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ABSTRACT

This document contains selected information consisting of text, data tables, and summaries related to two programs under the Individuals with Disabilities Education Act (IDEA): (1) the Early Intervention Program for Infants and Toddlers with Disabilities, Part H (renamed Part C on July 1, 1998) of IDEA, which covers services to children from birth through age 3; and (2) the Preschool Grants Programs (Section 619) of Part B of IDEA, which covers services to children from ages 3 through 5. The document includes charts indicating the number of infants and toddlers receiving early intervention services and the number and type of personnel employed and needed to provide early intervention services. The next section provides information on the number of children served under the IDEA, Part B Preschool Grants Program, the number of children ages 3-5 served in different educational environments, and the total number of teachers employed and needed to provide services. The following sections provide information specific to the Early Education Program for Children with Disabilities and discuss parent professional partnerships. (CR)

Programs for Young Children with Disabilities Under IDEA

excerpts from the

Nineteenth Annual Report to Congress on the Implementation of The Individuals with Disabilities Education Act

by the U.S. Department of Education (1997)

The National Early Childhood Technical Assistance System (NECTAS)

is a collaborative system, coordinated by the
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with

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August 1998

Preface

This document reproduces selected information from the U.S. Department of Education's *Nineteenth Annual Report to Congress on the Implementation of The Individuals with Disabilities Education Act* (1997). These selections consist of text, data tables, and study summaries related to two programs for young children and their families under the Individuals with Disabilities Education Act (IDEA):

- the Early Intervention Program for Infants and Toddlers with Disabilities, Part H (renamed Part C on July 1, 1998) of IDEA; which covers services to children from birth through age 3; and
- the Preschool Grants Program (Section 619) of Part B of IDEA, which covers services to children from ages 3 through 5.

These excerpts are reproduced without change along with the actual page number and table designations from the *Report.*

NECTAS compiled this information to provide the primary recipients of our TA services - the coordinators of state Part C and Section 619 programs, the chairs of state interagency coordinating councils, and outreach and model project personnel - and others with easy access to the sections of the *Report* that are most relevant to their work. The complete *Nineteenth Annual Report to Congress* (document number GPO:1997-616-188/90444) is widely available in libraries and the full text, exclusive of the data tables, is available at the U.S. Department's Web site at <http://www.ed.gov/pubs/OSEP96AnlRpt/index.html>.

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U.S. Department of Education

1997

EXECUTIVE SUMMARY

SECTION I

Context/Environmental Factors: This section has five modules that describe societal and educational factors that are currently affecting the delivery of services to children with disabilities and their families.

School Reform and Students with Disabilities: The Changing Context of Classrooms

- Over the past 15 years, general education reforms have focused on six major policy areas: standards development, assessment, accountability, governance, teachers, and finance. During the same period, special education programs have been changing as a result of efforts to promote inclusion of students with disabilities in regular education classrooms, to decrease inappropriate identification of students with disabilities (particularly cultural- or language-minority children), and to improve postschool results of all students receiving special education services.

- A recent national survey conducted by the Council of Chief State School Officers in collaboration with the Center for Policy Research on the Impact of General and Special Education Reform indicated that 38 States and the District of Columbia have standards ready in one or more content areas. Thirty-four States and the District of Columbia will apply those content standards to students with individualized education plans (IEPs).

- Teacher licenses for both special education and general education are moving toward fewer licensing categories. In special education, the trend appears to be toward more developmental and less content- or disability-specific categories. General education teacher license requirements in 22 States include a requirement that elementary teachers have some coursework related to students with disabilities, and 21 States have a similar requirement for secondary teachers. Eleven States require that general education teachers obtain practical

experience working with students with disabilities before obtaining a license.

Poverty Among Children: The Impact on Special Education

- Over the past 25 years, the overall poverty rate has remained relatively constant at approximately 12 percent; the child poverty rate has increased from 15 to 19 percent. Younger children have a greater likelihood of being in poverty. For the period 1990-95, the average annual poverty rate for children birth through age 2 was 25.7 percent, that of 3- through 5-year-olds was 24.3 percent, and that of 6- through 17-year-olds was 19.9 percent.

- Poverty increases the likelihood of problems that affect the education of children. Children of low-income families on average miss more days of school. A pattern of underachievement is also associated with children of low-income families. Students from low-income families are twice as likely to drop out of high school as their middle-income peers, and students from low-income families are 11 times more likely to drop out than their upper-income peers.

- Poverty has been associated with an increased risk of children being born with a lower than average birth weight. Low birth weight babies are at higher risk of developing learning disabilities, hyperactivity, emotional problems, mental illness, neurodevelopmental problems, and visual and hearing impairments. When poverty and low birth weight occur together, the number of students who need special education services is greater than would be predicted for those factors independently.

The Costs of Special Education

- Sources of cost information include historical data from previous national studies of special education costs and data collected from States in the 1980s as required by Section 618 of IDEA. Estimates of the current costs of special education are based on a recent State survey conducted by the Center for Special Education Finance (CSEF), the national per pupil cost of education, and the total amount of Federal expenditures for special education.

- Historical data show that the cost of special education has risen at a higher rate than the cost of general education as a whole. However, much of the cost can be attributed to the implementation of IDEA and to the costs associated with expansion of services to eligible children ages birth through 5. Current influences on the costs of special education include the: (1) growth in special education enrollment, (2) changes in the funding agencies and the types of services being provided, (3) revenue restrictions such as property tax restrictions that limit the growth in general education expenditures but have not limited the growth in special education expenditures, and (4) changes in the population such as the increase in economically and medically at-risk students.

- In response to a CSEF survey of 24 States, 13 reported that they could estimate their statewide cost of special education programs with a high degree of confidence, 9 States were either somewhat confident or confident of their data, and 2 States were not confident. States with a high degree of confidence in their data reported the average marginal cost of special education per student to be $5,435.

Problems Facing Education: Substance Abuse and Violence

- The use of illicit drugs, particularly marijuana, has increased among secondary school students since 1992. The use of alcohol among secondary school students and adults has remained stable or declined during the 1990s, and the use of cigarettes has increased among this population.

- Youth violence in the general community has increased dramatically over the past decade, and this trend is also evident in schools. In an attempt to understand the growing problems of violence and substance abuse, efforts are being made to understand the way in which this social problem may affect students with disabilities.

Disproportionate Representation: Can This Civil Rights Concern Be Addressed by Educators?

- Issues regarding minority students and students receiving special education services have been a focus of concern for both OSEP and the Office for Civil Rights (OCR).
- Data from the 1992 OCR Compliance Report and current OCR cases suggest disproportionate representation of racial and ethnic minorities in special education is an ongoing problem nationwide, with continuing concentrations in certain areas. For example, African American students appear to be overrepresented in programs for students with mental retardation, serious emotional disturbance, and specific learning disabilities.
- OSEP and OCR have continued to seek solutions to this civil rights issue by allocating additional resources to address the issue as a programmatic priority. Discretionary grant programs through OSEP have funded research and technical assistance activities that have provided insights into the issues concerning minorities in special education and strategies to resolve concerns. OCR has designated minority students in special education as a priority enforcement issue. It has conducted compliance activities on placement of students, equal access to pre-referral programs, and lack of access to regular education settings.

SECTION II

Student Characteristics: This section contains four modules related to the characteristics of students served under IDEA and the Federal funding that States received to serve these students.

Infants and Toddlers with Disabilities Served Under IDEA, Part H

- Funding for Part H has increased from $50 million in 1987 to $316 million in FY 1996. All States and Outlying Areas serve the children that meet eligibility criteria, and in 1995, 13 States and 1 Outlying Area served at-risk infants and toddlers.

- The number of infants and toddlers receiving early intervention services has increased from 145,129 in 1992 to 177,673 in 1995. Almost 50 percent of the children served in 1995 were in the 2- to 3-year-old range, whereas approximately 17 percent of the infants were 1 year old or younger. Only the 2- to 3-year-old age group had an overall increase during 1992-95.

Children Served Under IDEA, Part B Preschool Grants Programs

- In FY 1996, Congress appropriated $360,409,000, only slightly more than the $360,265,000 appropriated in FY 1995, for the Preschool Grants Program. However, the number of children served increased 4.9 percent from 522,710 on December 1, 1994, to 548,441 on December 1, 1995.

- Many States apply the general education reform efforts that are made within their States to programs that serve children ages 3-5 with disabilities. According to the *Section 619 Profile (Seventh Edition)*, 18 States have revised their Section 619 programs to reflect some of the general education reform efforts.

- On December 1, 1995, just over 50 percent of children ages 3-5 with disabilities were served in regular class placements, an increase of 2 percent from December 1, 1994. The second most frequent setting was separate class placements, followed by resource rooms. The use of separate facilities has declined over time.

Students Served Under IDEA, Part B

- Funding for the Part B Program has increased steadily from $251,770,000 in 1977 to $2,323,837,000 in 1996. The per child allocation has risen from $71 in 1977 to $418 in 1995. In 1996, the amount allocated for the 1996-97 school year did not correspond to the increase in the number of students with disabilities who were served, and the per child allocation dropped to $413. However, the $3,107,522,000 appropriation for FY 1997 will significantly increase the per child allocation for the 1997-98 school year.

- A total of 5,619,099 children and youth with disabilities ages 3 through 21 were served under IDEA, Part B during the 1995-96 school year, an increase of 188,876 (or 3.5 percent) from the previous year. The percentage

of children ages 6 through 17 with disabilities enrolled in school increased from 10.4 percent in 1994-95 to 10.6 percent in 1995-96.

- Students with disabilities ages 6 through 11 were the largest group served (2,581,061 or 45.9 percent) followed by students ages 12 through 17 (2,237,124 or 39.8 percent). Children ages 3 through 5 (548,441 or 9.8 percent) and 18 through 21 (252,473 or 4.5 percent) made up less than 15 percent of the students served; however, these two groups accounted for the largest increase in the percent of students served.

- As in past years, the largest disability categories continue to be specific learning disabilities (2,597,231 or 51.2 percent), speech or language impairments (1,025,941 or 20.2 percent), mental retardation (585,308 or 11.5 percent) and serious emotional disturbance (438,217 or 8.6 percent). The largest relative increases from 1994-95 to 1995-96 occurred in the traumatic brain injury (30.1 percent), autism (27.2 percent), and other health impairments (24.5 percent) categories. Most States attributed the increases in the two newest categories, traumatic brain injury and autism, to reclassification of students during the time of triennial re-evaluations. The increase in the other health impairments category was generally attributed to increased service to students with attention deficit/hyperactivity disorder.

Students with Attention Deficit/ Hyperactivity Disorder

- The American Psychiatric Association estimates that children with attention deficit/hyperactivity disorder make up between 3 and 5 percent of the school-age population. These children share common clinical syndromes associated with problems of inattention, hyperactivity, and impulsivity. In addition, many children with attention deficit/hyperactivity disorder experience co-occurring disabilities such as specific learning disabilities or serious emotional disturbance.

- There is no single test for attention deficit/hyperactivity disorder. An accurate diagnosis can be made by obtaining information about the child from personal histories on the child and his or her family, tests and

questionnaires that assess the child's behavior, and direct observation of the child in a variety of settings. The Professional Group for Attention and Related Disorders recommends a two-tier evaluation to properly identify children with the disorder. Tier 1 is a clinical evaluation to see if the child's symptoms meet the accepted standards for diagnosis of the disorder, and Tier 2 is an educational evaluation to determine if symptoms of the disorder have a negative impact on the child's classroom performance.

- Children with attention deficit/hyperactivity disorder may qualify for special education and related services under IDEA or under Section 504 of the Rehabilitation Act of 1973, as amended. Students must meet eligibility criteria under these Acts to receive services. Children with the disorder who require special education and related services because of the disorder are eligible for services under the "other health impairments" category of IDEA, Part B.

- Different treatments, with varying known effects and limitations, are used by physicians, psychologists, teachers, and parents to alleviate the symptoms of the disorder. Psychostimulant medications and educational programs are two treatments used for attention deficit/hyperactivity disorder.

SECTION III

School Programs and Services: This section has seven modules that examine some of the programs and services available within schools for children and youth with disabilities and their families.

The Continuum of Placements: From Regular Classes to Residential Facilities

- The environments in which students receive services vary according to the needs of the child. For example, in 1994-95, 87 percent of students with speech and language impairments were served in regular classes for 80 percent of the day or more, as compared with 9.7 percent of students with mental retardation. Students ages 6-11 were more likely to be served in regular class placements than were students ages 12-17 or 18-21. The percentage of students with disabilities ages 6-21 served in regular classes has gradually increased from 32.8 percent in 1990-91 to 44.5 percent in 1994-95.

- For a small percentage of students, mainly those with severe and profound disabilities, residential settings are considered to be the appropriate placement. During the 1994-95 school year, 35,150 students with disabilities ages 6-21 attended public or private residential placements. These students accounted for 0.7 percent of all students with disabilities, a percentage that has remained fairly constant over the past 5 years. Of these students served in residential settings, most have serious emotional disturbance (39.9 percent), hearing impairments (18.6 percent), mental retardation (10 percent), learning disabilities (9.3 percent), or multiple disabilities (9.1 percent).

Including Students with Disabilities in Statewide Assessments

- In 1995, 45 of 50 States administered statewide assessments to measure the performance of students; another 3 States were developing their statewide assessments. Practices governing and attitudes about the participation of students with disabilities in statewide assessments are changing; in 1992, 28 States indicated that they had participation guidelines for students with disabilities. In 1993, 34 States had guidelines; in 1994 and 1995, 45 States had participation guidelines. However, evidence suggests that State personnel can

only give general estimates of the number of students within the State who participate.

- Almost all States involve the IEP team in the decision to participate in statewide assessments. In many States, participation decisions take into consideration curricular alignment (i.e., how well the assessment is aligned with what the student is learning). A few States consider student placement, and a few States consider whether the resulting score will affect the validity or reliability of the measure.

- The number of States that had accommodation guidelines for statewide assessments rose from 21 in 1992 to 39 in 1995. The most frequently used accommodations are changes in setting, scheduling, presentation, and how responses are marked. Although use of all four types of accommodations measured has increased, the greatest increase has been in the use of extended time and reading items to students.

- Only 3 States have developed or are developing an alternate assessment for students unable to participate in regular State assessments. Kentucky has implemented an alternate assessment to contribute to the overall accountability scores. Maryland is field-testing an alternate assessment, and Texas is developing an alternate assessment system.

Developing a Partnership Between Families and Professionals

- During the past 25 years, the philosophy regarding the relationship between children with disabilities and the professionals who serve them has shifted from a child-focused to a more family-focused approach.

- A commitment to the parent-professional partnership is embedded throughout the Part H regulations. Some studies have found that a shift toward family-centered practices has occurred; however, some professionals perceived a moderate level of competence in their ability to work with parents and a higher level of competence working with children.

- Typically, parents of children with disabilities in primary and secondary programs are given less support and have less input into their child's education than parents of children age birth through 5. However, professionals are increasing the variety of methods used to communicate with families, including technology options such as the Internet and teleconferencing.

- Two institutional transitions in special education are the transition from IDEA, Part H, to IDEA, Part B, at age 3 and the transition from school to postschool activities. These are formal opportunities for parent-professional collaboration. Parent involvement can have a critical effect on the transition from school to post-school activities. Parents greatly influence students' perspectives about their vision for the future, how to plan for the future, and their self-determination.

The Continuum of Options in Dispute Resolution

- States have begun to use mediation and other alternative dispute resolution approaches to resolve educational differences and issues. In 1994, 39 States operated special education mediation systems, and 2 out of the 11 remaining States were developing formal mediation procedures. Most of the States without formal mediation systems have some form of mediation.

- OSERS has long supported using mediation and other less litigious means for settling disputes between families and schools.

- State and local educational agencies across the country have implemented several methods of using mediation, including single mediators, co-mediators, and a team or panel of mediators. Some States use SEA employees as mediators while others use individuals from an independent bureau or individuals with a legal background or special education and/or regular education background.

- A number of States and local educational agencies have implemented parent-professional partnership projects that try to enhance communication between parents and school personnel and minimize disagreements and conflicts. Also, many schools and school districts have

implemented conflict resolution programs for students and adults.

Monitoring Compliance with IDEA

- OSEP places the highest priority on compliance with those IDEA requirements that have the strongest positive relationship with improved services and results for students with disabilities and their families. OSEP tailors its monitoring and technical assistance activities in each State to maximize positive impact on educational services and results for students in that State.

- In the 1995-96 school year, OSEP began monitoring some States for compliance with the requirements of the Infants and Toddlers Program under Part H of IDEA. OSEP's monitoring procedures reflect the interagency focus of Part H and focus the monitoring process on requirements that are most closely related to improving results for infants and toddlers and their families. These include child find and public awareness, service delivery, and transition services for children at age 3.

- Thirteen Part B monitoring reports issued in FY 1996 found problems in the following four areas: student access to instruction and vocational preparation, transition from school to employment and other postschool activities, procedural safeguards, and how SEAs exercised their general supervision responsibilities.

Advances in Teaching and Instructional Design

- Over the past decade, a shift in curriculum for students with learning disabilities and related academic problems has occurred. Instead of focusing on a remedial model (mainly drill and practice of basic skills), problem-solving strategies are now commonly used.

- Explicit instruction, which emphasizes the use of explicit directions about what needs to be done, said, or written instead of leaving it up to the learner to make inferences, is one strategy being used to teach problem-solving skills. Through immersion in a learning environment that is rich in clear, explicit discussions of relationships and full of a systematic use of relevant

examples, students increasingly make linkages on their own.

- Cognitive strategy instruction provides students with a series of steps to help them distinguish important from less important material. It can be applied to a variety of academic areas, including expressive writing, reading comprehension, mathematical problem solving, and scientific reasoning. Students are taught a plan of action and then receive extensive feedback on their use of the plan.

- Anchored instruction recreates some of the advantages of informal learning environments, such as apprenticeships, that permit sustained exploration by students and teachers. This method enables them to see and understand how information and knowledge can be used as tools for real-world problem solving and can enhance intrinsic motivation and the ability to transfer information from one situation to another.

Advances in Technology for Special Education

- Remarkable progress has been made during the past 10 years in using technology to meet the needs of students with disabilities. In particular, researchers have customized technology to meet the needs of students with severe cognitive and physical disabilities. A primary source of funding for research projects in this area has been from OSEP.

- Students with severe impairments have increased independence levels through "low tech" solutions such as specially designed pencils, scissors, and silverware and "high tech" advances such as voice recognition systems, word prediction systems, and virtual reality.

- Students with learning disabilities, other cognitive disabilities, and behavioral disabilities have increased their basic skills with specially designed software packages for microcomputers. The technology has also enhanced computer capabilities for all users. For example, Hypercard™, a method that allows the user to click on a boldface text to access other information, pictures, or sound, was first developed for students with disabilities. It is now used by all Internet users.

SECTION IV

Results: This section contains two modules: one highlights a study that is measuring some of the results that infants and toddlers and their families are achieving, and one measures the completion rates of students served under IDEA.

The Part H Longitudinal Study (PHLS)

- The PHLS is gathering longitudinal data about how children with disabilities function, how their families change as their children age, and how services support child functioning and family change. A sampling approach has been designed that will yield a nationally representative sample of 3,300 children from 3 to 5 counties in each of 20 States across the United States.

- Specific child characteristics, including the type of disability, level of functioning within the developmental domains (cognitive, communication, motor, and self-help), and child engagement, will be examined.

- To measure family results, PHLS will gather data on families in a direct and functional way. Four critical result domains have been identified: (1) the family's capacity to meet the special needs of their infant or toddler, (2) parent perceptions of their needs and the extent to which they were met by Part H services, (3) parent perceptions of their internal and external support systems, and (4) the quality of life perceived by families.

Secondary School Completion

- Students with disabilities may complete high school by receiving a standard diploma identical to the one awarded to students without disabilities or by receiving a modified diploma, certificate of completion, or other credential documenting their program completion.

- There are many different ways to calculate graduation rates for students with disabilities. One method is to calculate the percentage of students with disabilities ages 17-21 who graduate with a diploma or certificate based on the total number of students with disabilities ages 17-21. Using this method, from 1993-94 to 1994-95, the percentage of students with disabilities

graduating with a diploma or certificate increased slightly from 27.9 percent to 28.4 percent.

- A second way to calculate the high school completion rate is to divide the number of students with disabilities ages 17 to 21 who graduate with a diploma or certificate of completion by the number of students graduating with a diploma, graduating with a certificate, reaching maximum age, or dropping out of school. This provides the proportion of students leaving high school who completed the program of study. The 1994-95 completion rate was 71.8 percent.

- From 1990 to 1995, three OSEP-funded dropout prevention projects identified effective strategies for helping students with disabilities to stay in school. These include monitoring student behavior, building relationships, promoting affiliation, teaching problem solving, and exhibiting persistence.

Information Specific to the Early Intervention Program for Infants and Toddlers with Disabilities

(Part H of IDEA; renamed Part C as of July 1, 1998)

Infants and Toddlers with Disabilities Served Under IDEA, Part H

Part H of the Individuals with Disabilities Education Act (IDEA) was adopted by Congress in 1986. Part H was designed to address the needs of infants and toddlers with disabilities and their families through a "statewide system of coordinated, comprehensive, multidisciplinary, interagency programs providing appropriate early intervention services to all infants and toddlers with disabilities and their families" (20 U.S.C. §1476 (a)).

Formulation of the goals for Part H and early intervention was influenced by multiple factors, including the historical context that led to the passage of Part H, the actual language used in the Part H legislation and regulations, and the professional literature. Part H contains the following purpose statement:

The Congress finds that there is an urgent and substantial need:

(1) To enhance the development of infants and toddlers with disabilities and to minimize their potential for developmental delay,

(2) To reduce the educational costs to our society, including our Nation's schools, by minimizing the need for special education and related services after infants and toddlers with disabilities reach school age,

(3) To minimize the likelihood of institutionalization of individuals with disabilities and maximize the potential for their independent living in society,

(4) To enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities (20 U.S.C. §1471), and

(5) To enhance the capacity of State and local agencies and service providers to identify, evaluate, and meet the needs of historically underrepresented populations, particularly minority, low-income, inner-city, and rural populations (20 U.S.C. §1471).

This statement sets forth a broad set of goals for early intervention programs and emphasizes serving both children and families.

Part H provides Federal funds to assist States in planning and implementing a system of early intervention services to:

(1) develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers with disabilities and their families;

(2) facilitate the coordination of payment for early intervention services from Federal, State, local, and private sources;

(3) enhance their capacity to provide quality early intervention services and expand and improve existing early intervention services being provided to infants and toddlers with disabilities and their families (20 U.S.C. §1471).

The first year of implementation for Part H was 1987. Part H was designed to be phased in over a 5-year period. However, it was later amended by adding two 1-year extensions to permit States to fully implement the law. All States provided an assurance that they had implemented Part H as of September 30, 1994. Funding for the program

has increased from $50 million in FY 1987 to $316 million in FY 1996.

Infants and toddlers from birth through age 2 are eligible for Part H services if they:

(1) Are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures in one or more of the following areas:

  (i) Cognitive development.

  (ii) Physical development, including vision and hearing.

  (iii) Communication development.

  (iv) Social or emotional development.

  (v) Adaptive development; or

(2) Have a diagnosed physical or mental condition that has a high probability of resulting in developmental delay (34 CFR 303.16).

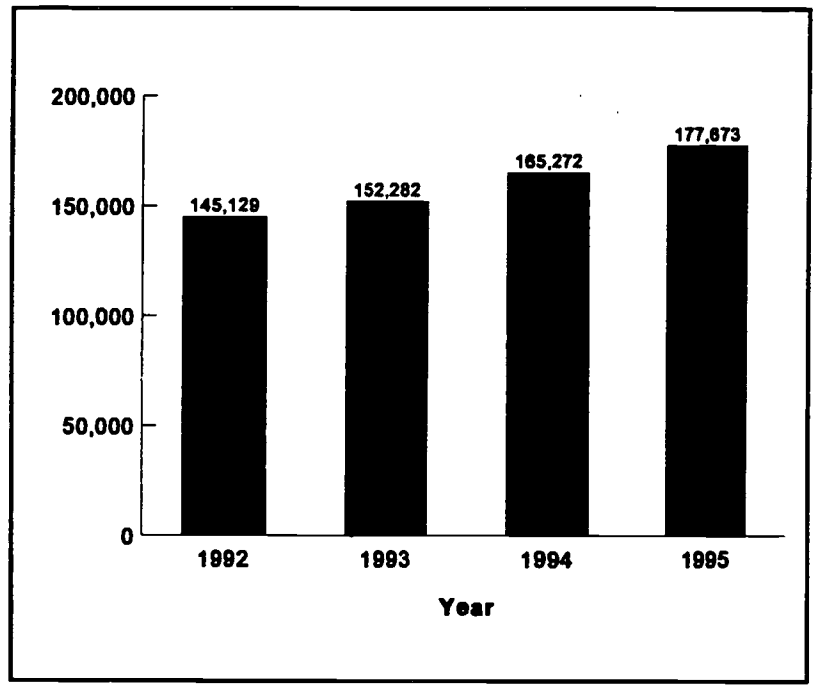
States have the discretion to serve infants and toddlers and their families who are "at risk of having substantial developmental delays if early intervention services are not provided" (34 CFR 303.16). In 1995, 13 States and one Outlying Area served at-risk infants and toddlers.[1]

Children eligible to receive services under Part H must have an individualized family service plan (IFSP) in place.

This section discusses the increasing number of infants and toddlers with disabilities who are being served under Part H of IDEA, the distribution of these children by age, and the percentage of infants and toddlers served in the

[1] States serving at-risk infants and toddlers were Arkansas, California, Colorado, Hawaii, Indiana, Maine, Massachusetts, New Hampshire, New Mexico, North Carolina, Ohio, Rhode Island, and Wisconsin. Guam also serves these children.

Figure II-1
Number of Infants and Toddlers with Disabilities Served Under IDEA, Part H



Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

resident population. (Further discussion on Part H can be found in "The Part H Longitudinal Study (PHLS)" in Section IV.1.)

Number of Infants and Toddlers Served

Figure II-1 shows the number of infants and toddlers and their families who have received services since December 1992.[2] Counts prior to December 1992 were considerably

[2] Counts of infants and toddlers served prior to 1994-95 include infants and toddlers served under the Chapter 1 Handicapped Program.

higher than the 1992 count. Discussions with State representatives indicate that these earlier counts were somewhat inflated because States had difficulty providing unduplicated counts of infants and toddlers served, and some States counted infants and toddlers who did not have an IFSP in place.

Since 1992, the States have reported a steady increase in the number of children served. During the past 4 years, the number of infants and toddlers served has increased by 22.4 percent. Ten States--Arkansas, California, Florida, Kansas, Kentucky, Mississippi, Montana, New Mexico, New York, and Oregon--reported increases of more than 50 percent, while 10 States and jurisdictions--Alaska, Arizona, District of Columbia, Massachusetts, Missouri, New Hampshire, North Carolina, Tennessee, Virginia, and Washington--reported serving fewer infants and toddlers with disabilities in 1995 than in 1992.

States vary in the percentage of infants and toddlers served under Part H. In 1995, six States served less than 1 percent of their resident birth to age 3 population under Part H, while 33 States served 1 to 2 percent of their resident population through Part H. Eight States served from 2 to 3 percent of the population. Four States served more than 3 percent of the population under Part H. One of those States, Hawaii, continues to serve the highest percentage among all States (6.73 percent). (See Appendix table AH1.)

It is likely that the overall growth in the number of infants and toddlers served is in part related to child find and public awareness efforts. Almost 50 percent of the children served in 1995 were in the 2- to 3-year-old range, whereas approximately 17 percent of the infants were 1 year old or younger, as shown in table II-1. Only the 2- to 3-year-old age group had an overall increase during the 4-year period of 1992-95.

A small study conducted in Colorado, North Carolina, and Pennsylvania sampled the families of 155 infants and toddlers with disabilities in early intervention programs in three counties of each State. The study found that average

Table II-1
Percentage Distribution of Ages of Infants and Toddlers Served Under IDEA, Part H 1992-95

Year	Ages			Total**
	Birth to 1	1 to 2 Years Old	2 to 3 Years Old	
1992*	18.8	34.2	47.1	100.0
1993*	20.3	35.1	44.6	100.0
1994	17.9	33.4	48.7	100.0
1995	16.8	33.4	49.8	100.0

* Includes infants and toddlers with disabilities served under the Chapter 1 Handicapped Program.

** Due to rounding, totals may not sum to 100 percent.

Source: U.S. Department of Education, Office of Special Education Programs. Data Analysis System (DANS).

age of referral to the program was 12.1 months in Colorado, 10.6 months in North Carolina, and 7.7 months in Pennsylvania. The most commonly used referral source was a physician or nurse (50 percent). The study also found that the sample collected in May of 1994 consisted of 24 (15 percent) infants ages birth to 1, 64 (41 percent) infants ages 1 to 2, and 70 (44 percent) toddlers ages 2 to 3 (Kochanek & Buka, 1994).

The Early Education Program for Children with Disabilities

The Office of Special Education and Rehabilitative Services (OSERS) in the U.S. Department of Education administers a variety of programs related to improving the quality and quantity of services to young children with special needs and their families. Selected early childhood projects are sponsored by OSERS and administered by the Office of Special Education Programs (OSEP) through the Early Education Program for Children with Disabilities (EEPCD).

These early childhood initiatives include demonstration projects, in-service training projects, outreach projects, research institutes, research and experimental projects, statewide data system projects, and a technical assistance center that support programs for infants, toddlers, and preschoolers with disabilities.

EEPCD, originally named the Handicapped Children's Early Education Program (HCEEP), was established in 1968 with a mandate to set up model demonstration projects for the delivery of special education and related services to young children with disabilities, from birth through the third grade. Three major needs were identified for early intervention programs: (1) locally designed ways to serve infants, young children, and their families; (2) more specific information on effective programs and techniques; and (3) distribution of visible, replicable models throughout the country.

Two major assumptions underlie this program: (1) only through early intervention with tested and successful program models can the highest quality services be provided for children with disabilities, and (2) the program should provide models of services rather than be a direct service delivery program. HCEEP was intended to provide an opportunity for any public or private nonprofit organization to develop and demonstrate high-quality services for a selected group of children and their families. It also was intended to provide an opportunity to demonstrate the effectiveness of locally designed approaches and disseminate those ideas across the nation to other agencies that might choose to use the model rather than develop their own program. EEPCD currently supports 109 projects, including 35 demonstration projects, 18 in-service training projects, 49 outreach projects, 6 research institutes, and 1 national technical assistance center.

The demonstration projects address a range of topics, including multidisciplinary intervention services for child and family; interagency collaboration in the provision of services; service delivery models; developmentally appropriate practices; transitioning children with disabilities into community settings; increasing and improving child care

options for children with disabilities; curriculum development; evaluation of child progress; services for infants with special health needs, including HIV infection and AIDS, or exposure to drugs in utero; and assistive technology. Projects in this priority area are developing and evaluating in-service training models that will prepare professionals and paraprofessionals to provide, coordinate, or enhance early intervention, special education, and related services for infants and toddlers with disabilities and/or for preschool children with disabilities. Outreach projects engage in awareness activities; stimulation of model replication sites; training of professionals, paraprofessionals, and parents; promotion of State involvement; product development and dissemination; and consultative activities. Outreach efforts have contributed significantly to informing people about effective programs for young children, to providing improved training and services, and to building continuity and interagency/inter-State collaborations. During 1995-96, four research institutes were funded. These institutes address interventions for children affected by parental substance abuse; barriers to the inclusion of preschool-age children with disabilities in classroom and community settings; influences on service patterns and utilization in early intervention and preschool programs; and the adoption of successful early intervention practices in children's early elementary education in order to improve the education of children with disabilities.

Summary

The increase in the number of infants and toddlers served under Part H (22.4 percent) since 1992 has been greater than the growth in the number of children and youth served under the Part B program for this same period (10.6 percent). However, the Part H growth rate is comparable to the growth rate of the number of children ages 3 through 5 that are served under Part B (20.4 percent). This growth in services to young children reflects one of the OSEP's policy goals--to strengthen early intervention to enable every child to start school ready to learn. Early intervention programs can benefit both the child and the family by helping the child become more involved in both

the community and the family and can diminish or prevent further developmental limitations and secondary or tertiary disabilities (Guralnick & Bennett, 1987).

The overall percentage of infants and toddlers with disabilities served under Part H as a function of the resident population has also increased, from 1.2 percent in 1992 to 1.5 percent in 1995. However, these percentages vary across the States. Children with disabilities ages 2 to 3 continue to be the most dominant age group, representing almost half of all those served under Part H.

References

Guralnick, M.J. & Bennett, F.C. (1987). *The effectiveness of early intervention for at-risk and handicapped children.* Orlando: Academic Press.

Kochanek, T.T. & Buka, S.L. (1994). *The Early Childhood Research Institute on Service Utilization: Study environments and a portrait of children, families and service providers within them.* The University of North Carolina Rhode Island College Center for Family Studies: Early Childhood Research Institute on Service Utilization.

The Part H Longitudinal Study (PHLS)

The Individuals with Disabilities Education Act (IDEA) affirms society's commitment that all students with disabilities have the right to a free appropriate public education. Part H of IDEA assists States to provide systems of intervention and family support services to enhance the development of infants and toddlers with disabilities and to enhance the capacity of families to meet the needs of their infants and toddlers. These national programs have defined a comprehensive approach to promote the development and quality of life of infants, children, youth, and adults with disabilities through individualized programs of services.

Now that these programs are in place, policy makers, advocates, and others are interested in learning about their effects. For example, the National Longitudinal Transition Study of Special Education Students (NLTS) has provided data on educational results for youth with disabilities. Now, 10 years after the inception of Part H, the Office of Special Education Programs (OSEP) is sponsoring the Part H Longitudinal Study (PHLS).

Background

When Congress passed Part H, it established a national policy of assisting States to develop early intervention systems for infants and toddlers with disabilities (children from birth through age 2). The statute requires all States participating in Part H to develop and implement a statewide system of coordinated, comprehensive, multidisciplinary, interagency programs providing appropriate early intervention services to all eligible infants and toddlers with disabilities and their families. In the years following passage of the legislation, State and local agencies engaged in a variety of activities in an attempt to enhance and improve existing services to conform to the vision and the requirements of Part H. The PHLS will gather information about

how these practices are influencing children and families served by the Part H service system.

The PHLS will examine the characteristics of infants and toddlers and families participating in Part H, the services they receive, and the results they experience. The PHLS will gather data on such questions as:

- At what ages do infants and toddlers enter Part H services? What services do children and families receive?
- What proportion of infants and toddlers who participate in early intervention services receive special education and related services at age 3?
- What are the costs associated with early intervention?

To address these types of questions, the PHLS will gather longitudinal data about how children with disabilities function, how their families change as their children age, and how services support child functioning and family change. While the PHLS will provide invaluable information to audiences at many levels of the Part H service system, its primary purpose is to provide nationally representative data about Part H participants, services, and results that can be used for future policy development and evaluation. A more in-depth understanding of the children and families served by Part H, the results of the services they receive, and the costs of the services is needed so that informed public policies regarding infants and toddlers with disabilities and their families can be formulated.

The Vision of Part H and the Need for the PHLS

Part H is a Federal program with four equally important purposes. They are:

(a) Develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers with disabilities and their families;

(b) Facilitate the coordination of payment for early intervention services from Federal, State, local, and private sources (including public and private insurance coverage);

(c) Enhance the States' capacity to provide quality early intervention services and expand and improve existing early intervention services being provided to infants and toddlers with disabilities and their families; and

(d) Enhance the capacity of State and local agencies and service providers to identify, evaluate, and meet the needs of historically underrepresented populations, particularly minority, low-income, inner-city, and rural populations (34 CFR 303.1).

All States are now participating in Part H.

A critical issue of interest to policy makers is whether Part H is achieving its intended effect. Part H was intended to bring about changes in four areas: at the State level, in local delivery systems, in the quality of services provided to children and their families, and in the production of positive effects on children and their families.

Changes at the State level. Part H was intended to create change in States' policies and the infrastructure for administering early intervention. For example, Part H requires States to designate a lead agency, form an Interagency Coordinating Council (ICC) to advise the lead agency, and develop personnel standards, as well as fulfill several other requirements.

Local service delivery systems. Many of the national policies established for Part H have also been adopted at the local level. Local services are coordinated among agencies. Procedures for identifying potentially eligible infants and toddlers, as well as procedures for making the general public and referral sources aware of the availability of early intervention services, are carried out at the local level. Also, local systems are reaching out to historically underrepresented groups.

Improve quality of services. Part H also was intended to improve the quality of services provided to children and families. For example, services are to be provided in accordance with an individualized family service plan (IFSP). Services are to be family-focused and provided in the natural environment, including the home and community settings in which children without disabilities participate.

Positive effects on children and their families. Part H was designed to have positive effects on infants and toddlers with disabilities and their families. Services are to be provided that will enhance development, minimize potential for developmental delay, and improve the family's capacity to meet the needs of their child.

States were given some flexibility in designing their Part H systems in order to incorporate their existing systems and services. States were also given the option to decide which agency within the State would best meet their needs as the lead agency for the Part H program. One aspect of understanding the results experienced by children and families who receive early intervention services is understanding how early intervention is provided at the State and local levels.

Goals of Part H: Impact on Service Systems

Recent research indicates that States have implemented Part H in many different ways (Garwood & Sheehan, 1989; Gallagher, Harbin, Eckland, & Clifford, 1994). However, little information exists on how these variations may be affecting the quality of service delivery and the impact of services on children and families. Some of the potentially significant ways in which States' implementation of Part H may differ include:

- Differences in the organization and the level and responsibilities of agencies involved in the early intervention system.

- The wide diversity of circumstances families may live in, as well as the variety of resources available to children with disabilities and their families.
- The diverse backgrounds, traditions, and approaches of the variety of professions involved in providing early intervention services.
- The history of early intervention service provision in each State, including the type and number of agencies that have provided services to this population.
- The different levels and stages of agency readiness, willingness, and financial capacity to implement the Part H program.

Goals of Part H: Child and Family Results

Bailey and Wolery (1992), in a review of the professional literature on early intervention, have suggested seven specific goals of early intervention, as listed below.

- Support families in achieving the goals they have for themselves and their children.
- Promote children's active engagement, independence, and mastery of the environment.
- Promote progress in key developmental domains.
- Build and support children's social competence.
- Promote the generalized use of skills in a variety of relevant settings.
- Provide and prepare children for normalized life experiences.
- Prevent the emergence of future problems or disabilities.

These goals and the congressional statement of purpose serve as guidelines that can be used to help identify indicators of program impact on both children and families.

A review of the major Part H goals indicates that the expected results associated with the program focus on preventing developmental delay and promoting the child's and family's adaptation. Most research on the effects of early intervention to date has investigated results related to disability, such as developmental status or social skills. These are critical results and will be included in the PHLS, but other results need to be examined as well. The specific child characteristics and results to be examined by the PHLS include:

- the type of disability,
- functioning within specific developmental domains (cognitive, communication, motor, self-help skills), and
- child engagement.

To measure family results, the PHLS will gather data on families framed in a direct and functional way. The following four critical result domains for families in early intervention have been identified.

- The family's capacity to meet the special needs of their infant or toddler with a disability.
- Parent perceptions of their needs and the extent to which they were met by Part H services.
- Parent perceptions of their internal and external support systems.
- The quality of life perceived by families.

In January 1996, OSEP funded SRI International, in conjunction with the Frank Porter Graham Child Development Center (FPG), the Research Triangle Institute (RTI), and the American Institutes for Research (AIR), to conduct the

PHLS. Year 1 of PHLS involved a design phase during which many options were explored and many choices were made about the final study design, the sample, and the areas to be measured. A national panel of advisors reviewed the study design and provided feedback. In Years 2 through 5 of the PHLS, the design will be implemented.

Study Design

Overview of Study Design

The PHLS is a longitudinal study of a nationally representative sample of children and families who are participating in early intervention services through Part H. The research questions posed for the study are both descriptive and explanatory. The design of the PHLS is based on a conceptual framework that identifies three key focal areas of study and their interrelationships: the characteristics of the children and families served under Part H, Part H services, and the results achieved by children and families who receive services. Specifically, the questions that are the primary focus of PHLS are:

- Who are the children and families being served by Part H?
- What early intervention services do participating children and families receive?
- What results do participating children and their families experience?
- How do results relate to variations in child and family characteristics and services received?

A sampling approach has been designed that will yield a nationally representative sample of 3,300 children from 3 to 5 counties in each of 20 States across the United States. The final sample of 20 States will be adequate to represent the key dimensions of Part H variation at the State level. Such State-to-State variations include the number of children served, geographic dispersion and population size,

eligibility definition, administrative variations (e.g., lead agency designation), and numbers of underrepresented populations served.

Data will be collected about the infants and toddlers and their families from parents (or legal guardians) via repeated telephone surveys. The surveys will begin when the families enter Part H services and will continue until the child is 5 years old. In addition to measuring child and family characteristics and results, data will be gathered from service providers about the early intervention services provided, including their costs, via a written survey. The goal of the written survey will be to provide data that can be used to better understand associations between services and results. The data analysis strategy involves using both descriptive statistics and multivariate analyses to examine the types of children and families in Part H, the services they receive, and the relationships between child and family results and Part H services.

Summary

During the past decade, various legislative programs, such as IDEA Parts B and H, have defined a comprehensive approach to promoting the development and quality of life of infants, children, youth, and adults with disabilities. Now, policy makers, advocates, and others are interested in learning about the effects of these efforts. OSEP is sponsoring the PHLS to provide data on the results for infants and toddlers and their families who receive services under IDEA, Part H.

The PHLS will examine the characteristics of a nationally representative sample of infants and toddlers and their families who participate in Part H, the services they receive, and the outcomes they experience. Data will be collected from parents or legal guardians and from service providers. The data will be analyzed using both descriptive statistics and multivariate analyses. The primary purpose of PHLS will be to provide nationally representative data about Part H participants, services, and outcomes that can be used for future policy development and evaluation.

References

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Garwood, S.G. & Sheehan, R. (1989). *Designing a comprehensive early intervention system: The challenging of public law 99-457.* Austin, TX: Pro•Ed.

Table AF2

Estimated Resident Population for Children Birth Through Age 2

STATE	NUMBER 1976-77	NUMBER 1994-95	NUMBER 1995-96	CHANGE IN NUMBER 1995-96 LESS 1976-77	CHANGE IN NUMBER 1995-96 LESS 1994-95	PERCENTAGE CHANGE IN NUMBER 1995-96 LESS 1976-77	PERCENTAGE CHANGE IN NUMBER 1995-96 LESS 1994-95
ALABAMA	168,571	180,511	178,938	10,367	-1,573	6.15	-0.87
ALASKA	22,985	32,368	30,918	7,933	-1,450	34.51	-4.48
ARIZONA	119,758	205,039	211,782	92,024	6,743	76.84	3.29
ARKANSAS	101,600	101,298	101,744	144	446	0.14	0.44
CALIFORNIA	905,356	1,695,405	1,653,825	748,469	-41,580	82.67	-2.45
COLORADO	119,945	159,325	158,555	38,610	-770	32.19	-0.48
CONNECTICUT	107,425	135,500	133,704	26,279	-1,796	24.46	-1.33
DELAWARE	24,031	29,742	30,404	6,373	662	26.52	2.23
DISTRICT OF COLUMBIA	21,879	25,881	23,678	1,799	-2,203	8.22	-8.51
FLORIDA	326,497	567,277	570,069	243,572	2,792	74.60	0.49
GEORGIA	238,240	325,946	328,305	90,065	2,359	37.80	0.72
HAWAII	44,038	57,239	57,587	13,549	348	30.77	0.61
IDAHO	48,199	51,843	52,798	4,599	955	9.54	1.84
ILLINOIS	480,209	549,180	550,204	69,995	1,024	14.58	0.19
INDIANA	241,571	242,796	242,079	508	-717	0.21	-0.30
IOWA	120,258	110,452	108,246	-12,012	-2,206	-9.99	-2.00
KANSAS	97,703	108,749	108,405	10,702	-344	10.95	-0.32
KENTUCKY	159,859	155,144	154,715	-5,144	-429	-3.22	-0.28
LOUISIANA	191,706	202,451	200,473	8,767	-1,978	4.57	-0.98
MAINE	45,342	44,433	42,529	-2,813	-1,904	-6.20	-4.29
MARYLAND	151,497	223,953	216,000	64,503	-7,953	42.58	-3.55
MASSACHUSETTS	199,539	247,643	242,830	43,291	-4,813	21.70	-1.94
MICHIGAN	398,356	407,712	399,821	1,465	-7,891	0.37	-1.94
MINNESOTA	168,494	190,119	188,289	19,795	-1,830	11.75	-0.96
MISSISSIPPI	124,496	124,276	124,547	51	271	0.04	0.22
MISSOURI	199,462	221,299	216,420	16,958	-4,879	8.50	-2.20
MONTANA	35,337	34,218	32,982	-2,355	-1,236	-6.66	-3.61
NEBRASKA	68,482	67,659	67,434	-1,048	-225	-1.53	-0.33
NEVADA	27,087	67,808	71,186	44,099	3,378	162.81	4.98
NEW HAMPSHIRE	34,650	46,419	43,838	9,188	-2,581	26.52	-5.56
NEW JERSEY	274,354	341,222	339,133	64,779	-2,089	23.61	-0.61
NEW MEXICO	62,481	82,924	81,641	19,160	-1,283	30.67	-1.55
NEW YORK	671,964	826,290	802,969	131,005	-23,321	19.50	-2.82
NORTH CAROLINA	241,141	301,038	302,603	61,462	1,565	25.49	0.52
NORTH DAKOTA	29,281	25,071	24,961	-4,320	-110	-14.75	-0.44
OHIO	455,603	462,468	455,084	-519	-7,384	-0.11	-1.60
OKLAHOMA	126,448	141,495	134,940	8,492	-6,555	6.72	-4.63
OREGON	102,271	121,768	123,168	20,897	1,400	20.43	1.15
PENNSYLVANIA	436,681	467,630	459,259	22,578	-8,371	5.17	-1.79
PUERTO RICO	.	.	.	.	.	.	.
RHODE ISLAND	31,948	41,973	39,298	7,350	-2,675	23.01	-6.37
SOUTH CAROLINA	137,829	162,938	153,738	15,909	-9,200	11.54	-5.65
SOUTH DAKOTA	32,129	31,879	30,695	-1,434	-1,184	-4.46	-3.71
TENNESSEE	186,466	217,040	216,078	29,612	-962	15.88	-0.44
TEXAS	625,199	939,926	946,613	321,414	6,687	51.41	0.71
UTAH	92,796	108,425	110,504	17,708	2,079	19.08	1.92
VERMONT	20,577	21,732	21,538	961	-194	4.67	-0.89
VIRGINIA	210,395	279,008	276,609	66,214	-2,399	31.47	-0.86
WASHINGTON	153,444	232,222	226,071	72,627	-6,151	47.33	-2.65
WEST VIRGINIA	82,782	64,196	62,516	-20,266	-1,680	-24.48	-2.62
WISCONSIN	193,983	204,350	201,715	7,732	-2,635	3.99	-1.29
WYOMING	20,624	19,230	18,878	-1,746	-352	-8.47	-1.83
AMERICAN SAMOA	.	.	.	.	.	.	.
GUAM	.	.	.	.	.	.	.
NORTHERN MARIANAS	.	.	.	.	.	.	.
PALAU	.	.	.	.	.	.	.
VIRGIN ISLANDS	.	.	.	.	.	.	.
BUR. OF INDIAN AFFAIRS	.	.	.	.	.	.	.
50 STATES AND D.C.	9,180,968	11,704,510	11,570,316	2,389,348	-134,194	26.03	-1.15

Population counts are July estimates from the U.S. Bureau of the Census.

The 1976-77 data were estimated from the 3-21 year old group.

October 1, 1996.

Table AG1

State Grant Awards Under IDEA, Part B, Preschool Grant Program and Part H

APPROPRIATION YEAR 1996
ALLOCATION YEAR 1996-1997

STATE	IDEA, PART B	PRESCHOOL GRANT PROGRAM	PART H
ALABAMA	40,895,889	5,640,150	4,483,470
ALASKA	7,445,561	1,322,423	1,545,710
ARIZONA	30,926,630	5,149,246	5,306,409
ARKANSAS	21,767,818	4,947,109	2,549,297
CALIFORNIA	228,622,421	36,022,407	41,438,233
COLORADO	28,189,964	4,694,437	3,972,753
CONNECTICUT	31,009,767	5,254,252	3,378,163
DELAWARE	6,415,559	1,273,857	1,545,710
DISTRICT OF COLUMBIA	3,133,152	253,984	1,545,710
FLORIDA	125,183,617	17,772,314	14,722,619
GEORGIA	54,500,058	8,737,835	8,226,009
HAWAII	6,468,961	857,114	1,569,551
IDAHO	9,586,202	2,011,527	1,545,710
ILLINOIS	103,277,776	16,385,574	13,785,909
INDIANA	54,064,193	8,046,763	6,065,530
IOWA	26,735,870	3,830,760	2,712,211
KANSAS	21,632,619	4,026,335	2,716,195
KENTUCKY	33,452,225	9,636,295	3,876,538
LOUISIANA	36,749,462	6,292,502	5,023,051
MAINE	12,862,856	2,331,796	1,545,710
MARYLAND	40,707,760	6,228,185	6,148,806
MASSACHUSETTS	64,529,602	9,346,216	8,621,533
MICHIGAN	76,182,721	11,971,373	10,017,913
MINNESOTA	39,676,213	7,075,455	4,873,116
MISSISSIPPI	26,960,663	4,336,103	3,120,649
MISSOURI	48,997,264	5,509,548	5,422,619
MONTANA	7,447,163	1,189,852	1,545,710
NEBRASKA	15,863,867	2,173,630	1,689,626
NEVADA	11,381,723	2,077,812	1,783,636
NEW HAMPSHIRE	10,206,502	1,424,148	1,545,710
NEW JERSEY	79,530,001	10,919,997	8,497,315
NEW MEXICO	19,201,461	2,994,648	2,045,597
NEW YORK	159,349,369	31,853,656	20,119,188
NORTH CAROLINA	59,357,530	10,940,998	7,582,020
NORTH DAKOTA	5,044,365	767,202	1,545,710
OHIO	91,825,830	11,947,090	11,402,583
OKLAHOMA	29,633,498	3,486,209	3,381,056
OREGON	26,241,486	4,001,396	3,086,097
PENNSYLVANIA	86,078,620	13,510,371	12,702,122
PUERTO RICO	18,127,953	2,326,545	4,549,818
RHODE ISLAND	10,118,522	1,531,123	1,568,805
SOUTH CAROLINA	34,921,251	6,775,530	3,852,059
SOUTH DAKOTA	6,432,855	1,428,085	1,545,710
TENNESSEE	51,036,950	6,661,992	5,414,050
TEXAS	178,197,295	21,173,206	23,718,333
UTAH	21,172,943	3,190,222	2,768,788
VERMONT	4,539,452	797,391	1,545,710
VIRGINIA	57,509,947	8,676,144	6,930,714
WASHINGTON	43,138,514	8,246,275	5,664,434
WEST VIRGINIA	18,358,789	3,177,753	1,798,698
WISCONSIN	42,946,007	8,889,438	5,553,755
WYOMING	5,064,508	1,021,186	1,545,710
AMERICAN SAMOA	2,546,094	34,783	514,925
GUAM	6,151,324	122,726	1,140,327
NORTHERN MARIANAS	1,570,112	23,626	342,733
PALAU	552,502	5,120	78,014
VIRGIN ISLANDS	4,663,611	87,286	671,647
BUR. OF INDIAN AFFAIRS	28,408,765		3,864,276
U.S. AND OUTLYING AREAS	2,316,593,632	360,409,000	315,754,000
50 STATES, D.C. & P.R.	2,272,701,224	360,135,459	309,142,078

State grants awards are initial allocations for the 1996 appropriation.

October 1, 1996.

Table AH1

Number of Infants and Toddlers Receiving Early Intervention Services December 1, 1995

STATE	0-1	1-2	2-3	BIRTH THROUGH 2 TOTAL	POPULATION	PERCENTAGE OF POPULATION
ALABAMA	143	472	713	1,328	178,938	0.74
ALASKA	68	133	231	432	30,918	1.40
ARIZONA	270	580	749	1,599	211,782	0.76
ARKANSAS	440	777	958	2,175	101,744	2.14
CALIFORNIA	3,079	6,512	8,528	18,119	1,653,825	1.10
COLORADO	903	1,268	1,746	3,917	158,555	2.47
CONNECTICUT	366	796	1,264	2,426	133,704	1.81
DELAWARE	290	533	565	1,388	30,404	4.57
DISTRICT OF COLUMBIA	18	58	364	440	23,678	1.86
FLORIDA	2,577	3,276	4,918	10,771	570,069	1.89
GEORGIA	657	1,265	1,550	3,472	328,305	1.06
HAWAII	1,513	1,230	1,131	3,874	57,587	6.73
IDAHO	141	277	427	845	52,798	1.60
ILLINOIS	1,222	2,732	4,075	8,029	550,204	1.46
INDIANA	809	1,404	1,975	4,188	242,079	1.73
IOWA	104	275	583	962	108,246	0.89
KANSAS	267	438	724	1,429	108,405	1.32
KENTUCKY	278	592	767	1,637	154,715	1.06
LOUISIANA	582	750	913	2,245	200,473	1.12
MAINE	71	239	539	849	42,529	2.00
MARYLAND	443	1,134	2,118	3,695	216,000	1.71
MASSACHUSETTS	1,763	2,636	4,085	8,484	242,830	3.49
MICHIGAN	827	1,404	2,153	4,384	399,821	1.10
MINNESOTA	373	787	1,462	2,622	188,289	1.39
MISSISSIPPI	142	233	341	716	124,547	0.57
MISSOURI	428	890	1,090	2,408	216,420	1.11
MONTANA	93	176	243	512	32,982	1.55
NEBRASKA	93	235	397	725	67,434	1.08
NEVADA	163	317	361	841	71,186	1.18
NEW HAMPSHIRE	175	318	520	1,013	43,838	2.31
NEW JERSEY	407	1,145	1,855	3,407	339,133	1.00
NEW MEXICO	168	599	980	1,747	81,641	2.14
NEW YORK	931	3,447	8,939	13,317	802,969	1.66
NORTH CAROLINA	519	1,501	2,316	4,336	302,603	1.43
NORTH DAKOTA	54	99	112	265	24,961	1.06
OHIO	1,939	5,188	8,078	15,205	455,084	3.34
OKLAHOMA	316	641	810	1,767	134,940	1.31
OREGON	202	492	785	1,479	123,168	1.20
PENNSYLVANIA	1,200	2,368	3,277	6,845	459,259	1.49
PUERTO RICO	923	1,955	1,915	4,793	.	.
RHODE ISLAND	163	341	472	976	39,298	2.48
SOUTH CAROLINA	324	685	888	1,897	153,738	1.23
SOUTH DAKOTA	40	129	207	376	30,695	1.22
TENNESSEE	543	1,046	1,567	3,156	216,078	1.46
TEXAS	1,523	3,510	5,045	10,078	946,613	1.06
UTAH	584	654	826	2,064	110,504	1.87
VERMONT	25	92	224	341	21,538	1.58
VIRGINIA	413	1,137	676	2,226	276,609	0.80
WASHINGTON	282	638	1,041	1,961	226,071	0.87
WEST VIRGINIA	461	547	656	1,664	62,516	2.66
WISCONSIN	418	1,124	2,074	3,616	201,715	1.79
WYOMING	51	146	237	434	18,878	2.30
AMERICAN SAMOA	9	18	13	40	.	.
GUAM	23	41	50	114	.	.
NORTHERN MARIANAS	10	16	18	44	.	.
PALAU	4	1	0	5	.	.
VIRGIN ISLANDS	8	20	28	56	.	.
U.S. AND OUTLYING AREAS	29,838	59,317	88,579	177,734	11,570,316	1.54
50 STATES, D.C. & P.R.	29,784	59,221	88,470	177,475	11,570,316	1.53

Population figures are July estimates from the Bureau of the Census. No census data are available for Outlying Areas.

Please see data notes for an explanation of individual State differences.

October 1, 1996.

Table AH2

Early Intervention Services on IFSPs Provided to Infants, Toddlers, and Their Families in Accord with Part H December 1, 1994

STATE	ASSISTIVE TECHNOLOGY SERVICES/ DEVICES	AUDIOLOGY	FAMILY TRAINING COUNSELING AND HOME VISITS	HEALTH SERVICES	MEDICAL SERVICES	NURSING SERVICES
ALABAMA	117	214	598	91	206	363
ALASKA	.	118	9	111	159	76
ARIZONA	17	111	142	9	0	0
ARKANSAS	307	278	819	277	632	232
CALIFORNIA	187	411	770	2,874	211	1,098
COLORADO	978	702	2,216	1,427	1,410	1,455
CONNECTICUT	182	256	54	2	52	116
DELAWARE	64	63	493	80	854	591
DISTRICT OF COLUMBIA	106	24	108	68	67	145
FLORIDA	178	549	4,349	339	1,382	923
GEORGIA	592	237	327	131	196	187
HAWAII	121	220	2,727	306	370	523
IDAHO	82	69	117	22	287	102
ILLINOIS	292	537	1,678	433	279	952
INDIANA	99	271	2,152	233	336	343
IOWA	14	56	147	16	28	71
KANSAS	159	250	410	147	119	161
KENTUCKY	116	66	105	4	30	40
LOUISIANA	85	315	699	364	416	138
MAINE	28	15	52	46	20	0
MARYLAND	5	583	176	14	30	218
MASSACHUSETTS	.	381	8,114	8,114	0	698
MICHIGAN	51	193	981	512	335	412
MINNESOTA	.	.	.	.	.	.
MISSISSIPPI	24	39	207	66	32	40
MISSOURI	96	71	1,286	.	853	269
MONTANA	50	129	482	71	229	17
NEBRASKA	91	39	52	2	17	2
NEVADA	22	86	728	156	573	0
NEW HAMPSHIRE	.	24	521	0	5	81
NEW JERSEY	300	219	1,502	113	127	856
NEW MEXICO	109	669	1,079	586	1,296	232
NEW YORK	168	421	3,518	10	72	273
NORTH CAROLINA	64	834	4,187	1,013	3,037	475
NORTH DAKOTA	36	69	132	42	59	31
OHIO	93	198	1,995	372	724	654
OKLAHOMA	0	3	97	1	2	64
OREGON	39	64	494	48	.	.
PENNSYLVANIA	100	274	1,343	27	21	320
PUERTO RICO	1	687	438	224	3,018	3,193
RHODE ISLAND	49	133	733	140	10	12
SOUTH CAROLINA	18	71	538	48	644	99
SOUTH DAKOTA	26	31	109	20	22	10
TENNESSEE	277	884	1,365	494	1,159	990
TEXAS	1,060	1,300	4,979	160	1,021	1,415
UTAH	100	183	1,286	390	78	918
VERMONT	10	19	57	.	62	19
VIRGINIA	82	175	277	58	174	107
WASHINGTON	106	32	468	28	24	115
WEST VIRGINIA	372	462	1,021	382	573	122
WISCONSIN	251	160	1,242	192	249	356
WYOMING	6	93	246	101	83	72
AMERICAN SAMOA	2	1	35	2	25	25
GUAM	10	29	177	0	0	85
NORTHERN MARIANAS	8	4	29	2	17	0
PALAU	.	.	.	.	.	.
VIRGIN ISLANDS	2	102	142	7	19	9
U.S. AND OUTLYING AREAS	7,352	13,424	58,008	20,375	21,644	19,705
50 STATES, D.C. & P.R.	7,330	13,288	57,625	20,364	21,583	19,586

Please see data notes for an explanation of individual State differences.

October 3, 1996.

Table AH2

Early Intervention Services on IFSPs Provided to Infants, Toddlers, and Their Families in Accord with Part H December 1, 1994

STATE	NUTRITION SERVICES	OCCUPATIONAL THERAPY	PHYSICAL THERAPY	PSYCHOLOGICAL SERVICES	RESPITE CARE	SOCIAL WORK SERVICES
ALABAMA	425	815	1,014	72	0	583
ALASKA	89	117	132	5	39	37
ARIZONA	46	1,073	1,129	14	521	0
ARKANSAS	206	363	501	238	160	383
CALIFORNIA	207	3,250	2,150	927	5,290	53
COLORADO	192	1,635	1,591	1,204	426	2,023
CONNECTICUT	20	517	645	7	0	30
DELAWARE	826	237	272	215	84	421
DISTRICT OF COLUMBIA	144	90	95	4	0	161
FLORIDA	106	1,825	2,144	440	87	1,115
GEORGIA	137	1,114	1,268	116	654	277
HAWAII	380	480	491	189	416	803
IDAHO	186	280	140	374	99	590
ILLINOIS	389	820	871	479	222	1,182
INDIANA	1,393	1,100	1,204	95	134	1,725
IOWA	21	116	184	33	15	49
KANSAS	275	524	445	162	129	358
KENTUCKY	13	444	604	45	140	103
LOUISIANA	321	522	595	10	61	97
MAINE	0	145	224	0	0	34
MARYLAND	10	1,285	1,924	87	22	74
MASSACHUSETTS	397	828	795	462	0	1,063
MICHIGAN	284	907	909	133	110	988
MINNESOTA	.	.	.	.	.	.
MISSISSIPPI	50	94	109	58	10	90
MISSOURI	21	883	914	.	.	16
MONTANA	147	174	174	54	268	75
NEBRASKA	.	357	392	24	.	22
NEVADA	96	199	280	558	0	558
NEW HAMPSHIRE	13	773	543	4	27	107
NEW JERSEY	285	1,377	1,508	189	63	2,177
NEW MEXICO	497	650	744	109	392	473
NEW YORK	45	3,969	4,147	379	211	895
NORTH CAROLINA	880	851	2,053	229	456	832
NORTH DAKOTA	103	118	71	14	37	39
OHIO	698	1,568	1,570	94	205	755
OKLAHOMA	18	237	428	14	10	14
OREGON	.	325	372	2	.	35
PENNSYLVANIA	92	2,373	2,815	282	0	998
PUERTO RICO	617	332	543	336	0	1,146
RHODE ISLAND	67	177	360	53	43	85
SOUTH CAROLINA	470	205	293	8	15	41
SOUTH DAKOTA	52	164	192	2	7	24
TENNESSEE	872	745	1,308	260	64	1,435
TEXAS	1,468	3,515	3,243	361	492	2,220
UTAH	234	776	463	50	21	270
VERMONT	30	80	115	5	27	13
VIRGINIA	123	718	1,190	23	223	177
WASHINGTON	.	439	311	129	9	168
WEST VIRGINIA	157	369	685	555	72	801
WISCONSIN	253	1,735	1,555	66	.	751
WYOMING	69	201	193	27	49	110
AMERICAN SAMOA	9	12	9	0	0	0
GUAM	9	16	28	0	0	36
NORTHERN MARIANAS	7	24	7	0	0	0
PALAU	.	.	.	.	.	.
VIRGIN ISLANDS	60	38	71	2	0	17
U.S. AND OUTLYING AREAS	13,509	41,981	46,013	9,198	11,310	26,529
50 STATES, D.C. & P.R.	13,424	41,891	45,898	9,196	11,310	26,476

Please see data notes for an explanation of individual State differences.

October 3, 1996.

Table AH2

Early Intervention Services on IFSPs Provided to Infants, Toddlers, and Their Families in Accord with Part H December 1, 1994

STATE	SPECIAL INSTRUCTION	SPEECH LANGUAGE PATHOLOGY	TRANSPOR-TATION	VISION SERVICES	OTHER EARLY INTERVEN-TION SERVICES
ALABAMA	624	1,016	130	303	.
ALASKA	390	137	7	76	2
ARIZONA	1,390	1,072	166	22	42
ARKANSAS	723	816	485	225	190
CALIFORNIA	19,601	2,309	1,796	190	3,496
COLORADO	1,303	1,139	186	316	2,943
CONNECTICUT	759	571	42	71	172
DELAWARE	162	352	118	32	95
DISTRICT OF COLUMBIA	22	126	151	34	62
FLORIDA	538	1,902	862	27	5,846
GEORGIA	1,529	1,269	797	72	.
HAWAII	1,232	647	589	32	410
IDAHO	437	284	94	38	876
ILLINOIS	1,978	1,288	433	248	523
INDIANA	2,604	1,374	1,137	118	132
IOWA	1,001	113	14	16	27
KANSAS	900	890	237	165	171
KENTUCKY	760	775	137	130	895
LOUISIANA	1,401	455	97	226	586
MAINE	232	307	227	0	0
MARYLAND	2,187	1,861	656	128	136
MASSACHUSETTS	1,712	893	2,109	722	0
MICHIGAN	1,856	815	391	102	1,095
MINNESOTA	.	.	.	.	.
MISSISSIPPI	190	56	70	44	29
MISSOURI	850	1,037	278	59	.
MONTANA	66	198	47	75	482
NEBRASKA	417	441	88	7	40
NEVADA	728	273	1	26	.
NEW HAMPSHIRE	498	760	41	72	902
NEW JERSEY	2,651	2,096	337	141	27
NEW MEXICO	871	829	391	479	0
NEW YORK	6,658	7,566	4,109	164	.
NORTH CAROLINA	5,503	2,013	895	802	.
NORTH DAKOTA	148	148	8	96	35
OHIO	1,496	1,830	425	65	2,265
OKLAHOMA	325	504	4	2	89
OREGON	794	383	96	166	46
PENNSYLVANIA	4,254	3,226	908	292	6,121
PUERTO RICO	17	167	6	200	0
RHODE ISLAND	349	469	297	27	33
SOUTH CAROLINA	99	153	28	77	107
SOUTH DAKOTA	271	245	148	15	18
TENNESSEE	1,669	1,511	640	270	218
TEXAS	6,307	4,714	1,717	597	583
UTAH	801	569	357	101	25
VERMONT	236	128	17	13	.
VIRGINIA	1,166	934	176	105	128
WASHINGTON	608	459	72	17	215
WEST VIRGINIA	1,439	829	488	276	205
WISCONSIN	2,455	2,577	1,272	118	..
WYOMING	272	301	169	6	49
AMERICAN SAMOA	19	14	35	6	.
GUAM	31	37	15	5	1
NORTHERN MARIANAS	18	17	2	2	137
PALAU	.	.	.	.	.
VIRGIN ISLANDS	72	64	12	7	94
U.S. AND OUTLYING AREAS	84,619	54,959	24,010	7,625	29,548
50 STATES, D.C. & P.R.	84,479	54,827	23,946	7,605	29,316

Please see data notes for an explanation of individual State differences.

October 3, 1996.

Table AH3

Number and Type of Personnel Employed and Needed to Provide Early Intervention Services to Infants and Toddlers with Disabilities and Their Families December 1, 1994

STATE	ALL STAFF		AUDIOLOGISTS		FAMILY THERAPISTS	
	EMPLOYED	NEEDED	EMPLOYED	NEEDED	EMPLOYED	NEEDED
ALABAMA	138	65	1	1	0	1
ALASKA	102	54	2	.	0	.
ARIZONA	171	28	0	1	1	1
ARKANSAS	964	6	5	0	0	0
CALIFORNIA	2,693	.	1	.	2	.
COLORADO	66	8	1	0	0	1
CONNECTICUT	394	88	7	4	4	4
DELAWARE	221	11	2	0	0	0
DISTRICT OF COLUMBIA	133	26	1	2	0	2
FLORIDA	186	.	10	.	12	.
GEORGIA	516	228	11	7	8	9
HAWAII	489	112	2	0	2	2
IDAHO	125	143	0	6	0	.
ILLINOIS	512	150	5	1	7	3
INDIANA	642	204	2	3	21	7
IOWA	1,312	.	55	.	0	.
KANSAS	309	70	4	2	1	6
KENTUCKY	276	103	8	3	1	4
LOUISIANA	281	75	1	1	2	2
MAINE	400	.	50	.	10	.
MARYLAND	343	6	6	.	0	.
MASSACHUSETTS	862	949	0	0	0	0
MICHIGAN	648	2	8	.	12	.
MINNESOTA	1,171	.	5	.	25	.
MISSISSIPPI	126	52	5	0	18	9
MISSOURI	173	.	1	.	.	.
MONTANA	79	2	0	0	5	0
NEBRASKA	180	1	1	0	0	0
NEVADA	72	2	1	.	.	.
NEW HAMPSHIRE	96	2	0	.	0	.
NEW JERSEY	286	19	0	0	0	0
NEW MEXICO	224	9	3	1	4	.
NEW YORK	8,552	960	123	16	.	.
NORTH CAROLINA	1,097	221	4	2	16	14
NORTH DAKOTA	28	4	0	0	0	0
OHIO	2,141	.	9	.	30	.
OKLAHOMA	144	30	2	0	0	0
OREGON	121	14	1	0	5	0
PENNSYLVANIA	1,077	111	4	1	4	1
PUERTO RICO	62	44	1	0	0	0
RHODE ISLAND	55	28	0	0	1	1
SOUTH CAROLINA	190	.	1	.	0	.
SOUTH DAKOTA	68	16	1	1	2	1
TENNESSEE	723	85	13	0	5	1
TEXAS	1,200	106	5	0	2	0
UTAH	106	13	0	0	8	1
VERMONT	40	11	0	0	0	0
VIRGINIA	440	65	4	1	6	0
WASHINGTON	189	.	11	.	4	.
WEST VIRGINIA	273	28	1	0	4	0
WISCONSIN	404	.	.	.	.	.
WYOMING	134	100	2	1	0	0
AMERICAN SAMOA	36	.	1	.	1	.
GUAM	17	2	1	0	.	.
NORTHERN MARIANAS	10	2	0	0	0	0
PALAU	.	.	.	.	.	.
VIRGIN ISLANDS	8	0	1	0	0	0
U.S. AND OUTLYING AREAS	31,306	4,254	382	54	223	70
50 STATES, D.C. & P.R.	31,235	4,249	379	54	222	69

The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the personnel categories because some States could not provide personnel data by category.

The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the individual States and Outlying Areas because of rounding.

Please see data notes for an explanation of individual State differences.

October 3, 1996.

Table AH3

Number and Type of Personnel Employed and Needed to Provide Early Intervention Services to Infants and Toddlers with Disabilities and Their Families December 1, 1994

STATE	NURSES		NUTRITIONISTS		OCCUPATIONAL THERAPISTS	
	EMPLOYED	NEEDED	EMPLOYED	NEEDED	EMPLOYED	NEEDED
ALABAMA	4	3	1	1	6	9
ALASKA	1	.	0	.	12	12
ARIZONA	3	1	0	0	15	2
ARKANSAS	25	0	6	0	73	2
CALIFORNIA	19	.	2	.	0	.
COLORADO	1	0	0	0	10	1
CONNECTICUT	15	1	1	0	35	24
DELAWARE	79	3	5	0	16	0
DISTRICT OF COLUMBIA	44	1	4	1	10	2
FLORIDA	33	.	1	.	1	.
GEORGIA	33	13	11	4	53	24
HAWAII	105	16	2	0	13	4
IDAHO	10	12	1	5	9	19
ILLINOIS	37	8	2	2	36	11
INDIANA	35	4	8	3	40	12
IOWA	20	.	1	.	54	.
KANSAS	22	3	9	1	19	7
KENTUCKY	27	3	6	2	17	13
LOUISIANA	1	3	0	2	11	11
MAINE	55	.	6	.	16	.
MARYLAND	26	.	0	.	23	.
MASSACHUSETTS	74	81	10	11	88	97
MICHIGAN	55	.	2	1	60	.
MINNESOTA	.	.	15	.	19	.
MISSISSIPPI	5	0	3	1	6	4
MISSOURI	4	.	0	.	22	.
MONTANA	3	0	0	0	5	0
NEBRASKA	0	0	0	0	4	0
NEVADA	1	.	3	.	3	.
NEW HAMPSHIRE	1	.	0	.	18	.
NEW JERSEY	35	7	0	0	25	3
NEW MEXICO	9	.	3	.	16	3
NEW YORK	1,412	60	101	19	861	141
NORTH CAROLINA	122	52	41	6	39	10
NORTH DAKOTA	1	0	0	0	5	1
OHIO	408	.	22	.	32	.
OKLAHOMA	9	2	0	0	10	9
OREGON	2	1	0	0	9	0
PENNSYLVANIA	22	2	1	0	85	14
PUERTO RICO	17	2	2	1	2	4
RHODE ISLAND	5	1	0	1	2	4
SOUTH CAROLINA	14	.	1	.	2	.
SOUTH DAKOTA	6	3	1	0	5	4
TENNESSEE	106	15	5	1	21	5
TEXAS	65	5	6	1	81	8
UTAH	19	1	0	0	3	3
VERMONT	4	0	2	1	3	2
VIRGINIA	29	8	9	2	28	10
WASHINGTON	15	.	1	.	32	.
WEST VIRGINIA	7	3	1	1	9	2
WISCONSIN	13	.	.	.	69	.
WYOMING	10	5	2	3	11	8
AMERICAN SAMOA	2	.	2	.	1	.
GUAM	3	1	0	0	0	0
NORTHERN MARIANAS	0	0	0	0	1	0
PALAU	.	.	.	.	.	.
VIRGIN ISLANDS	2	0	0	0	0	0
U.S. AND OUTLYING AREAS	3,075	318	300	70	2,043	485
50 STATES, D.C. & P.R.	3,068	316	297	70	2,040	485

The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the personnel categories because some States could not provide personnel data by category.

The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the individual States and Outlying Areas because of rounding.

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October 3, 1996.

Table AH3

Number and Type of Personnel Employed and Needed to Provide Early Intervention Services to Infants and Toddlers with Disabilities and Their Families December 1, 1994

STATE	ORIENTATION AND MOBILITY SPECIALISTS EMPLOYED	ORIENTATION AND MOBILITY SPECIALISTS NEEDED	PARAPROFESSIONALS EMPLOYED	PARAPROFESSIONALS NEEDED	PEDIATRICIANS EMPLOYED	PEDIATRICIANS NEEDED
ALABAMA	0	1	43	6	0	0
ALASKA	12	10	8	10	0	.
ARIZONA	0	1	27	3	0	1
ARKANSAS	1	0	380	1	1	0
CALIFORNIA	0	.	905	.	.	.
COLORADO	0	0	14	1	0	0
CONNECTICUT	0	0	24	7	0	0
DELAWARE	0	0	14	0	15	1
DISTRICT OF COLUMBIA	1	1	24	1	5	1
FLORIDA	0	.	10	.	10	.
GEORGIA	4	7	101	22	23	25
HAWAII	0	0	181	41	1	0
IDAHO	0	.	22	22	1	.
ILLINOIS	1	0	54	10	15	2
INDIANA	4	4	124	19	8	6
IOWA	1	.	0	.	0	.
KANSAS	0	2	67	12	6	3
KENTUCKY	2	7	8	2	11	1
LOUISIANA	0	1	46	5	0	0
MAINE	2	.	26	.	14	.
MARYLAND	2	.	34	.	2	.
MASSACHUSETTS	0	0	90	99	1	1
MICHIGAN	1	.	35	.	3	.
MINNESOTA	.	.	510	.	.	.
MISSISSIPPI	10	9	5	1	0	0
MISSOURI	.	.	.	.	1	.
MONTANA	0	0	9	1	0	0
NEBRASKA	0	0	68	0	0	0
NEVADA	1	.	8	.	2	0
NEW HAMPSHIRE	0	.	17	.	0	.
NEW JERSEY	0	0	24	1	1	0
NEW MEXICO	0	.	42	2	3	.
NEW YORK	23	8	365	78	.	.
NORTH CAROLINA	1	3	169	14	21	3
NORTH DAKOTA	0	0	1	0	0	0
OHIO	0	.	151	.	0	.
OKLAHOMA	0	0	0	0	0	0
OREGON	0	0	22	4	0	0
PENNSYLVANIA	6	2	130	12	1	0
PUERTO RICO	0	0	21	21	4	0
RHODE ISLAND	0	0	15	0	0	0
SOUTH CAROLINA	0	.	26	.	1	.
SOUTH DAKOTA	0	1	15	0	1	1
TENNESSEE	2	0	137	9	8	1
TEXAS	1	0	277	28	6	0
UTAH	0	0	23	1	0	0
VERMONT	0	0	0	0	0	0
VIRGINIA	3	1	49	4	7	1
WASHINGTON	0	.	15	.	8	.
WEST VIRGINIA	0	0	55	5	2	0
WISCONSIN	.	.	76	.	.	.
WYOMING	9	7	10	14	0	0
AMERICAN SAMOA	0	.	1	.	4	.
GUAM	.	.	2	0	.	.
NORTHERN MARIANAS	0	0	6	0	0	0
PALAU	.	.	.	.	.	.
VIRGIN ISLANDS	0	0	0	0	0	0
U.S. AND OUTLYING AREAS	86	65	4,486	453	188	48
50 STATES, D.C. & P.R.	86	65	4,477	453	184	48

The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the personnel categories because some States could not provide personnel data by category.

The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the individual States and Outlying Areas because of rounding.

Please see data notes for an explanation of individual State differences.
October 3, 1996.

Table AH3

Number and Type of Personnel Employed and Needed to Provide Early Intervention Services to Infants and Toddlers with Disabilities and Their Families December 1, 1994

STATE	PHYSICAL THERAPISTS		PHYSICIANS, OTHER THAN PEDIATRICIANS		PSYCHOLOGISTS	
	EMPLOYED	NEEDED	EMPLOYED	NEEDED	EMPLOYED	NEEDED
ALABAMA	8	8	0	0	2	1
ALASKA	9	.	0	.	0	.
ARIZONA	16	2	0	1	2	1
ARKANSAS	107	1	7	0	1	0
CALIFORNIA	0	.	9	.	23	.
COLORADO	3	1	0	0	2	1
CONNECTICUT	52	23	1	0	4	1
DELAWARE	25	2	0	0	4	1
DISTRICT OF COLUMBIA	9	2	0	1	1	2
FLORIDA	4	.	1	.	20	.
GEORGIA	50	23	19	19	13	9
HAWAII	8	4	0	0	2	0
IDAHO	3	26	1	.	4	6
ILLINOIS	34	13	0	0	6	3
INDIANA	49	19	19	3	3	3
IOWA	35	.	0	.	324	.
KANSAS	23	8	4	3	9	1
KENTUCKY	34	16	1	4	3	2
LOUISIANA	8	9	4	0	6	2
MAINE	28	.	7	.	0	.
MARYLAND	29	0	0	.	7	.
MASSACHUSETTS	85	94	0	0	49	54
MICHIGAN	50	.	9	.	19	.
MINNESOTA	85	.	.	.	18	.
MISSISSIPPI	6	6	0	0	4	2
MISSOURI	23	.	2	.	.	.
MONTANA	4	0	0	0	0	0
NEBRASKA	4	1	0	0	0	0
NEVADA	4	.	.	.	5	0
NEW HAMPSHIRE	12	.	0	.	2	1
NEW JERSEY	27	2	0	0	4	0
NEW MEXICO	13	2	2	.	2	.
NEW YORK	938	127	270	14	488	74
NORTH CAROLINA	31	7	5	1	58	6
NORTH DAKOTA	0	1	0	0	0	0
OHIO	43	.	0	.	86	.
OKLAHOMA	20	5	0	0	4	0
OREGON	7	1	0	0	1	0
PENNSYLVANIA	85	12	1	0	11	2
PUERTO RICO	2	4	0	0	2	1
RHODE ISLAND	5	6	0	0	2	0
SOUTH CAROLINA	2	.	0	.	0	.
SOUTH DAKOTA	5	4	1	0	0	1
TENNESSEE	39	11	19	2	4	7
TEXAS	58	7	0	0	3	0
UTAH	5	0	0	0	0	0
VERMONT	4	2	0	0	1	1
VIRGINIA	44	10	2	0	5	1
WASHINGTON	12	.	5	.	2	.
WEST VIRGINIA	14	4	1	0	5	1
WISCONSIN	58	.	.	.	.	.
WYOMING	0	0	4	2	3	4
AMERICAN SAMOA	2	.	3	.	1	.
GUAM	1	0	.	.	1	0
NORTHERN MARIANAS	0	1	0	0	0	0
PALAU	.	.	.	.	.	.
VIRGIN ISLANDS	2	0	0	0	0	0
U.S. AND OUTLYING AREAS	2,222	462	395	51	1,216	189
50 STATES, D.C. & P.R.	2,216	462	392	51	1,214	189

The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the personnel categories because some States could not provide personnel data by category.

The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the individual States and Outlying Areas because of rounding.

Please see data notes for an explanation of individual State differences.
October 3, 1996.

Table AH3

Number and Type of Personnel Employed and Needed to Provide Early Intervention Services to Infants and Toddlers with Disabilities and Their Families December 1, 1994

STATE	----SOCIAL WORKERS---- EMPLOYED	NEEDED	--SPECIAL EDUCATORS--- EMPLOYED	NEEDED	SPEECH AND LANGUAGE -----PATHOLOGISTS----- EMPLOYED	NEEDED
ALABAMA	12	8	39	11	9	11
ALASKA	4	.	30	10	12	12
ARIZONA	12	1	32	0	22	3
ARKANSAS	10	0	97	0	156	2
CALIFORNIA	2	.	1,423	.	0	.
COLORADO	2	1	19	0	9	2
CONNECTICUT	16	3	131	4	51	16
DELAWARE	17	3	13	0	21	0
DISTRICT OF COLUMBIA	7	3	10	2	11	3
FLORIDA	29	.	11	.	7	.
GEORGIA	36	13	70	23	59	23
HAWAII	41	15	29	7	11	7
IDAHO	12	3	30	28	12	17
ILLINOIS	30	13	158	32	49	16
INDIANA	50	16	168	16	47	16
IOWA	280	.	91	.	450	.
KANSAS	17	5	78	7	35	8
KENTUCKY	19	1	61	27	53	14
LOUISIANA	13	7	141	15	17	12
MAINE	40	.	15	.	46	.
MARYLAND	28	1	135	5	51	.
MASSACHUSETTS	113	124	182	200	95	105
MICHIGAN	62	.	182	.	74	1
MINNESOTA	200	.	100	.	182	.
MISSISSIPPI	10	6	30	7	13	8
MISSOURI	0	.	57	.	26	.
MONTANA	1	0	1	0	5	0
NEBRASKA	0	0	79	0	24	0
NEVADA	6	.	24	.	10	1
NEW HAMPSHIRE	1	1	22	1	20	.
NEW JERSEY	49	3	72	1	48	1
NEW MEXICO	14	.	27	1	23	1
NEW YORK	836	97	1,930	131	1,205	197
NORTH CAROLINA	126	34	208	19	70	13
NORTH DAKOTA	2	0	8	3	5	0
OHIO	264	.	782	.	156	.
OKLAHOMA	0	0	8	0	37	11
OREGON	1	1	38	4	17	1
PENNSYLVANIA	43	9	368	21	120	20
PUERTO RICO	3	5	0	0	5	3
RHODE ISLAND	3	6	11	4	5	5
SOUTH CAROLINA	1	.	139	.	5	.
SOUTH DAKOTA	1	0	13	1	8	1
TENNESSEE	50	3	111	2	60	17
TEXAS	87	3	123	11	110	19
UTAH	2	1	17	3	8	3
VERMONT	2	1	11	2	5	2
VIRGINIA	57	2	71	9	52	9
WASHINGTON	9	.	45	.	20	.
WEST VIRGINIA	39	3	83	1	24	6
WISCONSIN	.	.	95	.	94	.
WYOMING	10	4	37	20	25	20
AMERICAN SAMOA	3	.	9	.	2	.
GUAM	3	1	2	0	2	0
NORTHERN MARIANAS	1	0	1	0	0	1
PALAU	.	.	.	.	.	.
VIRGIN ISLANDS	0	0	1	0	1	0
U.S. AND OUTLYING AREAS	2,674	394	7,662	628	3,682	604
50 STATES, D.C. & P.R.	2,667	393	7,649	628	3,677	603

The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the personnel categories because some States could not provide personnel data by category.

The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the individual States and Outlying Areas because of rounding.

Please see data notes for an explanation of individual State differences.
October 3, 1996.

Table AH3

Number and Type of Personnel Employed and Needed to Provide Early Intervention Services to Infants and Toddlers with Disabilities and Their Families December 1, 1994

STATE	OTHER --PROFESSIONAL STAFF-- EMPLOYED	NEEDED
ALABAMA	14	4
ALASKA	11	.
ARIZONA	42	11
ARKANSAS	98	0
CALIFORNIA	306	.
COLORADO	6	1
CONNECTICUT	54	0
DELAWARE	10	1
DISTRICT OF COLUMBIA	8	3
FLORIDA	37	.
GEORGIA	26	8
HAWAII	94	14
IDAHO	20	0
ILLINOIS	77	36
INDIANA	64	73
IOWA	.	.
KANSAS	15	2
KENTUCKY	24	4
LOUISIANA	33	7
MAINE	85	.
MARYLAND	0	.
MASSACHUSETTS	75	83
MICHIGAN	74	0
MINNESOTA	12	.
MISSISSIPPI	12	0
MISSOURI	38	.
MONTANA	44	0
NEBRASKA	0	0
NEVADA	4	.
NEW HAMPSHIRE	3	.
NEW JERSEY	0	0
NEW MEXICO	63	.
NEW YORK	0	0
NORTH CAROLINA	188	36
NORTH DAKOTA	6	0
OHIO	158	.
OKLAHOMA	54	3
OREGON	19	1
PENNSYLVANIA	196	14
PUERTO RICO	3	3
RHODE ISLAND	6	1
SOUTH CAROLINA	0	.
SOUTH DAKOTA	10	0
TENNESSEE	144	10
TEXAS	378	25
UTAH	22	1
VERMONT	9	1
VIRGINIA	73	8
WASHINGTON	10	.
WEST VIRGINIA	28	3
WISCONSIN	.	.
WYOMING	13	12
AMERICAN SAMOA	4	.
GUAM	2	0
NORTHERN MARIANAS	0	0
PALAU	.	.
VIRGIN ISLANDS	1	0
U.S. AND OUTLYING AREAS	2,672	364
50 STATES, D.C. & P.R.	2,665	364

The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the personnel categories because some States could not provide personnel data by category.

The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the individual States and Outlying Areas because of rounding.

Please see data notes for an explanation of individual State differences.
October 3, 1996.

Table AH4

Number of Infants and Toddlers Birth Through Age 2 Served in Different Early Intervention Settings Under Part H December 1, 1994

STATE	EARLY INTERVENTION CLASSROOM	FAMILY CHILD CARE	HOME	HOSPITAL (INPATIENT)	OUTPATIENT SERVICE FACILITY
ALABAMA	223	11	224	5	325
ALASKA	17	2	358	.	1
ARIZONA	489	24	1,047	0	51
ARKANSAS	666	18	609	7	244
CALIFORNIA	10,594	.	10,537	.	.
COLORADO	692	3	378	1,129	454
CONNECTICUT	190	8	1,240	2	120
DELAWARE	554	4	1,370	2	2,769
DISTRICT OF COLUMBIA	133	0	1	38	32
FLORIDA	720	8	2,656	551	2,808
GEORGIA	589	71	1,074	8	1,176
HAWAII	305	6	3,291	12	138
IDAHO	318	1	507	5	30
ILLINOIS	3,005	49	3,872	0	26
INDIANA	1,352	104	2,148	62	377
IOWA	81	7	438	.	17
KANSAS	249	35	741	6	108
KENTUCKY	451	0	530	27	253
LOUISIANA	386	16	1,438	19	515
MAINE	0	0	395	21	27
MARYLAND	1,497	35	1,663	6	486
MASSACHUSETTS	.	.	8,114	.	.
MICHIGAN	966	18	2,109	30	49
MINNESOTA	.	.	.	.	.
MISSISSIPPI	124	0	149	0	26
MISSOURI	443	8	1,114	4	291
MONTANA	2	0	454	5	14
NEBRASKA	250	.	462	11	4
NEVADA	408	.	314	2	1
NEW HAMPSHIRE	134	16	616	0	0
NEW JERSEY	2,229	18	416	7	207
NEW MEXICO	275	7	1,051	19	39
NEW YORK	4,405	57	4,542	20	217
NORTH CAROLINA	935	127	3,455	0	25
NORTH DAKOTA	0	10	194	0	5
OHIO	2,935	5	3,065	45	177
OKLAHOMA	64	16	1,321	26	130
OREGON	207	18	634	3	13
PENNSYLVANIA	2,679	7	3,508	187	211
PUERTO RICO	.	.	.	.	4,183
RHODE ISLAND	218	14	684	0	4
SOUTH CAROLINA	50	4	1,058	15	378
SOUTH DAKOTA	108	6	190	1	42
TENNESSEE	849	11	640	84	1,409
TEXAS	3,891	124	4,645	11	36
UTAH	505	17	997	0	0
VERMONT	11	10	257	0	19
VIRGINIA	563	16	1,105	5	377
WASHINGTON	497	9	305	3	38
WEST VIRGINIA	325	12	999	1	162
WISCONSIN	1,510	37	1,181	11	494
WYOMING	84	11	188	8	8
AMERICAN SAMOA	15	.	.	4	9
GUAM	27	2	101	44	0
NORTHERN MARIANAS	0	0	31	0	0
PALAU	.	.	.	.	.
VIRGIN ISLANDS	.	.	.	.	.
U.S. AND OUTLYING AREAS	47,220	982	78,416	2,446	18,525
50 STATES, D.C. & P.R.	47,178	980	78,284	2,398	18,516

The sum of the individual age-year data may no equal total settings data because some States could not provide age-year data.

Please see data notes for an explanation of individual State differences.

October 1, 1996.

Table AH4

Number of Infants and Toddlers Birth Through Age 2 Served in Different Early Intervention Settings Under Part H
December 1, 1994

STATE	REGULAR NURSERY SCHOOL/ CHILD CARE	RESIDENTIAL FACILITY	OTHER SETTING	ALL SETTINGS
ALABAMA	43	5	.	836
ALASKA	3	2	7	390
ARIZONA	21	3	140	1,775
ARKANSAS	97	1	.	1,642
CALIFORNIA	.	.	.	21,131
COLORADO	16	0	787	3,459
CONNECTICUT	89	0	254	1,903
DELAWARE	47	3	210	4,959
DISTRICT OF COLUMBIA	0	0	0	204
FLORIDA	189	10	173	7,115
GEORGIA	236	1	84	3,239
HAWAII	3	0	128	3,883
IDAHO	3	0	5	869
ILLINOIS	94	8	883	7,937
INDIANA	107	13	32	4,195
IOWA	18	.	.	561
KANSAS	45	.	34	1,218
KENTUCKY	47	0	6	1,314
LOUISIANA	44	1	214	2,633
MAINE	228	0	9	680
MARYLAND	32	0	75	3,794
MASSACHUSETTS	.	.	.	8,114
MICHIGAN	7	1	418	3,598
MINNESOTA	.	.	.	.
MISSISSIPPI	6	0	22	327
MISSOURI	25	.	401	2,286
MONTANA	6	0	1	482
NEBRASKA	10	.	.	737
NEVADA	3	.	.	728
NEW HAMPSHIRE	16	0	8	790
NEW JERSEY	42	18	91	3,028
NEW MEXICO	7	2	80	1,480
NEW YORK	190	12	18	9,461
NORTH CAROLINA	1,398	0	57	5,997
NORTH DAKOTA	1	0	0	210
OHIO	16	6	269	6,518
OKLAHOMA	24	3	103	1,687
OREGON	40	12	82	1,009
PENNSYLVANIA	84	9	24	6,709
PUERTO RICO	.	.	.	4,183
RHODE ISLAND	66	0	0	986
SOUTH CAROLINA	18	0	68	1,591
SOUTH DAKOTA	8	2	2	359
TENNESSEE	87	0	76	3,156
TEXAS	672	6	67	9,452
UTAH	41	0	0	1,560
VERMONT	16	0	1	314
VIRGINIA	11	0	9	2,086
WASHINGTON	11	0	5	868
WEST VIRGINIA	35	3	1	1,538
WISCONSIN	78	1	9	3,321
WYOMING	19	0	8	326
AMERICAN SAMOA	0	0	7	35
GUAM	3	0	0	177
NORTHERN MARIANAS	0	0	0	31
PALAU	.	.	.	.
VIRGIN ISLANDS	.	.	.	.
U.S. AND OUTLYING AREAS	4,302	122	4,868	156,881
50 STATES, D.C. & P.R.	4,299	122	4,861	156,638

The sum of the individual age-year data may no equal total settings data because some States could not provide age-year data.

Please see data notes for an explanation of individual State differences.

October 1, 1996.

Evaluation Studies Program Summary

AN EVALUATION OF FAMILY-CENTERED COORDINATED PART H SERVICES IN NORTH CAROLINA

North Carolina Department of Human Resources, FY 1992

The Policy Context

Part H of P.L. 99-457 emphasizes the importance of using family-centered practices in delivering services to infants and toddlers with disabilities and their families. The legislation states that families should be more involved in the actual interventions, services should be more responsive to the whole family's concerns, and families should be empowered to have control of decision making. Part H of P.L. 99-457 also encourages interagency coordination as a way of remedying the fragmentation and lack of coordination in the system of service delivery to infants and toddlers and their families. This research project, conducted jointly by the North Carolina Department of Human Resources and the Frank Porter Graham Child Development Center at the University of North Carolina at Chapel Hill, consisted of two separate studies, each designed to address one of these two central aspects of the implementation of Part H in North Carolina.

The Family-Centered Service Study

The purpose of the family-centered study, composed of three related substudies, was to investigate family-centered practices in North Carolina. The first substudy measured families' and service providers' perceptions of the actual and ideal extent of family-centeredness of services. Two versions of the Family Orientation of Community and Agency Services (FOCAS) and Brass Tacks instruments were administered to 198 professionals (76 percent response rate) and 118 members of families receiving Part H services (43 percent response rate). Results showed that both professionals and families rated current Part H services as quite highly family-centered but not ideally so. The three best predictors of a high family-centered rating among professionals were: having no more than a bachelor's degree, working for a Mental Health/Development Disabilities/Substance Abuse Services program, and providing home-based (as opposed to center-based) services. For families, only experience with early intervention services predicted a high family-centeredness rating.

In the second substudy, telephone interviews were carried out with a subset of 20 families and 20 service providers from the first substudy (10 each with high and low family-centeredness ratings). These more open-ended interviews explored the respondents' views of family centeredness and experiences with the service

delivery system. Results suggest that families were sometimes "uninformed consumers" satisfied with services that could have been more family-centered. Families felt they had significant input in developing the Individual Family Service Plans (IFSPs) and valued professionals' personal characteristics but did not feel involved in the assessment of their child. Service providers believed in a family-centered approach, especially valued families that liked them, and felt interagency collaboration had enhanced their abilities to provide family-centered services. These professionals reported paperwork, lack of specialized services, the IFSP process, and families who appeared not to want services as barriers to effective service provision.

The third substudy developed and applied a family-centeredness rating scale to 100 IFSPs, 25 each from inclusive center-based programs, self-contained center-based programs, home-based early intervention programs, and health department home-based service coordination programs. Differences were found between center-based programs and the others on cohesion (a dimension including strategies matching outcomes, family's role, and lack of judgmentalism), and between home-based health programs and the others on functionality (necessity, context appropriateness, and active voice). Across all program types, IFSPs contained overwhelmingly more child-related than family-related goals.

The Interagency Service Coordination Study

This study examined three aspects of interagency coordination in North Carolina: (1) facilitators and barriers to coordination, (2) the functioning level of the Local Interagency Coordinating Councils (LICCs), and (3) written interagency agreements developed at the local level. A three-part research strategy combined a mail survey of 231 respondents, focus groups with 36 interagency professionals in three regions of the State, and analysis of local interagency documents.

Mail survey responses indicated people as the strongest facilitators of interagency coordination and resources and policies as the biggest barriers. These findings were supported in the focus groups, which also found some of the same barriers across the three regions of the State but found others particular to specific regions. Attention was focused on the following policy areas: eligibility and assessment, the respective roles of the LICCs and local consortia, lack of local administrative support, lack of common focus across agencies, and cross-agency staff training. On the level of functioning of the LICCs, survey findings and focus group results indicated that many LICCs have managed to complete the first two stages in a 4-stage developmental model, but some are still in the first stage. Few agencies provided documents broad enough to be considered true interagency agreements. The overall mean ranking of interagency coordination across all

counties, on a scale of 1-10 (with 1 representing no coordination and 10 indicating total coordination), was 6.38.

Recommendations From Both Studies

Recommendations based on the family-centered study findings included: reducing paperwork, providing training in strategies for collaborative decision making with families, training early intervention personnel to write high-quality IFSPs, and educating families to be better informed consumers. The interagency coordination study generated recommendations for improved staff training and technical assistance; policy revisions; sponsoring additional special activities, forums, studies and task forces; and developing systematic procedures to guide the development of local interagency agreements.

Information Specific to the Part B Preschool Grants Program
(Section 619 of Part B of IDEA)

Children Served Under IDEA, Part B Preschool Grants Program

The Preschool Grants Program, authorized under Section 619 of IDEA, Part B, was established to provide grants to States to serve young children with disabilities. All States and Outlying Areas have participated in the program since FY 1992.

Over the years, the preschool special education programs administered by those States have evolved, and now many States are involved in a variety of education reform efforts. Many of the efforts at the preschool level have focused on increasing collaboration between regular and special education agencies, revising funding policies, establishing transition agreements between agencies serving infants and toddlers birth through 2 years old with disabilities, and developing programmatic guidelines and policies. In many cases, these changes have influenced settings in which eligible children are served.

The following sections will highlight several key aspects of the Preschool Grants Program, including:

(1) Grant Awards for the Preschool Grants Program;

(2) Number of Preschoolers with Disabilities Served;

(3) Current Educational Reform Efforts; and

(4) Educational Placements of Preschoolers with Disabilities.

Grant Awards for the Preschool Grants Program

States and Outlying Areas are awarded Preschool Grants Program funds based on the number of 3- through 5-year-

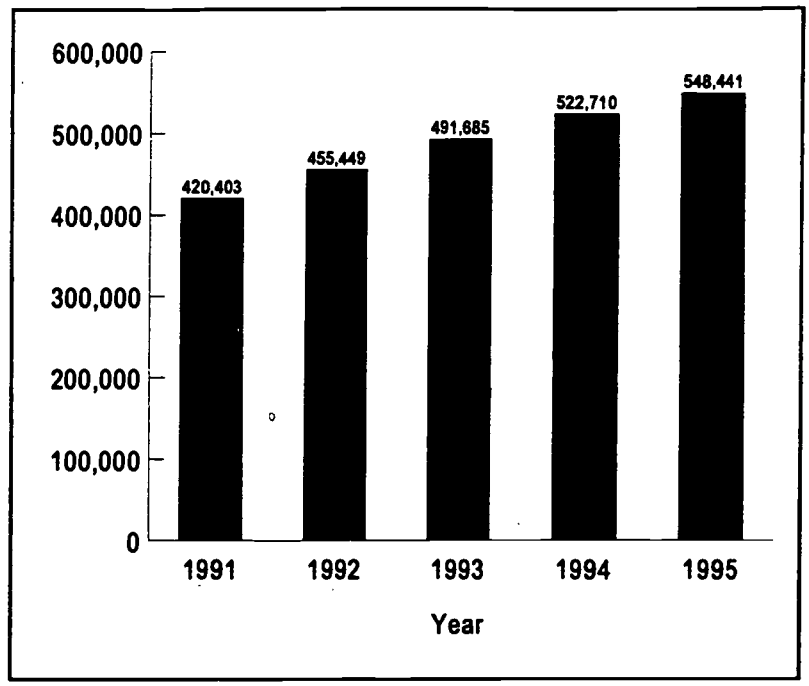
old children with disabilities served on December 1 of the previous year. In FY 1996, Congress appropriated $360,409,000, only slightly more than the $360,265,000 appropriated in FY 1995. However, the number of children served increased 4.9 percent, from 522,710 on December 1, 1994, to 548,441 on December 1, 1995. Grant awards made to each State in FY 1996 are shown in table AG1 in Appendix A.

States and Outlying Areas may set aside up to 20 percent of their Section 619 set-aside funds for the planning and development of a statewide comprehensive service delivery system for children with disabilities from birth through age 5 years; for the provision of direct and support services for children with disabilities ages 3 through 5 years; and at the State's discretion, for the provision of a free appropriate public education (FAPE) to 2-year-old children with disabilities who will reach age 3 during the school year. According to the 1996 *Section 619 Profile*, 20 States have retained the full 20 percent for this purpose. The most common uses of these funds were training activities, technical assistance, development of program materials, and planning or coordination activities. An additional 5 percent of Section 619 funds can be retained for administrative use. Among the 47 States that answered this survey question, 37 set aside the full 5 percent for this purpose, and two States reported using 0 percent. The remaining States reported using 4 percent (3 States), 3 percent (2 States), 2 percent (0 States), and 1 percent (3 States).

Number of Preschoolers with Disabilities Served

The Preschool Grants Program continues to grow. The growth in the number of preschool children (30 percent from 1991-92 to 1995-96) (see figure II-2) who received special education services under IDEA exceeded the growth in the general preschool population (8.3 percent from 1991-92 to 1995-96). This relationship is demonstrated in the increase in the percentage of preschool children served

Figure II-2
Number of Children Ages 3-5 Served on December 1, 1991, Through December 1, 1995



Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

under IDEA of the general population from 3.8 percent to 4.5 percent over this period.

The total percentage of the resident population ages 3-5 served under the program within each State continues to vary greatly (see table AA10 in Appendix A). Kentucky serves the highest percentage (9.2 percent), while the District of Columbia serves the lowest (1.6 percent). However, 41 States are serving 3 to 6 percent of their resident ages 3-5 population.

Current Educational Reform Efforts

Many States apply the general educational reform efforts that are made within their States to programs that serve children ages 3-5 with disabilities. According to the *Section 619 Profile (Seventh Edition)*, 18 States have revised their Section 619 programs to reflect some of the general education reform efforts. These States have made changes in the following areas:

- administrative organization;
- collaborative statements with other agencies;
- guidelines;
- outcome assessments;
- preschool special education criteria/classification;
- program evaluation procedures;
- program standards; and
- vision and goal-setting statements.

This section will highlight some of the reforms that have taken place in Rhode Island, Kentucky, and Minnesota. Telephone interviews were conducted with the Section 619 coordinators of these States. These States were chosen because of the innovative changes to their programs that serve eligible preschoolers. All three have promoted collaborative arrangements among agencies that serve children and families.

In Kentucky, local districts collaborate with other agencies in several ways. First, duplication of programs and services to the same children is avoided through careful planning. This entails allowing local agencies to operate the preschool program through contractual agreements with Head Start and other existing preschool programs. Second, blended or shared classrooms in which the children in a room are financially supported through several funding sources and agencies (such as the State, Head Start, Chapter 1, private tuition, or other sources) are encouraged. In a blended classroom, costs are shared, but separate audit trails are maintained for each source. The classroom must meet the operating requirements of each funding source, and children must receive all services for which they are eligible. Third, local agencies work with

child care providers and local family resource centers to assist in the coordination of before- and after-school child care. Fourth, collaborative agreements with medical, health, mental health, and social service agencies are fostered to meet the comprehensive needs of children and families. In 1994-95, 62 percent of the districts operated State-funded services in a collaborative arrangement with an outside agency. As a result of these efforts, 90 percent of children ages 3-5 were served in regular classes, 5 percent in resource rooms, and 2 percent in separate classes during the 1994-95 school year.

Similarly, in Rhode Island, preschool special education programs have been blended into general early childhood programs. A shared vision statement was developed by early childhood special educators and regular early childhood educators. All professional training is now done jointly, including summer institutes on inclusion practices and professional development in-service training. Curriculum planning, which has a strong emphasis on family involvement and assessments and evaluations, is also conducted jointly. During the 1994-95 school year, 93 percent of the preschool students were served in either regular classes, resource rooms, or separate classes. Among the 93 percent, 48 percent were served in regular classes.

In 1995, Minnesota unified services from a variety of programs that were previously handled by six separate State agencies for children and their families into one State agency called the Department of Children, Family, and Learning. Prior to that time, the Department of Education was the lead agency. The other five agencies that joined this collaborative effort were (1) the Department of Human Services, (2) the Department of Economic Security, (3) Minnesota Planning, (4) the Department of Corrections, and (5) the Department of Public Safety. Doing so allows the agency greater flexibility in using funding sources and promotes collaboration among previously separate entities. The new agency seeks to develop public policies that recognize that children's economic, psychological, and educational needs are inseparable.

Educational Placements of Preschoolers with Disabilities

OSEP collects data on preschoolers with disabilities who are served in each of eight different placements: regular class, resource room, separate class, separate school (public and private), residential facility (public and private), and homebound/hospital. Because these placement categories may not reflect all of the placement categories specific to preschoolers, OSEP provides optional instructions to States and Outlying Areas about reporting counts of preschoolers in each of the placement categories. Table II-2 includes a definition of each placement category as it applies to preschoolers with disabilities.

As shown in figure II-3, just over 50 percent of children ages 3-5 with disabilities were served in regular class placements on December 1, 1995. This is a 2 percent increase over the percentage served on December 1, 1994. The second most frequently used setting was separate class placement, followed by resource room. The percentage of children served in these two settings has remained fairly stable from December 1, 1994, to December 1, 1995. The use of separate facilities, both public and private, has declined (from 8.92 percent on December 1, 1994, to 5.5 percent on December 1, 1995), while the use of residential facilities has remained stable (0.3 percent to 0.2 percent) and the use of home/hospital placements rose slightly (1.9 percent to 2.6 percent).

Table II-2
Educational Environments for Preschoolers with Disabilities

Regular class includes children who receive services in programs designed primarily for nondisabled children, provided the children with disabilities are in a separate room for less than 21 percent of the time receiving services. This may include, but is not limited to, Head Start centers, public or private preschool and child care facilities, preschool classes offered to an age-eligible population by the public school system, kindergarten classes, and classes using co-teaching models (special education and general education staff coordinating activities in a general education setting).

Resource room includes children who receive services in programs designed primarily for nondisabled children, provided the children with disabilities are in a separate program for 21 to 60 percent of the time receiving services. This includes, but is not limited to, Head Start centers, public or private preschools or child care facilities, preschool classes offered to an age-eligible population by the public school system, and kindergarten classes.

Separate class includes children who receive services in a separate program for 61 to 100 percent of the time receiving services. It does not include children who received education programs in public or private separate day or residential facilities.

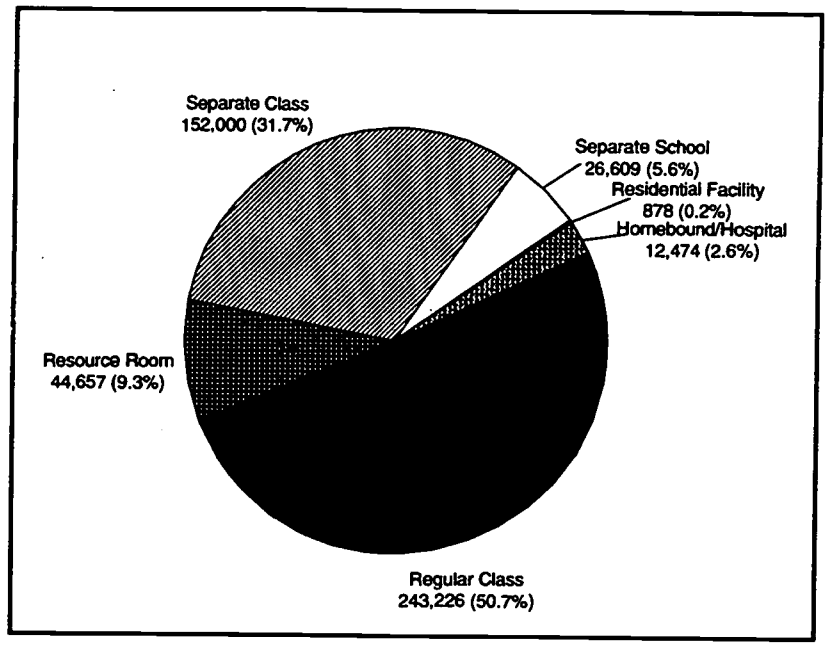
Separate school includes children who are served in publicly or privately operated programs, set up primarily to serve children with disabilities, that are NOT housed in a facility with programs for children without disabilities. Children must receive special education and related services in the public separate day school for greater than 50 percent of the time.

Residential facility includes children who are served in publicly or privately operated programs in which children receive care for 24 hours a day. This could include placement in public nursing home care facilities or public or private residential schools.

Homebound/hospital includes children who are served in either a home or hospital setting, including those receiving special education or related services in the home and provided by a professional or paraprofessional who visits the home on a regular basis (e.g., a child development worker or speech services provided in the child's home). It also includes children 3-5 years old receiving special education and related services in a hospital setting on an inpatient or outpatient basis. However, children receiving services in a group program that is housed at a hospital should be reported in the separate school category. For children served in both a home/hospital setting and in a school/community setting, report the child in the placement that comprises the larger percentage of time receiving services.

Source: OSEP Data Dictionary, Office of Special Education Programs, U.S. Department of Education.

Figure II-3
Number and Percentage of Children Ages 3-5 Served in Different Educational Placements on December 1, 1995



Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

Summary

The number of children served each year continues to increase, although the funds appropriated have remained almost level over the past 2 years. States continue to use the full continuum of placement options. However, there has been an increase in the number of children served in regular class placements, and the use of separate facilities has declined.

Creative ways of administering services are being developed. As shown in the examples in this module, State and local agencies are increasing the level of collaboration among agencies. This, in turn, is making access to services easier for families.

Reference

deFosset, S., Hardison, M., Ward-Newton, J. (1996). *Section 619 profile-seventh edition.* Chapel Hill, NC: National Early Childhood Technical Assistance System.

Table AA1

Number of Children Served Under IDEA, Part B by Age Group

During the 1995-96 School Year

STATE	AGE GROUP					
	3-5	6-11	12-17	6-17	18-21	3-21
ALABAMA	8,594	42,334	42,106	84,440	5,232	98,266
ALASKA	2,015	8,406	6,552	14,958	631	17,604
ARIZONA	7,893	36,684	28,579	65,263	2,965	76,121
ARKANSAS	7,520	21,238	22,786	44,024	2,336	53,880
CALIFORNIA	54,795	272,693	216,475	489,168	21,707	565,670
COLORADO	7,153	30,920	28,866	59,786	2,911	69,850
CONNECTICUT	7,359	33,705	31,707	65,412	3,455	76,226
DELAWARE	1,905	7,608	5,417	13,025	694	15,624
DISTRICT OF COLUMBIA	387	2,565	3,516	6,081	590	7,058
FLORIDA	27,080	153,113	117,965	271,078	12,026	310,184
GEORGIA	13,314	69,117	48,047	117,164	4,564	135,042
HAWAII	1,306	7,453	6,724	14,177	546	16,029
IDAHO	3,091	11,603	8,386	19,989	746	23,826
ILLINOIS	24,967	118,364	102,284	220,648	10,290	255,905
INDIANA	12,261	65,413	50,216	115,629	6,072	133,962
IOWA	5,837	28,719	28,429	57,148	3,262	66,247
KANSAS	6,135	24,996	20,408	45,404	2,063	53,602
KENTUCKY	14,683	36,831	28,166	64,997	3,209	82,889
LOUISIANA	9,588	37,892	38,851	76,743	4,728	91,059
MAINE	3,553	14,065	12,891	26,956	1,363	31,872
MARYLAND	9,486	47,422	40,067	87,489	3,888	100,863
MASSACHUSETTS	14,241	69,337	65,789	135,126	7,829	157,196
MICHIGAN	18,241	86,885	74,626	161,511	9,016	188,768
MINNESOTA	10,781	43,848	39,849	83,697	3,833	98,311
MISSISSIPPI	6,607	30,701	26,698	57,399	2,798	66,804
MISSOURI	8,395	56,180	51,583	107,763	5,249	121,407
MONTANA	1,766	8,434	7,400	15,834	764	18,364
NEBRASKA	3,312	19,294	15,166	34,460	1,536	39,308
NEVADA	3,166	13,473	10,673	24,146	890	28,202
NEW HAMPSHIRE	2,165	10,701	11,126	21,827	1,158	25,150
NEW JERSEY	16,639	95,023	76,528	171,551	8,872	197,062
NEW MEXICO	4,563	20,955	20,301	41,256	1,759	47,578
NEW YORK	48,536	158,300	164,844	323,144	23,161	394,841
NORTH CAROLINA	16,671	74,605	51,189	125,794	4,613	147,078
NORTH DAKOTA	1,169	5,543	5,024	10,567	619	12,355
OHIO	18,204	105,823	91,418	197,241	12,084	227,529
OKLAHOMA	5,312	32,927	30,234	63,161	3,255	71,728
OREGON	6,097	31,726	24,612	56,338	2,587	65,022
PENNSYLVANIA	20,586	91,028	88,206	179,234	11,109	210,929
PUERTO RICO	3,545	16,577	19,091	35,668	3,224	42,437
RHODE ISLAND	2,333	11,440	10,021	21,461	1,278	25,072
SOUTH CAROLINA	10,319	43,323	29,767	73,090	3,113	86,522
SOUTH DAKOTA	2,176	7,637	5,066	12,703	633	15,512
TENNESSEE	10,151	57,378	52,603	109,981	6,329	126,461
TEXAS	32,262	197,604	189,238	386,842	22,439	441,543
UTAH	4,861	25,565	20,121	45,686	1,916	52,463
VERMONT	1,215	4,597	4,921	9,518	513	11,246
VIRGINIA	13,284	66,320	56,068	122,388	6,087	141,759
WASHINGTON	12,565	50,413	39,412	89,825	4,500	106,890
WEST VIRGINIA	4,842	21,253	18,024	39,277	2,368	46,487
WISCONSIN	13,545	45,650	42,340	87,990	4,878	106,413
WYOMING	1,556	5,746	4,744	10,490	503	12,549
AMERICAN SAMOA	53	123	174	297	10	360
GUAM	187	762	798	1,560	119	1,866
NORTHERN MARIANAS	36	105	121	226	25	287
PALAU	5	59	50	109	1	115
VIRGIN ISLANDS	133	585	861	1,446	127	1,706
BUR. OF INDIAN AFFAIRS	.	.	.	.	.	.
U.S. AND OUTLYING AREAS	548,441	2,581,061	2,237,124	4,818,185	252,473	5,619,099
50 STATES, D.C. & P.R.	548,027	2,579,427	2,235,120	4,814,547	252,191	5,614,765

Please see data notes for an explanation of individual State differences.

October 1, 1996.

Table AA7

Number of Children Served Under IDEA, Part B by Age

During the 1995-96 School Year

ALL DISABILITIES

STATE	3 YEARS OLD	4 YEARS OLD	5 YEARS OLD	6 YEARS OLD	7 YEARS OLD	8 YEARS OLD
ALABAMA	1,099	2,371	5,124	5,743	6,575	7,084
ALASKA	394	640	981	978	1,269	1,515
ARIZONA	1,609	2,910	3,374	3,877	5,113	6,592
ARKANSAS	1,877	3,128	2,515	2,788	3,121	3,507
CALIFORNIA	11,727	20,441	22,627	28,509	37,840	47,331
COLORADO	1,444	2,715	2,994	3,223	4,142	5,153
CONNECTICUT	1,758	2,544	3,057	3,693	4,771	5,789
DELAWARE	357	689	859	1,116	1,346	1,424
DISTRICT OF COLUMBIA	20	140	227	168	262	379
FLORIDA	5,431	8,064	13,585	18,754	23,674	26,336
GEORGIA	2,256	4,405	6,653	9,189	10,763	11,987
HAWAII	290	421	595	847	1,053	1,207
IDAHO	713	1,098	1,280	1,379	1,779	2,101
ILLINOIS	4,620	8,299	12,048	15,315	18,739	21,114
INDIANA	2,202	3,925	6,134	8,658	10,715	12,332
IOWA	1,183	1,978	2,676	3,314	3,966	4,903
KANSAS	1,314	2,155	2,666	2,934	3,417	4,409
KENTUCKY	2,697	5,706	6,280	5,985	6,013	6,425
LOUISIANA	1,663	3,350	4,575	5,235	5,822	6,245
MAINE	801	1,469	1,283	1,467	1,943	2,386
MARYLAND	2,018	3,161	4,307	5,533	6,529	7,983
MASSACHUSETTS	3,200	5,570	5,471	7,998	10,405	12,239
MICHIGAN	3,864	5,906	8,471	10,479	12,032	14,988
MINNESOTA	2,389	3,890	4,502	5,107	6,130	7,379
MISSISSIPPI	768	1,700	4,139	5,702	5,548	4,907
MISSOURI	1,473	2,936	3,986	5,188	7,567	9,870
MONTANA	311	568	887	936	1,281	1,550
NEBRASKA	763	1,155	1,394	1,958	2,625	3,530
NEVADA	609	1,070	1,487	1,455	1,789	2,321
NEW HAMPSHIRE	522	761	882	973	1,340	1,756
NEW JERSEY	2,739	4,081	9,819	14,474	17,279	17,051
NEW MEXICO	1,171	1,645	1,747	2,081	2,714	3,509
NEW YORK	15,799	16,240	16,497	17,668	18,774	25,046
NORTH CAROLINA	2,979	5,335	8,357	10,558	12,191	12,730
NORTH DAKOTA	183	404	582	702	854	894
OHIO	3,240	5,080	9,884	12,620	16,393	18,812
OKLAHOMA	917	1,710	2,685	3,741	4,787	5,477
OREGON	1,417	2,213	2,467	3,072	4,299	5,631
PENNSYLVANIA	4,999	8,003	7,584	9,818	13,107	16,411
PUERTO RICO	669	1,262	1,614	1,778	2,212	2,791
RHODE ISLAND	452	790	1,091	1,375	1,852	2,028
SOUTH CAROLINA	1,348	3,200	5,771	7,038	7,790	7,866
SOUTH DAKOTA	395	733	1,048	1,161	1,261	1,410
TENNESSEE	1,384	2,904	5,863	7,686	9,155	9,877
TEXAS	5,783	10,187	16,292	21,096	27,867	33,701
UTAH	1,101	1,794	1,966	2,833	4,121	4,719
VERMONT	302	391	522	514	566	738
VIRGINIA	2,750	4,349	6,185	8,327	9,884	11,304
WASHINGTON	2,458	4,336	5,771	5,893	7,222	8,760
WEST VIRGINIA	705	1,471	2,666	3,018	3,660	3,850
WISCONSIN	2,819	4,823	5,903	6,477	6,994	7,683
WYOMING	399	580	577	626	907	1,035
AMERICAN SAMOA	17	24	12	9	9	16
GUAM	52	69	66	73	85	105
NORTHERN MARIANAS	11	15	10	7	17	17
PALAU	2	3	0	2	1	6
VIRGIN ISLANDS	59	49	25	68	67	81
BUR. OF INDIAN AFFAIRS	.	.	.	.	.	.
U.S. AND OUTLYING AREAS	113,522	184,856	250,063	311,216	381,637	446,290
50 STATES, D.C. & P.R.	113,381	184,696	249,950	311,057	381,458	446,065

Please see data notes for an explanation of individual State differences.

October 1, 1996.

Table AA10

Percentage (Based on Estimated Resident Population) of Children Served Under IDEA, Part B by Age Group During the 1995-96 School Year

ALL DISABILITIES

STATE	AGE GROUP 3-5	6-17	18-21	3-17	3-21
ALABAMA	4.71	11.75	2.10	10.32	8.54
ALASKA	5.98	12.00	1.67	10.72	8.98
ARIZONA	3.66	8.52	1.32	7.45	6.31
ARKANSAS	7.02	9.99	1.61	9.41	7.78
CALIFORNIA	3.21	9.01	1.32	7.62	6.44
COLORADO	4.30	9.11	1.45	8.14	6.83
CONNECTICUT	5.14	12.56	2.33	10.96	9.38
DELAWARE	5.97	11.18	1.95	10.06	8.49
DISTRICT OF COLUMBIA	1.60	9.10	2.59	7.11	6.20
FLORIDA	4.50	12.32	1.86	10.64	9.00
GEORGIA	3.96	9.30	1.13	8.18	6.75
HAWAII	2.29	7.28	0.80	6.15	5.02
IDAHO	5.59	8.33	0.98	7.82	6.42
ILLINOIS	4.51	10.91	1.64	9.54	7.99
INDIANA	4.92	11.61	1.85	10.27	8.51
IOWA	5.08	11.40	2.08	10.22	8.57
KANSAS	5.44	9.63	1.44	8.82	7.37
KENTUCKY	9.19	9.87	1.40	9.74	7.92
LOUISIANA	4.71	9.19	1.77	8.31	6.97
MAINE	7.21	12.65	2.13	11.63	9.76
MARYLAND	4.12	10.60	1.63	9.18	7.79
MASSACHUSETTS	5.50	14.53	2.80	12.56	10.71
MICHIGAN	4.22	9.57	1.74	8.48	7.15
MINNESOTA	5.32	9.80	1.60	8.94	7.58
MISSISSIPPI	5.25	11.22	1.62	10.04	8.25
MISSOURI	3.63	11.54	1.85	9.97	8.38
MONTANA	4.81	9.51	1.50	8.66	7.23
NEBRASKA	4.64	11.32	1.64	10.05	8.37
NEVADA	4.37	9.47	1.25	8.34	7.07
NEW HAMPSHIRE	4.31	10.87	2.19	9.55	8.27
NEW JERSEY	4.65	13.55	2.33	11.59	9.82
NEW MEXICO	5.36	12.38	1.77	10.95	9.19
NEW YORK	5.82	11.14	2.56	9.95	8.51
NORTH CAROLINA	5.24	10.68	1.18	9.52	7.80
NORTH DAKOTA	4.48	8.85	1.61	8.07	6.72
OHIO	3.79	10.25	2.01	8.96	7.57
OKLAHOMA	3.69	10.54	1.71	9.21	7.69
OREGON	4.64	10.39	1.57	9.27	7.76
PENNSYLVANIA	4.17	9.16	1.87	8.16	6.93
PUERTO RICO	.	.	.	.	.
RHODE ISLAND	5.45	13.80	2.75	12.00	10.24
SOUTH CAROLINA	6.27	11.68	1.46	10.55	8.62
SOUTH DAKOTA	6.61	8.89	1.46	8.47	7.08
TENNESSEE	4.52	12.65	2.20	10.98	9.15
TEXAS	3.42	11.02	2.03	9.41	7.95
UTAH	4.42	10.06	1.29	8.96	7.36
VERMONT	5.05	9.41	1.74	8.57	7.27
VIRGINIA	4.70	11.62	1.69	10.16	8.35
WASHINGTON	5.19	9.45	1.57	8.59	7.22
WEST VIRGINIA	7.35	13.38	2.15	12.28	9.91
WISCONSIN	6.22	9.42	1.75	8.82	7.44
WYOMING	7.59	10.83	1.64	10.26	8.48
AMERICAN SAMOA	.	.	.	.	.
GUAM	.	.	.	.	.
NORTHERN MARIANAS	.	.	.	.	.
PALAU	.	.	.	.	.
VIRGIN ISLANDS	.	.	.	.	.
BUR. OF INDIAN AFFAIRS	.	.	.	.	.
50 STATES AND D.C.	4.51	10.59	1.77	9.31	7.83

Percentage of children served is based on U.S. Census Bureau Estimated Resident Population, by State, for July 1995.

Please see data notes for an explanation of individual State differences.

October 1, 1996.

Table AB3

Number of Children Ages 3-5 Served in Different Educational Environments Under IDEA, Part B, During the 1994-95 School Year

ALL DISABILITIES

STATE	NUMBER							
	REGULAR CLASS	RESOURCE ROOM	SEPAR CLASS	PUBLIC SEPAR FACIL	PRIVATE SEPAR FACIL	PUBLIC RESID FACIL	PRIVATE RESID FACIL	HOME HOSP ENVIR
ALABAMA	6,966	806	404	101	26	36	9	133
ALASKA	658	183	513	0	28	0	0	3
ARIZONA	2,998	1,919	2,061	214	62	3	2	18
ARKANSAS	3,215	855	1,136	29	1,103	5	12	588
CALIFORNIA	27,446	2,923	19,081	1,801	265	48	6	453
COLORADO	3,958	1,023	1,658	60	5	9	2	38
CONNECTICUT	3,441	552	2,758	82	102	1	3	22
DELAWARE	850	746	283	131	0	0	0	0
DISTRICT OF COLUMBIA	111	12	97	112	6	0	0	0
FLORIDA	10,244	1,183	9,593	500	306	14	0	1,802
GEORGIA	6,734	3,019	2,502	168	166	1	53	168
HAWAII	309	101	744	5	5	0	0	0
IDAHO	1,179	735	639	150	0	1	1	16
ILLINOIS	11,020	706	10,203	1,947	226	18	0	138
INDIANA	7,713	65	2,483	590	105	17	13	79
IOWA	3,465	481	1,580	15	.	12	15	105
KANSAS	2,401	2,660	270	300	216	9	21	23
KENTUCKY	12,636	722	324	198	78	1	2	48
LOUISIANA	4,231	532	4,615	226	0	19	0	35
MAINE	1,928	108	164	76	643	0	1	300
MARYLAND	5,275	2,522	572	257	274	18	0	132
MASSACHUSETTS	12,679	252	1,130	41	115	.	3	47
MICHIGAN	5,316	608	5,833	3,032	.	1	0	2,882
MINNESOTA	3,956	1,261	3,704	1,284	58	11	4	480
MISSISSIPPI	3,615	875	1,413	305	50	23	2	104
MISSOURI	2,295	2,020	3,473	97	72	1	0	10
MONTANA	886	300	366	33	38	8	1	2
NEBRASKA	1,257	389	694	595	12	1	0	363
NEVADA	977	65	1,697	158	0	0	1	2
NEW HAMPSHIRE	1,018	157	604	119	17	0	5	74
NEW JERSEY	6,743	56	7,116	1,086	859	73	0	55
NEW MEXICO	1,240	147	2,487	.	3	5	0	78
NEW YORK	4,915	1,794	5,141	1,025	499	28	20	62
NORTH CAROLINA	10,505	662	2,599	565	399	113	11	260
NORTH DAKOTA	517	59	353	155	9	2	2	22
OHIO	8,068	1,366	7,316	1,266	0	3	0	174
OKLAHOMA	2,704	384	1,568	248	10	22	6	28
OREGON	2,821	302	997	268	234	2	7	157
PENNSYLVANIA	7,861	1,266	8,777	89	346	39	17	1,320
PUERTO RICO	1,351	377	964	109	140	10	2	378
RHODE ISLAND	1,015	288	676	13	129	0	0	0
SOUTH CAROLINA	7,237	808	1,471	297	22	8	0	33
SOUTH DAKOTA	873	334	981	14	6	2	8	10
TENNESSEE	7,072	822	1,620	154	101	21	0	35
TEXAS	15,359	1,227	11,035	191	3	8	0	206
UTAH	0	0	0	7	0	0	.	0
VERMONT	668	14	205	59	54	0	6	178
VIRGINIA	5,359	712	4,918	526	80	16	6	1,129
WASHINGTON	4,169	2,077	5,614	636	181	6	1	146
WEST VIRGINIA	352	2,898	1,065	13	9	10	3	116
WISCONSIN	5,162	1,237	6,455	188	6	8	0	16
WYOMING	264	20	14	1	2	0	0	0
AMERICAN SAMOA	52	0	0	0	0	0	0	0
GUAM	109	27	34	3	0	0	0	0
NORTHERN MARIANAS	33	0	0	0	0	0	0	2
PALAU	0	0	0	0	0	0	0	4
VIRGIN ISLANDS	.	.	.	.	.	.	.	.
BUR. OF INDIAN AFFAIRS	.	.	.	.	.	.	.	.
U.S. AND OUTLYING AREAS	243,226	44,657	152,000	19,539	7,070	633	245	12,474
50 STATES, D.C. & P.R.	243,032	44,630	151,966	19,536	7,070	633	245	12,463

Please see data notes for an explanation of individual State differences.

SEPAR=SEPARATE; FACIL=FACILITY; RESID=RESIDENTIAL; HOSP=HOSPITAL; ENVIR=ENVIRONMENT

October 1, 1996.

Table AB3

Percentage of Children Ages 3-5 Served in Different Educational Environments Under IDEA, Part B, During the 1994-95 School Year

ALL DISABILITIES

STATE	PERCENTAGE							
	REGULAR CLASS	RESOURCE ROOM	SEPAR CLASS	PUBLIC SEPAR FACIL	PRIVATE SEPAR FACIL	PUBLIC RESID FACIL	PRIVATE RESID FACIL	HOME HOSP ENVIR
ALABAMA	82.14	9.50	4.76	1.19	0.31	0.42	0.11	1.57
ALASKA	47.51	13.21	37.04	0.00	2.02	0.00	0.00	0.22
ARIZONA	41.20	26.37	28.32	2.94	0.85	0.04	0.03	0.25
ARKANSAS	46.31	12.31	16.36	0.42	15.89	0.07	0.17	8.47
CALIFORNIA	52.76	5.62	36.68	3.46	0.51	0.09	0.01	0.87
COLORADO	58.61	15.15	24.55	0.89	0.07	0.13	0.03	0.56
CONNECTICUT	49.43	7.93	39.62	1.18	1.47	0.01	0.04	0.32
DELAWARE	42.29	37.11	14.08	6.52	0.00	0.00	0.00	0.00
DISTRICT OF COLUMBIA	32.84	3.55	28.70	33.14	1.78	0.00	0.00	0.00
FLORIDA	43.33	5.00	40.58	2.11	1.29	0.06	0.00	7.62
GEORGIA	52.56	23.57	19.53	1.31	1.30	0.01	0.41	1.31
HAWAII	26.55	8.68	63.92	0.43	0.43	0.00	0.00	0.00
IDAHO	43.33	27.01	23.48	5.51	0.00	0.04	0.04	0.59
ILLINOIS	45.43	2.91	42.06	8.03	0.93	0.07	0.00	0.57
INDIANA	69.71	0.59	22.44	5.33	0.95	0.15	0.12	0.71
IOWA	61.08	8.48	27.85	0.26	.	0.21	0.26	1.85
KANSAS	40.69	45.08	4.58	5.08	3.66	0.15	0.36	0.39
KENTUCKY	90.20	5.15	2.31	1.41	0.56	0.01	0.01	0.34
LOUISIANA	43.81	5.51	47.78	2.34	0.00	0.20	0.00	0.36
MAINE	59.88	3.35	5.09	2.36	19.97	0.00	0.03	9.32
MARYLAND	58.29	27.87	6.32	2.84	3.03	0.20	0.00	1.46
MASSACHUSETTS	88.87	1.77	7.92	0.29	0.81	.	0.02	0.33
MICHIGAN	30.08	3.44	33.01	17.16	.	0.01	0.00	16.31
MINNESOTA	36.77	11.72	34.43	11.94	0.54	0.10	0.04	4.46
MISSISSIPPI	56.60	13.70	22.12	4.78	0.78	0.36	0.03	1.63
MISSOURI	28.80	25.35	43.59	1.22	0.90	0.01	0.00	0.13
MONTANA	54.22	18.36	22.40	2.02	2.33	0.49	0.06	0.12
NEBRASKA	37.96	11.75	20.96	17.97	0.36	0.03	0.00	10.96
NEVADA	33.69	2.24	58.52	5.45	0.00	0.00	0.03	0.07
NEW HAMPSHIRE	51.05	7.87	30.29	5.97	0.85	0.00	0.25	3.71
NEW JERSEY	42.18	0.35	44.51	6.79	5.37	0.46	0.00	0.34
NEW MEXICO	31.31	3.71	62.80	.	0.08	0.13	0.00	1.97
NEW YORK	36.45	13.30	38.13	7.60	3.70	0.21	0.15	0.46
NORTH CAROLINA	69.51	4.38	17.20	3.74	2.64	0.75	0.07	1.72
NORTH DAKOTA	46.20	5.27	31.55	13.85	0.80	0.18	0.18	1.97
OHIO	44.35	7.51	40.21	6.96	0.00	0.02	0.00	0.96
OKLAHOMA	54.41	7.73	31.55	4.99	0.20	0.44	0.12	0.56
OREGON	58.92	6.31	20.82	5.60	4.89	0.04	0.15	3.28
PENNSYLVANIA	39.87	6.42	44.52	0.45	1.76	0.20	0.09	6.70
PUERTO RICO	40.56	11.32	28.94	3.27	4.20	0.30	0.06	11.35
RHODE ISLAND	47.85	13.58	31.87	0.61	6.08	0.00	0.00	0.00
SOUTH CAROLINA	73.28	8.18	14.89	3.01	0.22	0.08	0.00	0.33
SOUTH DAKOTA	39.18	14.99	44.03	0.63	0.27	0.09	0.36	0.45
TENNESSEE	71.98	8.37	16.49	1.57	1.03	0.21	0.00	0.36
TEXAS	54.80	4.38	39.37	0.68	0.01	0.03	0.00	0.73
UTAH	0.00	0.00	0.00	100.00	0.00	0.00	.	0.00
VERMONT	56.42	1.18	17.31	4.98	4.56	0.00	0.51	15.03
VIRGINIA	42.04	5.59	38.58	4.13	0.63	0.13	0.05	8.86
WASHINGTON	32.49	16.19	43.76	4.96	1.41	0.05	0.01	1.14
WEST VIRGINIA	7.88	64.89	23.85	0.29	0.20	0.22	0.07	2.60
WISCONSIN	39.49	9.46	49.38	1.44	0.05	0.06	0.00	0.12
WYOMING	87.71	6.64	4.65	0.33	0.66	0.00	0.00	0.00
AMERICAN SAMOA	100.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
GUAM	63.01	15.61	19.65	1.73	0.00	0.00	0.00	0.00
NORTHERN MARIANAS	94.29	0.00	0.00	0.00	0.00	0.00	0.00	5.71
PALAU	0.00	0.00	0.00	0.00	0.00	0.00	0.00	100.00
VIRGIN ISLANDS	.	.	.	.	.	.	.	.
BUR. OF INDIAN AFFAIRS	.	.	.	.	.	.	.	.
U.S. AND OUTLYING AREAS	50.69	9.31	31.68	4.07	1.47	0.13	0.05	2.60
50 STATES, D.C. & P.R.	50.68	9.31	31.69	4.07	1.47	0.13	0.05	2.60

Please see data notes for an explanation of individual State differences.

SEPAR=SEPARATE; FACIL=FACILITY; RESID=RESIDENTIAL; HOSP=HOSPITAL; ENVIR=ENVIRONMENT

October 1, 1996.

Table AB7

Number of Children Served in Different Educational Environments Under IDEA, Part B by Age Group During the 1985-86 Through 1994-95 School Years

AGE GROUP 3-5

YEAR	REGULAR CLASS	RESOURCE ROOM	SEPAR CLASS	PUBLIC SEPAR FACIL	PRIVATE SEPAR FACIL	PUBLIC RESID FACIL	PRIVATE RESID FACIL	HOME HOSP ENVIR	TOTAL
1985-86	109,431	58,718	78,487	22,797	18,577	3,659	330	4,614	296,613
1986-87	116,898	55,529	78,227	20,526	18,962	1,098	440	5,703	297,383
1987-88	122,864	43,158	87,316	25,100	20,101	1,066	480	6,178	306,263
1988-89	140,364	53,706	87,595	26,106	16,698	1,080	338	6,573	332,460
1989-90	159,554	42,630	98,879	25,954	20,198	1,059	443	7,635	356,352
1990-91	163,723	47,946	99,233	30,020	18,897	969	348	7,252	368,388
1991-92	173,364	41,436	108,507	17,984	26,251	931	250	4,394	373,117
1992-93	220,018	56,599	141,566	22,199	13,222	1,541	313	7,270	462,728
1993-94	237,470	44,175	151,088	22,453	20,529	983	555	9,045	486,298
1994-95	243,226	44,657	152,000	19,539	7,070	633	245	12,474	479,844

AGE GROUP 6-11

YEAR	REGULAR CLASS	RESOURCE ROOM	SEPAR CLASS	PUBLIC SEPAR FACIL	PRIVATE SEPAR FACIL	PUBLIC RESID FACIL	PRIVATE RESID FACIL	HOME HOSP ENVIR	TOTAL
1985-86	726,586	807,144	408,345	40,955	22,199	9,532	3,420	6,813	2,024,994
1986-87	756,194	795,960	429,431	42,677	22,347	5,634	3,141	10,518	2,065,902
1987-88	832,284	747,080	431,042	47,685	23,191	4,509	2,784	6,266	2,094,841
1988-89	898,693	762,537	449,059	45,567	22,026	5,582	2,601	7,348	2,193,413
1989-90	937,329	748,115	463,525	45,186	24,156	6,144	2,626	6,303	2,233,384
1990-91	992,884	727,000	497,003	42,739	24,773	5,402	2,545	7,370	2,299,716
1991-92	1,075,455	726,035	463,267	37,018	27,467	5,872	2,098	5,141	2,342,353
1992-93	1,164,427	617,476	477,765	37,856	25,419	7,159	2,269	7,194	2,339,565
1993-94	1,313,089	608,776	472,899	33,112	14,456	4,416	2,295	6,429	2,455,472
1994-95	1,364,545	610,920	475,664	31,959	15,000	4,057	2,161	6,226	2,510,532

AGE GROUP 12-17

YEAR	REGULAR CLASS	RESOURCE ROOM	SEPAR CLASS	PUBLIC SEPAR FACIL	PRIVATE SEPAR FACIL	PUBLIC RESID FACIL	PRIVATE RESID FACIL	HOME HOSP ENVIR	TOTAL
1985-86	277,424	849,989	500,315	71,870	23,784	18,018	9,567	18,952	1,769,919
1986-87	287,018	852,796	507,702	59,822	24,302	11,658	9,714	17,254	1,770,266
1987-88	315,192	803,174	502,486	70,286	26,079	12,151	7,545	19,409	1,756,322
1988-89	335,057	779,691	487,524	63,144	26,071	12,918	7,210	22,532	1,734,147
1989-90	360,143	769,427	517,752	64,885	26,183	15,695	7,355	15,950	1,777,390
1990-91	400,416	783,562	526,763	59,118	27,034	14,701	7,259	14,038	1,832,891
1991-92	445,691	821,318	517,011	54,895	29,264	16,786	7,317	13,815	1,906,097
1992-93	609,919	759,618	530,137	54,342	25,825	15,179	7,655	14,517	2,017,192
1993-94	687,004	725,572	534,931	51,246	25,446	13,663	8,030	17,304	2,063,196
1994-95	745,534	731,410	548,839	50,958	27,919	14,249	8,219	18,621	2,145,749

Beginning in 1987-88, data on youth with disabilities served in correctional facilities were collected as duplicated counts of data reported under one of the other environments. Prior to this time, a separate unduplicated count was collected for students served in correctional facilities. These students are excluded from the totals in the years prior to 1987-88.

Beginning in 1989-90, States were instructed to report students in regular class, resource room, and separate class placements based on the percent of time they received services OUTSIDE the regular class (<21, 21-60, and >60, respectively) instead of the percent of time they received special education.

Reporting on autism and traumatic brain injury was required under IDEA beginning in 1992-93 and was optional in 1991-92.

SEPAR=SEPARATE; FACIL=FACILITY; RESID=RESIDENTIAL; HOSP=HOSPITAL; ENVIR=ENVIRONMENT

October 1, 1996.

Table AB7

Number of Children Served in Different Educational Environments Under IDEA, Part B by Age Group During the 1985-86 Through 1994-95 School Years

AGE GROUP 18-21

YEAR	REGULAR CLASS	RESOURCE ROOM	SEPAR CLASS	PUBLIC SEPAR FACIL	PRIVATE SEPAR FACIL	PUBLIC RESID FACIL	PRIVATE RESID FACIL	HOME HOSP ENVIR	TOTAL
1985-86	21,908	75,429	72,601	28,451	6,507	10,673	2,487	3,709	221,765
1986-87	30,392	85,661	73,600	21,530	7,299	5,624	2,415	3,774	230,295
1987-88	28,715	78,332	72,752	26,209	6,504	4,393	2,015	3,527	222,447
1988-89	32,132	79,255	71,315	26,023	7,075	5,290	2,095	3,204	226,389
1989-90	37,910	75,558	76,416	25,732	6,313	6,181	2,183	3,007	233,300
1990-91	39,319	80,278	71,013	23,916	6,515	4,621	2,250	2,993	230,905
1991-92	42,253	78,389	72,834	20,205	6,311	5,569	2,118	2,317	229,996
1992-93	56,802	79,024	70,399	20,034	5,867	4,522	1,828	3,088	241,564
1993-94	63,393	67,002	73,394	18,740	5,801	5,061	1,755	3,167	238,313
1994-95	66,360	64,310	73,181	16,994	5,864	4,019	2,445	3,266	236,439

AGE GROUP 6-21

YEAR	REGULAR CLASS	RESOURCE ROOM	SEPAR CLASS	PUBLIC SEPAR FACIL	PRIVATE SEPAR FACIL	PUBLIC RESID FACIL	PRIVATE RESID FACIL	HOME HOSP ENVIR	TOTAL
1985-86	1,025,918	1,732,562	981,261	141,276	52,490	38,223	15,474	29,474	4,016,678
1986-87	1,073,604	1,734,417	1,010,733	124,029	53,948	22,916	15,270	31,546	4,066,463
1987-88	1,176,191	1,628,586	1,006,280	144,180	55,774	21,053	12,344	29,202	4,073,610
1988-89	1,265,882	1,621,483	1,007,898	134,734	55,172	23,790	11,906	33,084	4,153,949
1989-90	1,335,382	1,593,100	1,057,693	135,803	56,652	28,020	12,164	25,260	4,244,074
1990-91	1,432,619	1,590,840	1,094,779	125,773	58,322	24,724	12,054	24,401	4,363,512
1991-92	1,563,399	1,625,742	1,053,112	112,118	63,042	28,227	11,533	21,273	4,478,446
1992-93	1,831,148	1,456,118	1,078,301	112,232	57,111	26,860	11,752	24,799	4,598,321
1993-94	2,063,486	1,401,350	1,081,224	103,098	45,703	23,140	12,080	26,900	4,756,981
1994-95	2,176,439	1,406,640	1,097,684	99,911	48,783	22,325	12,825	28,113	4,892,720

AGE GROUP 3-21

YEAR	REGULAR CLASS	RESOURCE ROOM	SEPAR CLASS	PUBLIC SEPAR FACIL	PRIVATE SEPAR FACIL	PUBLIC RESID FACIL	PRIVATE RESID FACIL	HOME HOSP ENVIR	TOTAL
1985-86	1,135,349	1,791,280	1,059,748	164,073	71,067	41,882	15,804	34,088	4,313,291
1986-87	1,190,502	1,789,946	1,088,960	144,555	72,910	24,014	15,710	37,249	4,363,846
1987-88	1,299,055	1,671,744	1,093,596	169,280	75,875	22,119	12,824	35,380	4,379,873
1988-89	1,406,246	1,675,189	1,095,493	160,840	71,870	24,870	12,244	39,657	4,486,409
1989-90	1,494,936	1,635,730	1,156,572	161,757	76,850	29,079	12,607	32,895	4,600,426
1990-91	1,596,342	1,638,786	1,194,012	155,793	77,219	25,693	12,402	31,653	4,731,900
1991-92	1,736,763	1,667,178	1,161,619	130,102	89,293	29,158	11,783	25,667	4,851,563
1992-93	2,051,166	1,512,717	1,219,867	134,431	70,333	28,401	12,065	32,069	5,061,049
1993-94	2,300,956	1,445,525	1,232,312	125,551	66,232	24,123	12,635	35,945	5,243,279
1994-95	2,419,665	1,451,297	1,249,684	119,450	55,853	22,958	13,070	40,587	5,372,564

Beginning in 1987-88, data on youth with disabilities served in correctional facilities were collected as duplicated counts of data reported under one of the other environments. Prior to this time, a separate unduplicated count was collected for students served in correctional facilities. These students are excluded from the totals in the years prior to 1987-88.

Beginning in 1989-90, States were instructed to report students in regular class, resource room, and separate class placements based on the percent of time they received services OUTSIDE the regular class (<21, 21-60, and >60, respectively) instead of the percent of time they received special education.

Reporting on autism and traumatic brain injury was required under IDEA beginning in 1992-93 and was optional in 1991-92.

SEPAR=SEPARATE; FACIL=FACILITY; RESID=RESIDENTIAL; HOSP=HOSPITAL; ENVIR=ENVIRONMENT

October 1, 1996.

Table AC1

Total Number of Teachers Employed, Vacant Funded Positions (In Full-Time Equivalency), and Number of Teachers Retained to Provide Special Education and Related Services for Children and Youth with Disabilities, Ages 3-5 During the 1994-95 School Year

STATE	-------EMPLOYED------- FULLY CERTIFIED	NOT FULLY CERTIFIED	VACANT POSITIONS	TOTAL POSITIONS (EMPLOYED + VACANT)	--RETAINED TEACHERS--- FULLY CERTIFIED	NOT FULLY CERTIFIED
ALABAMA	724	42	20	786	531	17
ALASKA	49	27	1	77	43	24
ARIZONA	214	85	7	306	175	79
ARKANSAS	101	141	19	261	23	59
CALIFORNIA	1,599	143	11	1,753	1,553	87
COLORADO	112	42	0	154	27	3
CONNECTICUT	.	.	.	.	.	.
DELAWARE	120	15	136	271	110	9
DISTRICT OF COLUMBIA	61	4	5	70	61	3
FLORIDA	1,461	76	33	1,570	1,310	35
GEORGIA	463	14	9	486	395	4
HAWAII	110	17	0	127	107	8
IDAHO	164	4	3	171	139	1
ILLINOIS	706	31	11	748	555	18
INDIANA	397	44	2	443	308	30
IOWA	303	27	1	331	266	3
KANSAS	299	.	6	305	252	.
KENTUCKY	1,569	166	41	1,776	1,393	68
LOUISIANA	434	344	6	784	395	246
MAINE	192	8	2	201	171	4
MARYLAND	380	29	4	412	363	23
MASSACHUSETTS	482	.	6	488	467	.
MICHIGAN	819	42	1	861	561	23
MINNESOTA	610	65	8	683	595	45
MISSISSIPPI	229	25	9	263	198	10
MISSOURI	562	75	2	639	274	32
MONTANA	77	4	9	90	21	1
NEBRASKA	97	10	1	109	92	0
NEVADA	268	25	5	298	237	21
NEW HAMPSHIRE	82	7	0	89	74	6
NEW JERSEY	956	0	3	959	955	0
NEW MEXICO	152	34	3	189	81	13
NEW YORK	2,651	1,081	127	3,858	2,288	704
NORTH CAROLINA	552	106	28	685	467	85
NORTH DAKOTA	88	2	3	93	83	2
OHIO	1,351	0	94	1,445	729	0
OKLAHOMA	238	15●	1	254	209	13
OREGON	38	42	15	95	35	35
PENNSYLVANIA	1,136	2	2	1,141	982	0
PUERTO RICO	103	0	0	103	103	0
RHODE ISLAND	117	2	2	121	106	0
SOUTH CAROLINA	560	46	21	626	464	24
SOUTH DAKOTA	136	1	2	140	119	0
TENNESSEE	305	5	1	310	305	5
TEXAS	.	.	.	.	.	.
UTAH	114	33	3	150	103	29
VERMONT	119	2	0	121	96	1
VIRGINIA	1,327	219	21	1,567	1,265	196
WASHINGTON	589	27	2	618	511	18
WEST VIRGINIA	142	30	7	179	129	24
WISCONSIN	619	28	0	648	521	26
WYOMING	56	0	0	56	.	.
AMERICAN SAMOA	4	11	0	15	4	11
GUAM	6	0	1	7	6	0
NORTHERN MARIANAS	41	.	7	48	29	.
PALAU	1	1	0	2	1	1
VIRGIN ISLANDS	12	0	1	13	12	0
BUR. OF INDIAN AFFAIRS	300	22	12	334	284	11
U.S. AND OUTLYING AREAS	24,396	3,219	713	28,328	20,583	2,057
50 STATES, D.C. & P.R.	24,032	3,185	692	27,909	20,247	2,034

The total FTE for the U.S. and Outlying Areas and the 50 States, D.C., and Puerto Rico may not equal the sum of the individual States and Outlying Areas because of rounding.
Please see data notes for an explanation of individual State differences.
October 1, 1996.

Table AG1

State Grant Awards Under IDEA, Part B, Preschool Grant Program and Part H

APPROPRIATION YEAR 1996
ALLOCATION YEAR 1996-1997

STATE	IDEA, PART B	PRESCHOOL GRANT PROGRAM	PART H
ALABAMA	40,895,889	5,640,150	4,483,470
ALASKA	7,445,561	1,322,423	1,545,710
ARIZONA	30,926,630	5,149,246	5,306,409
ARKANSAS	21,767,818	4,947,109	2,549,297
CALIFORNIA	228,622,421	36,022,407	41,438,233
COLORADO	28,189,964	4,694,437	3,972,753
CONNECTICUT	31,009,767	5,254,252	3,378,163
DELAWARE	6,415,559	1,273,857	1,545,710
DISTRICT OF COLUMBIA	3,133,152	253,984	1,545,710
FLORIDA	125,183,617	17,772,314	14,722,619
GEORGIA	54,500,058	8,737,835	8,226,009
HAWAII	6,468,961	857,114	1,569,551
IDAHO	9,586,202	2,011,527	1,545,710
ILLINOIS	103,277,776	16,385,574	13,785,909
INDIANA	54,064,193	8,046,763	6,065,530
IOWA	26,735,870	3,830,760	2,712,211
KANSAS	21,632,619	4,026,335	2,716,195
KENTUCKY	33,452,225	9,636,295	3,876,538
LOUISIANA	36,749,462	6,292,502	5,023,051
MAINE	12,862,856	2,331,796	1,545,710
MARYLAND	40,707,760	6,228,185	6,148,806
MASSACHUSETTS	64,529,602	9,346,216	8,621,533
MICHIGAN	76,182,721	11,971,373	10,017,913
MINNESOTA	39,676,213	7,075,455	4,873,116
MISSISSIPPI	26,960,663	4,336,103	3,120,649
MISSOURI	48,997,264	5,509,548	5,422,619
MONTANA	7,447,163	1,189,852	1,545,710
NEBRASKA	15,863,867	2,173,630	1,689,626
NEVADA	11,381,723	2,077,812	1,783,636
NEW HAMPSHIRE	10,206,502	1,424,148	1,545,710
NEW JERSEY	79,530,001	10,919,997	8,497,315
NEW MEXICO	19,201,461	2,994,648	2,045,597
NEW YORK	159,349,369	31,853,656	20,119,188
NORTH CAROLINA	59,357,530	10,940,998	7,582,020
NORTH DAKOTA	5,044,365	767,202	1,545,710
OHIO	91,825,830	11,947,090	11,402,583
OKLAHOMA	29,633,498	3,486,209	3,381,056
OREGON	26,241,486	4,001,396	3,086,097
PENNSYLVANIA	86,078,620	13,510,371	12,702,122
PUERTO RICO	18,127,953	2,326,545	4,549,818
RHODE ISLAND	10,118,522	1,531,123	1,568,805
SOUTH CAROLINA	34,921,251	6,775,530	3,852,059
SOUTH DAKOTA	6,432,855	1,428,085	1,545,710
TENNESSEE	51,036,950	6,661,992	5,414,050
TEXAS	178,197,295	21,173,206	23,718,333
UTAH	21,172,943	3,190,222	2,768,788
VERMONT	4,539,452	797,391	1,545,710
VIRGINIA	57,509,947	8,676,144	6,930,714
WASHINGTON	43,138,514	8,246,275	5,664,434
WEST VIRGINIA	18,358,789	3,177,753	1,798,698
WISCONSIN	42,946,007	8,889,438	5,553,755
WYOMING	5,064,508	1,021,186	1,545,710
AMERICAN SAMOA	2,546,094	34,783	514,925
GUAM	6,151,324	122,726	1,140,327
NORTHERN MARIANAS	1,570,112	23,626	342,733
PALAU	552,502	5,120	78,014
VIRGIN ISLANDS	4,663,611	87,286	671,647
BUR. OF INDIAN AFFAIRS	28,408,765		3,864,276
U.S. AND OUTLYING AREAS	2,316,593,632	360,409,000	315,754,000
50 STATES, D.C. & P.R.	2,272,701,224	360,135,459	309,142,078

State grants awards are initial allocations for the 1996 appropriation.

October 1, 1996.

Evaluation Studies

DETERMINING THE EFFICACY OF PRESCHOOL PROGRAMS FOR STUDENTS WITH DISABILITIES: A FEASIBILITY STUDY

Arkansas Department of Education, FY 1994

In recent years, Arkansas has expanded special education services to children 3-5 years of age. More than 7,000 children now receive services. If Arkansas is to continue to provide appropriate services to children ages 3-5, it must be able to demonstrate the effectiveness of these programs. The Arkansas Department of Education, in collaboration with the University of Arkansas at Little Rock, conducted a study to determine the feasibility of evaluating the effectiveness of preschool programs for children with disabilities in the State.

Feasibility Study Questions

The feasibility questions addressed in this study are as follows.

- What data are available about children served in preschool programs for children with disabilities?
- Are available data consistent across the population of children in preschool programs for children with disabilities?
- Can available data be analyzed to determine efficacy?
- What statistical analysis would be most effective with available data?
- Are portfolio assessment data available?
- What are the ways in which portfolio assessment data can be used to determine efficacy of programs?
- What is the best method to use the Interagency Coordinating Council (ICC) to help with determining the efficacy of programs?
- Given the state of services in Arkansas, availability of data, and availability of resources, what is an appropriate blueprint for determining efficacy of preschool services for children with disabilities?

Methodology

The study was conducted in two phases. Phase I covered the collection and analysis of data from record reviews and focus groups. During Phase I, each educational service cooperative (ESC) was asked to have each school district within its organizational structure submit the education folders of two children who had exited the preschool special education program at the end of the 1994-95 school year. The school districts were instructed to submit one folder for a child referred for special education services in kindergarten and the other folder for a child not referred for ongoing special education. A total of 363 folders were received. Sixty folders were randomly selected for data analysis. Half were for children who had been referred for special education programs in kindergarten, while half represented children not referred for special education in kindergarten. The folders were reviewed for information necessary for conducting an evaluation of the effectiveness of preschool programs for children with disabilities.

Two focus groups, one for professionals providing services to preschool children with disabilities and one for parents of children currently receiving special education services in preschool programs, were also conducted. The purpose of the focus groups was to assess the usefulness of focus groups for assessing the effectiveness of preschool programs for children with disabilities. The professional focus group consisted of five teachers who worked in preschool special education programs; the parent focus group consisted of seven adults representing five families.

Phase II covered analysis of the availability of data, identification of additional data needed, and assessment of the usefulness of focus groups for an evaluation of the effectiveness of preschool programs for students with disabilities in the State. This was accomplished with the feasibility advisory committee, which included national experts in the field of program evaluation.

Findings

The feasibility study resulted in several important findings, including:

- Substantial data (e.g., demographic, referral source, duration of services, age at intake, diagnosis of strengths and weaknesses, least restrictive environment (LRE) placement) are available to conduct a comprehensive evaluation of preschool special education programs;
- Available data are consistent across the State;

- The data are conducive to statistical analyses (i.e., descriptive, comparative, and causal) of the effectiveness of programs;

- Focus groups can provide information (e.g., program expectations, program perceptions, experiences with the program) that will be helpful in assessing the effectiveness of preschool programs for students with disabilities;

- Portfolio assessment data are not available. Children in Arkansas have not been extensively evaluated using portfolio data; and

- Involvement with the ICC, which primarily focuses on birth to 36 month programs, was determined to be unnecessary for the full evaluation.

Information Specific to the Early Education Program for Children with Disabilities (EEPCD)

Table II-1
Percentage Distribution of Ages of Infants and Toddlers Served Under IDEA, Part H 1992-95

Year	Ages			
	Birth to 1	1 to 2 Years Old	2 to 3 Years Old	Total**
1992*	18.8	34.2	47.1	100.0
1993*	20.3	35.1	44.6	100.0
1994	17.9	33.4	48.7	100.0
1995	16.8	33.4	49.8	100.0

* Includes infants and toddlers with disabilities served under the Chapter 1 Handicapped Program.

** Due to rounding, totals may not sum to 100 percent.

Source: U.S. Department of Education, Office of Special Education Programs, Data Analysis System (DANS).

age of referral to the program was 12.1 months in Colorado, 10.6 months in North Carolina, and 7.7 months in Pennsylvania. The most commonly used referral source was a physician or nurse (50 percent). The study also found that the sample collected in May of 1994 consisted of 24 (15 percent) infants ages birth to 1, 64 (41 percent) infants ages 1 to 2, and 70 (44 percent) toddlers ages 2 to 3 (Kochanek & Buka, 1994).

The Early Education Program for Children with Disabilities

The Office of Special Education and Rehabilitative Services (OSERS) in the U.S. Department of Education administers a variety of programs related to improving the quality and quantity of services to young children with special needs and their families. Selected early childhood projects are sponsored by OSERS and administered by the Office of Special Education Programs (OSEP) through the Early Education Program for Children with Disabilities (EEPCD).

These early childhood initiatives include demonstration projects, in-service training projects, outreach projects, research institutes, research and experimental projects, statewide data system projects, and a technical assistance center that support programs for infants, toddlers, and preschoolers with disabilities.

EEPCD, originally named the Handicapped Children's Early Education Program (HCEEP), was established in 1968 with a mandate to set up model demonstration projects for the delivery of special education and related services to young children with disabilities, from birth through the third grade. Three major needs were identified for early intervention programs: (1) locally designed ways to serve infants, young children, and their families; (2) more specific information on effective programs and techniques; and (3) distribution of visible, replicable models throughout the country.

Two major assumptions underlie this program: (1) only through early intervention with tested and successful program models can the highest quality services be provided for children with disabilities, and (2) the program should provide models of services rather than be a direct service delivery program. HCEEP was intended to provide an opportunity for any public or private nonprofit organization to develop and demonstrate high-quality services for a selected group of children and their families. It also was intended to provide an opportunity to demonstrate the effectiveness of locally designed approaches and disseminate those ideas across the nation to other agencies that might choose to use the model rather than develop their own program. EEPCD currently supports 109 projects, including 35 demonstration projects, 18 in-service training projects, 49 outreach projects, 6 research institutes, and 1 national technical assistance center.

The demonstration projects address a range of topics, including multidisciplinary intervention services for child and family; interagency collaboration in the provision of services; service delivery models; developmentally appropriate practices; transitioning children with disabilities into community settings; increasing and improving child care

options for children with disabilities; curriculum development; evaluation of child progress; services for infants with special health needs, including HIV infection and AIDS, or exposure to drugs in utero; and assistive technology. Projects in this priority area are developing and evaluating in-service training models that will prepare professionals and paraprofessionals to provide, coordinate, or enhance early intervention, special education, and related services for infants and toddlers with disabilities and/or for preschool children with disabilities. Outreach projects engage in awareness activities; stimulation of model replication sites; training of professionals, paraprofessionals, and parents; promotion of State involvement; product development and dissemination; and consultative activities. Outreach efforts have contributed significantly to informing people about effective programs for young children, to providing improved training and services, and to building continuity and interagency/inter-State collaborations. During 1995-96, four research institutes were funded. These institutes address interventions for children affected by parental substance abuse; barriers to the inclusion of preschool-age children with disabilities in classroom and community settings; influences on service patterns and utilization in early intervention and preschool programs; and the adoption of successful early intervention practices in children's early elementary education in order to improve the education of children with disabilities.

Summary

The increase in the number of infants and toddlers served under Part H (22.4 percent) since 1992 has been greater than the growth in the number of children and youth served under the Part B program for this same period (10.6 percent). However, the Part H growth rate is comparable to the growth rate of the number of children ages 3 through 5 that are served under Part B (20.4 percent). This growth in services to young children reflects one of the OSEP's policy goals--to strengthen early intervention to enable every child to start school ready to learn. Early intervention programs can benefit both the child and the family by helping the child become more involved in both

Developing a Partnership Between Families and Professionals

Developing a Partnership Between Families and Professionals

During the past 25 years, a significant shift in philosophy has occurred regarding the relationship between families of children with disabilities and professionals that serve them (Winton, 1994; Turnbull & Turnbull, 1996). Unlike the past, today's professionals consider the family as a unit instead of solely focusing on the mother-child dyad; they also understand there are family issues beyond those related to the child that must be addressed to effectively serve children with disabilities. Now professionals not only consider the needs of the family but also its strengths when developing educational programs that meet the child's needs. This philosophical shift has influenced the development of special education legislation and the relationship between families and professionals.

Involvement of families in decisions about their child's education is a central component of family-school collaboration (Turnbull & Turnbull, 1996), and the role that families can have in the education of their child with disabilities has evolved since the passage of P.L. 94-142. Families of school-aged children served through the IDEA, Part B have tended to be less involved in decisions than those of infants and toddlers served under Part H. Although families of school-aged children served under Part B are entitled to participate in their child's IEP meeting, many do not. A recent longitudinal study conducted in a large urban and primarily minority school district found that parent attendance at IEP meetings decreased over a 3-year period (Harry, Allen, & McLaughlin, 1995). In contrast, family participation is at the core of the Part H program. This emphasis is evident in many ways. One example is the importance given to families at the individualized family service plan (IFSP) meeting for infants and toddlers with disabilities. During these meetings, families are an integral part of the process of designing the IFSP. This perspective is, in part, an outgrowth of the systems perspective of human development,

which emphasizes that children with disabilities do not exist in a vacuum. To comprehend the impact of the disability, one must gain an understanding of the context of children's lives (Turnbull, Turnbull, & Shankon, 1995).

This module describes some of the changes that have occurred in parent-professional partnerships. The first section provides some recent theories related to family functioning. The remaining sections discuss the types of partnerships that have developed as a result of IDEA. The sections include:

- a systems perspective of human development;
- family collaboration in IDEA, Part H;
- family collaboration in IDEA, Part B; and
- the challenge of transition.

A Systems Perspective of Human Development

From a systems perspective of human development, the way an individual acts is a product of the interactions that occur between a person and his or her environment. This section will examine recent developments in family system theory related to the interactions within families and the interactions between families and professionals.

Family systems theory provides a framework for understanding what a family is and how it functions. It also provides professionals with a model of how to collaborate with families. Turnbull and Turnbull (1996) describe three assumptions that are central to family systems theory. They are: (1) the input/output configuration of the system; (2) the concept of wholeness and subsystems; and (3) the role of boundaries in defining systems (Whitechurch & Constantine as cited in Turnbull & Turnbull, 1996). The first assumption explains how the inputs (family characteristics) interact with the system to produce outputs (family function). For example, when a child with disabilities is

born (family characteristics), this places a new set of stresses on the family and may change how family members interact with each other and with individuals outside of the family (family function). The second assumption is that the system must be understood as a whole and cannot be understood by examining only its component parts (Whitechurch & Constantine as cited in Turnbull & Turnbull, 1996). For example, it follows from this assumption that it is necessary to understand the family to understand the child. Finally, the third assumption is that family subsystems are separated by boundaries that are created by the interaction of family members within the family unit and with outside influences. For example, the boundaries set with professionals are likely to be different from the ones set with family members.

Much of the knowledge about the changes in the relationships between parents and professionals that have occurred during the past 25 years can be attributed to the work done by Bronfenbrenner. He stressed that parenting behavior is influenced by environmental factors that are both internal to and external to the family. These parenting behaviors then influence the child's behavior. For example, Bronfenbrenner (1979, as cited in Dunst, Trivette, Hamby, & Pollock, 1990) stated:

> Whether parents can perform effectively in their child-rearing roles within the family depends on role demands, stresses, and supports emanating from other settings. Parents' evaluations of their own capacity to function, as well as their view of their child, are related to such external factors as flexibility of job schedules, adequacy of child care arrangements, the presence of friends and neighbors who can help out in large and small emergencies, the quality of health and social services, and neighborhood safety. (p. 7).

This quotation emphasizes the role that outside influences can have on families. Recognizing that role has been a critical factor affecting many of the changes that have occurred in the parent-professional relationship. It is important for anyone working with families to have an

understanding of family systems theory because it provides a framework for understanding families in an individualized and personalized way. Professionals who possess such an understanding are more likely to be attuned to the families and their strengths, expectations, priorities, and needs. Such an understanding in turn leads to a more effective and collaborative relationship with families--and families are most able to promote students' positive educational results (Turnbull & Turnbull, 1996).

Family Collaboration in IDEA, Part H

In 1986, Part H of IDEA stipulated that a family-centered approach be used in serving eligible children from birth to age 3. Also, a commitment to the parent-professional partnership is embedded throughout the Part H regulations. Part H established the individualized family service plan (IFSP) and required that professionals collaborate with families when developing a plan for the child, consider the entire family when deciding on services, and choose services that strengthen families. As part of these requirements, the IFSP documents the family's resources, priorities, and concerns related to the development of the child (34 CFR §303.344(b)).

In an attempt to measure the degree to which early intervention services are being implemented in a family-centered manner, McBride, Brotherson, Joanning, Whiddon, and Demmitt (1993) conducted semi-structured interviews with 15 families receiving early intervention services and with 14 professionals. A major finding of the study was that over time a shift toward family-centered practices had occurred. All of the families stated that professionals showed concern for the family not just the child with disabilities. Also, the professionals articulated that implementing the IFSP requirements changed their professional practice orientation from child-focused to family-focused. However, when describing their practice, 5 of the 14 professionals discussed goals that were still based on a child-focused orientation. The study also examined the families' role in the decision-making process. Four families deferred decision making to the profes-

sionals, and three families chose to share the role. Ten families believed they could learn the most about their child by observing the professional and answering questions, and more than half the families described their role in the decision-making process as having the final veto power. Finally, many of the families stated their emotional well-being had improved through contact with professionals who showed concern for their emotional needs and with other parents who were in a similar situation.

Another study (Bailey, Palsha, & Simeonsson, 1991) found that professionals were concerned about their changing roles. Results of a survey of 142 professionals working in early intervention programs in two States showed that professionals perceived a moderate level of competence in their ability to work with parents and a higher level of competence working with children. However, as a group, they considered their role of working with families as important. Their primary concerns were how family-centered practices would affect them personally and whether they had the skills to engage in such practices. This study also suggests that the level and type of training given to professionals can significantly influence parent-professional relationships.

Family Collaboration in IDEA, Part B

The relationship between parents and professionals may change when children with disabilities turn 3 and begin preschool. For most families, the setting in which services take place changes from the home to the school. Regularly scheduled private home visits between families and professionals end. Children are served within a group setting, and parents may be invited into the child's classroom. They may take on the role of parent helper or observer. Also, school districts may transition to an IEP to develop goals and objectives for the child instead of using an IFSP to address the needs of the child and the resources, priorities, and concerns of the family. Therefore, the goals and objectives tend to become more child centered than family centered.

Typically, parents of children in primary and secondary special education programs are given less support and have less input into their child's education than parents of children from birth through age 5 (Winton, 1994). However, there are both informal and formal ways (e.g., IEP and individualized transition plan (ITP) meetings) to encourage parent involvement and thereby increase collaboration. Informal involvement includes the many opportunities for parent-teacher communication. This can include written notes between school and home, parent involvement in the classroom and extracurricular activities, telephone contact, technology options such as the Internet, and conferences (Turnbull & Turnbull, 1996). Increasing this communication to include the accomplishments of the child as well as the child's needs is an important part of developing collaboration.

OSEP recognizes the importance of the role that families need to play and is taking steps to promote an increase in the participation of families served through IDEA, Part B and Part H. A four-step plan to strengthen the working relationship between families and schools has been proposed. It includes: "(1) increasing involvement of families in decision making, (2) improving information available to families, (3) linking families to other resources and supports in the community, and (4) reducing adversarial dispute resolution by using mediation" (U.S. Department of Education, 1995).

The Challenge of Transition

There are several important factors to consider when providing services to families. One, as mentioned earlier, is to have an understanding of the family's perspective in order to develop a collaborative relationship between families and professionals. Another is the understanding that one of the most important factors in families' lives is the attainment of certain milestones. Often these life milestones are used to determine when services should be given. These milestones or transitions that occur during one's lifetime can be traced in a variety of ways. Two of these possibilities, as described by Mallory (1996), are developmental

transitions and institutional transitions. Developmental transitions are associated with the maturational milestones an individual reaches in life, such as learning to walk or talk during the first years of life, reaching puberty, child bearing, and having children leave home. Institutional transitions mark the changes of moving from one institutional setting to another. They include events such as entering day care; elementary, middle, or high school; college or miliary service; and the work force.

The timing of when to administer services can be as influential on the family as the services themselves. Social policies have emphasized institutional transitions, which are often independent from the developmental transitions. This can have negative effects on individuals with disabilities and their families. For example, the individual experiencing the transition may lose his or her locus of control and transition from setting to setting, based on institutional transitions that are dictated by social policies such as laws and regulations. The likelihood of this happening increases if the individual has a disability and an assumption is made that the individual is less capable of making his or her own decisions (Mallory, 1996). However, if there is an open dialogue and a partnership between families and professionals, the likelihood of the family or individual losing control is reduced.

Two institutional transitions in special education are the transition from IDEA, Part H, to IDEA, Part B, at age 3 and the transition from school to postschool activities. These are formal opportunities for parent-professional collaboration. The Part B regulations contain provisions for a smooth transition from Part H to Part B (34 CFR §300.154) and for any transitions that take place while the individual is served through Part B or ready to exit any or all Part B services (34 CFR §§300.344(c) and 300.346(b)). The Part B regulations stress parent participation during IEP meetings as well as during transition periods (34 CFR §300.345). Fostering positive interactions during these meetings is especially important. Studies and testimony have shown that schools try to comply with legal mandates and procedures but have not made the effort to foster empowerment through collaboration (Green & Shinn, 1995;

Turnbull & Turnbull, 1996; National Council on Disability, 1995). However, strategies for involvement are being pursued. They include increased efforts to involve families in the assessment process (Winton, 1994) and using collaborative conference techniques to increase parent and student participation.

Parent involvement can have a critical effect on the transition process from school to postschool activities. A study by Morningstar, Turnbull, and Turnbull (1995) found that families greatly influenced decisions made by students with disabilities. With regard to the transition process, students' perspectives about their vision for the future, how to plan for the future, and their self-determination were all influenced by their families. Most of the students based their career plans on input received from parents and extended family members and not from career planning courses in school. Although the IEP process requires transition planning (34 CFR §300.346(b)), with the current format used during IEP meetings, the majority of the students found the IEP process irrelevant. Morningstar et al., suggest that parents' and extended family members' viewpoints be incorporated into the IEP process in a more meaningful way.

Summary

Family systems theory provides a framework for understanding the dynamics that are present within families. Children with disabilities and their families face a unique set of issues, as well as the usual challenges of childhood. Understanding the issues that are important to families is particularly critical when trying to develop a positive relationship between professionals and families. Both formal and informal avenues for collaboration exist. However, open communication is the integral component of developing this important collaborative relationship.

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Notes for Tables

Notes that are screened accompany tables that are not included in this packet

NOTES FOR APPENDIX A

Notes to the tables found in Appendix A contain information on the ways in which States collected and reported data differently from the OSEP data formats and instructions. In addition, the notes provide explanations of significant changes in the data from the previous year. Please note that counts of infants and toddlers receiving early intervention services according to an individualized family service plan include all children served, whether or not Part H monies are used to provide the services. For ease of reporting, these counts are referred to throughout as infants and toddlers served under Part H. The chart below summarizes differences in collecting and reporting of Part B data for 11 States. These variations affected the way data were reported for the IDEA, Part B child count and the educational environment, personnel, and exiting collections. Additional notes on how States reported Part B and Part H data for specific data collections follow this chart.

Table A-1
State Reporting Patterns for IDEA, Part B Child Count Data 1995-96, Other Data 1994-95

States	Differences from OSEP Reporting Categories Where H = Reported in the hearing impairments category O = Reported in the orthopedic impairments category P = Reported in the primary disability category R = Reported in other disability categories			
	Multiple Disabilities	Other Health Impairments	Deaf-Blindness	Traumatic Brain Injury
Colorado		O		
Delaware	P	O		
Florida	P			
Georgia	P			
Illinois	P[1]			
Michigan		O	H	R
Mississippi		O		
North Dakota	P			
Oregon	P[2]			
West Virginia	P			
Wyoming	P		H	

[1] While Illinois reported all students with multiple disabilities under their primary disability, it reported some teachers of students with multiple disabilities.

[2] On the exiting data table, Oregon used the multiple disability category to report students without a valid disability code.

Tables AA1 - AA14: Part B Child Count

NOTE: Twenty-four States suggested the increases in their counts of students with other health impairments were due to increases in the identification and inclusion of students with attention deficit disorder and attention deficit hyperactivity disorders. These States include:

Alabama	Idaho	Missouri	South Carolina
Arizona	Kansas	New Hampshire	Tennessee
Arkansas	Louisiana	New York	Vermont
Colorado	Maine	North Carolina	Virginia
Connecticut	Maryland	Oklahoma	Washington
Georgia	Minnesota	Rhode Island	West Virginia

California -- The State indicated that the increase in the number of students with autism and traumatic brain injury from 1994-95 to 1995-96 was due to the reclassification of students into these categories during their periodic review and re-evaluation.

Florida -- The State suspected that the increase in the number of students with autism from 1994-95 to 1995-96 was a result of the establishment of autism centers to assist districts in identifying students with autism.

Indiana -- The State said that the increases in the number of students with autism, other health impairments, and orthopedic impairments from 1994-95 to 1995-96 were a result of improvements in its data collection system.

Kentucky -- The State indicated that the increase in the number of students with other health impairments from 1994-95 to 1995-96 was due to the revision of the identification criteria for students with disabilities.

Maryland -- The State indicated that the increase in the number of students with autism was due to better identification of students with this disability and to the continuing reclassification of students as they are re-evaluated.

Massachusetts -- Massachusetts is prohibited by State law from collecting data by disability. Assignment to disability categories is based on a formula.

New York -- The State thought that the increase in the number of students with traumatic brain injury from 1994-95 to 1995-96 was the result of the reclassification of students during their triennial re-evaluation. New York attributed the increase in the number of students with autism from 1994-95 to 1995-96 to better identification and service provision at the local level.

North Carolina -- The State noted that the increase in the number of students with multiple disabilities was due to the first-time reporting of students who were served in community residential facilities; these facilities serve students with severe impairments.

Oregon -- The State indicated that the increase in the number of children ages 3-5 from 1994-95 to 1995-96 was due to an increase in early intervention identification.

Pennsylvania -- The State noted that it does not identify students by disability category on their IEPs. Rather, students are identified according to their needs. Students are only assigned to a disability category at the district level for purposes of Federal reporting. Hence, the State thinks that the changes in the disability categories were more reflective of variations in local reporting practices than the nature of the population being served.

South Carolina -- The State indicated that the increase in the number of students with other health impairments and multiple disabilities from 1994-95 to 1995-96 was due to improved reporting. The other health impairments and multiple disabilities are only used for Federal reporting, and the districts are beginning to report more accurate data in these categories.

Wisconsin -- The State indicated that differences between the 1993-94 and 1994-95 child count data were primarily due to a change to reporting students exclusively by their primary disability condition. In prior years, students were reported either by their primary disability condition or in the multiple disability category.

Tables AB1 - AB8: Part B Educational Environments

Alabama -- The State indicated that the increase from 1993-94 to 1994-95 in parent-initiated private school placements was due to increased services to preschool children in private day care and preschool programs.

Alaska -- The State indicated that the decrease in the number of students served in correctional facilities and the increase in parent-initiated private school placements from 1993-94 to 1994-95 were probably a result of Alaska's not having a computerized student record system that associated placements with students.

Arizona -- The State indicated that the increase in regular class placements from 1993-94 to 1994-95 was due to improved reporting; the decrease in private residential facility placements was due to increased efforts by the State to serve students in their home schools.

Arkansas -- The State indicated that the increase in private separate facility placements from 1993-94 to 1994-95 was due to a significant increase in the number of preschool children served in these facilities.

Colorado -- The State indicated that the changes in placement data from 1993-94 to 1994-95, which reflected an increase in regular class and decreases in resource room and separate class placements, were due to the use of new placement categories that more closely reflected the Federal categories.

Florida -- The State thought that the increase in homebound/hospital placements from 1993-94 to 1994-95 was due to the reporting of 3- through 5-year-old children served by Children's Medical Services in this placement.

Georgia -- The State provided the following explanations for changes in the data from 1993-94 to 1994-95: (1) the decrease in public residential facility placements was a result of a State rule adopted January 1994 that encouraged serving children in local school districts rather than in public residential facilities, and (2) the decrease in homebound/hospital placements was due to clarification of the definition of this placement (i.e., homebound/hospital for reasons of illness or injury versus psychiatric hospitalization at State-operated facilities).

Iowa -- The State indicated that the increase from 1993-94 to 1994-95 in resource room placements was a result of a study of placement categories in the State. The study resulted in many students being reported in less restrictive settings.

Massachusetts -- The State attributed the increase from 1993-94 to 1994-95 in private residential facility placements to improvements in data collection and reporting. Massachusetts is prohibited by State law from collecting data by disability. Assignment to disability categories is based on a formula.

Michigan -- The State indicated that the increase in homebound/hospital placements from 1993-94 to 1994-95 was due to the reporting of preschool children in this category; preschool children were previously reported under separate class. Michigan attributed the increase from 1993-94 to 1994-95 in public separate school placements to more accurate reporting of preschool data.

Mississippi -- The State thought that the increase from 1993-94 to 1994-95 in public residential facility placements was because the 1993-94 report was compiled from an incomplete data set whereas the 1994-95 report was based on complete data. Mississippi indicated that corrected 1993-94 data were not available.

Missouri -- The State provided the following explanations: (1) the increase from 1993-94 to 1994-95 in parent-initiated private school placements was due to large increases in private and parochial enrollments, and (2) the decrease from 1993-94 to 1994-95 in public separate school facility placements was due to an emphasis on serving students in less restrictive environments.

Nebraska -- The State indicated that the increase from 1993-94 to 1994-95 in public separate school facility placements was due to clarification of definitions and other refinements in reporting.

Nevada -- The State indicated that the increase from 1993-94 to 1994-95 in the number of regular class placements was a result of policies and practices encouraging service delivery in the regular classroom. Another factor that contributed to the data changes was that the Clark County School District undertook a major effort to conduct individual verifications of the accuracy of placement category reporting. The decrease from 1993-94 to 1994-95 in the

homebound/hospital placements was a result of better reporting; the information for the 1994-95 school year was based on individual student record data bases whereas the previous information was extrapolated based on staff assignments.

New York -- The State indicated that the increase from 1993-94 to 1994-95 in parent-initiated placements was due to clarification of the instructions in the data collection instruments. New York attributed the decrease from 1993-94 to 1994-95 in private separate school facilities to efforts to serve children in the least restrictive settings.

North Carolina -- The State indicated that the decrease from 1993-94 to 1994-95 in private residential placements was due to a shift towards serving more students in local school districts.

Ohio -- The State indicated that the decrease from 1993-94 to 1994-95 in public separate school facility placements was a result of the State's decision to phase out separate facilities and serve children in regular school buildings.

Pennsylvania -- The State attributed the decrease in parent-initiated private school placements to better reporting.

Puerto Rico -- The State indicated that the decrease from 1993-94 to 1994-95 in separate class placements was due to more children receiving services in resource rooms.

Tennessee -- The State attributed the increase in resource room placements to a general increase in the number of children served.

Texas -- The State provided the following explanations: (1) there was no discernible reason for the decrease from 1993-94 to 1994-95 in the public residential facility placements, (2) the increase in correctional facility placements was probably due to better reporting since the prior year data were not verified and hence could have been erroneous, and (3) the increase from 1993-94 to 1994-95 in parent-initiated private school placements was due to the prior year's data being estimated whereas the current data were extracted from a database of private school data.

Utah -- The State indicated that the decrease from 1993-94 to 1994-95 in public residential facility placements was due to movement of students from public residential facilities (especially from the State school for students with deaf-blindness) into local public schools and that the increase from 1993-94 to 1994-95 in correctional facility placements was the result of the opening of a new facility.

Alabama -- The State provided the following explanations for the year-to-year changes: (1) the increase from 1993-94 to 1994-95 in the number of teachers employed to serve preschoolers was due to the success of the State's Child Find efforts with an attendant increase in the preschool population, (2) the increase from 1993-94 to 1994-95 in the number of physical education teachers employed was due to a greater emphasis on the provision of adaptive physical education services, (3) the increase from 1993-94 to 1994-95 in the number of counselors employed was due to greater emphasis at the State level on the provision of counseling services, and to increased funding for counselors, and (4) the increase from 1993-94 to 1994-95 in the number of nonprofessional staff was due to the use of more aides to assist in serving students in regular classes.

Alaska -- The State indicated that the decrease from 1993-94 to 1994-95 in the number of diagnostic and evaluation staff employed and the decrease from 1993-94 to 1994-95 in the number of teacher aides needed resulted from the economic downturn in the State.

Arizona -- The State provided the following explanations: (1) the increase from 1993-94 to 1994-95 in the number of supervisors/administrators employed was probably due to the reinstatement of personnel who were previously released due to budgetary constraints, (2) the increase from 1993-94 to 1994-95 in the number of nonprofessional staff employed was due to an increase in the population being served and to the use of more support staff in the provision of special education, and (3) the decrease from 1993-94 to 1994-95 in the number of teachers needed to serve children ages 6-21 was probably due to inclusion, which has resulted in more children being served by regular education teachers and special education aides.

Arkansas -- The State indicated that the increase from 1993-94 to 1994-95 in the number of occupational therapists and physical therapists needed was a result of the 1994 compliance monitoring of the Arkansas Department of Education, which determined that Arkansas needed to provide more related services.

California -- The State indicated that the increase from 1993-94 to 1994-95 in the number of teachers needed to serve children ages 6-21 and the increase from 1993-94 to 1994-95 in the number of nonprofessional staff was due to an increase in the number of students. The State noted that many teachers on waivers or with emergency certificates were hired to meet the increased need.

Colorado -- The State indicated that the increase from 1993-94 to 1994-95 in the number of nonprofessional staff employed was due to refinements in the personnel classification schema; the State added a new category of nonclassified staff that included personnel who had previously been reported in other professional staff. Colorado stated that the increase from 1993-94 to 1994-95 in the number of teacher aides needed was also a result of improvements in reporting. In previous years, personnel with temporary teacher eligibility were reported as fully certified, whereas in the current year they were reported as not-fully certified.

Florida -- The State indicated that the decline from 1993-94 to 1994-95 in the number of vocational and physical education teachers employed to provide services to students with disabilities was the result of more inclusive programs where these students are no longer served in segregated settings with teachers who were employed to provide services only to students with disabilities. Conversely, the increase from 1993-94 to 1994-95 in the number of other professional staff was the result of the need for additional support personnel to help facilitate placement in more inclusive settings for students with disabilities. These personnel include staffing specialist and support facilitators. The increase from 1993-94 to 1994-95 in the number of interpreters employed was due to the increase in the number of students with hearing impairments.

Georgia -- The State provided the following explanations. First, the decrease from 1993-94 to 1994-95 in the number of audiologists employed was due to improvements in reporting; it appears that some districts overreported during the prior year. The State did not submit revised data for the previous year. Second, the increase from 1993-94 to 1994-95 in the number of counselors was due to three metropolitan school districts reporting an increase of 412 counselors; Georgia cannot confirm the accuracy of this increase. Third, the increase in the number of rehabilitation counselors was due to more districts taking advantage of a program that provided matching funds to hire rehabilitation counselors.

Hawaii -- The State reported that the increase from 1993-94 to 1994-95 in the number of counselors employed was the result of an actual increase in the number of counselors employed and some reclassification of staff from the other professional staff category.

Indiana -- The State indicated that the increase from 1993-94 to 1994-95 in the number of interpreters employed was a result of more students with hearing impairments being served in regular classrooms.

Iowa -- The State indicated that the increase from 1993-94 to 1994-95 in the number of other professional staff employed was due to better reporting of data from correctional and State-operated facilities. Iowa noted that the increase from 1993-94 to 1994-95 in total staff employed was due to the first-time reporting of speech pathologists and to an increase in the number of teacher aides employed.

Kentucky -- The State indicated that the differences between the 1993-94 and the 1994-95 data were due to only partial data being reported in 1993-94, whereas the 1994-95 figures represent more complete data.

Maryland -- The State provided the following explanations: (1) the increase from 1993-94 to 1994-95 in the number of teacher aides was due to the State's emphasis on inclusion, which resulted in a need for more aides in the classroom; (2) the increase from 1993-94 to 1994-95 in the number of psychologists was a result of better data collection, (3) the decrease from 1993-94 to 1994-95 in the number of other professional staff was due to better reporting and the separate reporting of

speech pathologists, and (4) the decrease from 1993-94 to 1994-95 in the number of nonprofessional staff was due to better reporting.

Massachusetts -- The State is prohibited by State law from collecting data by disability condition. The State reported all teachers as serving students in cross-categorical classrooms.

Michigan -- The State said that the decrease from 1993-94 to 1994-95 in the number of physical therapists employed was because districts were contracting with hospitals for these services; districts only contracted for exactly what they needed.

Minnesota -- The State indicated that the increase from 1993-94 to 1994-95 in the number of nonprofessional staff employed was a result of increased inclusion. Schools districts determined that hiring nonprofessional local staff to assist teachers was more cost-effective.

Mississippi -- The State indicated that the decrease from 1993-94 to 1994-95 in number of teachers and the increase in nonprofessional staff were probably a result of better reporting. The State noted that more staff were available to collect and process data in 1994-95 than in previous years. Furthermore, the 1994-95 data were subjected to more data checks than previous data. Mississippi thought that programming changes related to the inclusion of students with specific learning disabilities also contributed to the decrease in the number of teachers employed and needed. Similarly, the State thought that the increase from 1993-94 to 1994-95 in the number of nonprofessional staff was probably partially due to the category not being very well-defined.

Montana -- The State indicated that the decrease from 1993-94 to 1994-95 in the number of teacher aides employed and the increase from 1993-94 to 1994-95 in the number of nonprofessional staff employed was because some nonprofessional staff (mobility, medical, transportation, lunchroom, and behavioral aides) were reported in the teacher aides category in 1993-94. In 1994-95 they were reported under other nonprofessional staff.

Nevada -- The State indicated that the decrease from 1993-94 to 1994-95 in the number of diagnostic and evaluation staff and the increase from 1993-94 to 1994-95 in the number of other professional staff was due to the fact that the Clark County School District decided to report staff who performed diagnostic/evaluative services under the category of other professional staff. In the previous year, these staff members were reported in the diagnostic/evaluation category.

New Hampshire -- The State thought that the decrease from 1993-94 to 1994-95 in the number of counselors employed was due to overreporting in the past, when some districts reported the number of counselors rather than the full-time equivalency of counselors.

New Jersey -- The State indicated that the New Jersey Department of Education collects most of the personnel data from the Certificated Staff Report. Verification of the data is limited and results in year-to-year variation in some categories, such as vocational special education, physical education, and diagnostic and evaluation staff.

New Mexico -- The State indicated that the decrease from 1993-94 to 1994-95 in the number of occupational therapists employed may be related to the creation of a new licensed position of certified occupational therapy assistant.

New York -- The State attributed the increase in personnel to the implementation of new data procedures and forms and to the expansion of personnel categories. New York noted that the current data were collected from all service providers, whereas previously data were only collected from public schools.

Ohio -- The State indicated that the increase from 1993-94 to 1994-95 in the number of diagnostic and evaluation staff was due to increased service provision at the regional level. Ohio indicated that the decrease from 1993-94 to 1994-95 in the number of physical therapists employed was due to the fact that physical therapists prefer not to work in the school system because they are better compensated by private industry. The State did not report counts of teachers employed to serve students with other health impairments. Teachers of students with other health impairments were reported in the orthopedic impairment category.

Oklahoma -- The State indicated that the decrease from 1993-94 to 1994-95 in the number of counselors employed was due to assistance provided to districts to help them report only the full-time equivalency of counselors serving special education students. The increase from 1993-94 to 1994-95 in the number of other professional staff employed was primarily due to an increase in the number of job coaches employed to improve the transition services provided by schools. Other categories that contributed to the increase include certified occupational therapy assistants, physical therapy assistants, and nurses.

Oregon -- The State indicated that the data changes from 1993-94 to 1994-95 were due to refinements in data collection that led to improvements in data accuracy.

Puerto Rico -- The State indicated that the increase in the number of physical education teachers employed and needed was because State-funded vocational education teachers were not included on the previous report.

South Carolina -- The State indicated that increase from 1993-94 to 1994-95 in the number of teachers employed to serve children ages 3-5 was due to an increase in the population.

Texas -- The State thought that data changes were due to problems reported in the previous year. Corrected data were not provided for that year.

Wisconsin -- The State provided the following explanations for changes in the data from 1993-94 to 1994-95: (1) many of the changes in the personnel data are attributable to a modification of the data system, (2) the decrease in the number of teachers employed to serve children ages 6-21 was probably the result of more accurate reporting in full-time equivalents, and (3) the increase in the total number of personnel employed was primarily due to the first-time reporting of speech pathologists in this category.

Wyoming -- Wyoming suspects that the increase in the number of interpreters employed may be due to the reporting of sign language-trained aides in this category.

Tables AD1 - AD3: Part B Exiting

For individual States, percentages of students exiting in low-incidence disability categories may sum to more than 100 percent. This is due to the fact that exit data are collected over a 12-month period, while child count data are collected for a single day, December 1. As a result, students ages 14-21 who enter special education after December 1, and exit prior to December 1, may appear in the numerator (exiters) but not in the denominator (child count).

Arizona -- The State indicated that the increase from 1993-94 to 1994-95 in the number of students who exited was a result of more accurate reporting. The 1993-94 exiting data were not collected over an entire school year because this was a transition year for the State data collection. The 1994-95 data represent data collected over 12 months.

California -- The State indicated that the increase from 1993-94 to 1994-95 in the number of students who exited in the "return to regular education," "moved, known to be continuing," and "moved, not known to be continuing" categories was due to the elimination of the "Other" category and to an overall increase in the number of students.

Colorado -- The State indicated that the increase from 1993-94 to 1994-95 in the number of students who exited was because the prior years' figures did not represent a full year of data, whereas the current year does. Colorado noted that the State was unable to report a full year of data last year because the State was changing data systems.

Florida -- The State provided the following: (1) the decrease from 1993-94 to 1994-95 in the number of students with other health impairments that moved and were known to be continuing was because the prior year's data included hospital/homebound students [a disability category in Florida], whereas the current year's data did not, (2) the increase from 1993-94 to 1994-95 in the number of students with specific learning disabilities who dropped out was due to improvements in reporting, and (3) the increase from 1993-94 to 1994-95 in the number of students who returned to regular education was due to improvements

in reporting--the State noted that this was only the second year that these data had been collected.

Georgia -- The State noted that most of the increase from 1993-94 to 1994-95 in the number of students who returned to regular education and in the number of students who moved and were known to be continuing occurred among students with serious emotional disturbance. Georgia noted that many of these students were served in State psychiatric institutions, which traditionally have had high turnover rates, with students either returning to regular education or to their home district.

Idaho -- The State suspects that the increase from 1993-94 to 1994-95 in the total number of students who exited was a result of improvements in reporting. The State noted that the 1994-95 school year was only the second year that exiting data were collected through its data management system; previously, these data were collected through telephone calls.

Indiana -- The State indicated that the increase from 1993-94 to 1994-95 in the number of students who exited special education was the result of improvements in data collection procedures.

Iowa -- The State indicated that the increase in the number of students who exited was due to improved reporting.

Massachusetts -- The State did not collect data for "graduation through certificate or completion of IEP requirement" because all students graduate with diplomas. Massachusetts is prohibited by State law from collecting data by disability. Assignment to disabilities categories is based on a formula.

Michigan -- The State indicated that the increase from 1993-94 to 1994-95 in the number of students who exited was due to improved accuracy in reporting.

Minnesota -- The State thought that the increase from 1993-94 to 1994-95 in the number of students who exited through reaching maximum age for service was because adult service agencies encourage the parents of these students to keep them in school until age 22 in order to reduce the burden on these agencies.

New Jersey -- The State attributed the decrease from 1993-94 to 1994-95 in the number of students who exited through the moved, known to be continuing and dropped out bases of exit to the nature of their data collection. New Jersey collects exiting data from a stratified sample of 50 percent of the school districts based on enrollment that includes all districts having more than 25,000 pupils. The data are compiled from summary district reports with no option for independent verification. Variations from year to year may be attributed to the difficulties districts encounter in the definition of "moved, known to be continuing." Although the recordkeeping for dropouts is easier, districts still have some difficulty in tracking these data and reporting them systematically. The State did not collect data for "graduation

through certification or completion/fulfillment of IEP requirement" because all students who graduate receive a diploma.

Ohio -- The State combined exiting data for the other health impairments and orthopedic impairments categories. The data were presented under the orthopedic impairments category.

Oklahoma -- The State provided the following explanations for the increase from 1993-94 to 1994-95 in the number of students with learning disabilities who dropped out: (1) there has been a significant increase in the number of regular and special education students who were pulled out of school to be home-schooled by their parents, (2) there has been an increase in the number of students with learning disabilities who have entered the juvenile justice system, and (3) the dropout figures include students who left school to pursue full-time employment. The State noted that the dropout rate for students with learning disabilities (2.6 percent) was lower than the dropout rates for all students (5.5 percent) in grades 9-12.

Pennsylvania -- The State indicated that graduation with a certificate was not a valid basis of exit in the State.

Table AH1: Part H Child Count

Arkansas -- The State indicated that the increase from 1994-95 to 1995-96 in the number of children served was due to the integration of a program that served approximately 300 children into the Part H system. These children had been receiving early intervention services but had not previously been counted under Part H.

Connecticut -- The district indicated that the increase from 1994-95 to 1995-96 in the number of infants served was due to increased outreach and growth in the eligible population. Connecticut noted that there was not much outreach before full implementation.

District of Columbia -- The district thinks the increase from 1994-95 to 1995-96 in the number of children served was due to improvements in data collection. The District of Columbia noted that there was an increase in the number of providers that provided data.

Florida -- The State indicated that the increase from 1994-95 to 1995-96 in children served was an indication that its programs are fully operational and that public awareness and outreach have increased in effectiveness.

Kentucky -- The State attributed the increase from 1994-95 to 1995-96 in the number of children served to the success of its Child Find efforts.

Michigan -- The State indicated that the increase from 1994-95 to 1995-96 in the number of children served was primarily due to increased participation in the Detroit area. The Public Health Department, the Community Health Department, and the Detroit public schools all made concerted efforts to complete IFSPs for eligible children who were being served. Michigan added that the statewide growth was due to expanded collaborative participation of agencies outside of Special Education.

Mississippi -- The State indicated that the increase from 1994-95 to 1995-96 in the number of children served was due to program expansion and to a statewide increase in personnel.

New Hampshire -- The State indicated that the increase from 1994-95 to 1995-96 in the number of children served was due to increased public awareness and to the reorganization of its child intake process to a more centralized model.

New York -- The State indicated that the increase from 1994-95 to 1995-96 in the number of children served was partially due to better reporting by providers and partially due to actual increases in the number of infants and toddlers served.

North Carolina -- The State indicated that the decrease from 1994-95 to 1995-96 in the number of children served was a result of improvements in reporting. North Carolina said that the prior year data contained some duplication and that the current year's data were the first in which they could eliminate all duplication.

Rhode Island -- The State indicated that the increase from 1994-95 to 1995-96 in the number of children served was primarily a result of the initiation of several Child Find activities. Rhode Island reported that universal neonatal screening, which started in 1993, now includes hearing screening of all newborn infants. This change has resulted in this low incidence population entering early intervention shortly after birth. Another reason for the increase is that the success of the program has resulted in more referrals. Finally, because of the decrease in funding for other birth through age 3 programs, more children and their families have turned to Part H for services.

Utah -- The State indicated that the increase from 1994-95 to 1995-96 in the number of children served was due to expanded Child Find and public awareness at the State and local areas that has resulted in more children being identified. Utah noted that radio and television advertisement was utilized as were efforts to become more visible in local communities with displays, posters, and professional visits to the medical community.

Alabama -- The State indicated that the increase from 1993-94 to 1994-95 in the number of infants and toddlers who received various services was a result of the full implementation of Part H in 1994 and the transition from a paper collection system to an electronic data management system. Another factor that contributed to the increase is that one of the major providers, Children Rehabilitation Services, became more fully involved in providing and reporting services. A large proportion of the services provided by the Children Rehabilitation Services are medical and health services.

Arizona -- The State provided the following: (1) the decreases from 1993-94 to 1994-95 in the number of students receiving audiology services and vision services were because the current figures, unlike those from the prior year, did not include children who only received assessments, (2) the number of children who received respite services increased from 1993-94 to 1994-95 because more State funds became available for respite care, and (3) the increase from 1993-94 to 1994-95 in the number of children who received special instruction services was due to a change in how programs interpreted the definition of this service. Arizona noted that home visits and center-based parent/child groups were a mixture of direct child instruction and parent training/counseling and that the decision on how to report them is often arbitrary.

Arkansas -- The State indicated that the increase from 1993-94 to 1994-95 in the number of children who received assistive technology services/devices was due to developmental toys being added as an eligible service under this category.

California -- The State reported that the increase from 1993-94 to 1994-95 in the number of students who received health services was a result of a previously unserved population becoming eligible for Part H services when California implemented Part H in October of 1993. Because this population included children with speech delays, there was a concomitant increase in audiology services. California thought that the increase from 1993-94 to 1994-95 in the number of children who received health services was due to an increase in funding for these services.

Colorado -- The State indicated that the discrepancies between the 1993-94 and 1994-95 data were due to a change in reporting methodology. The 1994-95 data represented the compilation of data collected through a State-level data collection system plus data submitted by local interagency councils. Colorado further noted that its State-level data collection was significantly modified in 1994-95 by its new contractors, the University Affiliated Program at the University of Colorado Health Sciences Center. The State thought the current data were more accurate because of improvements in reporting, including the inclusion of local count figures.

Connecticut -- The State indicated that the increase from 1993-94 to 1994-95 in the number of infants who received assistive technology services/devices was because the prior year figures consisted of two months of data (October 1993

through December 1, 1993) whereas the current year's figures consist of a full year of data.

Delaware -- The State indicated that the decrease from 1993-94 to 1994-95 in the number of children who received other early intervention services was a result of the State doing a better job identifying specific services. The other early intervention services category has primarily been used by providers who find it difficult to identify specific services.

Florida -- The State indicated that there have not been any significant changes in service policy except for a shift to more therapeutic services from training, counseling, and other early intervention services. Florida thought this change in emphasis would explain the decrease from 1993-94 to 1994-95 in family training, counseling, home visits and other support services, social work services, and other early intervention services. The increase from 1993-94 to 1994-95 in health services, occupational therapy, physical therapy, and speech pathology were likely due to increased accuracy in data reporting, the fuller implementation of programs, and to a change in service emphasis.

Georgia -- The State indicated that the decrease from 1993-94 to 1994-95 in the number of children who received family training, nutrition, and psychology services were due to the availability of other resources, the erroneous inclusion of service coordination in prior year data, and clearer definitions and policies. Georgia said that the increase from 1993-94 to 1994-95 in respite services was due to efforts to encourage local programs to offer this service to families because State funds were available.

Idaho -- The State indicated that the increase from 1993-94 to 1994-95 in the number of children who received psychological services was a result of improvements in reporting and to increases in service delivery. One change that contributed to the increase was that providers started reporting psychological evaluations in this category, which they had not done before. Idaho indicated that the increase from 1993-94 to 1994-95 in other early intervention services was a result of the State's decision to report service coordination as a service in this category.

Indiana -- The State indicated that the decrease from 1993-94 to 1994-95 in the number of children who received health services was due to a clarification of definitions; the prior year data included services that should have been reported separately from health services. Indiana attributed the increase from 1993-94 to 1994-95 in social work services to the State's decision to report service coordination under social work services.

Michigan -- The State indicated that the increase from 1993-94 to 1994-95 in the number of children who received other early intervention services was due to the following: (1) the increased use of play groups as a means of serving a large number

of children while at the same time teaching parenting skills to parents and (2) an increase in the amount of assistance provided to parents.

Missouri -- The State indicated that the increase from 1993-94 to 1994-95 in the number of children who received family services and in the number of children who received medical services was due to better reporting and to the fuller implementation of the Part H program.

New Jersey -- The State indicated that the decrease from 1993-94 to 1994-95 in the number of children who received assistive technology services/devices was due to improved reporting. New Jersey provided vendors with clarifications of reporting requirements, definitions, and practices.

New Mexico -- The State indicated that the increase from 1993-94 to 1994-95 in respite care services was due to an increase in funding and that the decrease from 1993-94 to 1994-95 in other early intervention services was due to the elimination of the category and the reclassification of children into specific categories.

New York -- The State thought that the increase from 1993-94 to 1994-95 in number of children who received occupational therapy, physical therapy, speech language pathology, special instruction, and transportation was a result of the 66 percent increase in the number of children served between 1993 (5,699) and 1994 (9,461). New York thought that the increase from 1993-94 to 1994-95 in family therapy and counseling was primarily due to a tripling in the number of children served in New York City (from 765 in 1993 to 3,037 in 1994) where family counseling is a frequently authorized service. The State further thought that some of the fluctuation in the counts may be due to changes in the way the data were collected. In 1993, most of the data reported by municipalities were collected through a head count of the children served. By December 1, 1994, most of the municipalities used New York's automated data system (KIDS) to report their data. New York suspects that the data collected through KIDS were more accurate because the data in KIDS are also used for billing purposes.

Oregon -- The State indicated that the decrease from 1993-94 to 1994-95 in the number of children who received assistive technology services and the increase from 1993-94 to 1994-95 in the number of children who received vision services was due to improvements in reporting.

Puerto Rico -- Puerto Rico attributed the decrease from 1993-94 to 1994-95 in the number of children receiving health, medical, and nursing services to a lack of sufficient personnel to provide these services.

Tennessee -- The State indicated that the decrease from 1993-94 to 1994-95 in the number of children who received vision services was due to more accurate counting of service data.

Texas -- The State provided the following explanations for data changes between 1993-94 to 1994-95: (1) the number of children who received audiology services decreased because audiological screenings are no longer included in this count, (2) the number of students who received respite care services increased because local communities were able to develop and provide access to more respite services, (3) the number of children who received vision services increased because of increased efforts of the Texas Education Agency to find and service children with visual impairments, and (4) the number of children who received other early intervention services probably increased because of better reporting in this category.

Utah -- The State provided the following explanations concerning changes in the data from 1993-94 to 1994-95: (1) family training, counseling, home visits, and other support services increased because of a statewide effort to increase these services, (2) nursing services increased as a result of efforts made to increase ongoing health assessments, encourage families to get their children immunized, and promote additional nursing visits so families can complete hearing and vision screening, (3) physical therapy services and speech language pathology services increased because of greater availability of qualified professionals, and (4) transportation services increased because of efforts by the State to make early intervention services more accessible to families.

Washington -- The State indicated that the increase from 1993-94 to 1994-95 in the number of students who received assistive technology services/devices was a result of full implementation, which created a funding source for these services.

West Virginia -- The State indicated that the increases in the number of children who received services was a result of a growth in the child count and of efforts by the State to expand service delivery.

Table AH3: Part H Personnel Employed and Needed

Alaska -- The State indicated that the increase from 1993-94 to 1994-95 in the number of personnel employed was due to better reporting. In the past, personnel data were estimated from the number of children who received services, whereas the current figures are based on actual counts.

Arizona -- The State indicated that the increase from 1993-94 to 1994-95 in the number of other professional staff employed was because programs hired more coordinators, supervisors, and specialty personnel such as music therapists and massage therapists.

Arkansas -- The State indicated that the increase from 1993-94 to 1994-95 in the number of personnel employed was in response to the large increase in the number of infants and toddlers served. Arkansas noted that its voucher program contributed to the increase from 1993-94 to 1994-95 in the number of paraprofessionals.

Connecticut -- The State indicated that the increase from 1993-94 to 1994-95 in the number of other professional staff employed was a result of a need for more service coordinators. Connecticut noted that the overall increase in the number of personnel employed was a result of the increase from 1993-94 to 1994-95 in the number of children and families served.

Delaware -- The State indicated that the increase from 1993-94 to 1994-95 in the number of nurses employed was a result of the nursing staff from the Division of Mental Retardation Early Intervention Program joining the Part H team. Delaware noted that additional nurses were also hired. The State indicated that the increase from 1993-94 to 1994-95 in the total number of early intervention personnel was in response to the need to provide more services to Part H eligible children.

Georgia -- The State indicated that the decrease from 1993-94 to 1994-95 in the number of personnel employed and needed was due to a better understanding by field offices on how to properly calculate FTEs.

Hawaii -- The State indicated that the increase from 1993-94 to 1994-95 in the number of nurses employed was due to more accurate reporting and that the increase from 1993-94 to 1994-95 in the number of paraprofessionals was a result of an increase in the amount of services provided.

Idaho -- The State indicated that the decrease from 1993-94 to 1994-95 in the number of paraprofessionals needed was a result of the State's success in training and employing paraprofessionals.

Illinois -- The State indicated that the increase from 1993-94 to 1994-95 in the number of personnel employed was due to an increase in the number of children served and to improvements in reporting.

Indiana -- The State indicated that the increase from 1993-94 to 1994-95 in personnel employed was a result of its move to an open system. Child Find was expanded to include children who were outside the public system and were in need of services. More staff were needed to assess the needs of these children and provide them services.

Kansas -- The State indicated that the increase from 1993-94 to 1994-95 in the total number of staff employed was a result of the increase from 1993-94 to 1994-95 in the number of children who received services.

Kentucky -- The State attributed the increase from 1993-94 to 1994-95 in the number of physical therapists, special educators, and total staff employed to a change in the reporting process that resulted in improvements in reporting. Kentucky noted that it could now collect information on all qualified providers whereas it previously had no means of counting infants served by outside providers.

Louisiana -- The State indicated that the decrease from 1993-94 to 1994-95 in the number of paraprofessionals and the increase from 1993-94 to 1994-95 in the number of special educators was a result of its efforts to increase the quality of services to infants and toddlers by increasing the standards for personnel. Louisiana expects the number of paraprofessionals employed to continue to decrease.

Massachusetts -- The State indicated that the increase from 1993-94 to 1994-95 in the total number of staff employed was due to an increase in the number of families served.

Michigan -- The State indicated that the increase from 1993-94 to 1994-95 in the number of other professional staff employed was probably due to an increase in the identification of staff who were doing service coordination. Michigan correlated the increase from 1993-94 to 1994-95 in the total number of staff employed to the increase from 1993-94 to 1994-95 in the number of children served.

Minnesota -- The State indicated that the increase from 1993-94 to 1994-95 in the number of physical therapists employed was due to the availability of more accurate data. Minnesota noted that prior data were estimates and that beginning in 1995-96 actual counts will be available.

New Mexico -- The State indicated that the changes in personnel were due to their decision to report staff classified in the early childhood credential category under other professional staff rather than under special educators.

New York -- The State thought that the increase from 1993-94 to 1994-95 in the number of staff needed was probably due to the maturation of its data collection system. New York indicated that since March 1994 personnel data have been collected through the application process for early intervention providers. The State thought that more complete and accurate data were available in 1994-95 than in 1993-94.

Ohio -- The State indicated that the current figures reflect only those personnel providing services to children with IFSPs whereas the prior year data included all personnel who provided services to children ages birth through 3.

Pennsylvania -- The State indicated that the increase from 1993-94 to 1994-95 in the number of other professional staff employed was due to a clarification of the definition of the position. Pennsylvania noted that the data changes were a reflection of the continual evolution of early intervention services to establish the most efficient delivery system for these services.

South Dakota -- The State indicated that the decrease from 1993-94 to 1994-95 in the total number of staff employed was a result of better reporting. South Dakota suspects that the prior year data were more a count of the number of personnel rather than a count of full-time equivalency.

Virginia -- The State indicated that the following three factors contributed to the increase from 1993-94 to 1994-95 in the number of personnel employed: (1) there has been an increase in the number of children served, (2) there have been improvements in the ability of the State to accurately report personnel working for a variety of agencies, and (3) the State has clarified the instructions sent to local entities, which has resulted in a decrease from 1993-94 to 1994-95 in the number of personnel reported in the other category.

West Virginia -- The State indicated that the increase from 1993-94 to 1994-95 in the number of personnel employed was in response to increases in service delivery.

Table AH4: Part H Settings

Alabama -- The State indicated that the increase from 1993-94 to 1994-95 in outpatient facility placements occurred because one of the major providers, Children Rehabilitation Services, became more fully involved in providing and reporting services. The Children Rehabilitation Services provide a large proportion of their services in outpatient facilities.

Arizona -- The State indicated that the increase from 1993-94 to 1994-95 in home placements and the decrease from 1993-94 to 1994-95 in early intervention classroom/center placements was a result of the State's efforts to provide more home-based services. Arizona said that the increase from 1993-94 to 1994-95 in the number of infants and toddlers served in other settings was a result of the State's efforts to provide families with more options for service delivery.

Arkansas -- The State indicated that the increase from 1993-94 to 1994-95 in outpatient facility placements was due to an increase in the number of providers and to a growth in the eligible population.

Colorado -- The State indicated that the discrepancies between the 1993-94 and 1994-95 data were due to a change in reporting methodology. The 1994-95 data represented the compilation of data collected through a State-level data collection system plus data submitted by local interagency councils. Colorado further noted that its State-level data collection had been significantly modified in 1994-95 by its new contractors, the University Affiliated Program at the University of Colorado Health Sciences Center. The State thought the discrepancies could be attributed to an improvement in reporting methodology and to the introduction of local count figures.

Connecticut -- The State indicated that the increase from 1993-94 to 1994-95 in settings was due to the fact that the prior year data consisted of 2 months' data (October 1993 through December 1, 1993) whereas the current year's figures represents a full year.

Delaware -- The State indicated that the increase from 1993-94 to 1994-95 in early intervention classroom/center settings was a result of the State's contracting with more providers that offered center-based early intervention services.

Georgia -- The State indicated that the increase from 1993-94 to 1994-95 in outpatient service facility settings was due to an overall increase in the number of children who were served.

Illinois -- The State indicated that the increase from 1993-94 to 1994-95 in the number of children served in early intervention classroom/centers and home placements was due to an increase in the number of children served. The increase from 1993-94 to 1994-95 in other settings placements and the decrease from 1993-94 to 1994-95 in residential placements was due to a change in reporting at one facility that serves young infants who were awaiting placement in foster care.

Indiana -- The State noted that the decrease from 1993-94 to 1994-95 in family child care placements was due to a change in the service needs of the population. Indiana indicated that the increase from 1993-94 to 1994-95 in outpatient service facility placements was a result of the State's emphasis on providing more therapy services in community clinics.

Louisiana -- The State indicated that the increase from 1993-94 to 1994-95 in outpatient services facility placements was a result of the increased availability of services in this setting.

Michigan -- The State indicated that the increase from 1993-94 to 1994-95 in home settings was a result of the increase from 1993-94 to 1994-95 in the number of children being served. The State indicated that the increase from 1993-94 to 1994-95 in the other settings category was due to one special education center that reported all of its data under other settings rather than splitting the figures between home and centers settings. The center regularly provides 1 hour of center-based services and 1 hour of home visit each week.

Minnesota -- The State indicated that settings data by age year data were not currently available but would be collected starting in 1995-96.

Missouri -- The State indicated that the increase from 1993-94 to 1994-95 in other settings were due to a greater emphasis on serving children in more natural settings and to improvements in reporting.

New Jersey -- The State indicated that the increase from 1993-94 to 1994-95 in other setting placements was a result of a move toward serving children in more natural settings. New Jersey indicated that the increase from 1993-94 to 1994-95 in outpatient service facility placements was a result of more accurate reporting.

New York -- The State indicated that the increase from 1993-94 to 1994-95 in early intervention classroom placements, home placements, and total placements was a result of the 66 percent increase in the total number of children served between 1993-94 and 1994-95. New York suspects that the decrease from 1993-94 to 1994-95 in family child care settings may be due to problems with the 1993-94 head count. The State indicated that the decrease from 1993-94 to 1994-95 in other settings was a result of its efforts to better define and specify actual service settings.

Rhode Island -- The State indicated that the decrease from 1993-94 to 1994-95 in outpatient service facility placements was due to an increase in the number of qualified professional early intervention staff hired to provide direct services. Rhode Island indicated that the decrease from 1993-94 to 1994-95 in early intervention classroom/center placements was due to the aging out of many of the children who had received services in these settings.

Texas -- The State indicated that regular nursery school/child care placements increased because of increased efforts by the State to provide more services in natural environments.

Virginia -- The State indicated that the increase from 1993-94 to 1994-95 in outpatient service facility placements was due the efforts of local councils to increase the number of outpatient service facilities that participate in the Part H program.

Washington -- The State indicated that the increase from 1993-94 to 1994-95 in early intervention classroom/center placements was due to the following factors: (1) greater outreach to public schools that primarily serve children in early intervention classrooms, (2) better reporting by providers, (3) the full implementation of Part H in Washington created a funding source for programs, and (4) public schools, in response to the full implementation of Part H, started providing more complete data to the Part H lead agency.

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