child's problems?
1. Not at all _____
2. To a very little extent _____
3. To some extent _____
4. To a great extent _____
5. To a very great extent _____
6. Receiving Teacher Comments:

b. Which parts were most useful and why?

c. Which parts were least useful and why?

d. What additional information would you have found useful?
3a. To what extent did you find the Individual Educational Plan helpful in the development of educational programming for the child?

1. Not at all
2. To a very little extent
3. To some extent
4. To a great extent
5. To a very great extent

6. Receiving Teacher Comments:

b. Which parts were most useful and why?

c. Which parts were least useful and why?

d. What additional information would you have found useful?

4a. To what extent have you found the Individual Behavioral Ladder useful in assessing the child's progress and regression?

1. Not at all
2. To a very little extent
3. To some extent
4. To a great extent
5. To a very great extent

2 3 4
6. Receiving Teacher Comments:

5a. To what extent did you find the training and technical assistance provided by the Diagnostic Team useful in program implementation?
   1. Not at all
   2. To a very little extent
   3. To some extent
   4. To a great extent
   5. To a very great extent
   6. Receiving Teacher Comments:

6. To what extent has the child moved toward normalization?
   a. Not at all
   b. To a very little extent
   c. To some extent
   d. To a great extent
   e. To a very great extent
   f. Receiving Teacher Comments:
7. To what extent were the Diagnostic Team services instrumental in the child's movement toward normalization?
   a. Not at all
   b. To a very little extent
   c. To some extent
   d. To a great extent
   e. To a very great extent
   f. Receiving Teacher Comments:

8. If applicable, to what extent has the child successfully adjusted to his or her new placement?
   a. Not at all
   b. To a very little extent
   c. To some extent
   d. To a great extent
   e. To a very great extent
   f. Receiving Teacher Comments:

9. If applicable, to what extent were the Diagnostic Team Services instrumental in effecting a smooth transition for the child into his or her new placement?
   a. Not at all
   b. To a very little extent
   c. To some extent
   d. Receiving Teacher Comments:

   236
d. To a great extent

e. To a very great extent

f. Receiving Teacher Comments:

10a. In what ways has the child progressed?

b. In what ways has the child regressed?

in what ways has the child otherwise changed?
11. List below the child's characteristic positive behaviors and their frequencies.

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Frequency</th>
</tr>
</thead>
</table>

12. List below the child's characteristic negative behaviors and their frequency.

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>238</td>
</tr>
<tr>
<td></td>
<td>211</td>
</tr>
</tbody>
</table>
13. Teacher Comments:
EXHIBIT T

PARENT FOLLOW-UP RECORD

Instructions: The Parent Follow-Up Record is to be completed by the Case Leader or Team Social Worker one month after the termination of Team Services during a personal interview with the child's parents. The completed form must be forwarded to the Program Coordinator for use in informal program evaluation.

Identifying Information:

Child's Name: Sex: Date: Birthdate: I.D. #: 

Parent's Name:

Home Address:

Referring Agency or School:

Address of Agency or School:

Child's Current Program or Placement:

Name of Sending Teacher: Title:

Name of Case Leader: Title:

Questions:

1. To what extent did the Diagnostic Team increase your understanding of your child's problems?
   a. Not at all ______
   b. To some extent ______
   c. To a great extent ______

2. To what extent did you find the Diagnostic Team helpful in the development of a good educational program for your child?
   a. Not at all ______
   b. To some extent ______
   c. To a great extent ______

3. If applicable, to what extent was the Diagnostic Team instrumental in securing a better placement for your child?
   a. Not at all ______
   b. To some extent ______
   c. To a great extent ______
4. a. Since your child's involvement with the Diagnostic Team, what, if any, improvements have you observed in him or her in school? at home?

b. In what ways, if any, has he or she gotten worse?

5. Did you find the Diagnostic Team services helpful in any other ways? If so, please give examples.

6. Did you find the Diagnostic Team services inadequate in any way? If so, please give examples.

7. What, in your opinion, was the best thing that happened to (name of child) during his or her involvement with the Diagnostic Team?

8. Generally speaking, to what extent are you satisfied with the range and quality of services provided to your child by the Diagnostic Team?

   a. Not at all __________
   b. To some extent __________
   c. To a great extent __________

9. Parent Comments:
INDIVIDUAL BEHAVIORAL LADDER FOLLOW-UP SHEET

**DOMAIN:** __________________________

**SHORT RANGE PROGRAM OBJECTIVE:** __________________________

<table>
<thead>
<tr>
<th>3 Month</th>
<th>9 Month</th>
<th>6 Month</th>
<th>12 Month</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>I. BEHAVIORAL OBJECTIVES</th>
<th>II. DIRECTION OF BEHAVIORAL OBJECTIVE</th>
<th>III. FOLLOW-UP PERFORMANCE</th>
<th>IV. WAS OBJECTIVE ACHIEVED AT STANDARD SPECIFIED?</th>
<th>V. COMMENTS (e.g., rework, delete, retain with new time frame, etc.)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maintain</td>
<td>Maintained</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Decrease</td>
<td>Decreased</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increase</td>
<td>Increased</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acquire</td>
<td>Extinguished</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**ERIC**
EXHIBIT U.

CHILD FOLLOW-UP RECORD

Date: ___________________________ I.D. #: ___________________________

_____ 3 Month _____ 6 Month _____ 9 Month _____ 12 Month

Instructions: This form is to be employed on a quarterly basis for one year from the date of
the exit staffing. It is to be completed by the Case Leader, with assistance from the child's
receiving teacher, on each child who has received in-classroom services. The information
from the Child Follow-Up Record is to be used by the Case Leader in the revision of the
child's Individual Behavioral Ladder and by the Program Coordinator in formal program
evaluation.

A. General Information. Include the following:

Child's Name: Sex: Birthdate:

Parent's Name:

Home Address:

Referring Agency or School:

Address of Agency or School:

Child's Current Program or Placement:

Name of Sending Teacher: Title:

Name of Case Leader: Title:

B. Behavioral Ladder Follow-Up Sheet. Complete one sheet for each short range program
objective. Using the Individual Behavioral Ladder, enter in Column I the corresponding
behavioral objectives for the three month period under evaluation. Enter in Column II the
"direction" for each objective as specified in the Individual Behavioral Ladder. Finally, complete Columns II-V in cooperation with the child's receiving teacher.
Refer to the Individual Behavioral Ladder as necessary.

C. Achievement of Behavioral Objectives. Compute percentages on each of the
following items.

1. General Progress.

a. Across all diagnostic domains addressed in the Individual Behavioral Ladder,
what percent of the behavioral objectives for this follow-up quarter were
achieved?

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2. 216
b. For each diagnostic domain addressed in the Individual Behavioral Ladder, what percent of the behavioral objectives for this follow-up quarter were achieved?

(1) Motor Skills
(2) Sensory-Perceptual Skills
(3) Speech and Language Skills
(4) Academic Skills
(5) Social-Emotional Skills
(6) Self-Help Skills

c. For each diagnostic domain addressed in the Individual Ladder, what percent of the short range program objectives were achieved? (Compute percentage of short range program objectives for which all behavioral objectives were achieved for each diagnostic domain).

(1) Motor Skills
(2) Sensory-Perceptual Skills
(3) Speech and Language Skills
(4) Academic Skills
(5) Social-Emotional Skills
(6) Self-Help Skills

2. General Regression.

a. Across all diagnostic domains in the Individual Behavioral Ladder, for what percent of the behavioral objectives for this follow-up quarter was regression evident? (Include in this computation all behaviors that were to be 1) increased, but actually were decreased or extinguished, 2) maintained, but actually were decreased, 3) decreased, but actually were increased, maintained, or decreased. Refer to Columns II and III of the Individual Behavioral Ladder Follow-Up Sheet).

b. For each diagnostic domain addressed in the Individual Behavioral Ladder, for what percent of the behavioral objectives for this follow-up quarter was regression evident? (Compute for each domain as in 2a above).

(1) Motor Skills
(2) Sensory-Perceptual Skills
(3) Speech and Language Skills
(4) Academic Skills
(5) Social-Emotional Skills
(6) Self-Help Skills

D. Revision Information. After the child's Individual Behavioral Ladder has been revised based on Section C above, complete the following:

1. Number of objectives deleted:

2. Number of objectives added:

3. Number of objectives rewritten:
INSTRUCTIONS: This form is to be completed by the Case Leader on an annual basis for each child who has received in-classroom services until the child exits from the educational system. It is to be employed during a phone or personal interview at the end of each school year with the child's current teacher and forwarded to the Program Coordinator for use in Formal Program Evaluation.

A. GENERAL INFORMATION

1. Name of Child:

2. Case Leader:

3. Child's Current Placement:

4. Child's Current Teacher:
   a. Name:
   b. Phone Number:

5. Dates of Diagnostic Classroom Placement
   From __________ to __________
   Month/Year    Month/Year

B. Interview Questions

1a. To what extent do you feel that ___________ has advanced toward normalization in the current school year?

(1) Not at all: __________
(2) To a very little extent: __________
(3) To some extent: __________
(4) To a great extent: __________
(5) To a very great extent: __________
b. In what ways?

2a. To what extent do you feel that _______ has regressed during the current school year?

(1) Not at all: ___
(2) To a very little extent: ___
(3) To some extent: ___
(4) To a great extent: ___
(5) To a very great extent: ___

b. In what ways?

3a. To what extent do you feel that _______ deviates from the academic and social norms for the children in your classroom?

(1) Not at all: ___
(2) To a very little extent: ___
(3) To some extent: ___
(4) To a great extent: ___
(5) To a very great extent: ___

b. In what ways?
4a. To what extent do you feel that \underline{\text{name of child}} is failing to reach his or her potential?

(1) Not at all: __________
(2) To a very little extent: __________
(3) To some extent: __________
(4) To a great extent: __________
(5) To a very great extent: __________

b. In what ways?

C. For completion by Case Leader:

1a. How do the child's normative tests scores for the closing school year compare to those for previous years?

b. What, according to these scores, has been the nature of the child's movement toward or away from normalization?

<table>
<thead>
<tr>
<th></th>
<th>Academically</th>
<th>Socially</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) The child has deviated much further from the norm</td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td>(2) The child has deviated slightly further from the norm</td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td>(3) The child has advanced slightly toward the norm</td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td>(4) The child has advanced considerably toward the norm</td>
<td>__________</td>
<td>__________</td>
</tr>
<tr>
<td>(5) The child has achieved the norm</td>
<td>__________</td>
<td>__________</td>
</tr>
</tbody>
</table>

248
2. To what extent is the child achieving the Short Range Program Objectives established for him or her during Diagnostic Classroom Placement?

(1) Not at all: 
(2) To a very little extent: 
(3) To some extent: 
(4) To a great extent: 
(5) To a very great extent: 

3. To what extent is the child achieving the Long Range Program Objectives established for him or her during Diagnostic Classroom Placement?

(1) Not at all: 
(2) To a very little extent: 
(3) To some extent: 
(4) To a great extent: 
(5) To a very great extent: 

4. Comments:
EXHIBIT W.

INFORMAL EVALUATION DATA SUMMARY SHEET

Instructions: This form is to be completed on an annual basis by the Program Coordinator, using data from the Teacher and Parent Follow-Up Records. Retain one copy and forward one copy to Dr. Harold Berjohn, Director Regional Resource Center #7, 3202 N. Wisconsin Peoria, IL 61603.

A. General Information

1. Number of children receiving on-site services:

<table>
<thead>
<tr>
<th>Handicaps of children receiving on-site services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No handicaps</td>
</tr>
<tr>
<td>2. Retarded</td>
</tr>
<tr>
<td>3. Orthopedic</td>
</tr>
<tr>
<td>4. Speech Impaired</td>
</tr>
<tr>
<td>5. Hearing Impaired</td>
</tr>
<tr>
<td>11. Other (specify):</td>
</tr>
</tbody>
</table>

2. Number of children receiving in-classroom services:

<table>
<thead>
<tr>
<th>Handicaps of children receiving in-classroom services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. No handicaps</td>
</tr>
<tr>
<td>2. Retarded</td>
</tr>
<tr>
<td>3. Orthopedic</td>
</tr>
<tr>
<td>4. Speech Impaired</td>
</tr>
<tr>
<td>5. Hearing Impaired</td>
</tr>
<tr>
<td>11. Other (specify):</td>
</tr>
</tbody>
</table>

B. Teacher Follow-Up Data. Using the Teacher Follow-Up Records, compute the percentages of teachers indicating each of the response options for the following items:

1. Extent to which receiving teachers were satisfied with the services rendered by the Diagnostic Team (see item B.1.a on the Teacher Follow-Up Record):

   | 250 |

223
<table>
<thead>
<tr>
<th></th>
<th>On-Site:</th>
<th>In-Classroom:</th>
<th>Total:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Not at all:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>b. To a very little extent:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>c. To some extent:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>d. To a great extent:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>e. To a very great extent:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

2. **Extent to which the Diagnostic Summary increased receiving teachers' understanding of the child's problems (see item B.2.a. on the Teacher Follow-Up Record):**

<table>
<thead>
<tr>
<th></th>
<th>On-Site:</th>
<th>In-Classroom:</th>
<th>Total:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Not at all:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>b. To a very little extent:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>c. To some extent:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>d. To a great extent:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>e. To a very great extent:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

3. **Extent to which receiving teachers found the information in the Teacher Follow-Up Record useful in the development of educational programming:**

<table>
<thead>
<tr>
<th></th>
<th>On-Site:</th>
<th>In-Classroom:</th>
<th>Total:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Not at all:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>b. To a very little extent:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>c. To some extent:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>d. To a great extent:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>e. To a very great extent:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

4. **Extent to which receiving teachers found the data in assessing the child's progress and progress in the Teacher Follow-Up Record:**

<table>
<thead>
<tr>
<th></th>
<th>On-Site:</th>
<th>In-Classroom:</th>
<th>Total:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Not at all:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>b. To a very little extent:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>c. To some extent:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>d. To a great extent:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>e. To a very great extent:</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>
5. Extent to which receiving teachers found the training and technical assistance provided by the Diagnostic Team useful in program implementation (see item B.5.a on the Teacher Follow-Up Record):

<table>
<thead>
<tr>
<th>On-Site:</th>
<th>In-Classroom:</th>
<th>Total:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Not at all:</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>b. To a very little extent:</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>c. To some extent:</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>d. To a great extent:</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>e. To a very great extent:</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

6. Extent to which the children have moved toward normalization (see item B.6 on the Teacher Follow-Up Record):

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Not at all:</td>
<td>%</td>
</tr>
<tr>
<td>b. To a very little extent:</td>
<td>%</td>
</tr>
<tr>
<td>c. To some extent:</td>
<td>%</td>
</tr>
<tr>
<td>d. To a great extent:</td>
<td>%</td>
</tr>
<tr>
<td>e. To a very great extent:</td>
<td>%</td>
</tr>
</tbody>
</table>

7. Extent to which Diagnostic Team services were instrumental in the children's movement toward normalization (see item B.7 on the Teacher Follow-Up Record):

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Not at all:</td>
<td>%</td>
</tr>
<tr>
<td>b. To a very little extent:</td>
<td>%</td>
</tr>
<tr>
<td>c. To some extent:</td>
<td>%</td>
</tr>
<tr>
<td>d. To a great extent:</td>
<td>%</td>
</tr>
<tr>
<td>e. To a very great extent:</td>
<td>%</td>
</tr>
</tbody>
</table>

8. Extent to which children successfully adjusted to new placements (see item B.8 on Teacher Follow-Up Record):

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Not at all:</td>
<td>%</td>
</tr>
<tr>
<td>b. To a very little extent:</td>
<td>%</td>
</tr>
<tr>
<td>c. To some extent:</td>
<td>%</td>
</tr>
<tr>
<td>d. To a great extent:</td>
<td>%</td>
</tr>
<tr>
<td>e. To a very great extent:</td>
<td>%</td>
</tr>
</tbody>
</table>
9. **Extent to which Diagnostic Team services were instrumental in effecting smooth transition for children into new placements (see B.9 on Teacher Follow-Up Record):**

<table>
<thead>
<tr>
<th></th>
<th>On-Site:</th>
<th>In-Classroom:</th>
<th>Total:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Not at all:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. To a very little extent:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. To some extent:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>d. To a great extent:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>e. To a very great extent:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. **Parent Follow-Up Data.** Using the Parent Follow-Up Records, compute the percentages of parents indicating each of the response options for the following items:

1. **Extent to which parents' understanding of child's problems was increased (see item 1 on Parent Follow-Up Record):**

<table>
<thead>
<tr>
<th></th>
<th>On-Site:</th>
<th>In-Classroom:</th>
<th>Total:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Not at all:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. To some extent:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. To a great extent:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. **Extent to which parents found the Diagnostic Team helpful in the development of a good educational program for the child (see item 2 on Parent Follow-Up Record):**

<table>
<thead>
<tr>
<th></th>
<th>On-Site:</th>
<th>In-Classroom:</th>
<th>Total:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Not at all:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. To some extent:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. To a great extent:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. **Extent to which parents found the Diagnostic Team instrumental in securing better placement for the child (see item 3 on Parent Follow-Up Record):**

<table>
<thead>
<tr>
<th></th>
<th>On-Site:</th>
<th>In-Classroom:</th>
<th>Total:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Not at all:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. To some extent:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. To a great extent:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. **Extent to which parents were satisfied with the range and quality of Diagnostic Team services (see item 8 on Parent Follow-Up Record):**

<table>
<thead>
<tr>
<th></th>
<th>On-Site:</th>
<th>In-Classroom:</th>
<th>Total:</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Not at all:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. To some extent:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c. To a great extent:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
EXHIBIT X.

FORMAL EVALUATION DATA SUMMARY SHEET

Date: ___________________________ Program Coordinator: ___________________________

Instructions: This form summarizes data gathered on children who have received in-classroom services to be completed in an annual basis by the Program Coordinator, using data from the Child Follow-Up Records and Longitudinal Follow-Up Records. Retain one copy and forward one copy to Dr. Harold Berjohn, Director, Regional Resource Center #7, 3202 N. Wisconsin, Peoria, IL 61603.

A. General Information

1. Number of children receiving in-classroom services:

2. Handicaps of children receiving in-classroom services:
   a. ____ No handicaps
   b. ____ Retarded
   c. ____ Orthopedic
   d. ____ Speech Impaired
   e. ____ Hearing Impaired
   f. ____ Deaf
   g. ____ Visually Impaired
   h. ____ Blind
   i. ____ Emotionally Disturbed
   j. ____ Learning Disabilities
   k. ____ Other (specify)

B. Child Follow-Up Data. Using Section C of the Child Follow-Up Records, complete percentages for each of the following items:

1. Achievement of behavioral objectives across domains: ____%

2. Achievement of behavioral objectives for each domain: ____%
   a. Motor Skills ____%
   b. Sensory-Perceptual Skills ____%
   c. Speech and Language Skills ____%
   d. Academic Skills ____%
   e. Social-Emotional Skills ____%
   f. Self-Help Skills 254 ____%
3. Achievement of short-range program objective for each domain:
   a. Motor Skills
   b. Sensory-Perceptual Skills
   c. Speech and Language Skills
   d. Academic Skills
   e. Social-Emotional Skills
   f. Self-Help Skills

4. Regression across domains:

5. Regression for each domain:
   a. Motor Skills
   b. Sensory-Perceptual Skills
   c. Speech and Language Skills
   d. Academic Skills
   e. Social-Emotional Skills
   f. Self-Help Skills

6. Objectives deleted:

7. Objectives added:

8. Objectives rewritten:

C. Longitudinal Follow-Up Data

Using the Longitudinal Follow-Up Record, complete the percentage of teachers indicating each of the response options for the following items:

1. Extent to which children advanced toward normalization (see item B.1.a on the Longitudinal Follow-Up Record):
   a. Not at all:
   b. To a very little extent:
   c. To some extent:
   d. To a great extent:
   e. To a very great extent:

   ___ %
2. Extent to which receiving teachers felt children had regressed during the current school year (see item B.2.a. on the Longitudinal Follow-Up Record):
   a. Not at all: ___ 
   b. To a very little extent: ___ 
   c. To some extent: ___ 
   d. To a great extent: ___ 
   e. To a very great extent: ___ 

3. Extent to which receiving teachers felt that children deviated from the other children in the classroom (see item B.3.a. on the Longitudinal Follow-Up Record):
   a. Not at all: ___ 
   b. To a very little extent: ___ 
   c. To some extent: ___ 
   d. To a great extent: ___ 
   e. To a very great extent: ___ 

4. Extent to which receiving teachers felt children were failing to reach his or her potential (see item B.4.a. on the Longitudinal Follow-Up Record):
   a. Not at all: ___ 
   b. To a very little extent: ___ 
   c. To some extent: ___ 
   d. To a great extent: ___ 
   e. To a very great extent: ___ 

5. Nature of the children's movement toward or away from normalization (see item B.5.a. on the Longitudinal Follow-Up Record):
   a. Children deviated much further from norm: ___ 
   b. Children deviated slightly further from norm: ___ 
   c. Children advanced slightly toward norm: ___ 
   d. Children advanced considerably toward norm: ___ 
   e. Children achieved the norm: ___
6. Extent to which the children are achieving the Short Range Program Objectives established for them during Diagnostic Classroom Placement?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Not at all:</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>To a very little extent:</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>To some extent:</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>To a great extent:</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>To a very great extent:</td>
<td></td>
</tr>
</tbody>
</table>

7. Extent to which the children are achieving the Long Range Program Objectives established for them during Diagnostic Classroom Placement?

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>a.</td>
<td>Not at all:</td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>To a very little extent:</td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td>To some extent:</td>
<td></td>
</tr>
<tr>
<td>d.</td>
<td>To a great extent:</td>
<td></td>
</tr>
<tr>
<td>e.</td>
<td>To a very great extent:</td>
<td></td>
</tr>
</tbody>
</table>
INSTRUCTIONS: This form is to be completed by the Program Coordinator on an annual basis, using data from the Master Client Registry and Cas Contact Record, and forwarded to appropriate funding sources. The Informal and Formal Evaluation Data Summary Sheets may be attached. Retain one copy of the Federal Reporting Form and forward one copy to Dr. Harold Berjahn, Director, Regional Resource Center #7, 3202 N. Wisconsin, Peoria, IL 61603.

A. GENERAL INFORMATION:
1. Name of Program
2. District:
3. Address:
4. Name of Program Coordinator:
5. Phone Number:

B. MASTER CLIENT REGISTRY DATA:
1. Total number of children served:
2. Handicaps of children served (enter percent of total child population possessing each handicap):
   a. No Handicap
   b. Retarded
   c. Hard of Hearing
   d. Deaf
   e. Speech Impaired
   f. Visually Impaired
   g. Seriously Emotionally Disturbed
   h. Crippled
   i. Other Health Impairments
   j. Hearing Disabilities
   k. Multiple (specify j-k above)
3. Severity of handicaps of children served (enter percent of total child population falling in each category of severity):
   a. No Handicap
   b. Mild
   c. Moderate
   d. Severe

4. Age of children served (enter percent of total child population falling in each age group):
   a. Under 5
   b. 5 - 15
   c. Over 15

5. Services Requested (enter number and percent of total number of cases for each category):

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Classroom Placement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consulting Diagnostic Teacher</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deaf Educator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vision Educator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contractual Medical (specify)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (specify)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Services Provided:
   a. Diagnostic Classroom Placement
   b. Consultation
C. Case Contact Data

1. Average number of contacts per case: 

2. Type of contact (enter number and percent of total number of contacts for each category):

<table>
<thead>
<tr>
<th>Type of Contact</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone calls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conferences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Calls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Contact Persons (enter number and percent of total number of contacts for each category):

<table>
<thead>
<tr>
<th>Contact Person</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Support Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Consultants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Administrators</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sending/Receiving Teachers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Resource Person</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4. Purpose of contacts (enter percent only):
   a. Provide technical assistance
   b. Gather information
   c. Provide information
   d. Provide training
   e. Give demonstration
   f. Receive technical assistance
   g. Follow-up

   %   %   %   %   %   %
SECTION 4

HYPOTHETICAL CASE STUDY

FOR THE ILLINOIS - RRC DIAGNOSTIC TEACHING MODEL
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Introduction

The purpose of the following hypothetical case study is to provide examples of the written materials produced by the Diagnostic Team during Phase 2, Diagnosis, and Phase 3, Program Development and Testing. The primary purpose of these materials is to synthesize, organize, and summarize all the diagnostic and prescriptive information collected or generated on a given-child. Thus they represent the culmination of the many information-gathering and data-processing activities contained in the model.

While the hypothetical case study includes only portions of completed materials, it should nonetheless serve as a model for the content and format of written information produced on actual cases. Further explanation of these materials and their continuity in the context of the total IRDTM are contained in Section 2, "Flowcharts."
Purpose of the Diagnostic Team Objectives

The Diagnostic Team Objectives are devised at the onset of Phase 2, Diagnosis, and are based on the information collected during Phase 1, Initial Information-Gathering. The purpose of the Diagnostic Team Objectives is to establish the goals for the Diagnostic Team members during their involvement with the child in the delivery of on-site or in-classroom services. They also serve to delineate the division of labor and time frames for the Diagnostic Team and to identify the resource persons required in the diagnostic process.
<table>
<thead>
<tr>
<th>Objective</th>
<th>Diagnostic Team Member Responsible</th>
<th>To Be Completed By</th>
<th>Resource Persons Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Eliminate self-destructive behavior</td>
<td>Diagnostic Classroom Teacher</td>
<td>Nov. 15, 1976</td>
<td>Psychologist</td>
</tr>
<tr>
<td>2. Determine Edward's current level of intellectual functioning</td>
<td>Diagnostic Classroom Teacher</td>
<td>Oct. 10, 1976</td>
<td>Psychologist</td>
</tr>
<tr>
<td>3. Determine which academic skills Edward has acquired and needs to acquire</td>
<td>Diagnostic Classroom Teacher</td>
<td>Oct 31, 1976</td>
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<tr>
<td>4. Determine Edward's visual acuity</td>
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<td>Nov. 21, 1976</td>
<td>Ophthalmologist</td>
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<td>5. Obtain additional information concerning Edward's inverted foot and possible recommendations for therapy</td>
<td>Consulting Diagnostic Teacher</td>
<td>Nov. 15, 1976</td>
<td>Physical Therapist</td>
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<td>6. Determine the appropriateness of current medication prescribed for hyperactivity</td>
<td>Consulting Diagnostic Teacher</td>
<td>Nov. 3, 1976</td>
<td>Neurologist Pediatricon</td>
</tr>
<tr>
<td>7. Increase Edward's skills in verbal expression and language usage</td>
<td>Diagnostic Classroom Teacher</td>
<td>Nov. 30, 1976</td>
<td>Speech Therapist</td>
</tr>
<tr>
<td>8. Increase Edward's socialization skills</td>
<td>Social Worker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Determine the optimal learning environment and teaching strategies for Edward</td>
<td>Diagnostic Classroom Teacher</td>
<td>Nov. 30, 1976</td>
<td></td>
</tr>
<tr>
<td>10. Determine Edward's motivational patterns and optimal motivational strategies</td>
<td>Diagnostic Classroom Teacher</td>
<td>Nov. 30, 1976</td>
<td></td>
</tr>
</tbody>
</table>
Purpose of the Behavioral Change Plan

The Behavioral Change Plan, which is completed within one week after the initiation of on-site or in-classroom services, identifies the skills and behaviors the child realistically can be expected to acquire, increase, maintain, decrease, or extinguish during Phase 2, Diagnosis, and Phase 3, Program Development and Testing. It consists of a listing of behavioral objectives and for reinforcers the child and corresponding behavioral charts which are used to track the child's progress toward the achievement of the objectives.

The rationale for the Behavioral Change Plan is to facilitate the child's integration into a normal classroom environment through the development of socialization skills and the removal of disruptive or self-destructive behaviors. It thus incorporates the suggestions for behavioral change made by the child's sending teacher and parents, as well as the conclusions drawn from initial on-site observation of the child. Because behavioral change is so often brought about simply as a result of the extra attention the child receives from the Diagnostic Team, the ultimate effectiveness of the Behavioral Change Plan must be evaluated through a comparison of the pre- and post-placement observational data gathered on the child.

The Behavioral Change Plan Objectives not achieved by the child during Phases 2 and 3 may be included in the child's Individual Behavioral Ladder, which is completed at the conclusion of Phase 3.
Behavioral Change Plan Objectives

Upon exit from the diagnostic classroom, Edward will:

1. Slap himself on the head no more than once per day under normal conditions in the classroom or at home.
2. Make eye contact with the classroom teacher for at least ten seconds each time she calls his name.
3. Respond verbally using complete sentences composed of four or more words in correct order each time the classroom teacher asks him a question.
4. Given an arithmetic worksheet of 25 addition problems, sit in his chair at his desk for a period of 15 minutes without turning around, talking, throwing his pencil, or tearing the paper.
5. Voluntarily offer to share his toys with another child at least three times per week during play time.

Reinforcers to be used in conjunction with the change plan:

1. verbal praise
2. gold stars or "happy faces" on his worksheets
3. candy bars
4. putting puzzles together
5. use of the tope recorder
6. sitting in a rocking chair
7. feeding the fish
Purpose of the Diagnostic Summary

The Diagnostic Summary logically organizes and integrates the large amounts of disparate diagnostic data gathered from numerous sources during Phase 1, Initial Information-Gathering, and Phase 2, Diagnosis. As such, it represents the synthesis of all historical and current information on the total child.

The Diagnostic Summary should be attached to the child's Individual Educational Plan and forwarded to the child's receiving teacher, parents, and other persons responsible for program implementation.
SAMPLE DIAGNOSTIC SUMMARY

Child's Name: Edward Jones   Sex: Male   Birthdate: 5/15/66
Parent's Name: John and Sharon Jones
Home Address: 1694 W. Sunset   Springfield, Ill. 61523
Referring School: Benjamin Franklin Elementary School
School Address: 1700 W. Fourth   Springfield, Ill. 61525
Child's Current Program: Primary EMH
Name of Teacher: Mrs. Ruth Foster
Name of Case Leader: Thomas Smith    Title: Consulting Diagnostic Teacher

Reasons for Referral

Edward was referred to the Regional Resource Center on October 14, 1976, because of his distractibility, hyperactivity, short attention span, peculiar movement patterns during excitement or tension, difficulty in comprehension and lack of dexterity. The following questions were posed by the sending school and Edward's parents:

A. School
   1. At what level is Edward currently functioning intellectually and academically?
   2. What is the most appropriate program for Edward?

B. Parents
   1. What can be done about Edward's hyperactivity? Is the medication which is presently being given appropriate?
   2. How can we control Edward's behavior at home?
   3. What are Edward's abilities? disabilities?
   4. What are some of the prospects for the future?

Major Handicapping Conditions

Educable Mentally Retarded

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Developmental History

Edward was born at Springfield Memorial Hospital after what was apparently an uneventful labor and delivery. His weight at birth was seven pounds, fourteen ounces. He had significant problems with respiratory infections as an infant. Shortly after birth, he was noted to have inverted feet, the left one being handled by manipulation by the mother but the right one ultimately requiring the application of a short plaster cast for two months.

Some developmental lag was noted as he walked at seventeen months, talked at age three, and was toilet trained at age three and a half. Edward did not crawl; instead, he tended to move about on his back using his head and his feet, twisting his body in "snakelike" motions.

Medical Summary

Other than a tonsillectomy and adenoidectomy done in June of 1971, Edward has not been hospitalized. Records do show repeated contact with the doctor for respiratory problems, colds, inflammations of his throat, in addition to treatment for measles and chickenpox. According to Edward's medical record at Springfield Memorial Hospital, he has been formally seen at the clinic a little over 80 times in his first six years of life.

His doctor did a full musculoskeletal evaluation in 1972, and agreed that Edward had a peculiar gait which was due to internal rotation of the hips and narrow, slightly inverted feet. This condition was formally diagnosed as "internal rotation femur." For this, the doctor suggested exercises to be done in the home to work with the hips, knees and ankles. According to Mrs. Jones, these exercises were not effective and she discontinued them two weeks after the examination.

Edward has been prone to illness all of his life and Mr. and Mrs. Jones feel now that he suffers from allergies like his mother. Because of his frequent colds and allergies, Edward is either unable to or never learned to breathe through his nose.

Mr. Jones related that Edward is for the most part ambidextrous. If anything, he favors his right hand and his parents believe the only reason he favors this hand is the fact that Edward's sisters are constantly drilling him to use his right hand rather than his left.

Edward is currently taking erythrocin for high temperatures. He has been taking ritalin since he was four years old. The doctor has prescribed dimetapp elixir and aerone for his allergies.

Names of Doctors

<table>
<thead>
<tr>
<th>Doctor</th>
<th>Type</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. B. A. Mauzer</td>
<td>Pediatrician</td>
<td>1966-1976</td>
</tr>
<tr>
<td>Dr. J. B. Werntz</td>
<td>Ears, Nase, Throat</td>
<td>1968</td>
</tr>
<tr>
<td>Dr. John Rombo</td>
<td>Ears, Nase, Throat</td>
<td>1971 (tonsillectomy)</td>
</tr>
<tr>
<td>Dr. Theo. Hamsby</td>
<td>Allergist</td>
<td>1972</td>
</tr>
<tr>
<td>Dr. E. A. Thornton</td>
<td>Allergist</td>
<td>1974</td>
</tr>
</tbody>
</table>

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Social Summary

Mr. and Mrs. Jones are married and living together. Edward is the youngest of three children. He has two sisters, Mary, age 14, and Susan, age 16. Mrs. Jones indicates that Edward enjoys good relationships with his parents and sisters. She characterizes him as warm, though shy with new acquaintances. Edward is easily excitable and will slop himself on the head when he becomes angry. He often bangs his head on a chair or table in order to get attention from his parents. When provoked, he howls at the individual in question.

Edward's teacher described him as inattentive, timid, lacking friends, overdependent, and excitable. The other children in the classroom tend to ignore Edward and do not invite him to join activities. Edward prefers to play alone.

At home, Edward enjoys watching television, feeding birds, riding his bicycle, and playing with his race cars.

Educational Summary

Edward was not enrolled in Kindergarten until the age of six because of medical problems and immaturity. He attended Roosevelt Elementary School in 1972-74 for Kindergarten and First Grade. He repeated First Grade in 1974-75 and was then placed in an EMH class at Benjamin Franklin Elementary School in 1975 where he is currently enrolled. While at Franklin, he received the services of a Speech Therapist approximately two times a week.

Psychological Summary

Edward was seen by the school psychologist prior to enrollment at Franklin School. He was found to be functioning in the retarded range intellectually with an I. Q. of 64 on the Stanford Binet. The examiner found him to be highly distractible and easily frustrated. He would consistently slap his head if he met with failure. Fine motor control was very weak and Edward often switched from his right hand to his left when drawing or writing.

The school psychologist recommended that the parents take Edward to see a neurologist, but the parents refused at that time.

Diagnostic Team Objectives

See list attached.

Tests Administered

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<tr>
<th>Date</th>
<th>Name of Test</th>
<th>Scores Obtained</th>
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<td>Orientation</td>
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<td>Spelling</td>
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Tests Administered, Continued

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<td>Arithmetic</td>
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<td></td>
<td>Boehm Test of Basic Concepts</td>
<td>1 %ile</td>
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</table>

Summary of Diagnostic Information by Domain

1. Motor Skills

   Strengths: Edward enjoys physical activity and demonstrated adequate gross motor coordination when running or jumping. He has strong manipulative skills as demonstrated by the ease with which he puts puzzles together and dribbles a basketball.

   Weaknesses: Those activities involving balance are difficult for Edward. He cannot balance on either foot for more than two seconds. He cannot skip. When attempting balance oriented skills, he became frustrated and refused to participate.

   Edward’s eye-hand coordination is poor when involved in fine motor activities. He had difficulty placing pegs in a pegboard and stringing beads.

2. Sensory-Perceptual Skills

   Strengths: Edward’s visual acuity or farpoint was found to be 20/20 on the Snellen Eye Test.

   Hearing acuity and auditory discrimination were normal. (See audiologists report)

   Weaknesses: Difficulties were found in the areas of visual-motor integration, auditory and visual memory, auditory and visual memory for unrelated objects, and visual tracking. Vertical tracking is adequate, but he cannot track objects horizontally. (See the Keystone Visual Survey attached).

3. Speech and Language

   Strengths: Edward’s manual expression of ideas and concepts is superior to his verbal expression. He can pantomine ideas that he cannot express verbally.

   Weaknesses: Edward’s articulation was characterized by several errors. He omitted
Diagnostic Summary, Continued

/\n/ in the medial position of words, substituted /\/ for /\th/ in the final position,
/\bw/ for /\br/ in the initial position, and distorted the /\v/ sound in the word
"stove." All consonants and vowels were easily imitated in isolation. Intelligi-
ability broke down in conversational speech.

Edward consistently omits articles, nouns, and some verb forms. He usually
uses very short sentences of three or four words and often confuses the sequence
of words. He gets very frustrated when he cannot express himself and will some-
times stop what he is saying and shout "Stop!"

Academic

Reading Skills

Strengths:
Edward can:
- identify and write the letters of the alphabet
- give the sound for all consonants
- give the sound for long vowels
- read some sight words - I, can, cat, baby, blue, and, up, down,
  my, mother, house, red

Weaknesses:
Edward cannot:
- give the short vowel sounds for e, i, a, u
- tell a story in sequence
- track smoothly from left to right when reading
- use phonetic skills for word attack
- tell a story by looking at a picture
- associate objects that go together

Math Skills

Strengths:
Edward can:
- recognize and write numerals from 0-10
- adequately make 1-1 correspondence
- rotely count to 20
- tell time by the hour
- add one digit numerals from 1-5
- recognize and give the value of a penny, nickel, dime
- subtract using concrete objects

Weaknesses:
Edward cannot:
- correctly identify numerals past 10
- odd or subtract using numbers greater than 5
- make change
- tell time by half hour, quarter hour, minute
- read a calendar
- use a ruler

2 7 6
2 4 9
Writing Skills

Edward can write all letters in isolation using cursive writing, but he cannot connect them properly when forming words. Spacing is poor and he often reverses b, d, p, q.

Due to his poor sight vocabulary, Edward can only write words that he copies from the blackboard. He does not write a complete sentence.

Social/Emotional

Behavior which has been observed upon entrance in the Diagnostic Classroom includes:

1. Edward would shout "Stop!" when he became frustrated. Initially, this might occur 20-25 times per day.

2. Upon entering the classroom, Edward would go to the table in the corner and look at magazines. He refused to join in group activities with other children.

3. Edward would not allow any physical contact by the teacher or other children. This would also cause him to shout "Stop!"

4. Edward has shown some self-destructive behavior such as slapping his face or banging his head on the table.

5. His self-concept appears to be poor as he will often say, "I dumb" when he cannot complete a task.

Self-help Skills

Strengths: Edward can adequately dress and undress himself. He has no difficulty feeding himself or using the bathroom.

Weaknesses: Edward often came to school with dirty hands, face, neck, etc. He does not brush his teeth properly. He has difficulty tying his shoes and usually wears loafers so he can avoid this. Edward still walks up and down the stairs one step at a time holding on to the railing.
Purpose of the Long Range Program Objectives

The development of Long Range Program Objectives is the first step in Phase 3, Program Development and Testing, and is based on the in-depth evaluation of the child accomplished during Phase 2, Diagnosis. The Long Range Program Objectives are comprised of a statement of the levels of functioning that the child may be expected to achieve in each diagnostic domain by the time he or she reaches adulthood. Their purpose is to insure that subsequent steps in Phase 3, including the development of program prescriptions, behavioral objectives, and placement recommendations, take into full consideration the skills and competencies the child should eventually acquire.

The extent to which the child progresses toward achievement of the Long Range Program Objectives is investigated during Phase 5, Follow-up, through the use of the longitudinal follow-up component of the Formal Evaluation (or Child Tracking) System.
SAMPLE LONG RANGE PROGRAM OBJECTIVES BY DOMAIN

Motor

Edward will be able to use a lawn mower to cut the grass.

Sensory/Perceptual

Edward will be able to listen to and follow a series of directions.

Speech/Language

Edward will initiate and carry on a meaningful conversation with members of his family, peers, and adults.

Academic

Reading: Edward will be able to read and understand road signs, directional or other instructional signs, job applications, other forms, and newspapers.

Mathematics: Edward will be able to apply basic mathematical skills necessary for daily life (e.g. telling time, making change, adding a column of multiple digits, etc.)

Writing: Edward will be able to write his name, compose simple letters, fill out job applications, and other forms.

Social/Emotional

Edward will be able to appropriately plan and use his leisure time.

Self-Help

Edward will be able to wash, dry, and iron his own clothes.
Purpose of the Short Range Program Objectives

The Short Range Program Objectives, which are derived from the Long Range Program Objectives, specify the general skills and subskills that the child must acquire prior to achieving the Long Range Objectives. They thus act as a link between the future goals for the child and the tasks the child must master in the course of program implementations. The Short Range Program Objectives also form the foundation for the Task Analysis and the Individual Behavioral Ladder. The use of these objectives in this manner ensures that the behavioral objectives established for the child have meaning in terms of the child's eventual integration into the adult world.

The relationship between Long Range Program Objectives, Short Range Program Objectives, and behavioral objectives may be schematically depicted as follows:

```
  Long Range Program Objective
     ↓
  Short Range Program Objective
     ↓
       Behavioral Objectives (from Individual Behavioral Ladder):
```

The extent to which the child achieves the Short Range Program Objectives is assessed during Phase 5, Follow-Up, through the use of the Formal Evaluation (or Child Tracking) System.
SAMPLE SHORT RANGE PROGRAM OBJECTIVES BY DOMAIN

Motor

Edward will be able to use simple hand tools such as a hammer, saw, screwdriver, and hand drill.

Sensory/Perceptual

Edward will demonstrate his ability to visually track an object from left to right.

Speech/Language

Edward will correctly articulate the /th/ sound during spontaneous conversation.

Academic

Reading: Edward will be able to read a story orally from a third grade reading book with 85% comprehension.

Mathematics: Edward will be able to add or subtract numbers with multiple digits.

Writing: Edward will be able to write a complete sentence using correct punctuation.

Social/Emotional

Edward will voluntarily participate in group activities both in the classroom and at home.

Self-Help

Edward will improve his personal hygiene by brushing his teeth, bathing, changing his clothes, and combing his hair daily.
Purpose of the Task Analysis

A Task Analysis is performed on each of the Short Range Program Objectives to isolate the specific tasks and behaviors the child must master before he or she can attain the Short Range Objectives. It consists simply of a sequential listing of these tasks and behaviors. Standard behavioral checklists, behavioral inventories, and developmental scales may be used in the Task Analysis, although the tasks selected from them should be modified as necessary to reflect the response capabilities, levels of functioning, and developmental sequence of the individual child.

The completed Task Analysis is used first in the selection of initial program prescriptions -- i.e., in determining the instructional materials, learning environment, and teaching strategies that will best enable the child to perform the desired tasks. It is used again, after the program prescriptions have been tested and revised, in the design of the child's Individual Behavioral Ladder. Thus the Task Analysis might be viewed as an initial listing of many of the behaviors which, in the Individual Behavioral Ladder, are presented as behavioral objectives and tied to specific program prescriptions.
SAMPLE TASK ANALYSIS

Short Range Program Objective to be Achieved

Edward will be able to read a story from a third grade reading book orally with no pronunciation errors and 85% comprehension.

Task Analysis

In order to achieve the short range program objective cited above, Edward must be able to:

1. maintain adequate visual and auditory acuity.
2. visually discriminate shapes (e.g. circle, square, etc.)
3. visually discriminate letters and words.
4. auditorily discriminate environmental sounds.
5. discriminate the sounds of isolated letters and words.
6. identify and name all letters of the alphabet
7. form the sound/symbol relationship for each letter.
8. develop left to right progression.
9. blend letter sounds into words.
10. identify words that have the same sound in initial, medial or final positions.
11. develop a sight word vocabulary.
12. know the meanings of the words he can identify by sight.
13. read words in phrases.
14. read words in sentences.
15. read paragraphs.
16. sequence major events in a story.
17. pick out factual detail in a story.
18. start with a primer level reading book and progress until objective is met.
Purpose of the Individual Behavioral Ladder

The Individual Behavioral Ladder is completed after the program prescriptions have been selected, tested, and revised during Phase 3, Program Development and Testing. The purpose of the Individual Behavioral Ladder is to provide to program implementers a means of planning for and gauging the child's purposeful progress toward specific ends. Thus it contains, for each diagnostic domain, the Short Range Program Objectives and behavioral objectives the child is expected to achieve during the twelve months following the termination of on-site or in-classroom services. In addition, it ties these behavioral objectives to specific instructional materials and other program prescriptions recommended to facilitate the child's achievement.

Incorporated into the Individual Behavioral Ladder are many of the tasks isolated during the Task Analysis, as well as the Behavioral Change Plan Objectives not achieved during Phases 2 and 3.

The Individual Behavioral Ladder is attached to the Diagnostic Summary and Individual Educational Plan and distributed to the child's parents, receiving teacher, and other persons involved in program implementation. The child's achievement of the behavioral objectives is evaluated during Phase 5, Follow-Up, through the use of 3, 6, 9, and 12 month Child Follow-Up, which is part of the Formal Evaluation System of the IRDTM. For each of these three month time frames, the baseline data on the Individual Behavioral Ladder is compared to the child's follow-up performance and a determination is made as to whether or not the child achieved the behavioral objectives at the standard specified. This information is used in the revision of the Individual Behavioral Ladder, which is then redistributed to program implementers.
**INDIVIDUAL BEHAVIORAL LADDER**

**DIAGNOSTIC DOMAIN:**
Language

**SHORT RANGE OBJECTIVE:**
Follows simple oral directions

---

Name of Child: Edward Jones  
Date: Nov. 10/76  
ID #: 156  
Case Leader: Thomas Smith

---

<table>
<thead>
<tr>
<th>I. BEHAVIORAL OBJECTIVE</th>
<th>II. TIME FRAME (in months)</th>
<th>III. DIRECTION</th>
<th>IV. BASELINE PERFORMANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Upon hearing a series of three directions, verbalized by the teacher, Edward will carry out each in proper sequence within one minute after the directions are given.</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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V. PROGRAM PRESCRIPTIONS

Let's Learn Sequence  
Instructo Corporation

Language of Directions  
Alexander Graham Bell Associates

The following sequence of activity was used:
1. practicing directionality (left-right)
2. directions given by teacher
3. teacher demonstrates tasks
4. Edward carries out tasks
5. teacher gives direction
6. Edward repeats
7. Edward carries out directions
SAMPLE INDIVIDUAL EDUCATIONAL PLAN

Child's Name: Edward Janes  

ID#: 156

Date of Birth: 5/15/66  
Date of Referral: 10/14/76

Date of Classroom Placement: 10/28/76

Date of Classroom Exit: 11/30/76

Objectives


It is not unreasonable to expect Edward to be functioning adequately in several areas by adulthood. His motor skills, both gross and fine, will be at a sufficient level to enable him to move freely in his environment and to actively participate in recreational activities.

Both hearing and visual acuity are presently normal, although recent reports from optometrists indicate a shift to near-sightedness which eventually may need to be corrected with glasses.

Edward can be expected to comprehend oral language and carry on appropriate and spontaneous conversations with his family and friends. He may still rely, however, on gestures to communicate his ideas, particularly when conversing with persons who are unfamiliar to him.

Academically, we can expect Edward to acquire the skills necessary to carry out everyday activities such as reading road signs, directions, job applications, newspapers, and magazines. He should be able to manage money, make a budget, and compute basic mathematical problems.

Although Edward will continue to have difficulty expressing his thoughts in writing, he will be able to compose personal letters and fill out job applications and questionnaires if he has assistance.

Finally, Edward will develop sufficient skills to enable him to function independently in most situations. He is able to maintain good personal hygiene, care for personal belongings, and demonstrate appropriate social behavior when interacting with other people. He will need assistance in securing and maintaining living quarters, finding appropriate employment, and other higher level tasks such as filing tax returns and obtaining life or medical insurance.

2. Summary of Short Range Program Objectives.

Short term goals must be set annually for Edward to insure achievement of the long range objectives mentioned above. For the upcoming school year, Edward needs to concentrate on acquiring the following skills:

a. using hand tools in a safe and appropriate manner;
Edward Jones

b. initiating conversation and voluntarily contributing to classroom discussions;

c. following simple oral directions;

d. voluntarily interacting with peers in play activities;

e. reading stories at the third grade level with 85% comprehension;

f. adding and subtracting mathematical problems with multiple digits;

g. developing good grooming habits;

h. working independently.


The following behavioral objectives have been established for Edward and are expected to be achieved no later than 12 months after his exit from the Diagnostic Classroom. Refer to the Individual Behavioral Ladder for specific time frames.

a. Edward will look at a clock and be able accurately to tell the teacher what time it is each time he is asked.

b. Given a set of flash cards with one word from the Dolch List of Basic Sight Words written on each, Edward will read each word orally within five seconds after it is shown, missing no more than 10% of the total group of words.

c. Each time he is given an assignment, Edward will sit in his chair at his desk for 15 minutes without talking, kicking his feet, or throwing objects.

d. During the last ten minutes of each school day, Edward independently will button his coat, tie his shoes, and say "Goodbye" to the teacher before he leaves the classroom.

e. Edward will be able to write his full name in cursive writing on lined paper with proper letter formation, letter connections, and spacing. No letter will go above the top line or below the bottom lines.

Summary of Recommended Strategies

1. Teaching Strategies.

Material should be presented visually as much as possible since this appears to be Edward's stronger learning channel. Concepts should be presented by incorporating
concrete materials that Edward can manipulate. Tasks should include an integration of all senses so that Edward is looking, listening, and touching at the same time. Gradually reduce the visual stimuli as Edward's listening skills increase.

Edward prefers to communicate through gestures, and this should be allowed while his language skills are developing. Edward responds best to questions which require a simple one word answer, or activities which require him to point to an answer.

Include Edward in as many small group activities as possible and encourage him to respond verbally. He is fascinated by machines and works quite well with a tape recorder or Language Master. He should be given independent activities where he has an opportunity to use this equipment.

It is recommended that academic and non-academic tasks be carefully structured and that clearcut goals be set for Edward. Time should be set aside each morning and afternoon to talk with him about upcoming activities of the day.

There is a need for consistent discipline in the classroom. Although Edward has a strong need for warmth and praise from the teacher, he also needs to have limits set and he needs to be made aware of these limits. He should be allowed to formulate rules for his own behavior in the classroom. A list of these rules could then be taped to his desk as a constant reminder.

Academic tasks should last no longer than 15 minutes. Assignments should be kept to one page or worksheet at a time and gradually increased as Edward's academic skills develop. Instructions must be concise and direct. It is important that Edward repeat a series of directions to the teacher after they have been given to insure his understanding of them.

2. **Motivational Strategies.**

Edward is convinced that he cannot do things right and asks for the teacher's verbal approval at least ten times a day. It is recommended that simple tasks which Edward can do in the classroom such as coloring, giving the date, or watering plants be selected to provide him with opportunities to assume responsibility and experience success. He should be praised while doing these tasks. Positive reinforcement for the smallest accomplishment is imperative.

Edward responds well to gold stars or "happy faces" on his papers when he finishes a worksheet correctly. After Edward has been given an assignment and certain of the instructions, his requests for approval should be ignored until the task is completed.

A token system was implemented to increase Edward's participation in group activities. He received a token each time he spoke to another student during play time, offered to share a toy, or played with another child for ten minutes without leaving the play area. At the end of play time (a ten minutes period), these tokens could be traded for a cookie (1 token), a candy bar (3 tokens) or five minutes of individual activity of his choice (5 tokens).
Edward's strongest reinforcers were found to be verbal praise, puzzles, five minutes in a small rocking chair, and feeding the fish. He will work independently to finish these tasks in order to earn these privileges.

3. Environmental Strategies.

It is strongly recommended that Edward be in a highly structured classroom situation. He works best in a self-contained classroom with no more than ten children in the class. At this point, Edward cannot tolerate a great deal of change, so a rigid daily schedule of activities is recommended.

Edward's hyperactivity is manifested in nervous habits such as slapping his head, wringing his hands, and turning in his chair. These behaviors increase when he is required to attend to one task for more than 15 minutes, assignments are too complex, or other children are moving around the classroom. It is strongly recommended that Edward be worked with in a setting that has minimal distraction. He works best in isolation behind a screen or in a study carrel. Visual and auditory stimuli should be kept to a minimum as he is easily distracted by noise and movement around him.

Because Edward tires easily in the afternoon, a shortened school day is recommended. If this is not feasible, a rest period should be incorporated in his daily schedule.

Summary of Recommended Materials, Equipment, and Activities

The following materials and equipment were found to be highly effective for Edward:

<table>
<thead>
<tr>
<th>Domain:</th>
<th>Title/Author:</th>
<th>Publisher:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Activities</td>
<td>1937 Grande Avenue</td>
</tr>
<tr>
<td></td>
<td>William Brady, Geraldine</td>
<td>Baldwin, N.Y. 11510</td>
</tr>
<tr>
<td></td>
<td>Kanecki, Catherine Leidy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Move-Grow-Learn</td>
<td>Follett Educational Corporation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1010 W. Washington Rd.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chicago, IL 60607</td>
</tr>
<tr>
<td>Sensory/Perceptual:</td>
<td>Michigan Tracking Program</td>
<td>Ann Arbor Press</td>
</tr>
<tr>
<td></td>
<td></td>
<td>610 S. Forest St.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ann Arbor, MI 38104</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ideal School Supply Co.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>11000 S. Laverine Ave.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oak Lawn, IL 60453</td>
</tr>
<tr>
<td></td>
<td>Parquetry Blocks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dubnaff School Program</td>
<td>Teaching Resources Corp.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100 Boylston St.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Boston, Mass. 02116</td>
</tr>
<tr>
<td>Speech and Language:</td>
<td>Language Master</td>
<td>Bell and Howell Co.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7100 McCormick Blvd.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chicago, IL 60645</td>
</tr>
</tbody>
</table>

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Edward Jones

Individual Educational Plan

Peabody Language Development
Kit: Level #2
American Guidance Service
Publishers Building
Circle Pines, Minn. 55104

Academic:

Reading:
The linguistic approach was found to be highly effective. This approach concentrates on the development of word attack skills through the use of word patterns—three letter words using the same short vowel sound. These are supplemented by irregular words taught as sight words in order to produce sensible sentences and add interest.

Merrill Linguistic Readers
Charles E. Merrill Co.
1300 Alum Creek Drive
Columbia, Ohio 43216

Pala Alta
Harcourt, Brace, Javanovich Co.
757 Third Avenue
New York, N.Y. 10017

Math:
Cubical Counting Blocks
Milton Bradley Co.
Springfield, Mass. 01101

Moving-Up in Numbers
DLM, Inc.
7440 Natchez Avenue
Niles, IL 60648

Structural Arithmetic
H. G. Sterne
1900 S. Batavin Ave.
Geneva, IL 60134

Writing:
Multi-Sensory Alphabets
Ideal School Supply Co.
11000 S. Laverne Ave.
Oak Lawn, IL 60453

Write and See
Lyons and Carnahan, Inc.
407 E. 25th Street
Chicago, IL 60616

Placement Recommendations

It is recommended that Edward return to the Primary EMH class at Benjamin Franklin School. He should continue to receive the services of the Speech Therapist housed in that school.

As Edward's independence, communication, and socialization skills increase, placement in the EMH resource room should be considered. When that time comes, he should be
scheduled in as many regular non-academic classes (e.g., Physical Education, Music, Shop) as possible.

Recommendations for Program Implementation

1. Carol Lee, Speech Therapist at Benjamin Franklin School, should continue to work with Edward on articulation and verbal communication.

2. Edward's parents should be encouraged to continue his physical therapy sessions at Springfield Memorial Hospital under the supervision of the Physical Therapist, Ms. Phyllis Campbell. If this therapy is continued, Edward's inverted feet will be corrected. Mrs. Campbell may be reached at 752-1174.

3. Edward's parents have agreed to assist Edward in the development of his socialization skills by enrolling him in appropriate YMCA activities and by discouraging the dependency behaviors and encouraging the independent behaviors described in the behavioral objectives. Mr. and Mrs. Jones have been trained by the Consulting Diagnostic Teacher in simple behavior management techniques and seem to have a full grasp of them.

Recommended Follow-Up

1. Thomas Smith, Consulting Diagnostic Teacher, will continue to make monthly classroom observations of Edward for the remainder of the 1976-77 school year. He will also assist the receiving teacher in program implementation on an as-needed basis.

2. Carol Harding will conduct re-testing of Edward's strengths and weaknesses in reading and math no later than June 4, 1977.

3. Mike Watkins, Team Social Worker, will arrange for a physical examination with Edward's pediatrician and parents during the summer, with special attention to reviewing Edward's need for ritalin.

The following is a list of resource persons to contact if clarification or additional data is desired:

Carol Harding
School Psychologist
1315 S. Elementary
Springfield
752-7729

Dr. O. J. Wilkins
Neurologist
901 N. Third
Springfield
752-2116
Phyllis Campbell
Physical Therapist
Easter Seals
210 N. Oak
752-1002

Carol Lee
Speech Therapist
Raymond School
Springfield
752-7010

Adele Ray
Assistant Director
Regional Diagnostic Classroom
1706 N. Elm
Springfield
752-1073
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TITLE: ASSISTANT DIRECTOR, REGIONAL RESOURCE CENTER
(RRC, USOE, BEH, DHEW, PL 91-230, Title VI Section 621, 84 Stat. 181)

REPORTS TO: Director for Regional Programs

SUPERVISES: Regional Resource Center Staff

PRIMARY FUNCTION: Coordinate Regional Resource Center

RESPONSIBILITIES:

1. Serve as liaison staff person between Regional Resource Center personnel and central administrative personnel of District #150, the Department of Special Education, ISU, and the IOE.

2. Serve as liaison staff person between Regional Resource Center personnel and the administrative personnel of the Mid Central Association Special Education Cooperative.

3. Coordinate, on an as-needed basis, multidisciplinary intake, placement, consultative and educational staffings for Regional Resource Center students.

4. Provide inservice training programs and workshops for Regional Resource Center personnel.

5. Coordinate the Regional Resource Center personnel in educational diagnoses, research data gathering, prescriptive processes, parent education and dissemination of information.

6. Assist in the making of necessary reports as required by District #150, the Illinois Office of Education, and the U.S. Office of Education.

7. Assist the Director of the Regional Resource Center in evaluation of the personnel performance of personnel assigned to the Regional Resource Center.

8. Perform other duties and assume other responsibilities as may be assigned by the Director of the Regional Resource Center.
TITLE: TEAM CAPTAIN, REGIONAL RESOURCE CENTER

REPORTS TO: Director and Assistant Director, Regional Resource Center

PRIMARY FUNCTION: Assume responsibility for leadership and case-related decision making within the team.

RESPONSIBILITIES:

1. Call, preside over, and coordinate, on an as-needed basis, multidisciplinary intake, consultative, and educational staffings, for RRC students; take notes as required.

2. Gather case-related material prior to assignment of the case leader - past records, psychologicals, etc.

3. Assume responsibility for the flow of case information and files within RRC.

4. Assist in the coordination of educational diagnosis, research data gathering, prescriptive processes and parent education.

5. Act as liaison between RRC and MCA referral agent, schools, etc. prior to assignment of case leader.

6. Communicate the professional concerns of the team as a whole to the appropriate Director and Assistant Director.
TITLE: DIAGNOSTIC CLASSROOM TEACHER, REGIONAL RESOURCE CENTER

REPORTS TO: Director and Assistant Director, Regional Resource Center

PRIMARY FUNCTION: Provide clinical-diagnostic teaching and programming and follow-up for students served by the Regional Resource Center

RESPONSIBILITIES:

1. Develop, through the use of diagnostic instruments, scales, histories, teaching probes and clinical judgment, a descriptive diagnosis of each RRC student's learning abilities and disabilities.

2. Prepare educational prescriptions for RRC students.

3. Participate in multidisciplinary intake, placement, consultative and educational staffings for RRC students on an as-needed basis.

4. Plan and supervise activities of diagnostic aide assigned to RRC classroom.

5. Assist in providing in-service training, workshops, parent education, the preparing of required reports, and research and dissemination activities on an as-needed basis.

6. Serve as a consultant to teachers and parents concerning academic and behavioral adjustment of RRC students.

7. Provide demonstrations to educate parents, teachers, and teacher aides to the educational needs of RRC students.

8. Conduct follow-up on RRC students placed in programs.

9. Perform other duties as may be assigned by the Director and Assistant Director of the Regional Resource Center.
TITLE: CONSULTING DIAGNOSTIC TEACHER, REGIONAL RESOURCE CENTER

REPORTS TO: Director and Assistant Director, Regional Resource Center

PRIMARY FUNCTION: Provide assistance or case management in the areas of screening, evaluation, programming, and follow-up for children referred to RRC. Serve as a consultant to professionals and parents on an as-needed basis.

RESPONSIBILITIES:

1. Assist the RRC staff by providing professional expertise in the fields of mentally handicapped, learning disabled, emotionally disturbed and behaviorally disordered. Conduct diagnosis of, and devise instructional strategies and curricula for, RRC students.

2. Respond to RRC referrals from classroom teachers requesting consultation and assistance on educational and/or behavior management techniques.

3. Participate in multidisciplinary intake, placement, consultative, and educational staffings for RRC students on an as-needed basis.

4. Act as a substitute in the RRC diagnostic classrooms.

5. Secure materials to assist the classroom teachers upon request.

6. Conduct preliminary on-site screening of children referred for diagnostic classroom placement to insure that the referred child presents problems indicative of intensive evaluation to determine program needs.

7. Conduct on-site evaluations and/or make recommendations when the referred child does not present problems requiring intensive evaluation in the diagnostic classroom.

8. Assist in providing in-service training, workshops, parent education, the preparing of required reports, and research and dissemination activities on an as-needed basis.

9. Serve as a consultant to RRC team members, other professionals, and parents in areas of professional expertise.

10. Provide coordinative case management and follow-up services as assigned by RRC team.

11. Perform other duties as may be assigned by the Director and Assistant Director of the Regional Resource Center.
TITLE: EDUCATOR: VISION IMPAIRED, REGIONAL RESOURCE CENTER

REPORTS TO: Director and Assistant Director, Regional Resource Center

PRIMARY FUNCTION: Provide assistance or case management in the areas of screening, evaluation, programming, and follow-up for children referred to RRC. Serve as a consultant to professionals and parents on an as-needed basis.

RESPONSIBILITIES:

1. Assist the RRC staff by providing professional expertise in the field of vision impairment as it pertains to the diagnosis of, and development of instructional techniques and curricula for, RRC students.

2. Screen referred children to determine need for vision services. Interpret results and explain recommendations of visual examinations.

3. Provide hands-on diagnostic work (screening, evaluating and programming) in the RRC classroom and at local sites on an as-needed basis.

4. Participate in multidisciplinary intake, placement, consultative, and educational staffings for RRC students on an as-needed basis.

5. Assist in providing in-service training, workshops, parent education, the preparing of required reports, and research and dissemination activities on an as-needed basis.

6. Serve as a consultant to RRC team members, other professionals, and parents in areas of professional expertise.

7. Provide coordinative case management and follow-up services as assigned by RRC Team.

8. Perform other duties as may be assigned by the Director and Assistant Director of the Regional Resource Center.
TITLE: EDUCATOR: HEARING IMPAIRED, REGIONAL RESOURCE CENTER

REPORTS TO: Director and Assistant Director, Regional Resource Center

PRIMARY FUNCTION: Provide assistance or case management in the areas of screening, evaluation, programming, and follow-up for children referred to Regional Resource Center. Serve as a consultant to professionals and parents on an as-needed basis.

RESPONSIBILITIES:

1. Assist the RRC staff by providing professional expertise in the field of hearing impairment as it pertains to the diagnosis of, and development of instructional techniques and curricula for, RRC students.

2. Screen referred children to determine need for speech and language services. Interpret results and explain recommendations of audiological and speech and language evaluations.

3. Provide hands-on diagnostic work (screening, evaluating and programming) in the RRC classroom and at local sites on an as-needed basis.

4. Participate in multidisciplinary intake, placement, consultative, educational staffings for RRC students on an as-needed basis.

5. Assist in providing in-service training, workshops, parent education, the preparing of required reports, and research and dissemination activities on an as-needed basis.

6. Serve as a consultant to RRC team members, other professionals, and parents in areas of professional expertise.

7. Provide coordinative case management and follow-up services as assigned by RRC Team.

8. Perform other duties as may be assigned by the Director and Assistant Director of the Regional Resource Center.
TITLE: SCHOOL PSYCHOLOGIST, REGIONAL RESOURCE CENTER

REPORTS TO: Director and Assistant Director, Regional Resource Center

PRIMARY FUNCTION: Provide psychological services to students served by the Regional Resource Center

RESPONSIBILITIES:

1. Provide, on an as-needed basis, individual psychological services aimed at alleviating behavioral and/or adjustment problems of students served by the RRC.

2. Conduct, on an as-needed basis, individual psychoeducational case studies to assess academic and behavioral potential of RRC students.

3. Participate in multidisciplinary intake, placement, consultative, and educational staffings for RRC students.

4. Assist in providing in-service training, workshops, parent education, the preparing of required reports, and research and dissemination activities on an as-needed basis.

5. Serve as consultant to RRC team members, other professionals, and parents in areas of professional expertise.

6. Provide coordinative case management and follow-up services as assigned by RRC Team.

7. Perform other duties as may be assigned by the Director and Assistant Director of the Regional Resource Center.
TITLE: SCHOOL SOCIAL WORKER, REGIONAL RESOURCE CENTER

REPORTS TO: Assistant Director, Regional Resource Center

PRIMARY FUNCTION: Provide social work services to students served by the Regional Resource Center, provide case management, serve as "Team Captain" for RRC staff functions, and maintain records on RRC referrals.

RESPONSIBILITIES:

1. Provide, on an as-needed basis, individual social case work services aimed at alleviating social and/or emotional problems of students served by the RRC.

2. Serve as a liaison between the RRC staff and the families of RRC students.

3. Participate and assume "Team Captain" role, in multidisciplinary intake, placement, consultative, and educational staffings for RRC students.

4. Assist in providing in-service training, workshops, parent education, the preparing of required reports, and research and dissemination activities on an as-needed basis.

5. Serve as consultant to RRC team members, other professionals, and parents in areas of professional expertise.


7. Provide coordinative case management and follow-up services as assigned by RPC Team.

8. Perform other duties as may be assigned by the Director and Assistant Director of the Regional Resource Center.
TITLE: SPEECH THERAPIST, REGIONAL RESOURCE CENTER

REPORTS TO: Director and Assistant Director, Regional Resource Center

PRIMARY FUNCTION: Provide assistance or case management in the areas of screening, evaluation, programming, and follow-up for children referred to RRC. Serve as a consultant to professionals and parents on an as-needed basis.

RESPONSIBILITIES:

1. Assist the RRC staff by providing professional expertise in the fields of speech and/or hearing as relates to the diagnosis of, and development of instructional techniques and curricula for, RRC students.

2. Screen referred children to determine need for speech therapy and services of deaf educator. Interpret results and explain recommendations of speech and language evaluations.

3. Provide hands-on diagnostic work (screening, evaluating, and programming) in the RRC classroom and at local sites on an as-needed basis.

4. Participate in multidisciplinary intake, placement, consultative, and educational staffings for RRC students on an as-needed basis.

5. Assist in providing in-service training, workshops, parent education, the preparing of required reports, and research and dissemination activities on an as-needed basis.

6. Serve as a consultant to RRC team members, other professionals, and parents in areas of professional expertise.

7. Provide coordinative case management and follow-up services as assigned by RRC team.

8. Perform other duties as may be assigned by the Director and Assistant Director of the Regional Resource Center.
TITLE: TEACHER AIDE, REGIONAL RESOURCE CENTER

REPORTS TO: Diagnostic Classroom Teacher and Assistant Director, Regional Resource Center

PRIMARY FUNCTION: Provide in-classroom assistance to diagnostic classroom teacher.

RESPONSIBILITIES:

1. Assist Diagnostic Teacher in the conduct of formal and informal assessment and testing.

2. Assist Diagnostic Teacher in the trial implementation of prescriptive programming.

3. As necessary, provide special transportation for RRC students and/or their families.

4. Provide child care services (feeding, diapering, toilet training, etc.) as assigned by Diagnostic Classroom Teacher.

5. Perform other duties as assigned by Diagnostic Classroom Teacher and Assistant Director of the Regional Resource Center.
TITLE: CLERK-TYPIST, REGIONAL RESOURCE CENTER

REPORTS TO: Assistant Director, RRC

PRIMARY FUNCTION: Provide clerical services for the Regional Resource Center Staff

RESPONSIBILITIES:

1. Process correspondence for RRC Assistant Director, including dictation, transcription, composition and typing.

2. Process professional reports and correspondence for RRC staff.

3. Process all business forms, including travel requests, purchase orders, annual personnel evaluations, etc.

4. Process all project required reports and other general word processing.

5. Maintain a high level of professional expertise and flexibility in all interactions with project clients, and any other job related contacts.

6. Perform such other tasks and assume clerical responsibilities as may be assigned by the RRC Assistant Director and/or Director.
APPENDIX B
SUGGESTED QUALIFICATIONS FOR DIAGNOSTIC TEACHERS
Appendix B

SUGGESTED QUALIFICATIONS FOR DIAGNOSTIC TEACHERS

The following narrative presents a number of recommendations for selection criteria for Diagnostic Classroom Teachers and Consulting Diagnostic Teachers. This information was obtained during the course of nine "master performer" interviews conducted with Diagnostic and Special Education teachers from the Peoria Public School System during the week of March 2 - 6, 1976. The interviews were conducted by Reuben Chapman and Kirsten Preston of VIA, Inc.

The following are the recommendations made by the interviewers with respect to 1. education, 2. experience, 3. knowledge, 4. aptitude/orientation, and 5. skill requirements for diagnostic teachers:

1. **Education**

   The Diagnostic Teacher ideally should possess multiple certifications in several of the Special Education sub-specialties, including Learning Disabilities (LD), Educable Mentally Handicapped (EMH), Trainable Mentally Handicapped (TMH), Behavior Disorders (BD), Emotionally Disturbed (ED), and Early Childhood Education. Early Childhood Education was singled out for particular attention because it is one of the more unusual sub-specialties and because many of the children served by the RRC, regardless of chronological age, present emotional and academic skill levels that are normative for pre-school children. For each of the above areas in which the candidate for Diagnostic Teacher lacks certification, it was recommended that he or she possess substantial experience either in an "hands-on" setting or as a consultant to such a "hands-on" setting. In regions in which a Consulting Diagnostic Teacher is also employed, competence in these areas of expertise may be shared.
2. **Experience**

With regard to experiential requirements it was recommended that the Diagnostic Teacher possess experience with children with a wide range of ages and handicaps. Emphasized in this connection was experience with orthopedically handicapped children. It was also strongly recommended that the teacher have concrete experience in strictly diagnostic settings, in the delivery of "hands-on" individualized instruction, and in prescription writing.

3. **Knowledge**

The Diagnostic Teacher should possess a broad theoretical background in special education in general and the individualization of instruction and observation techniques in particular. Also mandatory are a thorough knowledge of psychological tests, developmental scales and instructional materials.

4. **Aptitude/Orientation**

A number of required aptitudes for the Diagnostic Teacher also emerged from the interviews. First, the Diagnostic Teacher should possess an aptitude for intense, short-term periods of working with a child, as opposed to the less intense, longer-range involvement typical of more normal classroom settings. This implies an ability to "let go," or to find job and/or personal satisfaction in diagnosis and prescription rather than in program implementation.

Also of great importance is an aptitude on the part of the Diagnostic Teacher for teamwork, as well as a non-threatening, non-authoritative manner. The latter is particularly significant in view of the fact that the Diagnostic Teacher must be able to obtain the assistance of potentially resistant receiving teachers.

Finally mentioned as necessary aptitudes for Diagnostic Teachers were high levels of frustration tolerance and persistence, due to the frequency with which behavior
problems and slow-learners (or seeming "non-learners") are encountered and the frequent need to try a number of diagnostic and prescriptive tools before any degree of success is attained. As one interviewee stated, the Diagnostic Teacher must be either an "optimistic realist or realistic optimist."

With regard to teacher orientation, two recommendations were made. First, the Diagnostic Teacher must have a "non-faddist," yet eclectic, frame of reference. Interviewees agreed that this orientation is a necessity in dealing with individualized diagnosis and programming for the child population served by the RRC. Secondly, the teacher must possess a viable strategy for "cracking" a given case, as well as a strong and positive rationale for this strategy. The strategy most often mentioned in the interviews was first, to assume that success on the child's part is possible and is the team responsibility; second, to define through diagnosis the child's strengths, weaknesses, and learning channels; and finally, to field-test an instructional program intended to remediate weak learning channels while inputting academic materials through the strong channels. However, it was agreed that it was not the content of the strategy itself, but rather its being geared to positives in the child that was most critical.

5. Abilities and Skills

Interviewees cited the following as the abilities and skills required by Diagnostic Teachers:

a. Ability to individualize diagnosis and prescription, including the ability to view the child apart from any set of norms or standards; the ability to choose from a wide range of diagnostic and prescriptive tools those appropriate to the individual child; the ability to measure the child's
progress against himself; and the ability to use theory eclectically.

b. Skill in the use of observational techniques, especially in identifying those subtle verbal and non-verbal behaviors and environmental factors which are often ignored but may nonetheless comprise valuable sources of diagnostic data.

c. Skill in the use of developmental scales.

d. Skill in the interpretation of formal test results and the translation of the test results into meaningful statements about the child’s handicaps and required remediation or programming.

e. Skill in the synthesis of large volumes of disparate diagnostic data.

f. Skill in task analysis including breaking diagnostic categories into subcategories, subskills and tasks which may be incorporated into behavioral objectives.

g. Skill in writing behavioral objectives.

h. Skill in interpersonal communications in both teacher-child interactions and teacher-team interactions.

i. Skill in team-building and the management of human resources.

j. Skill in modifying prescriptive recommendations to reflect on-site reality constraints.
APPENDIX C
ALTERNATIVE REPLICATION STAFFING MODELS
ALTERNATIVE REPLICATION STAFFING MODELS

Due to regional variations in population, existing programs, and resources available for replication, the Diagnostic Classroom Model will be reproduced at various sites with different program emphases and at different levels of complexity. The following narrative presents 1) the minimum team and supportive staff requirements for model replication, and 2) eight alternative staffing models for potential adoption by replicating regions. Each of the models may be modified to reflect regional constraints and strengths; however, it is strongly recommended that the minimum requirements are met whenever possible.

Minimum Requirements for Model Replication

There follows a discussion of the minimum diagnostic and supportive staff required for implementation of the Diagnostic Classroom Model.

1. Diagnostic Classroom Teacher. Full-time availability of a Diagnostic Classroom Teacher is required to staff the diagnostic classroom (see Diagnostic Classroom Teacher job description, p. 271).

2. Teacher Aide. Full-time employment of a Teacher Aide to assist in diagnostic classroom activities is highly desirable; half-time is the minimum requirement. (See Teacher Aide job description, p. 278).

3. Consulting Diagnostic Teacher. The part-time services of a Consulting Diagnostic Teacher are required to respond to referrals, to conduct screening of children referred for diagnostic classroom placement, and to deliver on-site services to children in schools served by the Diagnostic Team (see Consulting Diagnostic Teacher job description, p. 272). These job duties may in smaller regions be combined with those of the Program Coordinator (see #4 below).

4. Program Coordinator. This staff person should be minimally available on a part-time basis to perform general administrative duties, to manage the Child Tracking System, and to act as a substitute for the Diagnostic Classroom Teacher. (For a listing of administrative duties, see the job description for Assistant Director, RRC, p. 269). In smaller regions, the responsibilities of the Program Coordinator may be assigned to the Consulting Diagnostic Teacher (see #3 above). In regions in which it is not possible to employ a Consulting Diagnostic Teacher, it will be necessary for the Diagnostic Classroom Teacher to perform many of these administrative and consultative functions. However, it is strongly recommended that at least one part-time combination Program Coordinator/Consulting Diagnostic Teacher be employed in each region.
5. **Team Social Worker.** The Team Social Worker must be available on at least a part-time basis to deliver social work services to the students and families served by the Diagnostic Team (see School Social Worker job description, p. 276).

6. **Team Psychologist.** As with the Team Social Worker, a Team Psychologist must be available at least part-time to conduct psychological evaluations and provide individual psychological services to children served by the Diagnostic Team (see School Psychologist job description, p. 275).

7. **Team Specialists.** It is necessary for the Diagnostic Team to have ongoing, daily access to the consultative services of several team specialists, including a Deaf Educator, Vision Educator, and Speech Therapist. Access to a Media Specialist is also recommended. (See Team Specialist job descriptions, p. 273). The types of team specialists employed in replicating regions will depend on local program strengths as well as on the certifications and experience of other team personnel.

8. **Medical Personnel and Other Consultants.** To ensure that the Diagnostic Team is able to assess all aspects of the children they serve, it is mandatory that the services of medical and other consultative personnel be arranged as the need is indicated. (A listing of the types of consultants required by the Diagnostic Team appears in "Consultants Available to the RRC Team," p. 277). Funding for the use of medical services should be arranged through local sources whenever possible. In the event that local sources of funding are exhausted, requests for Direct Service Funds may be forwarded to the Regional Resource Center (see Memo RE: Use of Direct Service Funds, p. ).

**Alternative Replication Staffing Models**

There follows a series of options for replication of the Diagnostic Classroom Model. The first five models concern the levels of staffing which may be arranged for those diagnostic classrooms scheduled for operationalization in September, 1976. The sixth, "expanding" model proposes the use of one or more Consulting Diagnostic Teachers fully trained in the Diagnostic Classroom Model and responsible for coordination and implementation of the model in local Special Education Districts. The seventh and eighth models are sequential in that they allow for the gradual development of the replication effort during FY 76-77 and full classroom implementation during FY 77-78.

It is strongly recommended that regions choose to implement one of the first five models for the following reasons: 1) to maintain uniformity in the replication effort, 2) to ensure
the availability of technical assistance from the Regional Resource Center, and, 3) to ensure access to Direct Service Funds through the Regional Resource Center. While it is anticipated that the RRC will continue beyond its current contract, this funding does expire in January, 1977. Regardless of which model is adopted, it should be noted that student-teacher ratio should exceed 2:1, or 4:2, including the Teacher Aide.

**DIAGNOSTIC CLASSROOM STAFFING MODELS**

*Type I.* This skeletal staffing model allows for the operation of a single diagnostic classroom and minimizes the extent to which on-site services may be provided to schools served by the Diagnostic Team. The model also assumes that the Diagnostic Classroom Teacher will perform many of the functions ideally assigned to the Program Coordinator and Consulting Diagnostic Teacher.

<table>
<thead>
<tr>
<th>Staff</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Classroom Teacher</td>
<td>Full-time</td>
</tr>
<tr>
<td>Teacher Aide</td>
<td>Full or part-time</td>
</tr>
<tr>
<td>Team Social Worker</td>
<td>Part-time</td>
</tr>
<tr>
<td>Team Psychologist</td>
<td>Part-time</td>
</tr>
<tr>
<td>Team Specialists</td>
<td>Ongoing access</td>
</tr>
<tr>
<td>Medical and Other Consultants</td>
<td>Contracted or arranged as-needed</td>
</tr>
</tbody>
</table>

*Type II.* With the addition of a combination Program Coordinator/Consulting Diagnostic Teacher and the expanded use of the Team Social Worker, Psychologist, and Specialists, this model allows for the increased delivery of both on-site and in-classroom diagnostic and prescriptive services. As with the Type I model, it pertains to a single classroom.

<table>
<thead>
<tr>
<th>Staff</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Classroom Teacher</td>
<td>Full-time</td>
</tr>
<tr>
<td>Teacher Aide</td>
<td>Full-time</td>
</tr>
<tr>
<td>Program Coordinator/</td>
<td>Full-time</td>
</tr>
<tr>
<td>Consulting Diagnostic Teacher</td>
<td></td>
</tr>
<tr>
<td>Team Social Worker</td>
<td>Full or part-time</td>
</tr>
</tbody>
</table>
### Type III

This model, which is comprised of one fully staffed classroom, a fully staffed team, and a full-time administrator, provides for maximal delivery of on-site and in-classroom diagnostic and prescriptive services. It differs from Type II primarily in its increased emphasis on the delivery of on-site psychological, social work, and specialty services.

<table>
<thead>
<tr>
<th>Staff</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Classroom Teacher</td>
<td>Full-time</td>
</tr>
<tr>
<td>Teacher Aide</td>
<td>Full-time</td>
</tr>
<tr>
<td>Program Coordinator</td>
<td>Full-time</td>
</tr>
<tr>
<td>Consulting Diagnostic Teacher</td>
<td>Full-time</td>
</tr>
<tr>
<td>Team Social Worker</td>
<td>Full-time</td>
</tr>
<tr>
<td>Team Psychologist</td>
<td>Full-time</td>
</tr>
<tr>
<td>Team Specialists</td>
<td>Two or three full-time</td>
</tr>
<tr>
<td>Medical and Other Consultants</td>
<td>Contracted or arranged as needed</td>
</tr>
</tbody>
</table>

### Type IV

The Type IV model accommodates two diagnostic classrooms. While the composition of the Diagnostic Team in this model is the same as in Type III, additional emphasis is placed on services delivery to children placed in the diagnostic classrooms. The Regional Resource Center is staffed in accordance with the Type IV model.

<table>
<thead>
<tr>
<th>Staff</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Classroom Teachers</td>
<td>Two full-time</td>
</tr>
<tr>
<td>Teacher Aides</td>
<td>Two full-time</td>
</tr>
<tr>
<td>Program Coordinator</td>
<td>Full-time</td>
</tr>
<tr>
<td>Consulting Diagnostic Teacher</td>
<td>Full-time</td>
</tr>
</tbody>
</table>
Team Social Worker Full-time
Team Psychologist Full-time
Team Specialists Two or three full-time
Medical and Other Consultants Contracted or arranged as needed

Type V. This model is identical to the Type IV model except insofar as it allows for multiple classrooms and multiple teams. At least one fully staffed Diagnostic Team should be provided for every two diagnostic classrooms.

<table>
<thead>
<tr>
<th>Staff</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic Classroom Teacher</td>
<td>One full-time per classroom</td>
</tr>
<tr>
<td>Teacher Aide</td>
<td>One full-time per classroom</td>
</tr>
<tr>
<td>Program Coordinator</td>
<td>One full-time</td>
</tr>
<tr>
<td>Consulting Diagnostic Teacher</td>
<td>One full-time per two classrooms</td>
</tr>
<tr>
<td>Team Social Worker</td>
<td>One full-time per two classrooms</td>
</tr>
<tr>
<td>Team Psychologist</td>
<td>One full-time per two classrooms</td>
</tr>
<tr>
<td>Team Specialists</td>
<td>Two or three full-time per two classrooms</td>
</tr>
<tr>
<td>Medical and Other Consultants</td>
<td>Contracted or arranged as needed</td>
</tr>
</tbody>
</table>

Type VI. The Type VI "expanding" model assumes the full-time employment during FY 76-77 of one or more Consulting Diagnostic Teachers whose functions are: 1) to train previously identified Special Education Teachers in the use of the Diagnostic Classroom Model, 2) to manage the formation of the Diagnostic Team, 3) to provide ongoing consultation, and 4) to monitor the functioning of participating classrooms.

Type VII. This sequential model postpones the operationalization of the diagnostic classroom(s) until September, 1977. It consists simply of one or more Consulting Diagnostic Teachers whose responsibilities are to sell the model to local school systems, to coordinate the establishment of diagnostic classrooms, and to train team members in the Diagnostic Classroom Model.

Type VIII. Type VIII is also a sequential model; however, it proposes the establishment in September, 1976 of a "model" diagnostic classroom and Diagnostic Team (Type II, III, or IV) to be replicated within the region during FY 77-78. In this scheme, the Program Coordinator and/or Consulting Diagnostic Teacher is responsible for selling the model.
and coordinating the regional replication effort.

It is anticipated that one of these models will be adopted for use in each replicating region and further tailored to reflect the resources of the region.
APPENDIX D
CONSULTANTS AVAILABLE TO THE RRC TEAM
CONSULTANTS AVAILABLE TO THE RRC TEAM

In the context of the RRC Diagnostic Classroom Model, the term "consultant" is used to designate any individual contacted by RRC team members to provide information on, or services to, children served by the RRC.

Consultative services are obtained from many settings: public clinics, private practices, hospitals, public or private counseling and mental health agencies, school systems, court systems, etc. Generally speaking, the services of physicians in private practice are purchased through Direct Service Funds; consultation with other professional and paraprofessional personnel, who either have worked with the child, will work with the child, or can provide assistance in assessment and programming, are simply arranged. The nature of contacts made with consultants has ranged from brief phone calls (e.g., to clarify a technical term or test score) to extended conferences (e.g., for exploration or confirmation of a diagnosis or prescription).

There follows a listing of a variety of professional personnel whose services are available to the RRC Diagnostic Team. The consultants most often used by the team are family physicians, pediatricians, psychiatrists, neurologists, physical therapists, occupational therapists, school psychologists, speech therapists, and school social workers.

This list of consultants is by no means exhaustive. It should be noted in particular that not included on the list are a number of potential consultants whose services are not typically purchased, but who nonetheless are invaluable sources of diagnostic data, such as the child's sending teacher, previous teachers, teacher aides, volunteers, parents or guardians, siblings, etc. It should also be noted that considerable crossover occurs between the general categories listed below (e.g., a family physician may give insight into the social-emotional as well as the medical problems of a child).
CONSULTANTS AVAILABLE TO THE RRC TEAM:

Medical Consultants
1. Physicians, including family physicians, pediatricians, neurologists, orthopedic surgeons
2. Nurses
3. Occupational therapists

Cognitive Consultants
1. Psychologists, including school and developmental psychologists
2. Diagnosticians and psychometrists
3. Psychiatrists

Hearing Consultants
1. Otologists
2. Audiologists
3. Speech therapists
4. Nurses

Vision Consultants
1. Ophthalmologists
2. Optometrists
3. Vision educators
4. Nurses

Educational Consultants
1. Psychologists, including school and developmental psychologists
2. Diagnosticians and psychometrists
Social-Emotional Consultants

1. Psychologists

2. Social workers (school, court, welfare, private agency, etc.)

3. Psychiatrists

4. Family counselors/therapists
APPENDIX E

BIBLIOGRAPHY OF DIAGNOSTIC TESTS
BIBLIOGRAPHY OF DIAGNOSTIC TEST APPENDIX E

MOTOR


Harris Test of Lateral Dominance. Psychological Corp. Test to show right or left preference with hand, eye, foot. Age Range: six and over. Time: untimed.


SENSORY/PERCEPTUAL

VISUAL


Southern California Test Battery for Assessment of Dysfunction. A. Jean Ayres, Ph.D. Western Psychological Services, 1962. A battery containing the following tests which can be purchased separately: Southern California Kinesthesia and Tactile Perception Tests; Southern California Figure-Ground Visual Perception Tests; Southern California Motor Accuracy Test; Southern California Perceptual-Motor Tests; and the Ayres Space Test. Age Range: 4-11. Time: 20 minutes - 1 hour.

AUDITORY


Lindamood Auditory Conceptualization Test. Charles H. Lindamood and Patricia C. Lindamood. Teaching Resources. Measures child's ability to discriminate one speech sound from another and to perceive the number and order of sounds in sequence. Age Range: preschool-adult. Time: 10 minutes.

Appendix E, continued


SPEECH AND LANGUAGE


Illinois Test of Psycholinguistic Abilities. Samuel Kirk, Winifred Kirk, and James McCarthy. University of Illinois Press, 1966. An individually administered test which delineates areas of difficulty in communication and language processing. Age Range: 2 years, 6 months to 10 years, 3 months. Time: 1-1 1/2 hours.


Appendix E, continued


ACADEMIC

INTELLIGENCE AND GENERAL ACHIEVEMENT


Minnesota Preschool Scale. Stoelting Co. A series of 26 short subtests which provide an estimate of verbal and non verbal intelligence. Age Range: 1 year, 6 months to 6 years. Time: 30 minutes.


Appendix E, continued

SRA Primary Mental Abilities. L. L. Thurstone and Thelma Thurstone. Science Research Association, 1947. Group intelligence test designed to measure verbal meaning, number facility, reasoning, perceptual speed, and spatial relations.
Age Range: 5-adult. Time: 30 minutes to 1 hour.

Test of Concept Utilization. Richard L. Crager, Ph.D. Western Psychological Services, 1973. Individually administered test which assesses 5 areas of conceptual thinking.

Age Range: 5-adult. Time: 20 minutes.

ACADEMIC READINESS


READING

Botel Reading Inventory. Morton Botel, C.L. Holsclaw, and G. C. Commarota. Follett Publishing Co., 1961. A group of tests to determine a variety of reading skills such as: word recognition, comprehension, word attack skills, and word opposites. Grade Levels: 1-4. Time: 50 minutes.
<table>
<thead>
<tr>
<th>Test Name</th>
<th>Author(s)</th>
<th>Publisher</th>
<th>Description</th>
<th>Grade Levels</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Davis Reading Test</td>
<td>F. B. Davis and C. C. Davis</td>
<td>Psychological Corp.</td>
<td>Used to check reading comprehension skills.</td>
<td>8-13</td>
<td>40 minutes</td>
</tr>
<tr>
<td>Dolch Basic Sight Word Test</td>
<td>Dolch</td>
<td>Garrard Press</td>
<td>List of sight words grouped by 220 easy words and 220 harder words.</td>
<td>1-6</td>
<td>untimed</td>
</tr>
<tr>
<td>Dorenb Diagnostic Reading Test of Word Recognition Skills</td>
<td>Margaret Doren</td>
<td>American Guidance Service, Inc.</td>
<td>Subtests include letter identification, beginning sounds, etc.</td>
<td>1-6</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Durrell Analysis of Reading Difficulty</td>
<td>Donald Durrell</td>
<td>Harcourt, Brace, Jovanovich,</td>
<td>Designed to observe faulty habits and weaknesses in reading. Checks oral and silent reading, comprehension, spelling and word analysis.</td>
<td>1-6</td>
<td>30-90 minutes</td>
</tr>
<tr>
<td>Durrell Reading-Listening Series</td>
<td>Donald D. Durrell, Mary T. Hayes, Mary B. Brassard</td>
<td>Harcourt, Brace, Jovanovich,</td>
<td>Group tests of listening and reading ability.</td>
<td>1-9</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Gilmore Oral Reading Test</td>
<td>Harcourt, Brace, Jovanovich</td>
<td>An orally administered test which gives information about word accuracy, rate and comprehension.</td>
<td>Grade Levels: 1-8.</td>
<td>1-12</td>
<td>50 minutes</td>
</tr>
<tr>
<td>Gray Oral Reading Test</td>
<td>William S. Gray and Helen M. Robinson</td>
<td>Western Psychological Services.</td>
<td>Individually administered oral reading test that combines rate and accuracy.</td>
<td>1-12</td>
<td>50 minutes</td>
</tr>
<tr>
<td>Harrison-Stroud Reading Readiness Test</td>
<td>Lucille Harrison and James Stroud</td>
<td>Houghton-Mifflin Co.</td>
<td>The subtests include using symbols, visual discrimination, auditory discrimination, giving letter names, and using the context.</td>
<td>K-1</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Individual Reading Placement Inventory</td>
<td>Edwin Smith and Weldon Bradtmueller</td>
<td>Follett Publishing Co.</td>
<td>Subtests include word recognition, word analysis, oral paragraph reading, listening comprehension, and auditory discrimination.</td>
<td>1-7</td>
<td>20 minutes</td>
</tr>
<tr>
<td>McCullough Word-Analysis Test</td>
<td>Constance M. McCullough</td>
<td>Western Psychological Services.</td>
<td>Group or individual test of word analysis skills.</td>
<td>4-6</td>
<td>untimed</td>
</tr>
</tbody>
</table>
Appendix E, continued


MATH


Appendix E, continued


**SPELLING**


**HANDWRITING**


**SELF HELP**


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304
APPENDIX F

BIBLIOGRAPHY OF INSTRUCTIONAL MATERIALS AND EQUIPMENT
BIBLIOGRAPHY OF INSTRUCTIONAL MATERIALS AND EQUIPMENT

MOTOR

Body Management Activities. MWZ Associates.


SENSORY/PERCEPTUAL

Auditory Discrimination in Depth. Teaching Resources. A multisensory program that develops the auditory-perceptual skills basic to reading, spelling, and speech. All ages.


Cheves Program, Visual-Motor Perception Teaching Materials. Teaching Resources. There are eleven basic teaching materials. Each material is taught in isolation and then integrated to make them part of the total learning process.

Dubnoff School Program/2. Teaching Resources. Directional-Spatial Pattern board with exercise cards to promote the development of directionality.

Erie Program/1 - Perceptual Motor Exercise. Teaching Resources. This program is made up of three units: 1) Visual-perceptual exercises, 2) Perceptual Bingo, and 3) Visual-Motor Template Forms.

Fairbanks - Robinson Program. Teaching Resources. There are eleven subsections, each dealing with a specific area of perceptual motor problems, including, line and form discrimination, spatial orientation, figure-ground discrimination, spatial concepts and spatial relationships.

Fitzhugh Plus Program. Allied Education Council. Self-teaching workbooks designed to provide help in spatial organization, language and numbers.

Michigan Tracking Program. Ann Arbor Publishers. Symbol Tracking, Primary
Tracking, Visual Tracking and Word Tracking are workbooks which aid in the
remediation of visual discrimination, visual tracking, and sequencing skills.

Sounds I Can Hear. Scott, Foresman Co. Children identify sounds heard around school,

The Remediation of Learning Disabilities: A Handbook of Psychoeducational Resource
motor development, perceptual-motor skills, auditory and visual skills.

Visual Sequential Memory Exercises. Developmental Learning Materials. Helps transfer
cognitive functions involved in perception and memorization to academic work.
Grades: 1-3.

years old. Develop the coordinations of visual stimuli and meaning essential to reading
achievement.

SPEECH AND LANGUAGE

A Sequentially Complied List of Instructional Materials for Remediational Use with the
ITPA. Harold A. Rupert. Rocky Mountain Special Education Instructional Materials
Center.

Building Language Usage Power. Miller-Brody Productions, Inc. Elements of simple
sentences, action words, plural nouns, verb changes, recognizing main idea.
Contains 5 records with manuals. Grades: 3-6.

Concepts for Communications. Developmental Learning Materials. The CFC prog am is
divided into three units: 1) Listening with Understanding, 2) Concept Building, and
3) Communication.

Distar Language I and II. Science Research Associates. Highly structured program designed
to teach basic language concepts and build vocabulary. Grades: pre-school - 2.

Emerging Language. The Learning Business. Sequential behavioral objectives for language
acquisition from one word level to various informations. Materials not included.
Ages: 2-10.

Game Oriented Activities for Learning (GOAL). Milton Bradley. 337 lesson plans and
materials for ITPA-based activities. Grades: pre-school - 1.

Language of Directions (for Deaf). Alexander Graham Bell Association. Work-text for
teaching the language of direction for language deprived children as well as the deaf.

Language Master. Bell and Howell. A recorder/player for use with cards on which a strip
of 2-track tape is fixed. One track is recorded on student mode and one on instructor
mode. A large variety of pre-printed cards are available for instruction of language
development, word recognition, and arithmetic.


ACADEMIC

READING

Action Reading System. Scholastic Book Services. Reading levels from 2.0-5.0 Kit of reading material for secondary school students who are seriously behind in reading.

Basic Set of Word Making Cards. Word Making Productions, Inc. The set contains 420 color pictures of common objects, people and animals. In each unit there are pictures using one particular sound in all three positions in a word. Grades: K-4.

Conquests in Reading. Webster Division, McGraw-Hill. A work-text in which phonics instruction is integrated with reading, writing, and spelling. Grades: 1-6.

Cracking the Code. Science Research Association. A student workbook designed to utilized phonetic and sight word methods to teach inductive reading and comprehensive skills. Grades: 2-6.

Cycle-teacher Learning Aid. Field Educational Publications, Inc. Kit for practice in word attack skills, English, spelling, social studies and mathematics. Grades: 3-8.

Distar Reading Instructional System. Science Research Association. This system is based on learning by "seeing and saying." Complete teacher directions for group activities. Grades: K-2.

Edmark Reading Program. Edmark Associates. A programmed approach designed for students with extremely limited skills.

Handbook inDiagnostic Teaching. Phillip Mann and Patricia Sutter. Allyn and Bacon.


Peabody Rebus Program. American Guidance Service, Inc. This consists of three programmed workbooks which introduce the use of context clues, structural analysis, and phonetic skills. Grades: K-1.


Phonics We Use Learning Games. Lyons and Carnahan. A box with 10 games to teach consonant sounds, blends, vowel sounds, and other phonetic skills. Grades: 1-5.

Reading for Living Series. Laubach Literacy, Inc. A series of 9 booklets designed to develop the application of reading to life situations. Grades: 4-6.


Readmaster. Ken-a-vision. An electric pacing device which may be used for pacing reading or tachistoscopic presentation of single stimuli in reading and math.

Specific Skills Series. Barnell Loft, Ltd. Designed to develop these skills: following directions, getting the main idea, using the context, and drawing conclusions. Grades: 1-6.

Sullivan. Programmed Reading. McGraw-Hill Book Co. A linguistic reading program with a work-text which is self-correction and designed to be used independently by the student. Grades: 1-6.


Webster Classroom Reading Clinic. Webster Division, McGraw-Hill Co. A comprehensive remedial reading program. Grades: 3-6.

Attriblocs. Mind/Matter Corp. 60 blocks of various shapes used to teach shape discrimination, tactile skills, set theory, operations, and logical thinking. Grades: K-12.
Appendix F, continued


Continuous Progress Math Laboratory. Educational Development Corp. An individualized program that is correlated to leading math textbooks. The kit contains a learning card and a cassette tape for each lesson.

Distar Arithmetic I and II. Science Research Associates, Inc. These kits represent a structured approach to the teaching of fundamental mathematics.

Individualized Arithmetic Instruction. Love Publishing Co. This workbook consists of different exercise sheets such as arithmetic squares, grouping numbers, open problems, and coded arithmetic. Grades: 1-6.


Moving up in Numbers. Developmental Learning Materials. This is a kit of seven sequential units beginning with number sequence and proceeding through the operations of addition, two-digit multiplicands, and division. Grades: 1-6.


Numero Cubes. Developmental Learning Materials. Ten dice, some with dots and some with numerals, which may be used in a variety of ways to teach basic operations in arithmetic.

Primary Math Skills Improvement. Imperial International Learning Corp. This kit contains 40 tapes with approximately 4 worksheets per tape. Sheets are self-correcting. Grades: 1-6.

Rapid Easy Self-Teaching Chart. Cook and Company. These charts use a revolving disc tachistoscope to present number combinations in the four operations. Grades: 2-6.


Structural Arithmetic. Houghton-Mifflin Co. This program is designed for use of concrete materials which allows the child to discover the basic concepts of numeration and arithmetic operations through following a carefully planned sequence of experiments. Grades: K-3.

The Sensorithmetic Program. Developmental Learning Materials. Teaching basic number and arithmetic concepts through the use of sensory reinforcement materials.


SPELLING


HANDWRITING


Guides for Writing. Instruction Corp. Two acetate sheets lined for handwriting practice on the 2-ruled guides for writing.

I Can Do It. The Zaner-Bloser Co. Designed to utilize visual, auditory, kinesthetic and tactile processes to develop writing skills. Grades: 1-5.


Type It. Educators Publishing Service, Inc. A linguistically oriented typing manual. It is constructed to reinforce the reading and spelling patterns of the phonetically regular words in our language.

Write and See. Lyons and Carnahan, Inc. Programmed instruction in the formation of manuscript and cursive letters on lined paper.

SELF HELP


DUSO Kits. American Guidance Service. Developing Understanding of Self and Others (DUSO) is a program of activities, with an accompanying kit of materials, designed to help children understand social-emotional behavior. Grades: 1-3 (kit #1), 4-6 (kit #2).
APPENDIX G

BIBLIOGRAPHY OF BEHAVIORAL CHECKLISTS
BIBLIOGRAPHY OF BEHAVIORAL CHECKLISTS:
INVENTORIES AND CHECK LISTS OF ADAPTIVE BEHAVIOR

AAMD Adaptive Behavior Scales (Revised)
    American Association on Mental Deficiency

Balthazar Scales of Adaptive Behavior for Profoundly and Severely Retarded
    Research Press Company

Basic Concept Inventory
    Follett

Basic School Skills Inventory
    Follett

Behavioral Outcome Charts
    Colorado State College, Greeley, Colorado

Cain-Levine Social Competency Scale
    Consulting Psychologists Press, Inc.

California Preschool Social Competency Scale
    Consulting Psychologists Press, Inc.

Camelot Behavior Checklist
    Edmark Associates Bellevue, Washington

Child Behavior Rating Scale
    Western Psychological Services

Denver Developmental Screening Test
    Ladoca Publishing Foundation, Inc.

Developmental Evaluation Checklist
    Pediatric Services Roosevelt Hospital

Developmental Task Analysis
    Follett
Devereau Behavior Rating Scale
Devereau Foundation

Diagnostic Checklists (Developmental Skills) I, II, and III
Utah State Division of Health, Handicapped Children's Service

Evaluation Form for Trainable Mentally Retarded Children
Rocky Mountain Special Education Instructional Materials Center

Gesell Developmental Scale
Gesell Developmental Kit, Lumberville, PA

Individual Student Inventory
Tri-County Special Education District; Murphysboro, Illinois

Inferred Self Concept Scales
WPS

Inventory of Developmental Behaviors
Fox Developmental Center; Kankakee, Illinois

Louisiana Adaptive Behavior Scale
Division of Mental Retardation, Louisiana Health and Social Rehabilitation Services

Nebraska Client Progress System
Nebraska Department of Public Institutions

Ottawa School Behavior Checklist
Psychological Consultants, Inc.

Pupil Rating Scale - Screening for Learning Disabilities
Grune and Stratton

Riley Preschool Developmental Screening Inventory
Western Psychological Services

Santa Clara Inventory of Developmental Tasks
R. L. Zweig Associates
Title I Needs Assessment - Severely and Profoundly Retarded

Minnesota Department of Education; St. Paul, Minnesota

TMR Performance Profile

Reporting Service for Exceptional Children; Ridgefield, New Jersey

Vineland Social Maturity Scale

American Guidance Service, Inc.

Walker Problem Behavior Identification Checklist

WPS
1. The systematic design of instruction has been prolifically described in the literature, and much of the associated "jargon" has become common language in the field of education. Unfortunately, in spite of the popularity of the topic, systems approaches are more often discussed as being theoretically applicable to instruction than applied to the improvement of instructional practices.

A systems approach is a process by which instructional planning can be completed to meet the specific needs of individual learners. The process also provides a procedure by which teachers can evaluate their instruction in terms of individual learner progress as contrasted to overall "class" performance.

2. Behavioral Objectives

The primary index of the effectiveness of our instruction is the change in the behavior of the learner. We are committed to assisting students in acquiring new behaviors and in increasing or decreasing the occurrence of existing behaviors. The fact that we arrange experiences presumes that we have, either independently or with the learner, determined which behaviors should be increased and which behaviors should be decreased. These decisions need not occur randomly; they should occur by design.

We should specify the precise behavior the learner will acquire, the stimulus conditions

under which the behavior will occur, and the precise criterion which will indicate when the learner has been successful - we should state the objectives of our instruction in behavioral terms. Each of these objectives should then be subdivided into specific steps which the learner must master in order to meet the objectives.

3. **Conceptual Objectives**

The conceptual objectives describe the generalized goal or outcome of the total program. They should describe the general skills the "ideal" learner would demonstrate after the formal educational experience was completed. These objectives serve as a guide for the development of more specific objectives. From an instructional standpoint, they mean very little; from a developmental standpoint, they are essential.

   **Example:** The learner will be able to apply the skills necessary for obtaining and maintaining a vocational position.

4. **Educational Objectives**

Each conceptual objective must be reduced to the specific skill areas in which a learner must demonstrate competence for the conceptual objective to be met. The emphasis is placed on including all of the skill areas.

   **Example:** The learner will understand the procedures for acquiring a job.

5. **Instructional Objectives**

The educational objectives are represented by a variety of behavioral classes, e.g., identity, name, describe, demonstrate. Each educational objective must be reduced to classes of behavior with specific subject-area descriptors.

   **Example:** The learner will demonstrate the basis techniques of a job interview.

6. **Behavioral Objectives**

A number of behavioral objectives would be written to represent the class of behavior in each instructional objective. The behavioral objectives are comprised of four major
components: The individual learner, the conditions, the measurable verb (or action), and the criterion measures for the action.

Example: When asked five personal history questions in a hypothetical peer-directed job interview, the learner will answer each question accurately without reference to his notes.

Because of its precision the behavioral objective serves as a guide for the development and evaluation of instructional procedures.

7. The Condition

The learner might be faced with disaster if all his activities were directed toward a written response to printed material and we measured his progress with an oral check. The conditions indicate the procedures to be used in evaluation and guide us in selecting educational experiences. If mastery of a given skill is to be demonstrated by oral responding, it should be stated in the objective and the activities should be selected which increase the learner's skill in that area. Conditions can vary in terms of the amount of support the learner will receive, e.g., with teacher assistance, independently; the type of prompts the learner will use, e.g., given an alphabet card, with no cues; and the situation where the learner will demonstrate mastery, e.g., in the classroom situation, in a "real-life" situation.

8. The Action

Behavioral objectives specify what the learner can do, not what he "knows." Because the action is observable and measurable, we can precisely evaluate the effects of materials or activities in assisting the student to master the objective. The student's measured performance also serves as a guide for advancing him on the sequence of objectives.

9. The Criterion Measure

Stating the precise quantity or quality of responses which indicate mastery of a given
skill assures that each learner is advanced to more complex objectives only after he has the skills necessary for mastering them. We are also able to report the learner's progress more precisely; he doesn't just "know more," he can "do" a specific task at a specific level of accuracy.

10. The Objective Base

By proceeding through an objectives development sequence as depicted in Figure 1, we insure that the objectives for our students will be meaningful — directly related to their ability to perform after they have left the formal program.

The resulting behavioral objectives, in turn, provide numerous advantages for both learners and teachers:

- The teacher can effectively communicate with the learner, his parents and colleagues about the program.
- The teacher can reinforce the learner for specific progress toward the objective.
- The teacher can precisely measure progress.
- The teacher can locate the point in the sequence at which the learner is prepared to begin.
- The teacher can report progress in precise terms.
- The teacher can select materials and activities to meet the needs of the individual learner.
- The learner knows where he is going.
- The learner may more easily see the relevance of specific tasks.
- The learner can be involved in education decision-making.
- The learner knows what is expected of him.
- The learner can measure his own progress.
Figure 1
Guidelines for Writing and Sequencing Objectives

COMPETENCIES

Conceptual Objective

Educational Obj

Educational Obj

Educational Obj

Instructional Obj

Instructional Obj

Instructional Obj

Instructional Obj

Instructional Obj

Instructional Obj

Instructional Obj

Instructional Obj

Performance

* Behavioral Objective
References


APPENDIX I.

LIST OF PUBLISHERS
<table>
<thead>
<tr>
<th>Publisher</th>
<th>Address</th>
<th>City, State, Zip</th>
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<tbody>
<tr>
<td>Allied Education Council</td>
<td>P. O. Box 78, Galien, Mich. 49113</td>
<td></td>
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<tr>
<td>Allyn &amp; Bacon</td>
<td>470 Atlantic Ave., Boston, Mass. 02210</td>
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<td>American Guidance Service, Inc.</td>
<td>Publishers Building, Circle Pines, Minn. 55014</td>
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<tr>
<td>Ann Arbor Publishers</td>
<td>P. O. Box 338, Worthington, Ohio 43085</td>
<td></td>
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<tr>
<td>Barnell-Loft</td>
<td>958 Church Street, Baldwin, NY 11510</td>
<td></td>
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<tr>
<td>Behavioral Research Laboratories</td>
<td>P. O. Box 577, Palo Alto, Calif. 94302</td>
<td></td>
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<tr>
<td>Bell and Howell</td>
<td>7100 McCormick Rd., Chicago, IL 60645</td>
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<tr>
<td>Benefic Press</td>
<td>10300 W. Roosevelt Rd., Westchester, IL 60153</td>
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<tr>
<td>The Bobbs-Merrill Co.</td>
<td>4300 W. 62 St., Indianapolis, Ind. 46206</td>
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<tr>
<td>California Test Bureau</td>
<td>A Division of McGraw-Hill, Del Monte Research Park, Monterey, Calif. 93940</td>
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<tr>
<td>Continental Press, Inc.</td>
<td>Elizabeth, Pa. 17022</td>
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<tr>
<td>Council for Exceptional Children</td>
<td>1920 Association Drive, Reston, VA 20191</td>
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<td>Developmental Learning Materials</td>
<td>7440 N. Natchez Ave., Niles, IL 60648</td>
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<td>Devereau Foundation</td>
<td>Devon, PA</td>
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<td>Edmark Association</td>
<td>655 S. Orcas St., Seattle, Washington 98108</td>
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<tr>
<td>Educational Activities, Inc.</td>
<td>1937 Grand Ave., Baldwin, NY 11520</td>
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<td>Educational Developmental Laboratories</td>
<td>A Division of McGraw-Hill, 1121 Avenue of the Americas, New York, NY 10020</td>
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<td>Educator's Publishing Service</td>
<td>75 Moulton St., Cambridge, Mass. 02138</td>
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<td>Educational Testing Service</td>
<td>Princeton, NJ 08540</td>
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<td>Essay Press</td>
<td>Box 5, Planetarium Station, New York, NY 10024</td>
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<td>Fearon Publishers</td>
<td>6 Davis Drive, Belmont, Calif. 94002</td>
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<tr>
<td>Follett Publishing Co.</td>
<td>1010 Washington Blvd., Chicago, IL 60607</td>
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</table>
Instructo Corporation
Paoli, Penn. 19901

Numark Educational Systems
Forest Hills, NY 11375

Frank E. Richards Publishing Co.
324 First St.
Liverpool, NY 13088

Peterson Handwriting Co.
P. O. Box 249
Greensburg, PA 15602

Educational Innovations, Inc.
203 N. 4th St.
Carrolltown, IL 62016

Special Child Publications
4535 Union Bay Pl., N.E.
Seattle, Wash. 98105

Bureau of Publications
Teaching College Press
Columbia, University
525 W. 120th St.
New York, NY 10027

Grune and Stratton, Inc.
111 Fifth Ave.
New York, NY 10003

Research Press Company
CFS Box 3327
Champaign, IL 61820

Consulting Psychologist Press, Inc.
577 College Ave.
Palo Alto, Calif. 94306

Ladoca Publishing Foundation, Inc.
E. 51st Avenue of Lincoln St.
Denver, Cala. 80216

20800 Beach Blvd.
Huntington Beach, Calif. 92648

MWZ Associates
P. O. Box 144
Dayton View
Dayton, Ohio 45406

Visual Symbol Environment
64 East Second St.
Winona, Minn. 55987

Alexander Graham Bell Association for the Deaf, Inc.
1537 35th St., N.W.
Washington, D. C. 20007

Miller-Brody Production, Inc.
342 Madison Ave.
New York, NY 10017

Gage Educational Publishing, Limited
P. O. Box 5000
Agincourt, Ontario Canada MIS 3C7

The Learning Business
30961 Agoura Rd., Suite 325
Westlake Village, Calif. 91361

Milton Bradley
74 Park St.
Springfield, Mass. 01106

Childcraft Educational Corp.
150 E. 58th St.
New York, NY 10022

Educational Performance Associates
563 Westview Ave.
Ridgefield, NJ 07657

Lave Publishing Co.
6635 E. Villanova Pl.
Denver, Cala. 80222

Ward Making Production, Inc.
P. O. Box 1858
Salt Lake City, Utah 84110

L. B. Lippincott Co.
E. Washington Square
Philadelphia, PA 19105
Field Educational Publications
902 S. Westwood
Addison, IL 60101

Ken-a-Vision
5615 Raytown Rd.
Kansas City, Missouri 64133

Laidlaw Brothers
Thatcher and Madison Sts.
River Forest, IL 60305

Imperial International Learning Corp.
P. O. Box 548
Kankakee, IL 60901

David C. Cook Publishing Co.
850 Grove Ave.
Elgin, IL 60120